A Mixed-Methods Approach to Refining Self-Compassion Programming for Youth: Community-Based Participatory Research in Knowledge Translation

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Abstract

This dissertation addresses the onset of mental illness (i.e., depression, anxiety, behavioural disorders) and mental health (i.e., well-being, values) among youth (ages 14–21). Self-compassion (SC) programming may be a tool to help youth traverse this period of rapid personal and social growth with greater ease. However, there is only emerging evidence for the benefits of SC programming for youth in clinical and community settings, especially those living in small cities. Integrated knowledge translation (IKT) helps reduce the gap between research and practice uptake by engaging all those connected to the intervention in the research process, which can be particularly beneficial in rapidly changing youth culture. Collaborating with youth in program evaluation in mental health systems is often referred to as youth engagement (YE). However, the process of engaging youth, especially those living with mental health challenges, in research in program design and delivery is in its infancy. Community-based participatory research (CBPR) is an empowerment approach for working with communities and supports collaboration at all stages of the research process. Though rarely used in clinical program design and delivery, this project sought to use a CBPR lens to engage youth in SC intervention program evaluation and modification and then evaluate the outcomes of the modified program. Using a concurrent transformative mixed-methods research process, Manuscript 1 aimed to understand the experiences of youth living with mental health challenges ($N = 5$) in a SC intervention via a CBPR process for IKT. The qualitative data were analyzed via inductive thematic analysis. The group themes suggest that the youth learned about themselves and their relationship with others. The measures indicate some clinically relevant benefits. This study's findings add to the literature by understanding youth experiences from participation in a SC intervention and add information regarding CBPR in clinical practice. The recommend intervention modifications that

derived from the CBPR process were then delivered in a school setting. Using a 2 × 2 crossover design ($N = 29$), Manuscript 2 presents the SC modified program as a pilot project in a Grade 9 classroom in a small city centre. Data analyzed via analyses of covariance and nonparametric tests indicate no statistically significant results. However, floor and ceiling effects may have affected measurable change. In this relatively healthy group, the potential benefits of the SC in prevention programming emerged. The overall dissertation discussion focuses on the role of SC in youth prevention and intervention programming, the use of CBPR processes in IKT, limitations, future directions, and implications for practice and theory.

Résumé

Cette thèse traite de l'apparition de la maladie mentale (c.-à-d. la dépression, l'anxiété, les troubles du comportement) et de la santé mentale (c.-à-d. le bien-être, les valeurs) chez les jeunes (14-21 ans). Les programmes impliquant l'autocompassion peuvent être un outil pour aider les jeunes à traverser plus facilement cette période de croissance personnelle et sociale rapide. Cependant, les données probantes concernant les avantages des programmes impliquant l'autocompassion pour les jeunes en milieux clinique et communautaire, en particulier pour les jeunes vivant dans de petites villes, ne sont encore qu'émergentes. L'application des connaissances intégrée (ACi) permet de réduire l'écart entre la recherche et la mise en pratique en impliquant dans le processus de recherche toutes les personnes liées à l'intervention, ce qui peut être particulièrement utile dans le cas d'une culture qui évolue rapidement, comme c'est le cas chez les jeunes. Au sein des systèmes de santé mentale, la collaboration avec les jeunes pour l'évaluation des programmes est souvent appelée « engagement des jeunes ». Cependant, le processus d'engagement des jeunes, en particulier ceux qui vivent avec des problèmes de santé mentale, dans la recherche sur la conception et la prestation de programmes en est à ses débuts. La recherche participative communautaire est une approche pour travailler avec les communautés; celle-ci implique une reprise du pouvoir pour les participants et soutient la collaboration à toutes les étapes du processus de recherche. Bien que cette approche soit rarement utilisée dans la conception et la mise en œuvre de programmes cliniques, ce projet visait à utiliser la recherche participative communautaire en impliquant les jeunes dans l'évaluation et la modification d'un programme d'intervention impliquant l'autocompassion, puis pour évaluer les résultats du programme modifié. À l'aide d'un processus de recherche transformative à méthodes mixtes simultanées, le manuscrit 1 visait à comprendre les expériences de jeunes vivant avec des problèmes de santé mentale (N = 5) dans une intervention impliquant l'autocompassion par le biais d'un processus de recherche participative communautaire pour l'ACi. L'analyse thématique inductive a été utilisée pour l'analyse des données qualitatives. Les thèmes suggèrent que les jeunes ont appris sur eux-mêmes et sur leurs relations avec les autres. Les mesures indiquent certains avantages cliniquement pertinents. Les résultats de cette étude s'ajoutent à la littérature existante en présentant les expériences des jeunes qui participent à une intervention impliquant l'autocompassion et offrent des connaissances concernant la recherche participative communautaire dans la pratique clinique. L'intervention basée sur les modifications recommandées lors du processus de recherche

participative communautaire a ensuite été offerte en milieu scolaire. À l'aide d'un plan croisé 2 × 2 (N = 29), le manuscrit 2 présente le programme modifié d'intervention impliquant l'autocompassion en tant que projet pilote dans une classe de 9e année d'un centre urbain de petite taille. Les données analysées à l'aide d'analyses de covariance et de tests non paramétriques n'indiquent aucun résultat statistiquement significatif. Cependant, les effets plancher et plafond peuvent avoir affecté les changements mesurables. Dans ce groupe relativement sain, les avantages potentiels d'une intervention impliquant l'autocompassion dans les programmes de prévention sont apparus. La discussion générale de la thèse se concentre sur le rôle de l'autocompassion dans la programmation de la prévention et de l'intervention auprès des jeunes, l'utilisation des processus liés à la recherche participative communautaire dans l'ACi, les limites, les orientations futures et les implications pour la théorie et la pratique.

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Contribution to Original Knowledge

I, Alisha Henson, declare that the current dissertation represents original scholarship. My goal is to make a distinct contribution to knowledge in the field of psychology and interdisciplinary studies regarding youth mental health. This dissertation represents an original investigation and has not been submitted for the purpose of any other academic degree. I prepared this dissertation under the supervision of Dr. Ada Sinacore, as well as the members of my dissertation committee: Dr. Bassam Khoury, Dr. Lynette Monteiro, and Dr. Purnima Sundar. Dr. Jessica Ruglis and Dr. Marilyn Fitzpatrick were also instrumental in formulating and executing this dissertation. Additionally, engaged youth collaborators, youth participants, gatekeepers, and practitioners played an integral role in the research process from its inception.

Contribution of Authors

I was the first author on the manuscripts in this dissertation, which were coauthored by my supervisors, Dr. Ada Sinacore, Dr. Jessica Ruglis, and Dr. Marilyn Fitzpatrick, and my colleagues, Dr. Dianna Lanteigne and Abby Doner, BSW. This research project originated from my experience as a youth engagement facilitator working within the Ontario children's mental health system. I generated the research concepts and research questions based on my learning, knowledge, and collaboration with youth, practitioners, and academics in the field of mental health. I was also the key originator of the methodology and delivery of the research processes.

For Manuscript 1, I facilitated all preliminary discussions with the community to develop the research project. Dr. Fitzpatrick and Dr. Ruglis were influential in the research development and delivery phases. I contacted Christopher Germer, who agreed to use the Mindful-Based Self-Compassion program in my research project. I then met with Dr. Lynette Monteiro, a self-compassion practitioner, to revise the 8-week program for critical components and determine what aspects of the program the practitioners would deliver in session with the youth. I assembled the practitioners (Dr. Dianna Lanteigne and Abby Doner) who delivered the intervention. I was instrumental in the recruitment process and met with the youth to evaluate the intervention. Volunteer Daniel Parker transcribed the audiotaped interviews into an Excel spreadsheet. Abby Doner and I analyzed all interviews and the participant workbooks and then compared our results. Dr. Sinacore was instrumental in the data analysis process and in supporting the writing of the manuscript.

Manuscript 2 presents the outcomes of community school-based intervention. With the support of the school board mental health lead, Lisa Lariviere, I met with the school board and discussed the project's goals. Once we agreed on the process and ethics, I met with the teacher

and mental health practitioner connected with the specific school to discuss the goals and align the project with the curriculum. I delivered the intervention and collected all the data. I cleaned the data for analysis. Dr. Dianna Lanteigne and I discussed the initial data analysis process. I then hired Dr. Jose Correa to advise me on the data analysis and interpretation process. Dr. Correa also ran the analysis. Dr. Ruglis supported the initial manuscript writing process and submission to the *Journal of Counselling and Psychotherapy Research*. Dr. Ada Sinacore played a crucial role in managing the reviewer's comments and editing the manuscript for publication. The journal's editors then published the article:

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Chapter 1: Introduction

Global estimates indicate that 10% to 20% of young people have experienced mental health challenges (Kessler et al., 2007), and three-quarters of all adult mental illness has an onset before age 24 years (Kessler et al., 2005). This dissertation focuses on youth (ages 14 to 24 years). This developmental period traverses the transition from childhood to adulthood as a critical developmental period to support mental health and potentially thwart lifelong mental illness. Various social and personal factors lead to increased distress (Mikkonen & Raphael, 2010; Raphael, 2011), such as an individual's geographical location and access to mental health services. Youth living with mental health challenges in small communities often face increased stigma (Crumb et al., 2019), which limits their support seeking. However, few studies have researched the effects on mental health of living in a small city in Canada, where mental health resources are limited. Therefore, youth living with mental health challenges in small city centres are the community of interest for this project.

During the transition to adulthood, youth mental illness increases (Kessler et al., 2012), especially for those with social factors that may impede their psychological and emotional development (Boak et al., 2018; Viner et al., 2012). Youth who engage in their communities are more likely to flourish, experience mental well-being, and engage in value-congruent behaviour (Hides et al., 2020; Keyes et al., 2012). At the same time, those who disengage may languish, which increases their risk for mental illness (Keyes, 2006). Mental illness and mental health are not two ends of the same continuum but intertwined spectrums (Hides et al., 2020). For example, young people who struggle with mental health can continue to navigate life (e.g., attend school or participate in extracurricular activities); however, challenges in mental illness can result in deficits in mental health and vice-versa. Therefore, we must help youth learn to navigate and

persevere through the transition to adulthood and all the challenges associated with this developmental period.

Self-compassion (SC) is an approach that may be able to help reduce the onset of mental illness while helping youth learn to participate in life and navigate foreseeable social, emotional, psychological, and developmental challenges (Bluth et al., 2017, 2018; Lathren et al., 2019). Although SC is beneficial for mental health and well-being, social factors may affect the development of SC, especially for young assigned females at birth (AFAB) during the transition to adulthood (Bluth et al., 2017, 2020). However, researchers have found that interventions can be effective in the development of SC for youth and adults (Carona et al., 2017; Craig et al., 2020; Germer & Neff, 2013, 2019). Two emerging evidence-based, SC-focused interventions that support a reduction in mental health symptoms and an increase in well-being derive from Neff and Germer's (2013) Mindful Self-Compassion (MSC) program. Making Friends With Yourself is an MSC adaptation for adolescents created by Karen Bluth and Lorraine Hobbs (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016). However, the developers of Making Friends With Yourself did not include youth in the refinement of the MSC program or get input from youth living with mental health challenges, which might have led to different outcomes. Therefore, understanding youth, especially those living with mental illness, may help refine an SC program for those struggling with mental health or living in small city centres.

To reduce the research-to-practice gap in clinical uptake of an SC program, formerly referred to as knowledge translation (KT; Wathen & MacMillan, 2018), in this project I worked from an empowerment framework and engaged the community in this research process. For this framework, I used youth engagement (YE) in mental health programming principles (Jull et al., 2017; Pereira, 2007). YE in mental health programming is an empowerment approach that

allows young people to advocate for changes in agencies where they seek service (Dunne et al., 2017). Youth engaged in mental health system reform often report a goal of collaborating with agencies on the development of psychotherapeutic interventions; however, the process has yet to be clearly defined (Pereira, 2007). Community-based participatory research (CBPR; Collins et al., 2018) is an approach that may help clarify the role of YE in intervention research. CBPR is an empowerment approach for working with communities to define research questions and areas of need (Israel et al., 2013). Through a CBPR process, the engagement of youth in SC intervention modification emerged as a research topic. Therefore, this research project sought to engage youth living with mental health challenges in SC program modification and application. The second phase of the project was to examine outcomes from youth participation in the modified program in a small city centre school.

As noted above, there is a lack of evidence in understanding the potential benefits of SC programming for youth living with mental health challenges in small city centres, from program evaluation to future intervention implementation. SC has the potential to help youth increase their mental health and decrease symptoms of mental illness. Without intervention, many young people will continue to struggle through the transition to adulthood, with potential for lifelong personal and societal implications. The main objective of the current project was to explore the potential benefits of SC for youth living with mental health challenges in a small city centre and add to the literature of emerging SC interventions for this population. KT via YE and CBPR was used to enrich and expedite this process for youth living with mental illness in a small city adjacent to rural communities. Chapter 2 of the dissertation reviews the current literature regarding SC and the benefits of SC intervention for reducing the onset of mental illness and the cultivation of mental health, while highlighting the gap in the literature for the application of SC

for youth living in a small city centre. This review introduces the importance of KT in the refinement of SC for community-based programming and using the frameworks provided by YE to work with youth and developing appropriate interventions for this population.

Chapter 3 presents an overview of CBPR principles and the method of the overall study. Chapter 4 presents Manuscript 1, "An Exploration and Evaluation of a Self-Compassion Program With Youth Living With Mental Health Challenges: A Community-Based Participatory Research Approach." This manuscript focuses on the results of a mixed-methods study of the experiences of youth living with mental health challenges in a small city centre in an emerging evidence-based SC intervention and their ongoing evaluation and modification of the program for their community. Chapter 5 presents Manuscript 2, "Self-Compassion for Youth in Small City Centres: A School-Based Pilot Project." This manuscript details the application of the CBPR-modified SC program in the small city for AFAB youth during their transition to high school. Finally, Chapter 6 presents an general discussion of the learning outcome of the study and application of this research to both theory and practice.

Chapter 2: Comprehensive Literature Review

This chapter reviews existing literature on associated concepts and current scholarship pertinent to this study. The review begins by setting the context of youth mental illness as an epidemic and factors that contribute to mental health development. The review explores SC in promoting mental health and reducing mental illness in community settings and the emerging evidence of SC interventions. Next, there is a review of the available literature on the importance of (KT in adolescent mental health practices. There is an emphasis on the challenges with evidence-based practice for psychotherapeutic and community interventions and the importance of practice-based evidence, knowledge uptake, and systems communications when working with youth. The review highlights the importance of integrated knowledge translation (IKT) as a best practice for youth mental health. YE is introduced as a practice to advocate for youth empowerment in the systems in which they participate (i.e., mental health centres, schools). Adding youth voices to the emerging evidence on SC interventions has the potential to increase programs' suitability for youth while increasing equity by empowering youth as collaborators in intervention modifications. The chapter concludes by offering a rationale for the study approach and research questions.

Youth Mental Illness and Mental Health

Defining Adolescence and Youth

Adolescence is the gradual process of development from childhood to adulthood, defined by cognitive and neurobiological changes, physical maturation and puberty, increased risk-taking behaviour and social goals, and an increase in values development outside the family (Casey et al., 2008; Yurgelun-Todd, 2007). In North America, current factors affecting adult status attainment include staying in school longer, extended living with caregivers, and challenges to

acquiring long-term occupations (Lawrence et al., 2015). These social transitions, coupled with emerging neurological research, suggest that adolescence includes individuals ranging from 10 to 25 years (Sawyer et al., 2018). This paper uses the term *youth* to represent the transitional age group between adolescence and adulthood (ages 14 to 24 years) as a distinct developmental period that captures physiological, social, physical, and neurological changes and the cultural aspects that distinctly affect this age group (United Nations, 1981) and are often represented in theories of youth development.

In his psychosocial developmental theory, Erikson (1968) proposed that adolescence primarily focuses on developing a healthy identity to acquire a clear sense of self and self in relation to others. A successful progression toward identity development is linked to greater well-being and a reduced onset of mental illness while moving toward the potential for healthy intimate relationships in young adulthood (Vleioras & Bosma, 2005; Wiley & Berman, 2013). Additionally, Bronfenbrenner's (1977) social ecology model highlights that social factors outside a young person's characteristics (Bronfenbrenner & Morris, 1998; 2006; Ungar et al., 2013) can significantly affect the development of mental illness or experience of well-being. Therefore, both individuals and the context in which they develop must be considered to understand how young people navigate this crucial developmental period. In this study, I explored youth mental wellness via two axes. One focused on *mental illness* (i.e., stress, anxiety, depression, conduct disorder) and the other on *mental health* (i.e., psychological or social well-being, satisfaction with life, and values). It is essential to understand that mental health and mental illness are not extremes of the same continuum but two interconnected axes (Keyes, 2002, 2005); both of them are instrumental to a healthy transition to adulthood (Hides et al., 2020; Keyes, 2006). The terms

"mental health challenges" and "mental illness" are used interchangeably in this paper and do not indicate a clinical diagnosis.

Youth Mental Illness

The American Psychiatric Association (2020, para. 1) defines mental illness as "health conditions involving changes in emotion, thinking or behaviour (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work [school] or family activities." Global epidemiological reports indicate that 10% to 20% of children and youth are affected by mental illness (Kieling et al., 2011), and suicide is the fourth leading cause of death for 15- to 19-year-olds (World Health Organization, 2021). In youth populations, the increase in depression, anxiety, behavioural disorders (e.g., hyperactivity and oppositional disorders), and substance use has affected development (Kessler et al., 2012; Lawrence et al., 2015; Mental Health Commission of Canada, 2017). Ongoing global and environmental distress, the crucial spotlight on social inequalities, and mounting mental health issues due to the COVID-19 pandemic have exacerbated underlying challenges. The goal is to ensure that youth have the skills to manage their distress and social factors that affect them today, in the hope of a better future.

Youth in Context

In Canada, 68.8% of adults with diagnosed mental illnesses report an onset during their adolescence (Government of Canada, 2006); 10% to 20% of Canadian adolescents have a mental illness, and suicide is the second leading cause of death of young people (Mental Health Commission of Canada, 2013). In Ontario, where this research project originated, longitudinal analysis from 1991 to 2017 indicated that 19% of students rate their mental health from fair to poor (up 11%–13% from 2007), and 39% of students report experiencing moderate to severe

anxiety or depression (Boak et al., 2018). These numbers do not account for the most at-risk youth and those who did not achieve a diploma (Uppal, 2017), but they highlight the prevalence of mental health distress. Georgiades et al. (2019) reported that although 21.84% of youth met the criteria for a mental health disorder, only 43.71 % of these young people sought community support (20.01% in a mental health clinic, 29.92% at school). Personal, social, and environmental factors play a role in the onset of mental distress.

Ecological context is crucial for understanding the individual's experience. Canadian youth in small to medium city centres report more significant mental health concerns (32.64%) than their urban (19.11%) or rural (23.02 %) counterparts, and youth rate their own mental health challenges as more significant than their parents rate the youth's mental health challenges (21.8% vs. 18.2%; Georgiades et al., 2019). These numbers highlight the need to understand youth mental illness in small to medium Canadian city centres and the importance of including youth perspectives. In Canada, researchers often focus on rural and urban centres without thinking specifically about small city centres, where resources are often limited and social conditions vary. Understanding the experiences of these youth requires communicating with them directly and attempting to understand their personal and social contexts, as opposed to relying on adult observational accounts.

Social Determinants of Health

The social determinants of health (SDH) are living conditions based on economic and community factors that significantly affect mental illness. In Canada, examples of SDH that affect youth are personal and family income, parental and personal employment status, safe housing, educational attainment, aboriginal status, gender, race, and disability status (Mikkonen & Raphael, 2010). Youth are not able to control the social circumstances into which they are

born; however, the SDH factors have significant implications for the onset of mental illness, leading to long-term personal consequences and economic and social burdens. Young people who struggle with housing, food scarcity, family income, and access to services and disengage from educational settings are at an increased risk of developing a mental illness (Raphael, 2009, 2011), such as depression, anxiety, behavioural disorders, and substance abuse (Carod-Artal, 2017; Elovainio et al., 2015; Harrop & Catalano, 2016; Lemstra et al., 2008). In turn, challenges with mental health affect future SDH (Alegría et al., 2018). Therefore, young people born into challenging situations are more at risk for mental illness and its long-term consequences. Mental illness has been found to influence development in other areas of life, such as physical health, social development, and educational and occupational achievement, and impede a healthy transition to adulthood (Fazel et al., 2014; McGorry et al., 2007; Patel et al., 2007; Viner et al., 2012). It is difficult to change some features related to the onset of mental illness, such as social ecology (i.e., challenging environments), family interactions (e.g., attachment insecurity, childhood trauma); others, such as genetics, are impossible to change. Thus, interventions are necessary. Communities need to help youth develop skills to endure the challenges of adolescence and learn to nurture well-being while clarifying their personal values and goals in the hope of a successful transition to adulthood.

Youth Mental Health

The World Health Organization (2007, p. 1) has defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." This definition highlights that good mental health is not merely the absence of

mental illness but the ability to navigate life stresses and engage in roles outside the home. Factors that contribute to mental health are well-being and prosocial values.

Youth Well-Being

Deci and Ryan (2006, p. 1) defined well-being as "optimal psychological experience and functioning." Well-being has been measured in several ways, such as subjective (Diener & Chan, 2011; Long et al., 2012), social (Keyes, 1998), and psychological (Ryff, 1989, 2013) well-being. *Subjective well-being* is the scientific term for the experience of happiness or satisfaction in life (Diener, 1994; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). This paper uses the term *emotional well-being* (EWB) to convey the personal feeling of satisfaction. Measured by feelings of positive and negative affect, life satisfaction, and subjective happiness, EWB is concerned with feeling good or satisfied with life (Deci & Ryan, 2006; Waterman, 2008). Researchers have noted that high levels of EWB play a role in reduced substance misuse (Zullig et al., 2001), lower levels of mental illness (Arslan, 2021), greater academic success (Bücker et al., 2018), and healthy eating and exercise behaviours (Frisch, 2000). However, the link between subjective well-being and lower levels of mental illness is not always direct. An alternative approach to well-being is measured via psychological well-being.

Presented as a lifespan model, *psychological well-being* (PWB) focuses on how individuals strive to reach their potential (Ryff & Singer, 2008). Ryff (1989, 2013) developed a multidimensional framework based on psychological theories focused on defining wellness qualities beyond subjective evaluations. The PWB framework comprises six dimensions: *personal growth* (i.e., a sense of continued growth and development as a person), *positive relations with others* (i.e., quality relationships with others), *environmental mastery* (i.e., the ability to manage life effectively), *autonomy* (i.e., a sense of self-determination), *purpose of life*

(i.e., the belief that one's life has purpose and meaning) and *acceptance of self* (i.e., knowledge and tolerance of self). A large body of literature has documented the benefits (e.g., better physical health, reduced mental illness, academic success) of PWB for both adolescents and adults (Ruini et al., 2003, 2009; Ruini & Ryff, 2016). In addition to the benefits of personal well-being, Keyes (1998) highlighted the importance of connections to others and society for overall well-being. *Social well-being* (SWB) is an individual's perception of their capacity to function in society and their sense of belonging (Keyes, 1998, 2006). The components of SWB proposed by Keyes are *social acceptance* (i.e., having positive, trusting opinions of other people*), social integration* (i.e., sharing interests and feeling connected to society), *social contribution* (i.e., feeling that one is a vital and contributing member of society), *social coherence* (i.e., feeling that one cares and understands the world around them), and *social actualization* (i.e., feeling that institutions and citizens focus on the potential of society). Together the benefits of EWB, PWB and SWB have been explored.

Keyes et al. (2002, p. 208) proposed that mental health is a pattern of symptoms of both positive feelings and positive functioning in life. Adults and youth who are truly thriving in life have aspects of all three types of well-being (EWB, PWB, and SWB; Keyes, 2005, 2006). Individuals who are flourishing are less likely to experience depression, anxiety, and suicidal ideation or engage in risky behaviours (e.g., smoking, skipping school, substance use); they have better relationships to self and others than their moderate and languishing (low-well-being) counterparts (Hides et al., 2020; Keyes et al., 2012). Overall, nourishing well-being in young people helps youth engage in rich and meaningful lives for themselves, their families, and their communities. Cultivating youth well-being is a systemic challenge. An alternate approach to well-being is in values clarity and values-congruent living.

Youth Values

Researchers have conceptualized values in diverse ways in human behaviour (Inglehart & Baker, 2000). Values are everyday personal, social, and cultural norms that shape civilizations (Harrison & Huntington, 2000). Researchers study values in various contexts, but this review focuses on personal values that motivate behaviour and stimulate mental health in youth. Schwartz (1992) argued that personal values help guide behaviour, justify actions, and aid in evaluating the world. Knafo and Schwartz (2001) described a cross-cultural lifespan theory of personal values that has been validated in over 60 countries. Schwartz (2012) tested youth values in 30 different countries (ages 15 to 21 years) and found that youth aged 15–17 years were more concerned with self-enhancement values (e.g., self-direction, hedonism, achievement) than prosocial values (e.g., benevolence, universalism). The focus on self-enhancement values during adolescence may reflect a movement away from primary caregivers and the emergence of independence. However, as youth in Schwartz's study transitioned to young adulthood (18–21 years), they showed a greater inclination toward prosocial values, which is crucial for mental health. Young people who are clear about their values have the potential to engage in goal setting, decision-making, and behaviours that correspond with their values (Alsaker & Kroger, 2006) and the capacity to make healthier life choices. Therefore, exploration and actions toward values are imperative to identity development and goal-directed behaviours.

Values guide life choices; goals are personal aims and aspirations (Grouzet et al., 2005), often in service of those values. The difference between values and goals is that people constantly move toward their values, but they are never fully achieved; however, goals can be achieved daily via actions (Hayes et al., 1999, 2006). Intrinsic values and goals (e.g., focused on self-acceptance, affiliation, and community) are more prosocial and beneficial for the self and

the community. Researchers have linked intrinsically motivated values and goals to high self-esteem and lower incidents of antisocial behaviour (e.g., school and police delinquency), risky sexual choices, drug use, depression, and anxiety (Kasser, 2011; Lönnqvist et al., 2009; Maio et al., 2009; van Tuijl et al., 2014). Conversely, researchers report that extrinsic values (e.g., focused on financial success, social recognition, and appearance) and goals are primarily defensive and less satisfying to pursue, which leads to lower levels of mental health (Kasser, 2014; Kasser et al., 2014). Additionally, engaging goals in service of values increases well-being (Kasser, 2014). Therefore, values and goals that are intrinsically motivated are more advantageous for youth development, and there is a potential to nurture prosocial values through healthy community participation (e.g., engagement in community programs). These values may be crucial for mental health and thwarting mental illness in youth.

Summary

The transition from adolescence to adulthood is difficult due to peer, academic, emotional, cognitive, and physiological development; however, these systemic social factors beyond the individual's control may exacerbate mental health symptoms and impact mental health. Interventions are critical in helping youth transverse this developmental period with greater ease. Although changing SDH is a complicated and essential task, youth must be engaged in interventions to reduce mental illness. Furthermore, mental health is not merely the absence of mental illness. Society should help youth cultivate positive feelings and positive engagement in personal and social developmental tasks. Nourishing well-being and values may arm young people with resources to become more resilient to rapidly changing personal and social contexts. Finally, there is a gap in the literature that addresses mental illness and health by engaging youth voices, specifically in small city centres. Engaging youth in research from these centres would

potentially enrich the outcomes. SC is one potential program that may help youth traverse this difficult developmental period by assisting young people in navigating inevitable life challenges.

Self-Compassion

Taught through interactions with primary caregivers (Gilbert, 2005, 2009), compassion is the ability to acknowledge and attune to another's struggles and then actively try to alleviate their pain (Pepping et al., 2015). However, people cannot engage in compassion for others if they are unable to be compassionate toward themselves (Germer, 2009). SC is the ability to recognize personal distress and then try to actively reduce discomfort (Baer et al., 2012; Neff, 2003a). Therefore, compassion for self and others are intertwined constructs; the cultivation of one affects the other (Khoury, 2019), and both are at the root of healing and well-being (Makransky et al., 2012). Gilbert (2005, p. 1) argued that compassion involves being open in a nondefensive and nonjudgmental way to the suffering of self and others, which includes the desire to relieve suffering, an awareness of the cognitions related to the cause of suffering, and engagement in compassionate prosocial behaviours to reduce suffering. Moreover, Neff (2003b) posited that SC is the internally motivated capacity to accept negative thoughts, emotions, and sensations and actively engage in empathy toward the self when challenged. These definitions help clarify the importance of compassion for self and others in the healing process. Although compassion for self and others is essential to healthy development and a key component in different psychotherapeutic practices, this dissertation focuses on SC exclusively, given the importance of self in youth development.

Over 1,000 articles, dissertations, and books have focused on Neff's conceptualization of SC (McGehee et al., 2017). This dissertation explores SC as operationalized by Neff (2003a) as a construct that may help youth traverse this developmental period by reducing the onset of mental

illness while cultivating mental health. SC contributes to healthy identity development (Hope et al., 2014) through the acceptance of life's emotional pain and understanding that distress is not permanent, that one is not alone, and that one can actively care for oneself (Neff, 2011). This study first explores how Neff operationalized and measured SC for use in Western contexts and defines how SC shares qualities with mindfulness while emphasizing the capacity to face life challenges. Unless otherwise stated, the dissertation solely focuses on research using Neff's SC definition. Finally, the review explores current SC interventions based on Neff's conceptualization while highlighting gaps in intervention practice.

Operationalizing SC

Although SC is rooted in Buddhism, Neff operationalized SC for both research and psychotherapeutic practice (Neff, 2003a, 2003b). Neff's conceptualization of SC was not the first time this concept was delivered in Western psychotherapy, but it is the focus of this dissertation. According to Neff's definition, SC comprises three core components that interact to produce a compassionate mindset. First, Neff operationalized *self-kindness* as the ability to be caring and understanding toward oneself by encouraging dialogue with oneself instead of motivating through *self-judgment*, such as harsh language and insults. Second*, common humanity* recognizes failure and challenges are part of the human condition, that all people have flaws and make mistakes. Common humanity challenges *isolation* and reminds that pain is a natural part of the human condition, thus helping to create a connection with others. Thirdly, *mindfulness* in SC is an awareness of personal pain without rumination or *over-identification* with negative thoughts, emotions, and experiences (Neff, 2003a, 2003b; Neff & Dahm, 2015). Mindfulness has been operationalized by researchers in various contexts.

Mindfulness

Mindfulness has grown exponentially within the field of psychology through practices such as mindfulness-based cognitive therapy (Segal et al., 2002; Teasdale et al., 2000), mindfulness-based stress reduction (Kabat-Zinn, 1982), dialectical behaviour therapy (Linehan, 1993, 2018), acceptance and commitment therapy (Hayes et al., 2006), and mindfulness in schools (Fernando, 2013; Meiklejohn et al., 2012). Mindful-based interventions (MBIs) are mental health interventions that use mindfulness. Differences and similarities exist regarding how researchers have operationalized mindfulness in MBIs. Originating in the East, mindfulness or *sati* (Grossman 2011) has been translated by Western practitioners in various ways. Schmidt (2011) and Monteiro et al. (2014) argued that the definitions and practices acculturated for use in the West have divided mindfulness from the original Buddhist *dharma*.

Mindfulness is one aspect of a Buddhist approach to life, including practices for cultivating wisdom, concentration, and ethical conduct (Smith, 2017). Nurturing various Buddhist principles while ignoring others depends on how Western mental health researchers and practitioners operationalize mindfulness. Using thematic analysis, Nilsson and Kazemi (2016, p. 188) explored the definitions of mindfulness used in Western psychotherapeutic practices. These authors noted five core themes: (a) attention and awareness, (b) present-centredness, (c) external events, (d) cultivation, and (e) ethical mindedness. Though it is critical to analyze the debates between Eastern and Western practices of mindfulness, the suitability of appropriating mindfulness for use in Western psychology, and the importance of understanding the ethical principles related to Buddhism, it is beyond the scope of this paper (see Baer, 2015; Crane et al., 2017; Grossman, 2015). What is important is how practitioners use mindfulness in psychotherapeutic approaches. Current mindful practices often used in the West focus on

attention, monitoring without judgment, and loving-kindness (Germer & Neff, 2019). Loving-kindness meditations are focused on the awareness of suffering and cultivating compassion and kindness toward the self and others during the suffering. Loving-kindness is the root of SC processes.

How researchers and practitioners have defined mindfulness in SC is critical for the current study. "Self-compassion entails mindful awareness of our negative thoughts and emotions so that they are approached with balance and equanimity" (Neff & Dahm, 2015, p. 122). In comparison, Kabat-Zinn (1994; Ludwig & Kabat-Zinn, 2008) defined mindfulness as cultivating present-moment awareness. Mindfulness in SC focuses on the awareness of negative experiences (i.e., thoughts and feelings), not experiences in general, as often used in other MBIs. However, SC is cultivated in other MBIs and is not exclusive to SC interventions (Birnie et al., 2010; Keng et al., 2012; Tirch et al., 2014). Finally, SC is cultivated in relationships and is critical in developing mental health and reducing mental illness.

SC: Mental Illness and Mental Health

Using Neff's (2003) SC definition, researchers have found that SC is beneficial across the lifespan to reduce mental illness, cultivate mental health, and navigate life challenges (Allen & Leary, 2014; Moreira et al., 2015; Wu et al., 2018). Additionally, a considerable body of literature supports the argument that high SC levels are negatively correlated with negative affect (e.g., shame, fear) and positively correlate with well-being (Hall et al., 2013; Hollis-Walker & Colosimo, 2011; Karatzias et al., 2019; Kotera et al., 2021; Lenger et al., 2020; Neff & Costigan, 2014; Neff & Pommier, 2013; Yarnell & Neff, 2013; Zessin et al., 2015). These findings become increasingly pronounced during the transition to adulthood (Bluth et al., 2017; Marsh et al.,

2018) and may be more advantageous than other theories focused on relationships to self, such as self-esteem, which is often a focus in schools and mental health promotion programming.

William James (1890, as cited in Mruk, 2006) first introduced the concept of self-esteem in the late 1890s. Since that time, educators and clinicians have focused on developing self-esteem as an essential variable in youth development. Although a large body of research focuses on the benefits of self-esteem in youth, Germer and Neff (2019) argued that SC is a better predictor of youth mental health. Germer and Neff argued that self-esteem is externally motivated based on one's judgment of personal successes or failures compared to others. In contrast, SC is based on individual goals, focusing on empathy toward oneself and reducing self-criticism. Therefore, although SC and self-esteem benefit healthy development, SC is intrinsically motivated and offsets unhealthy patterns. A large body of evidence highlights the relationship between low self-esteem in youth and struggles with depression, anxiety, and substance use (Sowislo & Orth, 2013; Trzesniewski et al., 2006). In a sizable ninth grade adolescent study (n = 2,448, $M_{(age)}$ = 14.65 years, SD = 0.45), Marshall et al. (2015) found that those who had both low SC and self-esteem experienced a reduction in mental health between Grades 9 and 10. However, the same decrease in mental health was not found in those with low self-esteem but high SC. These results suggest that high SC may mitigate the effect of low self-esteem on mental illness; thus SC is potentially a more valuable target for intervention. For further discussion regarding the benefits of SC over self-esteem, see Germer and Neff (2019). There is emerging evidence highlighting the benefits of SC for helping youth navigate life challenges in a variety of ecological contexts.

SC and SDH

There is a growing but limited body of literature addressing the relationship between SC and a variety of SDH factors (e.g., sexuality, gender expression, racial minority status, socioeconomic status, trauma). The findings paint a complex profile concerning SC and experiences of marginalization and highlight the need to increase SC to help youth navigate difficult social and personal experiences. The relationship between marginalization experiences and SC in student gender identity, sexual orientation, and race remain unclear. In Vigna et al. (2018), high school students were categorized based on gender/sexual identity and racial minority or majority status. The researchers reported differences in experiences of victimization, mental illness, and SC levels. Those students who identified with the minority race category and gender/sexual majority had the highest SC levels. In contrast, students who identified with the majority race and minority gender/sexual identity had the lowest SC and the most significant mental illness concerns. Therefore, those who were White and identified as members of the lesbian, gay, bisexual, transgender, and queer/questioning-plus (LGBTQ+) community reported greater victimization, the lowest SC levels, and the most significant challenges with mental illness. Hence, the impact of structural discrimination experiences varied between different minority groups; SC mediated the relationship between discrimination and mental health concerns. Overall, Vigna et al. (2018) suggested that students who identify as majority race and minority gender identity/sexual orientation are at a higher risk for mental illness and lower SC levels. In contrast, racial minority youth who likely experienced more systemic discrimination developed SC and are persevering (Lenger et al., 2020; Vigna et al., 2020). However, further research is needed to understand how marginalized youth develop SC and manage potential

victimization. Family factors may play an essential role in helping youth managing their experiences of marginalization.

The relationship between SC and socioeconomic status also reveals an interesting pattern of effects on youth well-being and mental health. SC mediates the relationship between financial challenges and emotional regulation difficulties (Sünbül & Güneri, 2019). Bluth et al. (2020) report that adolescents whose fathers had limited education or professional degrees had lower SC levels than those whose fathers had some college experience. These results indicate that socioeconomic status is not the critical factor in developing SC in youth (Bluth et al., 2020) and highlight the previously noted importance of compassion and secure attachments with primary caregivers (Gilbert, 2020; Neff & McGehee, 2010). Although the research between SDH and SC is in its infancy, further analysis may add to the literature regarding the current social, environmental, and political climates and their effect on marginalized youth groups' mental health. For example, in Canada, aboriginal status has been identified as a critical SDH risk indicator. However, beyond addressing race as a variable in research, no studies have directly addressed SC in this population, despite the high levels of mental illness and suicide incidents in Canadian First Nations youth. Further research is needed, but it is beyond the scope of the current study. What will be further addressed in this dissertation is the importance of understanding youth context and experiences. Only one SC study (Bluth et al., 2017) addressed SC in youth in a small city (population 1,000–29,999). However, Bluth et al. (2017) did not explore the experience of marginalization or use urban–rural comparison groups to understand the ecological, social, and personal factors affecting the experiences of this small city centre group.

Beyond the SDH, trauma also plays an important role in the onset of mental health challenges in youth. SC plays a role in circumventing adverse outcomes for challenging childhood experiences. In situations where youth are involved in child protection due to caregiver maltreatment, both depression and suicidal ideation correlate with lower SC levels (Tanaka et al., 2011). However, adolescents who can develop high SC despite trauma (i.e., sexual assault, sibling or peer bullying, witnessing violence) can reduce the impact of these challenges (Jativa & Cerezo, 2014). In inpatient settings, Vettese et al. (2011) found that participants aged 16–24 in a concurrent addiction and mental illness program with low SC were more likely to have experienced childhood maltreatment and struggle with emotional dysregulation, greater addiction severity, and severe mental illness. However, SC mediated the relationship between childhood maltreatment and emotional dysregulation, suggesting that those with higher SC still struggle but can better regulate. These findings indicate that SC has the potential to buffer childhood maltreatment experiences and psychological struggles, even for vulnerable or marginalized youth.

In summary, researchers have begun to address the impacts of social determinants of health, marginalization, and trauma on SC and mental illness. Although primary caregiver relationships play a vital role in SC development, further exploration is needed to understand why some youth are self-compassionate despite life challenges. Additionally, future research must explore SC in youth living in small city centres where the socioeconomic disparities are evident, the experience of marginalization and trauma is often hidden, and mental health services are limited.

SC and Youth Mental Illness

Neff and McGehee (2010) pioneered the study of SC in youth. In a study with 235 adolescents, ages 14 to 17 years ($M_{(age)}$ = 15.20) and 287 young adults ages 19 to 24 years ($M_{(age)}$ = 21.10), Neff and McGehee measured the relationship between SC and a variety of developmental and mental illness factors. They found that AFAB adults had lower SC levels than young assigned males at birth (AMAB); there were no differences based on biological sex in the adolescent groups. After controlling for sex in the young adult group, SC was found to have a significant negative correlation to depression (adolescents, $r = -.60$, $p < .05$; young adults, $r = -.51$, $p < .05$) and anxiety (adolescents, $r = -.73$, $p < .05$; young adults, $r = -.67$, $p < .05$). High SC positively correlated with maternal support, secure attachment styles, less egocentrism, and healthy family functioning. At the same time, low SC related to insecure attachment styles (except for dismissing attachment styles) and family challenges. Researchers began exploring the relationship between SC and youth mental illness and mental health following this seminal study.

Within the literature on SC in youth, there is debate regarding SC and mental health based on age difference (younger versus older adolescents and young adults) and the difference in binary (male–female) sex categories (Bluth & Blanton, 2014, 2015; Hope et al., 2014; Neff, 2003a; Neff, Rude, & Kirkpatrick, 2007). Differences between SC in males and females have emerged. Bengtsson et al. (2015) analyzed compassion (other-directed compassion, SC, and environmental compassion) in early adolescent development (ages 12–14, n = 471). They authors reported that females have more compassion for others and the environment, whereas males have higher SC. The results suggest that females may be socialized to be more compassionate to others, whereas males are more compassionate to themselves during early adolescence.

However, some studies have reported changes as adolescent AFABs emerge into young adulthood.

SC decreases for both sexes with age, especially in AFABs (Bengtsson et al., 2015; Muris et al., 2016; Neff & McGehee, 2010). AFAB youth are at particular risk for low levels of SC. Bluth and Blanton (2015) compared AFAB and AMAB students in middle school (Grades 6–8) and in high school (Grades 9–12). They found that high school AFAB youth had significantly lower SC and life satisfaction levels and higher perceived stress, negative affect, and depression than same-aged AMAB or younger students. Bluth and Blanton did not find this difference based on assigned sex in the middle school youth. Additionally, despite no evident difference in middle school, SC decreased in AFAB youth during the transition to high school (Bluth and Blanton, 2015). Muris (2016) further supported this finding and reported that older AMABs (15–17 years) had higher SC scores than older AFABs (sex-based differences were not found in the younger cohort, 13–14 years). This research further supports the argument that as youth transition through adolescence and into young adulthood, AFAB youth are at risk for lower levels of SC than their AMAB peers and potentially at risk for the onset of depression and anxiety. Finally, Bluth et al. (2017) replicated the Bluth and Blanton (2015) study in a larger sample of middle school (Grades 7–8) and high school (Grades 9–12) students. Regression analysis indicated that SC levels were similar for both AMAB groups ($b = -.02$, $p = .24$, 95% CI [−0.05, 0.01]), while SC was lowest for older AFAB adolescents ($b = -.11$, $p < .00001$, 95% CI [−0.15, −0.08]). The authors also noted that elevated SC levels have a buffering effect on the onset of depression and anxiety. These findings highlight the need for SC during the transition to adulthood to reduce the onset of mental illness, especially for AFABs.

Youth with higher levels of SC are less at risk for the onset of mental illness, such as depression (Ferrari et al., 2018; Raes, 2010), anxiety (Gill et al., 2018), eating disorders (Pullmer et al., 2019; Rodgers et al., 2018), substance abuse (Miron et al., 2014; Wisener & Khoury, 2020), and nonsuicidal self-injury (Jiang et al., 2016; Xavier et al., 2016). A systematic review conducted by MacBeth and Gumley (2012) indicated a robust negative relationship between SC and psychopathology (n = 4007; 95% CI [−0.52,−0.51], z = −34.02, p < .001) in a meta-analysis of 32 young adult studies (22 studies with participant mean age between 18 and 25 years). The results indicated that SC negatively correlated with depression (r = −.35, p < .001) and anxiety (r = −.26, p < .01) and positively with self-efficacy (r =.50, p < .001). Additionally, Marsh et al.'s (2018) meta-analysis, which included 19 studies of adolescent SC, indicated that high levels of anxiety, depression, and stress were related to lower levels of trait SC in adolescents (ages 10–19 years).

Interestingly, there appears to be no literature addressing SC and conduct disorder or oppositional defiant disorder—two critical behavioural disorders in adolescents. Challenges with SC are potentially more evident in young people who struggle with internalizing disorders. There is unmistakable evidence that elevated levels of trait SC reduce the onset of mental illness in youth and that intervention is vital. There is also evidence of the benefits of SC for mental health.

SC and Youth Well-Being

Elevated levels of SC are beneficial for the development of mental health indicators, such as experiences of well-being. The relationship between SC and EWB indicates that higher SC levels are associated with lower levels of negative affect and perceived stress, but not life satisfaction (Bluth & Blanton, 2014) in healthy adolescent samples. In a sample of elite Korean

athletes (varsity $M_{(age)}$ = 21.5 years, SD = 1.2; high school $M_{(age)}$ = 17.9 years, SD = 0.8), SC was found to have a significant relationship to all factors of EWB. Additionally, Jeon et al. (2016) noted that SC partially mediates the relationship between EWB and social support. Finally, adolescents with high SC were less anxious and stressed and reported more EWB (i.e., greater positive affect, less negative affect, higher life satisfaction) than their low-SC peers (Bluth et al., 2015). Therefore, although these youth continued to experience daily life challenges, those with high SC appeared less overwhelmed and seemed to hold distress in balanced awareness, experiencing both positive and negative affect. However, perceived satisfaction with life seems variable.

SC also plays a role in PWB, which focuses on positive functioning in daily living. Individuals high in SC are more likely to continue to engage in a task despite difficulties, understand how to navigate challenges, and step back and re-evaluate goal-directed living when needed. Few studies document the relationship between SC and PWB. However, in a study of female university athletes (N = 83, $M_{(age)}$ = 18.70), Ferguson et al. (2014) found SC to be positively correlated with PWB (r =.76, p < .01). Athletes high in SC were more likely to take the initiative; have awareness; assume responsibility for their thoughts, emotions, and actions; and not avoid challenges. In the same study, a subset of athletes (n = 11, $M_{(age)}$ = 19.72 years, SD = 2.20) was interviewed. They reported that SC helped them persevere, offer themselves kindness when facing challenges, acknowledge accomplishments, have patience in their individual growth, recognize rumination, and keep disappointments in balance when working toward a goal (Ferguson et al., 2014). These authors highlighted the benefits of SC in the pursuit of goal-directed living and the capacity to engage in positive life choices despite challenges.

PWB has several components that SC may affect in various ways. For example, one could easily argue that the PWB component of self-acceptance would be high in someone who has high SC; however, other factors such as purpose in life may manifest differently. In an adolescent sample of students in Hong Kong (age = 12–16 years, $M_{(age)} = 14.23$, $SD = 1.35$), Sun et al. (2016) found sex effects for how SC interacts with the individual components of PWB. Regression analysis indicated that the relationship between SC and PWB was different for AMABs and AFABs. Although overall SC was similar for both assigned sex groups, the individual components highlighted differences in PWB potentially based on social gender expectations. SC's mindfulness was found to be more adaptive for AMABs and led to increased autonomy, purpose in life, environmental mastery, and personal growth. Sun et al. did not find the same relationship between PWB and common humanity or self-kindness. At the same time, common humanity was the strongest predictor of PWB for AFABs and led to greater autonomy, environmental mastery, positive relationships with others, and personal growth (Sun et al., 2016). Overall, SC helps facilitate adolescent PWB, which is essential for engagement in social and behavioural tasks for their future. However, based on socialization, there is a difference in the degree of SC and how it interferes with engagement in life. Further research is needed to understand how to foster SC in the service of PWB and SWB.

Pandey et al. (2019) conducted research with university students (134 AMAB, $M_{(age)} = 25.11$, $SD = 1.66$; 138 AFAB, $M(age) = 21.89$, $SD = 1.87$) and found that that SC was significantly correlated with PWB and SWB. The authors explored the positive and negative components of SC and reported that together self-kindness, common humanity and mindfulness positively correlate with greater PWB, $r(270) = .362$, $p < .01$, and SWB, $r(270) = .162$, $p < .01$. Pandey et al. concluded that the positive aspects of SC offer personal acceptance and the ability

to manage personal and social failures. At the same time, cultural expectations on the importance of caring for others while being hard on oneself may have influenced the negative subscales. Pandey et al. is the only study to date that analyzed the relationship between SWB and SC in youth. Overall, the limited body of evidence does suggest that SC helps youth to feel more positive about their lives (EWB), feel that they can engage in life with a meaningful purpose (PWB), and feel that they can develop healthy social relationships (SWB). However, Keyes (2005) argued that well-being and mental illness are two separate but related dimensions. Therefore, SC may be a route to help youth learn to persevere in life while learning to engage in trajectories and life choices in service of SWB and PWB.

SC and Values

Research focusing on SC and its relationship to personal values and goals is scarce. In university samples, researchers have found that SC supports the pursuit of goal attainment, goal orientation, and goal re-engagement (Ferguson et al., 2014; Hollis-Walker & Colosimo, 2011; Hope et al., 2014; Neely et al., 2009; Neff et al., 2005). Additionally, Neff et al. (2005) found that individuals high in SC are more intrinsically motivated to pursue goals, understand new concepts, and not compete solely to avoid failure. However, researchers have yet to examine the relationship between SC and goals in adolescents or SC and personal values development or engagement in value-based living. One study did find that engagement in self-affirmation statements increased SC and prosocial behaviours (Lindsay & Creswell, 2014), while another reported benefit of teaching SC as a strategy for overcoming values incongruent behaviour (Fitzpatrick et al., 2016). These studies highlight the role that SC may play in prosocial value development and valued congruence; however, few studies have directly measured change in SC intervention studies.

Yadavaia and colleagues (Yadavaia, 2013; Yadavaia et al., 2014) reported increases in SC as an outcome of participation in acceptance and commitment therapy (ACT; Hayes et al., 1999) intervention, which includes explicit teaching on values clarity and values-based living. Furthermore, SC interventions explicitly teach the importance of values to help manage discomfort associated with values incongruence (Bluth & Eisenlohr-Moul, 2017). A large body of literature explores the significance of values from a positive youth development framework (Search-Institute, 2016; Wiium & Dimitrova, 2019). The positive youth development model includes the importance of a positive identity. Still, few studies address personal values for youth living with mental health concerns or the relationship between SC and values-based living. There is a growing body of evidence that interventions can increase SC, but the practice for youth living with mental illness is in its infancy.

SC Interventions to Reduce Mental Illness and Promote Mental Health

Briere (2012, p. 272) argued that according to many Buddhist perspectives, compassion is developed through mediation; more specifically, compassion toward self and others is nurtured through loving-kindness meditations. Loving-kindness or *metta* mediations are steps beyond basic awareness or attention; they focus on universal, unselfish love for oneself and others, which is the root of true happiness (Germer, 2009). Loving-kindness meditations go beyond focusing on the breath; they use kind words and ways of relating to the self to help relate to the sufferer. SC is built on this principle. However, MBIs both and directly and indirectly cultivate SC or use loving-kindness meditations.

Initially, MBIs such as mindfulness-based stress reduction (Kabat-Zinn, 1982) and mindfulness-based cognitive therapy (Segal et al., 2002) did not explicitly focus on compassion teachings in the training, but over time evidence suggested that explicit compassion teaching

were beneficial for the development of SC (Frostadottir & Dorjee, 2019) in these programs. Alternatively, ACT (Hayes et al., 1999, 2004) focuses on the importance of psychological flexibility and within this approach uses compassion as a way to mindfully observe distressing thoughts, feelings, and sensations and not allow this discomfort to drive actions or state of mind (Hayes et al., 2006; Tirch et al., 2014). Researchers have reported the interaction between increased SC and ACT interventions (Esmaeili et al., 2018; Ong et al., 2019; Yadavaia, 2013; Yadavaia et al., 2014). ACT-based programs implicitly increase SC but do not use SC teachings as core components of the program. While compassion focused programs and trainings explicitly address SC as part of the intervention.

A variety of programs focus on the explicit development of compassion, such as Compassion Cultivation Training (Jazaieri et al., 2014), Cognitively-Based Compassion Training (Pace et al., 2013), Mindfulness-Based Compassionate Living (Bartels-Velthuis et al., 2016), Mindfulness-based Cognitive Therapy (Kuyken et al., 2010; Rimes & Wingrove, 2011), Compassion Focused Therapy (CFT; Gilbert, 2005) and MSC (Neff & Germer, 2013). Although there is a growing body of literature reporting the benefits of Compassion Cultivation Training, Cognitively-Based Compassion Training, and Mindfulness-Based Compassionate Living, only emerging benefits supported these programs when this dissertation project began. The two most commonly used approaches that focus on explicit compassion training were CFT (Gilbert, 2005) and MSC (Neff & Germer, 2013).

Although both CFT and MSC directly focus on the importance of compassion for healing and managing life stressors, these approaches define compassion differently. CFT interventions are focused on compassion through an evolutionary biopsychosocial lens (Gilbert, 2005, 2009). Gilbert (2005, 2020) argued that compassion derives from human threat systems and the need for

interconnectedness. Gilbert argued that compassion is a learnable skill that includes two main components for change: the psychology of engagement is the awareness of suffering and its cause, and the psychology of alleviation of suffering through active means. The components of psychological engagement include distress tolerance, empathy, sympathy, sensitivity, nonjudgement, and motivation. At the same time, the psychology of alleviation focuses on attention, imagery, reasoning, behaviour, feelings, and sensory experiences. Tirch et al. (2014) noted that CFT is a clinical intervention that uses mindfulness and active engagement in the presence of suffering and compassion for clinical populations. CFT focuses on the belief that individuals learn to have a healthier relationship with themselves and others through healthy coregulation. A body of literature highlights the benefits of CFT in adult clinical populations (Craig et al., 2020), but only a small emerging body of literature reports the benefits in adolescent clinical groups (Bratt et al., 2020; Carona et al., 2017) and nonclinical populations (Beaumont et al., 2016, 2021). Furthermore, there appears to be limited access to the protocols for these treatments (Craig et al., 2020). Alternatively, the benefits of MSC have been reported in both adult and adolescent populations and will be the focus of this dissertation.

There are a variety of programs based on Neff's (2003b) conceptualization of SC. Neff's graduate student McGehee (2010) piloted the first SC intervention with youth. A weekend SC intensive program was delivered at a private preparatory school with 17 students in Grades 9–11 ($M_{(age)}$ = 15.18 years). The weekend intensive focused on the three main components of SC via psychoeducation and group activities. Participants completed pre–post intervention questionnaire packages and follow-up qualitative questions. The results indicated that the weekend intervention did not support significant increases in SC, happiness, or social connectedness, nor was there a decrease in anxiety or depression. Qualitative results indicated that the youth reported mixed

feelings about their experience. Some youth stated that they felt some of the activities were "goofy," preferred smaller and sex-based groups, and felt the surveys were too long. Engaging youth in the workshop's development might have circumvented some of these concerns and helped develop a youth-relevant program. Collaborating with youth could improve these results, troubleshoot challenges through peer recruitment, develop youth-friendly activities, and recommend ways to engage youth via alternative approaches (e.g., arts, videos, use of language). Overall, the results indicate that despite the potential benefits of SC intervention, programming psychoeducation alone was not enough to generate change and that process-based intervention was necessary.

The second intervention based on Neff's (2003a, 2003b) model, the MSC program for adults, was initially proposed by Germer (2009) and further developed by Neff and Germer (2013). MSC is a process-based intervention focused on mindfulness, loving-kindness, supporting self through difficult moments, and taking on new challenges. The fifth session of the program focuses on how core values help individuals meaningfully engage in their lives and how SC can help individuals manage difficult moments. The goal of the MSC program is to increase participants' capacity to tolerate and manage difficult emotions. Exercises and feedback within the group help generate compassion for others and feelings of common humanity. Neff and Germer (2013) conducted a randomized control pilot study using an 8-week MSC program. The program included teachings, meditations (e.g., formal sitting mediations such as loving-kindness mediations of sending love to oneself and others, learning to hold distress in balance awareness, and being aware of breathing), informal practices (e.g., psychoeducation, learning grounding techniques, and learning to identify the inner critical voice), group discussions, and homework. Participants in the treatment condition (n = 24, $M_{(age)}$ = 51.2 years) and waitlist control group (n

= 27, $M_{(age)}$ = 49.11 years) completed pre–post intervention measures, as well as 6-month and 1-year follow-ups. Neff and Germer conducted a matched-pairs repeated-measures analysis of variance. In comparison to the control group, the MSC group significantly increased in SC (F = 31.79, $p < 0.01$), mindfulness (F = 8.03, $p < 0.01$), compassion for others (F = 11.91, $p < 0.01$), and life satisfaction (F = 8.09, $p < 0.01$). Significant mental health challenges were note in decreased depression (F = 17.42, $p < 0.01$), avoidance (F = 4.48, $p < 0.05$), and stress (F = 4.13, $p < .05$). There were no significant group differences for social connectedness or happiness. The findings suggest that individuals can decrease their mental health symptoms while EWB and SWB can remain constant. The results remained constant at the 6-month and 1-year follow-ups for all measures. Although the results were promising, the participants in this nonclinical population participants were all older AFAB adults with above-average IQs, and most had previous meditation experience.

Germer and Neff (2013) did conduct a clinical case study with an adult AMAB and again reported significant benefits for mental health challenges and well-being. As an emerging evidence-based program, the MSC program is taught in many centres across North America. The program guides practitioners to deliver the model to community groups and psychotherapeutic environments within their practices (Germer & Neff, 2019). MSC outcomes and research suggest that the program is beneficial for adults; however, youth may respond to the program differently based on their developmental needs.

After the onset of this dissertation study, Karen Bluth and Lorraine Hobbs and their colleagues (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016) developed a manualized SC program for adolescents. Making Friends With Yourself was designed based on the MSC program (Neff & Germer, 2013) for community youth ages 14–17. Making Friends With

Yourself is a 6-week program that covers an overview of SC and mindfulness, mindful practices, psychoeducation regarding the teenage brain, self-compassion versus self-esteem, exercises focused on finding the compassionate voice, gratitude, and values. Making Friends With Yourself is similar to MSC but includes more hands-on activities, mindful movement, and shorter meditations (Bluth et al., 2016). Bluth et al. (2016) noted the Making Friends With Yourself program is presented in a more developmentally appropriate framework for adolescents. Making Friends With Yourself was piloted with 34 mentally healthy (no depression or suicidal ideation) youth from well-educated families. The authors employed a crossover design with an intervention and waitlist control group but collapsed the data to increase power. Using a mixed-methods approach (pre–post questionnaire packages and audiotapes of the sessions), the intervention participants engaged in a 6-week, 90-min SC program and were offered recommendations for homework. The resulting paired *t* tests indicated that increased SC affected lower levels of depression, perceived stress, and negative affect because of the intervention. When controlling for baseline SC, hierarchical regression indicated increases in SC resulted in increased life satisfaction, decreased anxiety, and perceived stress, but not depression or positive affect. Overall, the program was well received. Bluth et al. (2016) noted that the youth had significant outcomes on negatively worded (e.g., depression, anxiety, negative affect) measures but not the positively framed measures (e.g., positive affect, social connectedness). This finding may be because SC interventions focus on coping with difficult moments versus building feelings of happiness. However, given the focus on common humanity in SC, null results for social connectedness are surprising. Bluth et al. (2016) included participant feedback as part of the process but did not include youth in the program's development phase. Further analysis of the benefits of Making Friends With Yourself was needed.

Bluth and Eisenlohr-Moul (2017) further explored the potential benefits of the Making Friends With Yourself intervention in consecutive 8-week programs for five different cohorts (*n* = 45; two high school groups aged 14–17 years, two middle school cohorts aged 11–13 years, and one mixed cohort aged 11–17 years). The participants completed questionnaire packages online at pre–post and a 6-week follow-up. After controlling for demographic factors that may affect mental health, mindfulness, SC, gratitude, reliance, and curiosity all increased, while perceived stress decreased. All results remained stable at follow-up. Curiously, the intervention did not influence depression or anxiety. SC covaried perceived stress, depression, reliance, and curiosity when high school students experienced more significant increases in SC than middle school students when looking specifically for within-person trends. Therefore, individually the impact was more notable for the high school than the middle school students but not enough for statistical significance. Finally, the Making Friends With Yourself research to date may not capture the experiences of marginalized youth groups, such as those living with mental health concerns. The youth in Bluth and Eisenlohr-Moul's (2017) program were from generally affluent and highly educated families (71% had mothers with master's, doctorate, or professional degrees, and 65% had fathers with master's, doctorate, or professional degrees); Bluth et al. (2016) excluded those with depression from the study. Hence, further investigation is needed into how youth living with mental illnesses from small city centres, where access to resources is limited and the sociodemographic profile is modest, understand the MSC program's concepts. Additionally, further investigation could highlight how youth would adapt the MSC program for their peers living. This process may also help with program uptake in an area with fewer available resources, while supporting KT from research to practice.

Summary

SC decreases the onset of mental health challenges and mediates the relationship between trauma, social challenges, and mental illness. Alternatively, SC in youth can increase well-being and values-based living, but further research is needed. During the transition to adulthood, youth, especially AFABs, are at an increased risk for low SC, and internalizing disorders and intervention are vital. SC studies are often in urban settings and do not represent youth's experiences of living with mental health challenges or small city centres. Youth in small city centres are grossly underrepresented in psychotherapeutic research (Mammen & Sano, 2012). Little information exists regarding mental health for youth living in small city centres versus their large city or rural counterparts. Thus, by engaging youth living with mental health challenges living in small city centres in modifying an adult SC program for their peers, we may help champion this rarely empowered youth voice in the process of program development and evaluation, a process known as KT.

Knowledge Translation

Over the last several years, there has been a movement toward ensuring that psychotherapeutic settings use best practices. Evidence-based practices (EBPs) are often considered the pinnacle for mental health intervention approaches due to their systematic design, meta-analysis, and randomized control trials (Fixsen et al., 2009). Conversely, scholars have noted that EBPs often fail to address system challenges, the uniqueness of individual clients and settings, and the challenges of practitioners not working in a controlled environment as represented in the studies, even though these are part of the EBP mandate (Cook et al., 2017). Therefore, EBPs do not capture the uniqueness of marginalized, vulnerable, historically oppressed, and geographically diverse or isolated groups. For small city centre communities,

who do not live close to urban settings or have collaborations with hospitals or universities, and youth living with mental health challenges within these communities, EBPs may fail to capture the distinct realities of their experiences.

Cook et al. (2017) suggested that there are many reasons why psychotherapeutic practices should not solely focus on EBPs: (a) generalizability, (b) vague standards for what constitutes enough evidence, (c) the challenges on constant reuptake of new EBPs in an often burdened and underfunded psychotherapeutic environment, and (d) the lack of acknowledgement of clinicians' expertise. Another challenge of concentrating on EBP is that there is a lag (on average 7 to 17 years) between the initial publication and use of the research in community practice (Green, 2008; Morris et al., 2011). Finally, there are several challenges to ensure the uptake of research was used efficiently in psychotherapeutic settings (Rye et al., 2019). Alternatively, practice-based evidence documents therapeutic outcomes and can account for individual clients and communities (Green, 2006; Portney, 2020). The practice-based evidence process is then repeated in several therapeutic settings to ensure the practice informs a large-scale research body. However, overburdened systems often result in information staying within the community, not being reported as qualitative data but focusing on quantitative numbers measuring change to justify services and funding delegation. Large funding data sets weaken the power of information for specific demographics, and the clients' individual experiences are lost.

Given mental illnesses are an ever-growing epidemic in Western cultures (Twenge, 2011), the societal burden of care for those struggling (Malla et al., 2018), the increased risk for mental health challenges in marginalized youth (Kidd et al., 2017), and the emphasis on EBP in programming, researchers and practitioners have called for the synchronicity of EBP and practice-based evidence (Barkham & Mellor-Clark, 2003; Tasca et al., 2014) to help facilitate a

more rapid and enriching process for program development and to highlight marginalized voices. The integration process originated in non-health-related fields (i.e., agricultural research, marketing, management) under different names (i.e., dissemination and implementation science/research, KT, and integration; Rabin & Brownson, 2012). Because this research project originates in Canada, KT is the preferred term. The Canadian Institute of Health Research (2015) has acknowledged the importance of KT, which is creating science that is integrated into systems to promote change and reduce lags in application.

KT research focuses on decreasing the gap between research and uptake of intervention by stakeholders (McGrath et al., 2009). When first introduced, KT focused on stakeholders, including researchers, management, and staff members, as key informants and highlighted the need for ongoing training and coaching (Fixsen et al., 2009; Tasca et al., 2014). Currently, the movement toward widening the definition of stakeholders includes policymakers, executive directors, practitioners, family members, and clients. By broadening the definition, researchers can address challenges in integrating innovative programs into clinical settings, support clinicians with ongoing training, and determine if systemic factors impede program integration. Integrating individuals who use the practices into the uptake and research process is known as IKT, which often uses participatory approaches to research (Jull et al., 2017, 2018).

In line with critical YE principles (Fox et al., 2010), Green (2008) called for participatory research to develop interventions and program evaluations that engage both practitioners and clients in the process. Green's goal was to increase validity, applicability, and usage and inform and expedite evidence-based program development. By engaging youth, the goal was to evaluate the constructs used in EBP collaboratively and inform programs that are more accessible for marginalized peer groups. The engagement of young people in research for their peers is crucial

given how rapidly youth culture changes, how the language and examples used in the program may not be relevant to the context where the practice occurs, and how EBP may not account for the experiences of marginalized communities. Although IKT highlights the need to engage knowledge users in the research process, it fails to emphasize the importance of community-driven research and the underpinnings of social justice found in YE; (Iwasaki, 2015). This empowerment framework for working with youth helps inform researchers and practitioners. Therefore, IKT helps guide the dissemination and implementation process, while YE provides the critical lens for engaging youth living with mental health challenges in an empowerment process for community-level change.

YE in Mental Illness and Mental Health

It has been over 30 years since almost all members of the United Nations (but not the United States) ratified the Convention on the Rights of the Child (CRC; 1989). The CRC called for action in the nondiscriminatory best interests of children and youth worldwide. The goal was to protect the rights and dignities of all people under the age of consent and empower youth with the right to express their views freely in all matters affecting them (CRC, 1989, Article 12). Schools, communities, and programs within signatory nations responded by including youth voices in systems change, advocacy, and program development.

As a result of the CRC, agencies worldwide began to create strategic plans for service delivery that centred youth voices in programming that directly affected them. While mandating the fair and nondiscriminatory treatment of youth, programs started to seek youth collaborations (Ontario Centre of Excellence in Child and Youth Mental Health, 2016) in almost all sectors of life. Specific to mental health, collaborations include involving youth in the development of mental health strategies, campaigns for reducing stigma and improvement of health outcomes,

clarifying program designs, health care reform, research, health literacy, health education, and participation in program development, implementation, and evaluation (Manion, 2010). Some benefits reported in the literature for youth who participate in change initiatives include increased social skills, sense of belonging, prosocial personal values, healthy relationships with adults, and empowerment (Checkoway & Gutierrez, 2006). There is emerging evidence for the benefits of engaging youth in mental health programming.

YE is the preferred term for youth participation in mental health system reform. YE is designed to support youth living with mental health challenges to develop positive skills while advocating for changes within the communities and the systems where they seek services. YE has been popularized in many countries (e.g., Canada, Australia, United Kingdom, Israel, and Ireland), and YE practitioners report benefits for youth, agencies, and communities (Coates & Howe, 2014, 2016; Garinger et al., 2016; Ramey & Rose-Krasnor, 2015; Ramey et al., 2016; Timor-Shlevin & Krumer-Nevo, 2015). One goal of YE is to help increase collaboration as proposed in Hart's (1992) ladder of participation and potentially reduce power differentials inherent in many traditional mental health practices (Prilleltensky & Nelson, 2002). The ladder of participation consists of eight rungs. The bottom rungs (1–3) highlight situations in which youth are manipulated, used as decoration, or tokenized and where their input is not genuinely received; the focus is on adult goals. The five upper levels engage youth as genuine partners. Each rung helps move toward equitable participation, moving from youth-informed practices to shared decision-making. The pinnacle of the ladder should promote benefits for both the youth and the program practitioners.

Alternatively, Wong et al. (2010) developed a typology based on disagreements within the field regarding best practice for engagement. One end of the continuum represents

autonomous participation, where youth have control over the process regardless of adult involvement. The other end of the continuum represents vessel participation, where adults drive the activity and youth are engaged as program recipients. The centre of the continuum is designated as pluralistic*,* a balance of power where both adult and youth voices are represented, control is shared, and engaged partnerships develop. Pluralistic best represents youth–adult partnerships. Given the importance of empathy, authenticity, mutual respect, and shared objectives between the therapist and client in psychotherapy (Gelso, 2014; Lambert & Barley, 2001), the pluralistic approach best represents a therapeutic relationship and may highlight the mutual benefits of YE in mental health programming.

There has been an increase in literature signifying the mutual benefits of youth and adults engaging in collaborative systems change (Zeldin et al., 2008, 2013, 2015). The benefits youth experience from collaborating with adults in a supportive environment include opportunities for authentic decision-making, development of new roles and strategies, gains in awareness of marginalization and prosocial values, increased feelings of self-worth, engagement in value-based actions, and the experience of positive social change within communities (Akiva et al., 2014; Krauss et al., 2014; Liang et al., 2013).

YE has been slowly emerging in Canadian youth mental health programs. YE was introduced to children's mental health in Ontario in 2007 as a pilot project. The guiding principles of YE are sustaining mutually respectful relationships, providing equality to all regardless of their social determinants, engaging youth as skilled contributors, and working with youth to uncover individual strengths (Pereira, 2007). This process includes accepting those struggling with various mental health challenges and provides an environment that honours youth experiences and engages those living in multiple communities. Overall, YE's goal is to

help youth develop personal and social capacities and engage in purposeful activities that are beneficial and meaningful to the self and the wider community. Few documented programs have engaged youth in EBP intervention development or delivery, although this is a goal of YE.

Youth Net/Réseau Ado is an innovative YE program run by youth for youth with mental health workers' support (Davidson et al., 2006). Goals for the program include engaging youth in conversations regarding the accessibility of current mental health services and designing and implementing services. Youth Net offers various programs for youth at risk for subclinical and clinical mental health concerns (e.g., support groups, art-based groups, mindfulness groups). Researchers have explored the mental health benefits of Youth Net qualitatively, but quantitative change has yet to be measured. Additionally, the interventions dispensed are not focused on the delivery and uptake of EBP, as is often the goal in mental health agencies in order to adhere to quality control and the appropriate allocation of funds. Finally, the program is not based on a youth–adult partnership (pluralistic) model is but youth-driven; this offers little clarity about the professional's role and renders the programming challenging to fund.

Alternatively, Australia's Headspace program is one of the most regularly investigated and highly funded YE programs to date (Coates & Howe, 2014, 2016; Rickwood et al., 2019). Focused on engaging youth in service design and delivery (Coates & Howe, 2014), Headspace youth are involved as consultants at mental health centres across Australia to help reduce barriers and support more youth-friendly programming (Hodges et al., 2007). Headspace's impressive engagement process accounts for the individual community needs in delivering EBP while accounting for practice-based evidence from clinicians and youth. Headspace also offers continual staff training and ongoing communication regarding youth experience in programming delivery and governance (Rickwood et al., 2019). Through the Youth Reference Group,

Headspace youth participate in service design, delivery, and evaluation. However, the process of engagement is unclear, as is the level of participation the youth have in designing and delivering EBP for their specific demographic. Therefore, although there has been a call for YE within youth mental health centres, few approaches document how to engage youth in IKT practices, which helps provides the rationale for my project.

Rationale for Study

Youth mental illness (e.g., depression, anxiety, disruptive behaviours) and challenges with mental health (e.g., well-being and values clarity and goal-directed living) are on the rise in Canada and have lifelong personal and social implications (Boak et al., 2018; Raphael, 2011). Society needs to better support youth in developing skills required to manage the social, emotional, and individual challenges associated with transitioning to adulthood. SC is an individual's capacity to be kind and nonjudgmental toward oneself when experiencing difficulties in life (Neff, 2003a) and may be vital in helping youth traverse this difficult developmental period. Youth with high SC have fewer symptoms of mental illness and more well-being and value-directed behaviours (Marsh et al., 2018). There is early evidence for the benefits of MSC (Neff & Germer, 2013) and the refined adolescent Making Friends With Yourself (Bluth et al., 2016) programs for increasing well-being and decreasing mental distress. However, there limited research reporting the benefits of MSC-derived programs for marginalized youth (e.g., youth living in small city centres or youth living with mental health challenges). Understanding the experiences of youth and practitioners in these programs may help in the uptake of these interventions in various communities. The process of researching evidence-based or informed research in clinical and community settings is known as IKT (Nguyen et al., 2020). Although IKT includes the voices of practitioners, stakeholders, and

clients in the research process, the process rarely involves youth living with mental health challenges. YE (Sinclair et al., 2019) is an approach to working with marginalized youth that may provide a basis for understanding the benefits of SC interventions for youth living with mental health challenges in small city centres and has the potential to help with IKT from program evaluation to implementation. Therefore, this research project seeks to engage youth living with mental health challenges from a small city centre in evaluating and modifying a SC intervention to reduce mental health symptoms while increasing well-being and value-based living. I collaborated with youth living with mental health challenges in a small city centre in the IKT process from emerging evidence-based program modification to community uptake.

Chapter 3: Overall Method

Interpretive Framework and Associated Philosophical Beliefs

Based on my experiences as a researcher and clinician, I bring a certain set of beliefs and assumptions to the research process. Creswell (2007, 2013) has helped guide researchers to define these assumptions and frame them into interpretive frameworks (i.e., positivism, social constructionism, transformative, pragmatism, and critical, feminist, or queer frameworks). It is essential to understand the underlying assumptions inherent within the qualitative research framework of this project. My philosophical beliefs guide the research process, and it is important that these assumptions are explicitly stated prior to exploring the methodological approach used in this dissertation project. Here I clarify the interpretative framework and related ontological, epistemological, axiological, and methodological beliefs (Creswell, 2007, 2013) that guided this research process.

Interpretive Framework

Creswell (2007) highlighted the importance of explicit identification of the interpretative lens in qualitative research with marginalized groups. This project is rooted in critical theories of psychology, which call for identifying social issues and empowering individuals and communities (Fay, 1987). This call has resulted in social justice and critical pedagogical orientations such as community psychology and feminist, multicultural, LGBTQ+ and antiracism theories (Arredondo & Tovar-Blank, 2014; Fox et al., 2009; Freire, 2018; Larson, 2008; Levitt, 2019; Prilleltensky, 2001; Wilkinson, 1997). However, there is a need to understand how social justice and empowerment manifest in developing psychotherapeutic interventions (Goodman et al., 2004; Prilleltensky, 2001). Spong and Waters (2015) conducted a review of the literature exploring the potential for CBPR in counselling and psychotherapy. The authors highlighted the

benefits of including CBPR in psychotherapy to embrace social justice and empowerment for collaborators, which is in line with the call for empowerment orientations in counselling psychology (Goodman et al., 2004).

Participatory research approaches offer guidelines for engaging youth in research that are compatible with YE principles. A large portion of Manuscript 1 highlights the importance of pluralistic partnership (Wong et al., 2010) when engaging youth as collaborators and not as passive recipients of the intervention. Participatory research is a broad term focused on empowering community members to work in partnership with researchers to plan, implement, evaluate, and disseminate research that has the potential to directly impact their community (Bergold & Thomas, 2012). Participatory research approaches align with a critical theoretical lens and create a link between social science and social activism to empower marginalized communities, highlight political inequalities, and engage in social change (Wallerstein & Duran, 2017). Although it is infrequently used in psychotherapeutic research settings, community psychology and public health have recognized the importance of a participatory approach to interventions for several years (Israel et al., 2013; Minkler & Wallerstein, 2011). The use of a participatory research approach in this project allowed me to collaborate with practitioners and youth to share their intervention experiences; increase validity, applicability, and usage; and inform and expedite EBP development (Chambers & Norton, 2016). Although there are several approaches to participatory research, a review is beyond the scope of this paper. This project will focus on CBPR.

CBPR is an engaged research framework (Prilleltensky & Nelson, 2002) that works with marginalized groups to advocate for community needs in care systems. The research questions are not academically driven but originate in the community itself. Guba and Lincoln (1994)

explored the importance of real-world inquiry when approaching research from a critical theoretical lens. Critical approaches invite the convergence of sociocultural experiences. Influenced by those who participate, the study outcomes are interchanges between the researchers and their collaborators. A CBPR approach is vital for critical inquiry into YE in mental health program development because it allows the community to participate in problem identification, research development, the research itself, and iterative learning, which supports the process of IKT from research to program uptake. CBPR presents nine principles of approach (Israel et al., 2008), which are consistent with the philosophical beliefs of this project.

Ontological Beliefs

Ontological beliefs focus on the nature of reality (Creswell, 2013). CBPR highlights the issues of power and privilege inherent in traditional positivist research and focuses on the reality of the community involved in the project. The first two CBPR core principles identified by Israel et al. (2008) recognize the community as a unit of identity (Principle 1) and highlight the importance of building upon strengths and resources within that community (Principle 2). Therefore, the ontological beliefs in this project from a critical lens approach align with CBPR principles, which explicitly includes all voices (i.e., researcher, the community of interest, the practitioners, academics, and gatekeepers) in the research and provide evidence of the lived experiences of the marginalized community.

Epistemological Beliefs

Epistemological beliefs are focused the researchers attempt to reduce the distance between themselves and "that being researched" (Creswell, 2007, p. 17). This goal is congruent with the third and fourth principles of CBPR identified by Israel (2008). Israel's (2008, p. 50) third principle is that in all phases of the CBPR process there should be a collaborative, and

equitable partnership, while the fourth principle stresses that CBPR "promote(s) co-learning and capacity building among all partners." Israel's principles promote equity between the researcher and the community. The decision to use a CBPR lens to add to the SC intervention literature and practice resulted from years of consultation and collaboration with youth involved with mental health care, practitioners, the local school district, and university-based academics. I focused on the principles of CBPR to support youth, adult mental health practitioners, and scholars to work collaboratively to ensure the research was rooted in individual experiences and needs and employed joint decision-making, and to help determine the best practices for engaging and conducting research with youth (Jacquez et al., 2013). Through my lived experience as a child and family therapist, years of mental health community engagement with youth as collaborators, and meetings with mental health practitioners, the benefits of SC in youth mental health emerged as an important and necessary topic to research within this community.

Axiological Beliefs

Creswell (2007, 2013) argued that axiological beliefs are focused on the values of the researcher and the research process. The researcher must explicitly acknowledge their value and potential biases. As a psychotherapist who delivers SC and MBIs in her practice, who works with community youth, and who is a former YE facilitator, I worked hard to be aware of my biases toward the importance of engaging youth voices and the benefits of SC for the IKT process. I previously worked as a YE facilitator at a nonprofit child and youth community mental health agency, and I trained YE to practitioners across Ontario. The youth I engaged with often discussed how youth participation in program development, evaluation, and delivery was crucial for their community. The youth were aware of the top-down nature of EBP and gatekeeper hesitation toward engaging youth in the program delivery and felt that these programs did not

reflect their realities. However, EBPs were essential for program funding and efficiency in an overburdened system. My felt experience of the pull between youth and delivery of EBPs was the spark for this project. YE principles of mutual respect, equity, and engagement (Pereira, 2007) and the fifth CBPR core principle focused on the importance of integrating and achieving a balance of research and action for the mutual benefit of all partners (Israel et al., 2008) help to address these values and hold awareness of these principles throughout the project. I held my beliefs toward the importance of YE and my power and privilege as an adult, an academic, and a mental health practitioner in mind while engaging in this project. The seventh CBPR principle requires the involvement of all parties in a cyclical and iterative process. Additionally, the ninth core principle requires a long-term approach and commitment, which helped to bracket my beliefs and values and ensure that the outcomes reflect the community's beliefs, given the importance of time constraints in academic research.

Methodological Beliefs

Researchers use methodological beliefs to answer the question, "What is the process of the research?" (Creswell, 2007). In this case, the methodological beliefs detail the overall research process. The research questions were rooted within the specific community and follow the sixth principle of CBPR. The sixth principle of CBPR emphasizes the local relevance of health problems (e.g., youth living with mental health challenges) and ecological perspectives (e.g., youth in small city centres) of the participants and attends to the multiple SDH and disease (Israel et al., 2008). This project aims to address nourishing mental health in the community while engaging in mental health intervention from an ecological perspective. The project brings together IKT to modify the MSC program for a specific marginalized group while holding an awareness of their ecological needs as youth living in a small city centre with mental health

challenges. The hope is to develop a model for CBPR-modified evidence-based SC interventions for this group. The methodology also focuses on using CBPR from program design to dissemination to benefit all partners involved in the project (Israel et al., 2008; CBPR Principle 8) to help support IKT. Information regarding the use of CBPR in intervention studies is detailed below.

CBPR in Intervention Research

Internationally, CBPR has emerged as an essential framework to engage individuals living outside a major urban centre in health interventions for their communities (Bainbridge et al., 2013; Devia et al., 2017; O'Fallon & Dearry, 2001; Puffer et al., 2013). However, there is limited research on the use of CBPR for psychotherapeutic interventions to increase usability. One challenge in engaging youth in CBPR for psychotherapeutic interventions is that the process is slow and iterative, which can be daunting, misunderstood, and sluggish to produce for academia, where there is a push toward publication goals for dissertations or tenure (see Jacobs, 2010). Although CBPR allows for a flexible research approach, only a small body of research has used CBPR principles in experiential design practices (Jones et al., 2008). There is a growing body of literature for the use of participatory research with child and youth research (Bergold & Thomas, 2012; Collins et al., 2018; Khodyakov et al., 2014; Rosenbaum-Asarnow & Miranda, 2014), but engaging youth as partners in psychotherapy research is still in its infancy. Therefore, integrating youth into the development of psychotherapy interventions is a novel and challenging process.

Murray et al. (2013) modified EBP trauma-focused cognitive behavioural therapy using CBPR principles but included academics, mental health agencies, and parents as stakeholders without consulting youth who have experienced trauma. At the same time, L'Etang and Theron

(2012) created a modified cognitive behavioural therapy therapeutic intervention for youth (ages 18–24 years) living with HIV and AIDS in South Africa. The researchers consulted the youth during the project's assessment phase but not during the modification phase of the program. The authors relied on practitioners to review the content of the intervention and the methods. One participating young person was then invited to trial the intervention. L'Etang and Theron argued that ethically including only one participant was best for the youth's mental health given that the program was still in the developmental phase. They also felt that the practitioners provided enough feedback to move forward with the program. Although this process was ethically sound, by not including youth living with the challenges of being diagnosed with HIV or AIDS in developing the intervention, the authors disempowered their lived experiences. Additionally, by engaging only one person in the trial program and relying on the practitioners and researchers, this could be construed as tokenism (Hart, 1992).

One model of distinction for using CBPR in psychotherapeutic prevention and intervention programming for youth is the Cognitive Behavioral Intervention for Trauma in Schools (Kataoka etal., 2003; Jaycox, 2004; Jaycox et al., 2007, 2012; Ngo et al., 2008). Jaycox and colleagues developed the program in Los Angeles, California, through community-research partnerships with schools and mental health leads. The schools initiated the intervention based on community needs; collaboration persisted during program development and iterative program modification, dissemination, and implementation, where modification depended on individual communities' needs. Although there is extensive research on the success and ongoing adaptation of the program, the youth did not collaborate on the project. Therefore, YE in CBPR for developing psychotherapeutic interventions is an innovative approach to research that may help understand how to use SC programming in communities not often represented in research.

It is crucial that researchers and stakeholders collaboratively participate in IKT under YE and CBPR principles. Although at times difficult, the research process attempted to modulate between the ladder of participation's (Hart, 1992) upper five rungs to allow for genuine youth participation while focusing on moving the research forward at a pace in accordance with university policy. At times, the youth initiated and then led the research process; at others, the researcher moved the process forward while engaging in shared decision-making. This research highlighted the strengths of the community of youth mental health consumers by engaging them as collaborators and offers insight into the SC and MSC programs, which allowed for consumer's voices to inform evidence. CBPR is a methodological approach to cooperative and equitable health research, but it does not provide specifics regarding study methods (Isreal et al., 2005). Therefore, CBPR uses various research design, data collection, and methods of analysis. The dissertation project resulted in two manuscripts that followed a CBPR iterative learning process.

Research Design

Manuscript 1

Chapter 4 presents Manuscript 1, a project focused on engaging youth living with mental health challenges from a small city centre in the participation and mixed-methods evaluation of the MSC program. The youth participated in a MSC group and then met with me to engage in a CBPR evaluation of the program. The primary goal was to understand both the qualitative youth experiences and quantitative mental health and mental illness outcomes from participation in the MSC program. The second objective was to engage in the CBPR program evaluation, assess SC theory and learning inherent in the program, and use the information learned to help with an iterative modification of the program for peers in the community. I used a concurrent

transformative mixed-methods approach (Hanson et al., 2005; Johnson & Onwuegbuzie, 2004), emphasizing the qualitative data. The qualitative and quantitative data were collected simultaneously, analyzed separately, and then compared. I analyzed the qualitative data via thematic analysis (Braun & Clarke, 2012) and the quantitative data for narrative change in clinical descriptors. Iterative changes were made throughout the delivery of the MSC program based on the CBPR collaborations and applied to Manuscript 2. The youth from the CBPR study recommended that the modified SC program be delivered in a school-based setting to help with transportation issues in small city centres, reduce stigma in seeking out services, and help reduce barriers to seeking support outside school hours. Additionally, the group felt strongly about engaging younger youth during the transition to high school to help reduce the onset of mental health challenges.

Manuscript 2

Manuscript 2, found in Chapter 5, engaged in a 2 × 2 crossover design evaluation of the CBPR-modified SC intervention for AFAB Grade 9 physical health and education class in the local anglophone public high school in a small city centre. The goal of the pilot project was to understand if Grade 9 AFAB students who participate in a refined school-based SC program would experience an increase in mental health (i.e., well-being, SC, and value-based living) and a reduction in symptoms of mental illness (i.e., depression, anxiety, anger, destructive behaviour, low self-concept). The details of the individual projects will be presented in Chapters 4 and 5, while this chapter will outline the overall methodology.

Participants

Manuscript 1 Participants

I presented the goal of this engaged research project to the executive director of the local children's mental health centre in hopes of partnering with the organization for space and a small amount of funding. After the presentation, the executive director presented the proposal to the board of the organization. The board offered space and an allowance of money (Can$1,200) to help purchase yoga mats, binders, snacks, lunch, Can$5 Tim Horton gift cards for participants, and Can$10 Tim Horton gift cards for volunteer practitioners affiliated with the study. Youth participants also received a Can$50 stipend or a 25-hr volunteer credit for their participation. Youth in Ontario must complete 40 hr of community volunteering to graduate from high school; however, all the youth chose the money.

After receiving ethics approval from McGill (Ethics #469-0413; see Appendix A), I recruited youth from various settings within the community. I identified the community of interest as any youth (between the ages of 16 and 21 years) who had experience seeking mental health support from a formal professional and lived in the small city affiliated with the project. The inclusion criteria helped to focus on a community that might have experienced marginalization as youth living within a small city centre and who had experienced mental health challenges. This small city has a population of less than 17,000. Youth over the age of 12 can consent to mental health treatment in Ontario; however, university ethics required that youth be over the age of 16. It was necessary to include only those who could consent to participate in hope of increasing agency. I recruited youth from local schools and community support programs. Emails were sent to the local college, high schools, and LGBTQ+ group (see Appendix B). With gatekeeper permission, I placed posters at each local anglophone high school,

at the children's mental health centre, and at the community grocery stores. The local LGBTQ+ youth group did not respond to the request. The posters (see Appendix C) advertised an information session about a potential collaborative research project to promote youth mental health.

I hosted a recruitment session at the local Salvation Army youth group, which met at the local children's mental health centre, and met five youth individually. I used a script for recruitment (see Appendix D) that focused on the importance of confidentiality, the timeline, and the level of commitment required from participants. We discussed the benefits of participation: remuneration, learning about research processes, skills to support personal well-being, and an opportunity to advocate for change in their community's mental health. The youth asked questions and discussed any concerns. At the end of the recruitment session, individuals interested in the project completed a consent form (see Appendix E), a one-page demographic information contact sheet (see Appendix F), and the Depression, Anxiety and Stress Scale–21 (DASS21; Akin & Çetın, 2007).

The demographic information sheet and DASS21 measures gathered the information for exclusion and inclusion criteria (i.e., participants were not in crisis and had experience in formal mental health programming). None of the youth revealed that they were in crisis on the demographics form. However, four youth were in the extremely elevated range for depression on the DASS21. I contacted the four youth via telephone to conduct additional screening to determine if they were at risk for suicidality and if they felt they could participate in the study. The screened youth were not actively suicidal, were connected to a mental health professional, and were invited to participate in the study. I sent an email inviting the youth to participate in the study (see Appendix G). The goal was to recruit 12–14 youth with the goal of retaining eight or

nine to remain engaged for the entirety of the project (Becker et al., 2005). (For further information regarding the demographic data of the youth who agreed to participate, see Appendix H). As indicated on the demographics table, the youth who dropped out of the project were older and more ethnically diverse than those who participated in at least 50% of the intervention.

Manuscript 2 Participants

The CBPR group wanted to recruit students for further iterations of the modified SC during their transition to high school. The decision to engage all AFAB students was based on theory and through collaboration with the school board. The local anglophone public school wanted to partner with the project and felt that the program met the curriculum goals of the physical health and education classes. The Ontario physical health and education curriculum focuses on promoting well-being and strategies to reduce mental distress (Government of Ontario, 2015).

I made a presentation to the local public school board proposing a collaboration. In that meeting, we agreed upon modifications to the recruitment process. The board required that parents consent to their children's participation in the program and that the youth assent. The school board approved the project (see Appendix I). Prior to entering the high school, I met with the school board's mental health lead, the school's principal, the classroom teacher, and the school's mental health worker. We discussed the importance of integrating into the curriculum without changing significant aspects of the theory. Additionally, we agreed that the school's mental health worker or a teacher would attend sessions as an observer and be available to students whom the process might trigger.

Once cleared by McGill ethics (#356-0118; see Appendix J), I presented on the first day of classes during the second semester of school (January–June) to about 20–24 students enrolled in one of two all-AFAB Grade 9 physical education and health classes. The school did not report the exact number of students enrolled in the classes. My initial goal was to recruit 26 students per group in order to achieve a moderate effect size (Cohen, 1992). Students enrolled in one of two AFAB Grade 9 health and physical education classes at the school. Both classes were taught by the same teacher and followed the same curriculum. The presentation followed a similar script to Manuscript 1 (see Appendix K). I discussed the importance of confidentiality, timeline, the study design, and the benefits to youth who participated. The benefits were the potential development of skills to support personal well-being, the ability to participate free of charge in a program that generally costs upwards of Can$300, and an opportunity to add their voice to the conversation on changing mental health within their community. The meeting also provided an opportunity for youth to ask questions and discuss any concerns regarding the project design. I informed the youth that they have the right to not participate in the project or to withdraw from the project at any point without affecting their grades. At the end of the session, interested students took a consent form home to their parents/guardians that offered them the right to contact the me with questions and an assent form to give the students time to review the project and make an informed choice (see Appendix L).

The following week, all students who returned their assent and consent forms completed an electronic version of the pre-intervention questionnaire. The students were given Chromebooks with a link to Qualtrics (https://www.qualtrics.com/login/), where they completed the pre-intervention package. Each student was assigned a workshop participant number that linked to their questionnaire. Two students were not in attendance on the second day of class but

wished to participate. Once I received their assent and consent forms, an email was sent to them that included the link to a pre-intervention questionnaire. The students completed all the questionnaire packages before the first intervention session. I screened for a mental health crisis via the demographics form and the BYI-II (Beck et al., 2005). I screened for any youth at risk for suicide ideation and hopelessness (as per two questions on the BYI-II) and those who score in the extremely high range for depression. The high-risk youth and their parents were contacted immediately by me or the school support worker. These students were then followed by the mental health worker throughout the project and given crisis support information (see Appendix M). The at-risk youth were allowed to continue with the project if they agreed to connect regularly with mental health support at school or the local youth mental health centre (via walk-in or assigned therapist). During the intervention, the school support worker was available for private consultation for all participants. The local community mental health program also agreed to be available for anyone who would like to debrief with the mental health worker not affiliated with the project.

Finally, I facilitated the group. I am trained as a clinician and trained in group facilitation (therapeutic and research) and crisis management (suicide risk assessment training). I monitored the students throughout the project. In total, 33 students agreed to participate. Group A was the first group to participate in the intervention (February–April), followed by Group B (April–June). When not participating in the intervention, the students engaged in school as usual. The two groups participated in the intervention 1 day a week for 8 weeks, with three additional sessions for quantitative measure completion. Students were randomly assigned to one of the two classes by the school. Students who elected not to participate in the study engaged in a curriculum-based health class.

Measures

Quantitative Measures

Demographic Questionnaire. An 18-item demographic questionnaire asked participants for information about their age, caregivers, cultural identification, gender identity, sexual orientation, work, extracurricular activities, financial comfort, and mental health status. (See Appendix N for demographics sheet used in Manuscript 2).

Depression, Anxiety and Stress Scale–21 (DASS21). The DASS21 is the short version of the original 42-item model (Lovibond & Lovibond, 1993, as cited in Lovibond & Lovibond, 1995). The DASS21 is a self-report inventory designed to measure experiences of depression, anxiety, and stress as three separate constructs. Examples of questions include "I found it hard to wind down" or "I couldn't seem to experience any positive feelings at all" (see Appendix O). Lovibond and Lovibond have validated the DASS21 for use with individuals aged 14 and older. Questions in the Depression subscale focus on experiences of hopelessness, loss of interest, low mood, and low self-concept. The subscale does not measure suicidal ideation, issues with sleep, or appetite. The Anxiety subscale measures physiological changes (e.g., dry mouth, difficulties breathing, trembling hands) and feelings of panic. Finally, the Stress subscale is focused on agitation (e.g., feeling on edge, feeling touchy) and difficulties relaxing.

There are seven items on each subscale on the DASS21. The measure asks participants to rate on a 4-point scale ranging from 1 (*does not apply to me at all*) to 4 (*applied to me very much or most of the time*) how often the statements applied to them over the last week (e.g., "I found it hard to wind down"). The scores are multiplied by two, and then the severity of distress is measured against the original 42-item measure proposed by Lovibond and Lovibond (1995). The

severity rating for each subscale ranges from normal to extremely severe. The DASS21 is not a diagnostic tool.

Initially developed using healthy samples as the norm, exploratory factor analysis indicated that the significant factor loadings for depression range from 0.52 to 0.84, for anxiety from 0.55 to 0.91, and for stress from 0.48 to 0.82 (Antony et al., 1998; Osman et al., 2012). Osman et al. (2012) also noted the excellent reliability (Cronbach's $\alpha = .94$ for depression, .87 for anxiety, and .91 for stress). In adolescent samples, the factor loadings are 0.73 to 0.89 for depression, 0.53 to 0.90 for anxiety and 0.51 to 0.82 for stress (Moore et al., 2017). At the same time, the test–retest reliability is .86 for depression, .80 for anxiety, and .82 for stress (intraclass correlation coefficients; da Silva et al., 2016). Finally, the internal consistency was depression, $\alpha = .88–.92$; anxiety, $\alpha = .79–.81$; and stress, $\alpha = .81–0.82$ (Evans et al., 2020; Tully et al., 2009).

In Manuscript 1, I used the DASS21 as a screening measure. The DASS21 is not a clinical measure and was overly sensitive to the challenges of the group that experienced mental health challenges. Before the first meeting, I requested an amendment to the ethics regarding the mental health measures for the project. The Beck Youth Inventory–II (Beck et al., 2005) replaced the DASS21 because the measure is more sensitive to clinical variability.

Beck Youth Inventory–II. The BYI-II (Beck et al., 2005) consists of five scales: Depression, Anxiety, Anger, Disruptive Behaviour, and Self-concept. Each scale consists of 20 items that the youth (ages 7–18 years) rate on a 4-point scale from 1 (*never*) to 3 (*always*). Examples of questions include "I worry people might tease me" or "I argue with adults" (see Appendix P for excerpts). I summed the total scores for each subscale. High scores on the mental health measures indicate more significant concerns (average to extremely elevated). In contrast, high scores on self-concept indicate a greater relationship to self (much lower than average to

average). This measure is valid and reliable for clinical and community settings (Beck et al., 2005). The reliabilities reported in the BYI-II manual indicate that the internal consistency for adolescents aged 15 to 18 years ranges from $\alpha = .91$ to $\alpha = .96$ for the five scales, while the test–retest reliability for a subsample of 65 youth over 8 days ranges from .83 to .93. The validity measured via factor analysis signified that the same cohort of youth ($n = 100$) on the mental health measures ranged from .54 to .82 for AFAB and .62 to .84 for AMAB. The self-concept factor analysis ranges from −.40 to −.59. The Cronbach's alpha for the school-based study (Chapter 5) was BYI Self-Concept, $\alpha = .96$; BYI Anxiety, $\alpha = .95$; BYI Depression, $\alpha = .97$; BYI Anger, $\alpha = .94$; and BYI Disruptive Behaviour, $\alpha = .83$. I did not calculate Cronbach's alpha in Manuscript 1 (Chapter 4) due to the small sample size.

Self-Compassion Scale–Short Form. Researchers primarily use the Self-Compassion Scale (SCS) developed by Neff (2003a) to measure SC. Neff employed undergraduates in focus groups to conceptualize the SC constructs for research and use appropriate language. The scale comprises 26 items, and researchers have validated the measure for use with adolescents (age 14+) and young adults (Neff et al., 2007; Neff & McGehee, 2010) in many different languages. The original 26-item scale consists of questions relating to SC's three positive core components (self-kindness, common humanity, and mindfulness) and three contradictory elements (self-judgment, isolation, and over-identification). Each of the positive components has an opposite negative factor that is reverse scored to compute an overall SC score. Neff (2003a) reported that the full-scale measure has excellent internal consistency ($\alpha = .93$) and test–retest reliability (0.93 for the total SC score). The SC short form (SCS-SF; Raes et al., 2011) is a 12-item SC measure with good internal consistency ($\alpha \geq .86$). Therefore, both the long and short forms have good psychometric properties, with the long form being best suited for component studies.

There is an ongoing debate about whether the SCS should be used as a higher order single-factor measure (overall SC score), measured via the six factors (three positives and three negative subscales), or two factors (compassionate responding vs. uncompassionate responding). There is evidence for the use of all approaches, but Neff and colleagues (Neff & Tóth-Király, 2020; Neff et al., 2017) argued that there is confirmation for the higher order single-factor model and the six-factor model originally proposed. Additionally, Neff et al. (2019) continued to support using the SCS-SF as a valid and reliable measure. The measure was scored based on the total SC score and not based on the individual factors. The SCS-SF was used to help reduce the number of questions posed during data collection. (For further information regarding this debate, see Brenner et al., 2017; Kotera & Sheffield, 2020; López et al., 2015; Neff, 2016). Examples of questions on the SCS-SF include "I try to see my failures as part of the human condition" and "When I'm feeling down I tend to obsess and fixate on everything that's wrong." The Cronbach's alpha for the school-based study (Chapter 5) with the SC-SF was $\alpha = .86$. I did not calculate Cronbach's alpha in Manuscript 1 (Chapter 4) due to the small sample. (See Appendix Q for measure.)

The Mental Health Continuum–Short Form. First introduced by Keyes (2005), the Mental Health Continuum–Short Form (MHC-SF) is the 14-item version of the 40-item Mental Health Continuum (Keyes, 2002). Well-being has been defined and measured in several ways, such as emotional (EWB; Diener & Chan, 2011; Diener et al., 1985; Long et al., 2012), social (SWB; Keyes, 1998; Keyes et al., 2002), and psychological (PWB; Ryff, 1995, 2013; Ryff & Keyes, 1995). Feeling good, positive, or satisfied with life are examples of *hedonic* well-being, which measures feelings of positive and negative affect and feelings of subjective happiness, while *eudaimonic* well-being goes beyond happiness and addresses an individual pursuit to strive

toward fulfilling their potential (Kashdan et al., 2008; Waterman, 1993; Waterman et al., 2010). PWB is similar to eudaimonic well-being based on striving to reach potential (Ryff & Keyes, 1995; Ryff & Singer, 2008). Additionally, Keyes argued that SWB is also a eudaimonic pursuit and is an essential variable in functioning (Keyes, 1998, 2002). The MHC-SF is a well-being measure that includes six items measuring PWB, five items for SWB, and three items measuring EWB (see Appendix R).

The MHC-SF includes three items that measure EWB, including feelings of happiness, satisfaction, and interest in life. Ryff and Keyes (1995) developed a multidimensional framework for PWB based on a combination of theories focused on defining qualities of wellness beyond subjective evaluations. The PWB framework comprises six dimensions measured on the MHC-SF: personal growth (a sense of continued growth and development as a person), positive relations with others (quality relationships with others), environmental mastery (to manage life effectively), autonomy (a sense of self-determination), purpose of life (the belief that one's life has purpose and meaning) and acceptance of self (knowledge and tolerance of self and limitations). Keyes (1998) highlighted the importance of social interactions and community as essential constructs in eudaimonic well-being beyond PWB factors. Keyes proposed five items related to SWB and represented them on the MHC-SF: social integration, social acceptance, social contribution, social actualization, and social coherence.

The 14-item MHC-SF, available for both adults and adolescents, asks participants to rate how often they experienced the feelings of well-being in the last month on a 6-point scale ranging from 1 (*never*), to 3 (*2–3 times a week*), to 6 (*every day*). Examples of the questions on the MHC-SF include "During the past month, how often did you feel… happy" (Q1) or "that people are basically good" (Q7). (See Appendix R for the complete measure.) In Manuscript 1, I

scored the MHC-SF categorically to represent youth whose well-being was flourishing, moderate, or languishing in mental health. *Flourishing* represents an individual who experienced one of three items of EWB and six of 11 items of PWB or SWB "every day or almost every day" in the past month. *Languishing* represents an individual who experienced one of three items of EWB and six of 11 PWB or SWB "never or only once or twice" in the past month. Individuals who are neither languishing nor flourishing are labelled moderately mentally healthy. In Manuscript 2, I scored the MHC-SF using the total score, with higher scores representing greater well-being.

The MHC-SF has been validated in both adult (Keyes et al., 2008; Lamers et al., 2011) and adolescent samples (Donnelly et al., 2019; Luijten et al., 2019; Söderqvist & Larm, 2021). In a Canadian university sample ($M_{(age)}$ = 18.4, *SD* = 2.4), the MHC-SF internal consistency Cronbach's alpha coefficients ranged from α = .78 to α = .90; while the reliability coefficients ranged from .79 to .90 (Jöreskog's rho). The fit indices based on a multigroup confirmatory factor analysis indicated that items loaded significantly with their well-being factor (0.94) for the three-factor well-being model and 0.84 for one overall well-being factor (Doré et al., 2017). The Cronbach's alpha for the school-based study (Chapter 5) was α = .94. I did not calculate Cronbach's alpha in Manuscript 1 (Chapter 4) due to the small sample size.

Values Questionnaire. The Values Questionnaire (VQ; Smout et al., 2014) is a 10-item instrument that measures an individual's felt awareness and perseverance toward or felt obstructions or avoidance away from living a valued life. Participants rated on a 7-point Likert-type scale ranging from 0 (*not at all true*) to 6 (*completely true*) how true each statement was for them over the past week. Five items measure progress (VQP), and five items measure felt obstruction (VQO) in valued living in the past week. Examples of VQP questions include "I

worked toward my goals even if I didn't feel motivated to," while an example of a VQO question is "Difficult thoughts, feelings or memories got in the way of what I really wanted to do" (see Appendix S for the measure). Smout et al. (2014) defined values on the VQ from an ACT (Hayes et al., 1999) framework in that values are self-determined principles that guide behaviour. Higher scores on the VQP and VQO (scale ranging from 0 to 30) indicated more felt progress or obstruction toward an individual's values, respectively. The benefit of using the VQ instead of alternate valuing measures is that the youth do not need to define their values but focus on value-directed behaviours (see Appendix S).

Developed in an undergraduate sample ($M_{(age)}$ = 20.4 years, SD = 4.5 years), this measure has yet to be validated in adolescent samples. In the initial scale development study, Smout et al. (2014) reported an excellent fit in the confirmatory factor analysis ($\chi^2(33) = 47.3$, $p = .51$, $CFI = .99$, $RMSEA = .04$, 90% CI [0.00, 0.06]) and good internal consistency for VQP, $\alpha = .87$, and VQO, $\alpha = .87$. Since that time studies continue to report adequate reliability and validity with undergraduate students and both community and clinical adults. Researchers reported internal consistency to be between 0.68 and 0.89 for the VQP and between 0.64 and 0.90 for the VQO (Dereix-Calonge et al., 2019; Levin et al., 2017a, 2017b; Mosher et al., 2017). Two studies to date have used the VQ with adolescent samples. Bernal-Manrique et al. (2020) did not report validity and reliability in their sample, while Weeks et al. (2020) reported internal consistency for the VQO as 0.90 for LGBT+ adolescents (n = 152, $M_{(age)}$ = 15.88, range 13–18 years). The researchers did not use the VQP. Cronbach's alpha for the school-based study (Chapter 5) for VQP was $\alpha = .87$ and for VQO, $\alpha = .81$. I did not calculate Cronbach's alpha in Manuscript 1 (Chapter 4) due to the small sample size.

Multidimensional Student Satisfaction With Life Scale. Used solely in manuscript two, the Multidimensional Student Satisfaction With Life Scale (MSSLS; Huebner, 2001) is a 40-item, 6-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*) that assesses students' felt satisfaction in a variety of areas in their lives (i.e., school, family, friends, self, and living environment; Huebner, 1994; Huebner et al., 1998). Examples of questions on the MSSLS include "My friends are nice to me" or "I like being in school" (see Appendix T for the measure). There is a robust body of literature suggesting the reliabilities for adolescents range from 0.70 to 0.90 and test–retest reliability over 2 to 4 weeks ranging from 0.70 to 0.90 (Dew & Huebner, 1994; Greenspoon & Saklofske, 1997; Huebner, 1994; Huebner et al., 1998). In a study focused solely on MSSLS during the transition to high school (Grades 8–10), Antaramian and Huebner (2009) reported test–retest reliabilities for 1 year ranging from 0.29 to 0.59 (excluding friends) and 0.41 to 0.59 after 2 years. Friends was the only category that was not satisfactory reliable after 1 year, which the researchers suggest was due to peer challenges during that timeframe. The researchers also noted acceptable internal consistency (ranging from 0.82 to 0.95) for research purposes for each of the 3 years in all domains of the MSSLS except for satisfaction with self during Year 1 (see Veronese & Pepe, 2020 for a review). For this paper, the total score for the scale was used, with higher scores representing greater overall satisfaction with life. Cronbach's alpha for the school-based study (Chapter 5) with the Multidimensional Student Life Satisfaction Scale (MSLSS) was $\alpha = .92$. The MSLSS was not used in the CBPR study (Chapter 4).

Qualitative Data

YE Feedback. The Student Commission at the Centre for Excellence in Youth Engagement (Pancer et al., 2002) recommended critical components for understanding youth

experiences in engagement: head, heart, and feet. Scott (2003) added a relational connectedness component, spirit. The questions focus on *head*, or what they learned from the experience (cognitive aspect); *heart*, or what they felt about their participation in the experience (affective aspect); *feet*, or what they intend to do as a result of their involvement (behavioural factor); and *spirit*, or how their experience connects or contributes to something outside of the self. The qualitative YE measure developed for this dissertation used these recommendations. I used this qualitative process monitoring measure in both studies. The measure includes nine questions focused on what the participants learned during each session. Examples include how the youth can apply their learning to their lives, how the youth felt about what they learned, if the youth felt the space was welcoming, and if the youth felt they had the opportunity to share their thoughts and experiences (see Appendix U).

Other Qualitative Measures. I also collected qualitative data for Manuscript 1 via workbooks (see Appendix V for example pages), interviews (see Appendix W for template), and researcher observations and mind-maps (see Appendix X for examples). Additionally, I collected workbook data for Manuscript 2. However, due to COVID-19 and other unforeseen circumstances, I am not presenting these data in this dissertation project.

Procedures

Manuscript 1 (Chapter 4) outlines the mixed-methods research project completed in collaboration with the youth living with mental health challenges. Manuscript 2 (Chapter 5) presents the quantitative data from the school-based pilot study. Both manuscripts highlight the procedures for conducting these studies and are not shown in this chapter. Additional procedures and analysis outcomes can be found in the appendices. From Manuscript 1, Appendix Y presents the thematic maps and Appendix Z presents the table of the pre–post qualitative descriptors of

the quantitative data. Finally, from Manuscript 2, Appendix AA presents the map of the participants included in the data analysis table and Appendix BB presents the student demographics.

Rigour for Qualitative Data

As noted in manuscript one, rigour was applied using Morse's (2015) refined rigour for qualitative data framework. Morse returned to the language of reliability and validity often used in positivist research. Morse linked validity and reliability to the trustworthiness constructs posed by Lincoln and Guba (1986) in their goal of assessing the quality of qualitative research. Lincoln and Guba focused on credibility, transferability, and dependability. Internal validity (credibility) helps determine if the outcomes represent the participants' experiences. External validity (transferability) examines how the results transfer to the larger community. Reliability (dependability) focuses on the study's methods and results for replication (Merriam & Grenier, 2019; Morse, 2015; Morse et al., 2002). I used a variety of approaches to achieve rigour in both studies.

The validity, formerly referred to as credibility, was attained via a variety of approaches.

1. A prolonged engagement of the process was obtained by spending several years developing relationships with the community of interest. I also spent 5 weeks building a relationship with the participants in Manuscript 1 to build trust and honour individual participant experience with the approach. I used observational notes that reflected the youth for member checking and debriefing. Finally, I applied the lessons learned in Manuscript 1 to present a community-refined SC in Manuscript 2.

2. I used multiple data sources for triangulation (i.e., participant workbooks, participant interviews, observational notes). Using various data collection approaches helped advocate for

youth voices (qualitative data), understand their felt outcomes compared to peers (quantitative data), and understand the overall experience of clinicians and gatekeepers.

3. I used reflectivity to help bracket my biases.

4. The practitioner who helped guide the workshop coded the data from Manuscript 1 separately; we then met and discussed our findings to achieve peer-reviewing. The goal was to increase interrater reliability and challenge discrepancies in themes. Additionally, the clinicians from Manuscript 1 reviewed the modifications made to the SC program in Manuscript 2 to ensure that their experiences with the material were also captured. I used a thick description of the data to achieve reliability. The peer reviewer and I also analyzed those data to the point of saturation. An audit trail of the entire process was developed and is available upon request.

Chapter 4: Manuscript 1

An Exploration and Evaluation of a Self-Compassion Program With Youth Living With Mental Health Challenges: A Community-Based Participatory Research Approach

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Abstract

This study aims to understand youth experiences in a self-compassion (SC) intervention using a community-based participatory research (CBPR) approach in support of knowledge translation. Five cisgender White youth ($M_{(age)}$ = 16.84 years) who had experience with mental health challenges agreed to collaborate. After receiving ethics approval, all interested youth who met the inclusion criteria participated in one CBPR workshop and four SC intervention sessions. After each intervention session, the group met to discuss their experiences and modify the intervention. A concurrent transformative mixed-methods research process, prioritizing the qualitative research, was used. Qualitative data were gathered using participant workbooks, post-intervention interviews, CBPR notes, and researcher observations. The quantitative data focused on pre–post mental health, well-being, and values. The quantitative measures were analyzed using qualitative descriptors used in clinical settings. Inductive thematic analysis was used to generate individual participant narratives and overall group themes. The youth reported benefits from participation. Group themes were (a) relationships to self, (b) building awareness, (c) relationships to others, and (d) values and goals. The outcomes account for youth experiences with SC and as collaborators in this program's CBPR modification. This study's findings add to the literature by understanding youth experiences from participation in a SC intervention and as collaborators in research for knowledge translation. The study also adds information regarding CBPR in clinical practice.

Keywords: self-compassion, mental health, knowledge translation, community-based participatory research (CBPR), values

Exploration and Evaluation of a Self-Compassion Program With Youth Living With Mental Health Challenges: A Community-Based Participatory Research Approach

Young people worldwide are experiencing an increase in mental health issues, leading to economic burdens and lifelong disease (Whitney et al., 2019). In Canada, there has been a significant increase in anxiety, depression, and conduct-related concerns (Mental Health Commission of Canada, 2017); it is expected that by 2041, 1.2 million Canadian children and youth (ages 9–19 years) will be living with a mental illness (Smetanin et al., 2011). Without intervention, these young people are at risk for lifelong complications. Furthermore, many young people who experience distress do not seek professional support and may not be represented in these epidemiological numbers. There is an urgent need to give young people with the skills necessary to navigate mounting personal, community and global crises (e.g., social media bullying, racism, COVID-19, climate change) so that they can become healthy and contributing adults. Consequently, there is a need to explore new and innovative ways to connect by understanding youth experience and the onset of mental illness.

The term *youth* represents the transitional age group between adolescence and adulthood (ages 14–24 years); this developmental period's physiological, social, and neurological changes and cultural aspects distinctly affect this age group (Larson et al., 2019). Canadian youth are more likely to rate their diagnosable mental health challenges as more significant than their parents rate youth's mental health challenges, female youth report greater concerns than males, and youth in small city centres report more significant challenges than their urban or rural counterparts (Georgiades et al., 2019). An increased understanding of challenges affecting the youth within a specific community and communicating directly with those young people to share their experiences will help enrich clinical and community-based interventions.

Self-Compassion

Self-compassion (SC) is the internally motivated capacity to be aware of and accept personal positives and negatives while actively alleviating emotional discomfort (Baer et al., 2012). According to Neff's (2003a, 2003b) definition, SC is an individual's capacity to be aware and not over-identify with their discomfort (i.e., mindfulness), a desire to relieve personal suffering (i.e., self-kindness) and an ability to see challenges as part of the broader human condition (i.e., common humanity). Self-kindness, mindfulness, and common humanity are the three key components of Neff's SC conceptualization and may be instrumental in helping young people cope with unescapable life challenges. In adolescent and young adult samples, trait SC has been found to contribute to healthy identity development and well-being (Lathren et al., 2019; Marsh et al., 2018) and to negatively correlate with symptoms of mental distress (Bluth et al., 2018; Muris et al., 2016). Overall, SC contributes to healthy development, but unfortunately, there is a decrease in SC during the transition into adolescence (Bluth et al., 2017), suggesting that this is a crucial phase in life for SC interventions.

Two evidence-based manualized self-compassion interventions use Neff's operationalization of SC. Mindful Self Compassion (MSC; Neff & Germer, 2013) is beneficial for adult populations, while Bluth et al. (2016) developed a program for adolescents and children. MSC was the only manualized SC intervention with emerging evidence of success when this research project began and was the basis for Bluth et al.'s intervention. Although both programs have reported significant benefits for mental health and well-being (Bluth & Eisenlohr-Moul, 2017; Neff & Germer, 2013), the literature has yet to clearly identify youth experiences in the program. The goal of these programs is to help individuals identify their struggles and actively engage in processes to alleviate their distress. An exploration of youth's understanding

and application of SC teachings and mental health outcomes from participating in MSC may help clinicians understand how to help young people navigate their current struggles without identifying a specific personal or societal challenge. However, the approach to engaging youth in the production of an emerging evidence-based intervention is vital for its application and uptake in communities. The science of using clinical interventions from evidence-based research in community settings is known as knowledge translation (KT).

Knowledge Translation

In Canada, KT is focused on decreasing the gap between research, evidence-based practices (EBPs), and uptake of intervention by stakeholders (Canadian Institute of Health Research, 2015). EBPs are often considered the gold standard for applied practice; however, they often fail to address systemic challenges in real-world settings (Cook et al., 2017). The practice of integrating individuals who use the intervention into KT is known as integrated knowledge translation (IKT). IKT often uses participatory approaches to research to capture the lived experiences of stakeholders who used the practice and can speak to the strengths and pitfalls from a community perspective. However, the research is often a top-down process that does not account for community goals or the consumer's experiences. Engaging youth in intervention research for their peers is crucial, given how rapidly youth culture changes and how EBP does not account for marginalized communities' experiences. In this case, the goal is engaging youth living with mental health challenges in an emerging EBP for their community.

Focused on health and social inequities, community-based participatory research (CBPR) uses a bottom-up research approach driven by the community's needs. CBPR allows youth, mental health practitioners, and researchers to engage in collaborative inquiry from initial problem identification to evaluating and implementing an emerging EBP (Wallerstein & Duran,

2003; 2006; 2010; 2017). Although it is infrequently used in psychotherapeutic research settings, community psychology and public health researchers have recognized the importance of participatory approaches to interventions for at least a decade (Minkler & Wallerstein, 2008; 2011). Participatory research allows both practitioners and youth to share their intervention experiences and increase validity, applicability, usage, and inform and expedite EBP development (Chambers & Norton, 2016). The lack of studies of CBPR in psychotherapeutic research highlights a significant gap in the literature and serves as an opportunity for interdisciplinary inquiry. Specifically, the use of CBPR allows for a collaborative investigation of SC programming benefits for youth populations to help facilitate KT.

Critical approaches to research invite the convergence of sociocultural experiences and can lead to outcomes based on those who attend and the interchanges between the researchers and the participants (Guba & Lincoln, 1994). Using a CBPR approach allows youth, adult mental health practitioners, and scholars to work collaboratively on this project to ensure the research is rooted in individual experiences and needs, employs joint decision-making, and helps explore best practices for conducting research with youth (Jacquez et al., 2013). Based on the first author's (AH) lived experiences as a child and family therapist, years of mental health community engagement with youth collaborators, and mental health practitioners' meetings, the mental health benefits of SC emerged as an essential and necessary topic of research for this community.

The purpose of this mixed-methods study was to gain an understanding of youth experiences in SC programming from a CBPR perspective. The investigation had three main questions:

1. What were the youth experiences of SC programming?

2. What have the youth learned about values from participation?

3. After participation in the SC intervention and participation in the CBPR iterative modification of the program, how do youth define SC and its three main components (i.e., self-kindness, common humanity, and mindfulness)?

Method

We used a concurrent transformative mixed-methods research process (Creswell et al., 2003; Hanson et al., 2005) emphasizing the qualitative data. This study analyzed the qualitative data narratively by analyzing inductive themes of each participant's experience in the process as individuals and the overall group experience (Creswell, 2013). Observational notes and memos from CBPR debriefings were analyzed as part of the process. Due to the small sample size, the quantitative data were analyzed by looking for a change in the data's clinical descriptors. A concurrent transformative method allows for an advocacy approach to better understand the experiences of the youth collaborators. This advocacy approach was used to add to the literature and practice of SC interventions for youth, which resulted from 4 years of consultation and collaboration with youth involved with mental health care, practitioners, the local school district, and university-based academics. This research article first presents a brief narrative of the process of problem identification and research methods developed with the community of interest. It then focuses on the outcomes of the intervention.

Participants

Youth who had mental health programming experience and lived in the children's mental health centre's catchment areas were the primary population of interest. Small city centres (population 1,000–29,999; Statistics Canada, 2017) are grossly underrepresented in research (Walmsley & Kading, 2018) and create a unique demographic for inquiry. All individuals

interested in the project were asked to complete a consent form, a one-page demographic sheet, and the Depression, Anxiety and Stress Scale (DASS; Lovibond & Lovibond, 1995). The demographic sheet and DASS were used to gather information for exclusion and inclusion criteria. Only youth who had experience in mental health programming and were not in crisis (not actively suicidal and not in the extremely elevated range on the DASS Depression index) were permitted to participate. Mental health programming experience was defined as having sought mental health support from professionals with appropriate training (Rickwood et al., 2005).

Youth Collaborators

Twelve youth met the inclusion criteria for participation and were invited to attend the first workshop session. Seven youth withdrew from the project for various reasons (e.g., family crisis, interpersonal conflict). This research focuses on the five youth who participated in at least 50% of the project (the workshop and at least two MSC intervention sessions). Participants were given pseudonyms (see Table 1). Four participants identified as cisgender females and one as a cisgender male (mean age 16.84 years, *SD* = 0.69, range 16.1–17.9). Four youth identified as heterosexual and one as bisexual. All were White, born in Canada to Canadian-born parents, and primarily English speakers (80%; one French–English bilingual). Most (71.4%) of the youth lived with at least one biological parent. None of the participants worked, but 80% indicated they had the money for basic needs most of the time, and 80% said they had money for fun sometimes. The youth who withdrew from the study also identified as cisgender, but they were older (mean age 18.31 years, *SD* = 1.29, range 17.0–20.5) and more ethnically diverse. The youth were offered a Can$50 stipend for their continued participation in the project. They also received snacks, lunch, and yoga mats.

Practitioners

Three mental health practitioners volunteered to participate. One was a psychologist who had training in SC, and two were bachelor-level social workers (BSWs) who worked with youth. The psychologist led the intervention, while one BSW helped engage the youth and attend to any questions or needs for clarity. The second BSW was available to youth who needed additional support. The practitioners received a Can$25 gift card.

Measures

The measures used were part of a more extensive research process. (For a research description of the measures, please see Henson et al., 2020). Due to the small sample size, there was not enough power for significant statistical analysis (Cohen, 1992). The quantitative data were analyzed by looking for a change in the individuals' data via clinical descriptors. The information presented is focused on the clinical use of the measures.

Demographic Questionnaire

An 18-item questionnaire included information about age, caregivers, gender identity, sexual orientation, cultural identification, work, extracurricular activities, financial comfort, and mental health.

Self-Compassion Scale–Short Form (SCS-SF)

The SCS-SF (Raes et al., 2011) consists of 12 items asking participants to rate how often they behave in a stated manner on a 5-point scale ranging from 1 (*almost never*) to 5 (*almost always*). Interpretation of the total score categorizes low, moderate, and high SC.

Mental Health Continuum–Short Form (MHC-SF)

The MHC-SF (Lamers et al., 2011) is a 14-item measure asking participants to rate on a 6-point scale ranging from 1 (*never*) to 6 (*every day*) how often they experienced EWB (e.g.,

happiness, satisfaction), psychological well-being (e.g., purpose in life, personal growth) and social well-being (e.g., social contribution, social coherence). The scores determine if the youth has flourishing (experiencing all three types of well-being), languishing (rarely experiencing the three types of well-being) or moderate (other variants) well-being.

Values Questionnaire (VQ)

The VQ (Smout et al., 2014) is a 10-item instrument that measures an individual's awareness of living a valued life. Values were defined as self-determined principles that guide behaviour. Five items measure progress toward values (VQP), and five items measure felt obstruction (VQO) in valued living in the past week. Higher scores on the VQP and VQO indicated more felt progress or obstruction toward valued living.

Beck Youth Inventory–Second Edition (BYI-II)

The BYI-II (Beck et al., 2005) consists of five scales: Depression, Anxiety, Anger, Disruptive Behaviour, and Self-Concept. Each scale has 20 items asking youth to rate how often they have felt or thought a certain way (from *never* to *always*). The totals for each subscale are summed. Higher scores on the mental health measures signify more significant concerns (range from average to extremely elevated). Higher self-concept scores denote a healthier relationship to self (much lower than average to average).

Procedure

Developing the Research Question and Reflexivity

AH has worked with youth living with mental health challenges for several years from a model focused on building youth–adult partnerships, supporting youth as decision-makers, and identifying roles that youth can assume within mental health organizations (Pereira, 2007). The youth were predominantly interested in program design and implementation for emerging

adolescents. Pilot projects and consultation with the mental health community explored how best to engage youth in research and what interventions might be beneficial. Youth experiences with mindfulness and SC became a key area of therapeutic inquiry. Informal and formal meetings with individuals involved in various aspects of mental health programming across Canada helped further develop the research question and procedures. Beliefs in the benefits of engaging youth in modifying and evaluating EBP were bracketed by seeking supervision both at the academic and community level during project development and throughout the intervention. This project's initiators were the community of interest, youth living with mental health challenges.

The research ideas were presented to the children's mental health organization in the city of interest. The youth mental health centre board supported the research by providing space and a small sum of money. The research process began once ethics approval was received from the affiliated university. The recruitment goal was to collaborate with youth who had experience with mental health challenges and who were interested in exploring mental health intervention design and implementation.

CBPR Workshop and MSC Interventions

The group met at the local children's mental health centre once a week for five consecutive Saturdays (a CBPR workshop and four SC sessions) to learn about the process and then evaluate and modify the Mindful Self-Compassion (MSC Neff & Germer, 2013) program.

CBPR Workshop. The mental health practitioners were not invited to the CBPR workshop, to maintain their role and build group cohesion. During the workshop, the youth completed their pre-intervention questionnaire packages and focused on building group safety via icebreakers (see Appendix CC), developing group norms, and practicing *mind-mapping*.

Mind-mapping offers verbal and nonverbal processing of visual maps of key words, images, and language used by the group and is taught as part of the academic curriculum in Canada.

MSC Intervention Sessions. Following the workshop, the group participated in four intensive and condensed versions of the MSC program (3 hr), including meditations, workbooks, discussions, and reflexive journaling. The condensed version of the MSC program was created in collaboration with a trained MSC practitioner and advisor to the project. AH was in an adjacent room taking observational notes. Two MSC training lessons from the original 8-week program were presented at each intervention session. The silent retreat was not included in the CBPR investigation. The sequences of sessions were as follows.

Session 1. Discovering Mindful Self-Compassion was an introduction to self-compassion and its three components: introducing mediation and using a SC break to help manage distress. Practicing Mindfulness focused on formal and informal practices of mindfulness, such as learning to be aware of present-moment experiences with acceptance.

Session 2. Practicing Loving-Kindness focused on repeating the phrases that invoke positive feelings for the individual. Finding Your Compassionate Voice helped identify and soothe the inner critic with compassion.

Session 3. Managing Difficult Emotions was focused on exploring the cognitive and physical components of emotions and how to soften the difficult emotions with compassion. Living Deeply was an exploration of personal core values that bring meaning to each life and ways to engage in SC when not living in values congruence.

Session 4. Transforming Relationships asked participants to focus on a challenging relationship with another person. This session focused on releasing old wounds and cultivating forgiveness. Embracing Your Life focused on anger and savouring goodness and gratitude.

At the end of each session, the practitioners left while the youth and AH had lunch and debriefed (1–1.5 hr). During the debriefing, we held group discussions and used mind-mapping to keep a record. We explored the youth experience with the MSC techniques, deconstructed SC constructs, explored questions generated by observations, and discussed adapting the practices for peers. In congruence with CBPR (Israel et al., 2005), information that emerged during debriefing was reflected to the youth for feedback. The youth then completed a qualitative tool to assess felt engagement and progress monitoring. Information learned was used iteratively in the following session (e.g., soft music, fidget toys, options for meditation positions, warm-ups, and reducing the length of the meditations to 5-7 min). Practices to use at home each week were recommended and a reminder email was sent midweek between sessions (see Appendix DD).

Workbooks. The youth were given workbooks that contained activities related to the intervention with space for personal reflections as prompted by the facilitators, reflection on specific questions posed in the workbook, and artwork or personal expression.

Post-Intervention. At the end of Session 4, participants were asked to complete questionnaire packages, consent to have their workbooks photocopied, and schedule individual interviews with AH. Two weeks later, the youth met with AH for a postsession interview that was audio-recorded and later transcribed (see Appendix EE for confidentiality agreement). During the interviews, the youth were asked open-ended questions about SC's components and gave feedback about their overall experience. The practitioners and AH met separately to talk about their observations.

Data Analysis

The qualitative data (i.e., workbooks and semistructured interviews) were first analyzed narratively to explore each participant's experience in the process. The data were then analyzed

via inductive thematic analysis (TA) by examining each group members experiences across the intervention. As a method of analysis, TA allows for an exploration of themes that emerge from the participant's experiences in the intervention from a critical lens of inquiry (Braun & Clarke, 2012). The analytic method followed the Braun and Clarke (2006) process, which proceeds from familiarizing oneself to the data through generating codes and searching for themes. Once the themes were generated, maps of the themes were created, and ongoing refinement ensued. Particular attention was paid to the semantic approach to the inductive analysis, which allows for the data to be described based on the participants' language and then interpreted for implications and meaning (Terry et al., 2017). The researcher observations, memos from the CBPR group discussions, and the felt engagement reported weekly by the youth helped guide and further inform the research findings. Finally, the data were used to generate SC and values definitions based on the participants' experiences.

The quantitative data were collected at the beginning of the workshop. The youth then participated in the intervention, and the quantitative data were collected again at the last session or prior to the individual interviews (1 week after the last session). As noted above, a concurrent transformative mixed-methods (Creswell et al., 2003; Hanson et al., 2005) design was used (Qual + quan). AH analyzed both the qualitative and quantitative data during the data analysis phase and transformed the quant data into qualitative data (Leech & Onwuegbuzie, 2009) to help inform the narratives of the youth. A single-subject design (Ganz & Ayres, 2018; Price et al., 2015) was not appropriate due to inconsistencies in youth attendance: The intervention exposure was not the same for all the youth. The concurrent transformative approach is also in line with the critical theories and participatory research ideologies to empower the voices of the youth and help facilitate a new perspective on the data.

Rigour

Evolving from Lincoln and Guba (1986), Morse (2015) expanded the qualitative rigour language, highlighting validity and reliability to extend the standard for appraising qualitative research. A variety of approaches were used in this study (Merriam & Grenier, 2019). Validity was attained using the following techniques:

1. Triangulation: Multiple data sources (i.e., participant workbooks, participant interviews, quantitative data, observational notes, and discussion with practitioners) were used to understand the youth's overall experience.
2. Prolonged engagement of the process was obtained by spending 5 weeks with the group, plus more than 2 years meeting youth and practitioners working in youth mental health across Ontario to discuss the project.
3. Reflectivity was used to help bracket our biases toward the process.
4. Catalytic validity is an empowerment approach that challenges academics to create benefits for the community with whom the research is drawn (Lather, 1986; Rose & Johnson, 2020).
5. Peer-reviewing: The BSW who helped guide the workshop separately coded the data. We individually coded the data and then compared our results. Together we decided the primary themes. The goal was to increase interrater reliability and challenge discrepancies in themes. Reliability was achieved through a thick description of the data that were examined until the point of saturation. Finally, there was an audit trail of the entire process.

Results

The results of the intervention are first presented narratively to isolate the individual experiences of participants. The youth are presented by the number of sessions they attended. The results then illustrate the overall group inductive themes. Finally, each participant's final narrative is presented to highlight their individual learning.

In the beginning, all five youth reported moderate scores on the MHC-SF. At the end of the intervention, the MHC-SF for four participants remained moderate; Drew's score decreased to languishing. Additionally, all the youth felt a decrease in values obstructions (VQO), and four participants (except Taylor) experienced an increase in progress toward their values (VQP). These outcomes suggest that youth who participate in SC programming within a CBPR framework feel more inclined to engage in values-based behaviours with fewer obstacles interfering with their success. There was no effect on well-being. Due to a lack of noteworthy findings, no further information will be presented on these results.

Introduction to Collaborators' Individual Narratives

Attended Two Sessions

Taylor. At the beginning of the process, Taylor reported significant challenges with low SC (SCS-SF). Her self-concept was in the much lower than average range, while her anxiety, depression, anger, and disruptive behaviours were all extremely elevated (BYI-II). Her workbook highlighted her struggle to manage her academics and her physical and emotional violence toward herself and others. She reported that when upset she would "completely throw myself so much hate. I ask myself if I'm a good person . . . and is there anyone who even cares about me?"

Although Taylor was only present for the first two sessions, she began to identify benefits by engaging in the present-moment thinking and noticing her resistance. Taylor reported that she was resisting doing her schoolwork and found that mindfulness could help her slow down and take homework one question at a time. Simultaneously, she could use SC to take breaks when overwhelmed, calm down, and return to the problem with a new perspective.

Attended Three Sessions

Jordan. At the beginning of the intervention, Jordan indicated low SC and much lower than average self-concept. She had mildly elevated anxiety, depression, and anger, with moderately elevated disruptive behaviours. She noted that at school, while at risk of expulsion, she would "talk back to teachers, refuse to do my work, I get kicked out of class . . . refuse to hand over my phone, say 'Why are you so stupid,' 'What he [teacher] gonna do?'" She began to understand the importance of valuing herself and living in the present instead of resisting discomfort (i.e., "staying in class, getting a job, dropping friends who were bad for me").

Parker. At the beginning of the intervention, Parker reported low SC but above-average self-concept. He also had average depression and disruptive behaviours with mildly elevated anxiety and anger. During the first session, Parker reported knowing how he should treat himself but using negative internal dialogue for motivation. He was treating others with compassion but was hard on himself. During Session 1, Parker was cynical about the process but was open to learning. He began to think about his emotions and his resistance.

Drew. Drew reported low SC, while her mental health indicators suggested a much lower than average self-concept and extremely elevated levels of anxiety, depression, anger, and disruptive behaviours. Drew reported struggling with feeling isolated and unloved. She worried that relationships would end, so she pushed others away to feel safe. During the first session,

Drew indicated that when upset, she responded, “If I’m hurt, I’ll feel ashamed because this doesn’t happen to everyone. Only the ones who deserve it . . . I’ll shut down and stop talking. I just lose all the characteristics everyone loves about me.” During the same session, Drew began to highlight the potential benefits of SC; “It’s not wanting to support someone else, not about excuses!!! It’s all about you and what you want and need. Everyone needs a friend.”

Attended Four Sessions

Alex. At the beginning of the intervention, Alex was experiencing substantial struggles with her mental health. She reported low SC and lower than average self-concept. On the BYI-II, she reported elevated levels of anxiety, depression, anger, and disruptive behaviour. During the first session, Alex wrote that she was dealing with insecurities and difficulties with feeling safe in interpersonal relationships. She noted that when she experienced difficulties, she would “think negative thoughts and berate myself. I will cry a lot and blame myself for everything . . . and say that’s the reason nobody likes me.” Alex used the sessions to build a healthier relationship with herself and focused on supporting herself through difficulties.

Inductive Analysis

The participants’ experiences were analyzed inductively and resulted in the following themes: relationships to self, building awareness, relationships to others, and values and goals. Each theme was reported by all the participants, with the exception that Taylor did not report on values and goals.

Relationship to Self

All five participants reported experiencing a change in how they related to themselves. The youth spoke about an increased motivation for self-kindness (i.e., thoughts, words, behaviours), reducing the power of the inner critic, learning healthy responses to discomfort, and

experiencing an increase in self-acceptance. The youth experienced an increase in motivation for self-kindness and reducing the inner critic's power. The youth explored their relationship with their inner critic and whether this voice was ineffectively trying to help guide or protect them.

Parker explored how his inner critic was trying to help avoid sadness and anxiety when struggling with self-doubt. His inner critic was often angry with him: "You stupid idiot, just do it, or else you'll fail, and your life is ruined and you'll die alone." Through self-kindness, Parker was able to discover that his inner critic "was just trying to help me, but it wasn't doing it the right way, while drowning out my self-compassionate voice." He was also able to learn to nurture himself through difficult moments by changing the messaging while persevering: "come back to it with a fresh mind and get a new start. . . . It won't be like this forever. Another word that comes to mind is nourishment. It can't get worse!"

Taylor also explored her relationship with her inner critic. She felt her inner critic expressed itself through violence toward herself and destructive criticism. She felt that via words of compassion, she could tell herself "It's ok to suffer sometimes. You're not the only one feeling like this . . . give yourself love and kindness. Never give up, you're worth it, ignore the hate, love everything, but yourself more."

All five participants also began acknowledging unhealthy patterns and working on healthier responses. Jordan reported struggling academically and behaviourally while in school. In her final interview, she shared that she felt more responsible for her behaviours. She was trying to focus on school and taking an extra year of Grade 12 to increase her postsecondary success. She reported that she was at risk of getting kicked out of school, but she reflected on her actions and thought about different options through the process. She challenged herself to take a more active role at school, to handle disagreements with increased personal responsibility. Alex

also noted that she noted an increase in healthy behaviours. She reported that before the intervention, "I never really wanted to do anything before, whether it be chores, or draw, or read or anything. . . . I'd be so stressed, and I just want to sleep." Following the intervention, she noticed, "I'm going for walks, I'm drawing, I'm doing a lot more." Overall, the group noticed distress and increased their behavioural activation and healthier coping strategies.

Although all participants reported an increase in self-acceptance, Alex's learning experience to accept herself was profound. Alex struggled with body image and personal issues in her family, leading her to feel unlovable and unaccepted. Through the process, she was able to remember "how pain is normal and not let things affect me too much . . . and I need to love myself." She was able to soften her experience of distress. She learned to understand her anger to cope with sadness and reported hiding to reduce feared ridicule. She now focused on her goals: "I'd always want to put make-up on and hide my acne . . . and now I can go to school no make-up, and sweatpants, and feel great." She felt she had built a healthier relationship with herself.

Building Awareness

All the participants reported an increase of awareness, learning the capacity to acknowledge and engage, and they noticed the benefits of present-moment living. Through the SC process, all the participants became more aware of uncomfortable thoughts, feelings, and sensations and focused on managing their challenges. They also identified the benefits of present-moment living for internal peace.

Each participant explored a personal challenge that they experienced in life and a built awareness of related thoughts, feelings, and sensations. Drew reported struggling with feeling safe in interpersonal relationships. She would become avoidant to evade the emotional discomfort and potential ridicule from others. Through the process, she realized her thoughts and

emotions were trying to protect her and began to use more compassionate language to motivate her to do the things she was avoiding. She would encourage herself by saying, “Don’t listen to the trash, you are more powerful than anything. . . . It will benefit you in the end.” Her flexible thinking increased, and she noted that “maybe the relationship or friendship will work out . . . and not become trash the way my parents have shown me it turns out. I’ll never know until I try.”

Taylor felt that through awareness that she was avoiding school and the fear of failure, she could “tell myself to just go with the flow. . . . I should stop stressing about things because stressing will make things worse.” Finally, Parker explored his challenges with school and indicated that through awareness, he could remind himself, “I am indeed feeling this, and I need to accept that I’m feeling this” instead of avoiding. He indicated that he could use awareness to help motivate behaviours. He reported that “if I resist, it makes it so much worse. . . . If I teach myself SC then I will stop hurting myself and do the calculus and just get it done.”

Awareness of challenges also offered participants the opportunity to live in the present and respond based on their individual needs versus being flooded by difficulties in the past or the fears of the unknown future. Drew reported, “I want to engage in the moment all the time, I wouldn’t have my phone out all the time. . . . No worries and no regrets, just this time with the people I love,” suggesting the benefits of present-moment living instead of avoidance via social media. All the participants noted the benefits of the capacity to be comfortable with the present versus avoiding. For example, Alex felt that through present-moment living, “you just stop thinking about your past and start living in the moment, you will have more happiness . . . all of your worries or past experiences will be behind you but never forgotten.”

Meditations also helped the youth learn to slow down and reduce distress or to attune to positive experiences. Parker reported that through one meditation, he "felt calmed and relaxed"; Taylor said, "What came up for me is that a warm welcoming presence was flowing through my body making me feel like a good person inside." A guided meditation using a stone resonated with all the participants and helped with present-moment awareness. After the SC stone meditation, Jordan felt she "could keep this rock with me, through the good days and the bad. My rock has impurities and imperfections, but despite all flaws, it is still beautiful." She later reported using the rock to help support her through a difficult moment outside the session. The SC stone also resonated with Drew, who indicated that she "really liked it, so I'll watch it carefully . . . makes me feel stable, and I need to watch myself in the stone."

Relationships to Others

Each participant explored learning to identify toxic relationships, learning about themselves through others, and learning about the importance of identifying healthy relationships (i.e., connection and communication). During the first session, the participants identified their capacity to be a good friend and explored how they connected with a loved one in need. The cisgender females all explored toxic relationships with others and were working toward setting healthier boundaries. They all identified family, friends, or peers as sources of challenge and discomfort in their lives while also identifying other beings as support sources. Drew explored her fear of relationships: "When someone wants to have a friendship or relationship I tend to push people away because I don't want to turn out like my parents. I don't want to be hurt, but I also don't want to hurt them." Through the program, she explored her desire to connect and realized that her dog was a comfort source. "I thought about my dog. . . . I relaxed when I thought of this . . . we always just click when we're together."

Alex was able to identify others who brought her joy while setting boundaries with those who cause her perceived harm. She reported knowing that she was being judged by others but learning to acknowledge the positive people in her life. “I thought about her [a friend] and how supportive she is and if I ever need her she is there, so I feel happy when I think of how she makes me smile & laugh.” Although Parker did not explicitly explore his relationships with others during the intervention, he shared information about the critical people in his life, how he would like to share what he learned about SC with his family, and the importance of mutual respect.

The group also began to explore personal ethics and boundaries in relationships. They reflected on how their family and community relationships taught them about themselves and how they want to engage in the world. Alex was able to acknowledge that she must emulate the type of relationship she wanted: “Be honest with others to get the same honesty back.”

Values and Goals

Values and goals were primarily addressed in Session 3. Although both Taylor and Parker were absent, values and goal-directed behaviours were noted in four of the five narratives (including Parker). The themes related to values and goals were learning to value oneself and prioritizing their individual needs, the capacity to identify goals, and the desire to persevere. There was also a slight but emerging theme of valuing others via gratitude.

There were definitive statements regarding the discovery of the importance of valuing the self. Jordan indicated, “value yourself, treat yourself till you have nothing left”; Alex stated, “I vow to love myself through the rough times”; Parker specified that he “vowed to be someone you can talk to, may I be there for you.” He made this pledge in honour of himself and his relationship with others, while Drew reported, “If you value yourself, it would make sense that

you would give yourself that self-compassion." In the final interview, the four participants indicated that the process helped clarify academic goals for the future, focusing on persevering and being able to sit with discomfort while working to achieve the goal. They also explored an increase in task engagement and participation in their communities.

Parker and Alex reported in the last session that they were learning about the importance of valuing and paying gratitude to their relationships with others and the benefits of these positive relationships. During a gratitude exercise, they focused on the benefits of positive people in their lives and appreciated offerings. For example, Alex paid tribute to those who stepped in to support her and give her hope and "the love, honesty, and loyalty I receive." At the same time, Parker noticed tangible things such as his friend who offered to be the designated driver, his computer, and the opportunities, love, and support provided by others.

Narratives of Participants' Overall Experiences

Taylor

During the final interview, Taylor struggled to articulate her experience in the program. She talked about the benefits of sharing with others and learning she was not the only one who struggled. She also reported benefits from mindfulness, especially grounding techniques. She felt the program's overall benefit was learning to be more patient, confident, and willing to take more risks. Her SC (SCS-SF) increased from low to high, while stability was reported for self-concept (much lower than average). At the same time, her anxiety and disruptive behaviours remained extremely elevated (BYI-II). There was a decrease in depression and anger (extremely elevated to moderately elevated).

Jordan

Jordan reported that she was learning to prioritize her goals and to take care of herself. During the interview, Jordan indicated she was willing to work through challenges with others versus "shutting them out" and felt more responsible. She was spending more time with her family and friends and hoped to participate in her community. She thought that the program had helped her clarify and reach her goals. Jordan noted she felt she could now persevere through difficulties. "I speak out more to people that I don't really know. . . . I'll read in front of the class. . . . I'm up to try something new," and instead of fighting, she now "can actually like work through your problems." Finally, most of Jordan's scores on the measures remained stable except for SC (low to moderate) and her depression (mildly elevated to average).

Parker

Parker reported that he struggled with self-doubt regarding school and used his inner critic as a tool for motivation. Parker noted that through mindfulness and present-moment living, he could feel more peaceful and less stressed. He was learning to accept his distress and then use SC to cope with the feelings, recognizing that pain will pass and that taking breaks is important. Parker reported during his interview that he felt he was "more ready to give myself chances and accept myself when I make mistakes." He felt that the process "has made me much more confident in sharing my feelings, especially in a group situation." The measures indicated that Parker's SC increased from low to moderate and his anxiety and anger decreased from the mildly elevated range to average. However, he increased from average to moderately elevated depression, which he indicated was due to an issue with a peer.

Drew

Drew reported that learning to live in the present moment was beneficial, and she "wouldn't have my phone out all the time. . . . No worries and no regrets, just this time . . . with the people I love." She also reported that through SC, she could be less resistant to uncomfortable emotions. During the final interview, Drew talked briefly about feeling more upbeat and feeling more confident at school. She enjoyed the group process and thought she was able to learn a lot from sharing. Drew reported that she was more likely to engage in nonpreferred tasks and that she felt "It like help me prove that, after high school . . . I can be confident enough to go on further with my education." At the end of the intervention, Drew's SC increased from low to moderate. Her depression and anger reduced from extremely elevated to moderately elevated, while her anxiety and disruptive behaviours remained stable (i.e., extremely elevated range).

Alex

Alex used the process to explore her emotions, relate to her compassionate voice, and develop a safe space when overwhelmed. Through the meditations, she "wouldn't be so stressed. I wouldn't feel anger from my past or fear for my future." She felt freedom in the concept of living presently. She explored her relationship with her inner critic and found that she was causing herself needless suffering. She focused on her role in taking care of her well-being, and she began to value herself and those that support her. Finally, she explored valuing loyalty and honesty, and she found that she must emulate values in hopes of reciprocation. Alex reported learning that "self-compassion will help you lessen your resistance towards the situation by believing in yourself." She felt that SC "give(s) you the confidence to face your problems . . . instead of pushing away the problem and making everything worse."

During the final session, Alex reported that she ".. would like to remember how pain is normal and not to let things affect me too much, that I am beautiful, and I need to love myself." At the end, Alex was high SC and there were no longer reported concerns on the BYI-II with self-concept, anxiety, depression, anger or disruptive behaviour. Alex stated that when she began the program, "I didn't see a point in life. I wanted to die." She went on to describe how the program affected her: "After I started realizing my feelings and having self-kindness, I'm a lot more positive . . . and I see a good thing in life, and that I want to move forward."

Discussion

This study's primary goals were to understand youth experiences from participation in the MSC-modified intervention and how youth then define SC theory's primary elements from which the intervention derived. This clinical research was unique in that it followed a CBPR process, which calls for the community to participate at all stages of the research process (Israel et al., 2008). The youth participated in all stages due to the iterative modification of the program. However, due to time constraints they did not participate in the TA process.

Based on the data analysis, four main themes represent the participants' experiences in the SC intervention: relationship to self, relationship to others, building awareness, and values and goals. Currently, few research studies focus on the qualitative outcomes of participation in SC programming. Although their study had a limited focus on SC, Binder et al. (2019) found similar results, which support the current analysis that SC training offers insights into the self and its relationship to others. However, the present study expands that analysis and focuses on youth experiences with the program and the training principles.

Developing a more positive relationship to self was reflected in an increase for all participants, as measured on the SCS-SF and in the theme of relationship to self. There is a

significant body of literature suggesting that high SC levels are positively correlated with well-being, positive connection to self, and buffers against adverse life experiences (Marsh et al., 2018). Simultaneously, qualitative analysis indicates that youth feel that being self-compassionate would increase acceptance of self and work on self-improvement (Klingle & Van Vliet, 2019). The youth reported an increase in SC that was reflected in the quantitative SCS-SF results. These outcomes support the principle that youth who participate in SC-based intervention learn to accept themselves and acknowledge unhealthy ways of relating to the self, thus promoting that the intended theoretical underpinnings transcend theory to application. However, self-concept remained stable for two youth at much lower than average, while two experienced an increase in self-concept and one remained stable at average. The two youth that remained stable at much lower than average missed the final session. Perhaps the focus on transforming relationships and embracing life was important for feeling increasingly positive about oneself. This result further highlights that SC is not focused on building a sense of self but transforming how one relates to oneself (Germer & Neff, 2019).

The theme of building awareness was explicitly noted by all the participants. Differences exist in how mindfulness is operationalized in practice in the Western context. Kabat-Zinn (1994) defined mindfulness as cultivating present-moment awareness by paying attention nonjudgmentally in the present moment; however, Neff and Germer (2013) operationalized mindfulness as the capacity to hold painful experiences in a balanced awareness and then actively engaging with the discomfort (Neff, 2003). The youth identified both factors in their experience. The youth acknowledged the benefits of present-moment living and simply noticing thoughts, feelings, and sensations as well as the importance of awareness of difficulties and

engaging in self-soothing or behavioural activation to make changes. This finding highlights the exploration of mindfulness that participants engage during the MSC process.

Although common humanity is a core principle of the intervention, the theme of relationship to others appeared to be more focused on cultivating a healthy relationship and learning to identify toxic relationships than understanding the shared experience of human suffering. This finding may be a reflection on youth experience in interpersonal relationships. Adolescence is a time of individuation, moving away from the primary caregiver, and finding their community away from their primary families (Lane & Fink, 2015). This social learning and the importance of social acceptance are challenging to navigate. Therefore, the outcomes of relationships to others may be experienced differently depending on the participants' age. However, even in the mixed-methods analysis of an MSC-modified program for adolescents, Bluth et al. (2016) did not find youth focusing on others to be an outcome. Relationships with others as an outcome of MSC programming may be an important area for future research.

The Living Deeply session of the MSC program is focused on personal core values and engaging in value-congruent behaviours. Although there is some controversy regarding the use of values in Western mindfulness-based interventions versus the practices initially addressed in the Buddhist tradition, it is beyond this paper's scope (see Monteiro et al., 2019). The theme of values and goals was an outcome of the SC process. The youth identified what was important to them and engaged in cognitive refocusing and behavioural change toward their values and goals. The youth began to use the language of valuing themselves and others and paying gratitude to those important in their lives. The changes in values and goal-directed living have previously been suggested in the literature (Tirch et al., 2014) and are reflected in the values measure. Most of the youth reported fewer felt obstructions (VQO) and more progress (VQP) in moving toward

their values. Increased value-based living may lend itself to long-term change in well-being as measured by the MCH-SF. The youth reported stable, moderate well-being; however, latent changes may include an increase in both psychological well-being (e.g., purpose in life) and social well-being (e.g., social contribution).

The benefits and barriers from the intervention allow for further investigation regarding applying the program to specific populations. The youth reported an increase in safety and connection, but ongoing security issues in relationships outside the sessions persisted. The workbooks indicated residual fear of ridicule but that the youth were aware and working to address it. In youth populations, the fear of judgment and resisting forgiveness may need to be more explicitly addressed. The youth reflected on the challenges of interpersonal relationships and explicit judgment, which led to difficulties with forgiveness and resistance to let go of the anger associated, despite knowing it was harmful. In a world where judgment is brutal and damaging, the fear of ridicule and abuse of power is continuously reinforced. The effects of bullying and oppression and the universal core need to be loved and accepted should be addressed explicitly with examples relevant to the community.

The participants' overall benefits reflect the outcomes noted in other MSC-modified youth intervention studies (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016). However, it is interesting that the participants' qualitatively reported benefits were not consistently echoed in the outcomes of mental health measures (BYI-II). There was no consistent pattern of results in the mental health measures. The theme of building awareness may also help account for the inconsistent findings on the BYI-II mental health measures. Four of the five youth reported less depression (one reported a mild increase, but he said this was due to situational challenges), and four of five youth reported decreased anger. The youth were better able to hold their emotions

with balanced awareness. At the same time, the themes relationship to self, relationship to others, and values and goals may have helped with behavioural activation. Additionally, the three youth who missed the last two sessions remained quite anxious at the end of the intervention. The final sessions—Managing Difficult Emotions, Living, Transforming Relationships, and Embracing Your Life—may be particularly important for anxiety. Further research is needed. Finally, further research is needed into why these three same youth continued to have extremely elevated levels of disruptive behaviour. There is little research addressing behavioural disorders and SC. Both Miron et al. (2014) and Wisener and Khoury (2020) reported that dispositional SC had an inverse relationship to substance use; however, future research focused on externalizing behavioural disorders and SC is essential. Overall, Alex had the most significant outcomes for mental illness across all measures, thus suggesting a potential for a dosing effect. The MSC program was initially developed as a seminar focused on awareness and not personal therapy (Germer & Neff, 2013). Youth in clinical settings may benefit from pairing the intervention with individual treatment to help target their distress and behaviours.

This study's third core goal was to identify how youth define SC and its three main components. The youth in this study defined the concepts as follows:

- *Self-compassion* is not suffering by yourself. It is about not ignoring your pain or taking your emotions out on yourself. It is about recognizing your struggles and managing them either by reaching out for support or helping yourself feel better.
- *Self-kindness* is the awareness of your relationship with yourself. Learning to build a healthier relationship with yourself and trust that we all have a purpose. It is important to be open, kind, and positive toward oneself without relying on others.

- *Mindfulness* is the act of being present in the now and building awareness of thoughts, feelings, and behaviours. Letting go of the past and not worrying about the future, learning to pay attention and make healthy choices.
- *Common humanity* is the capacity to see difficulties as a normal part of life. It can grow from healthy relationships and safe spaces. It is learning that pain does not last forever and that not all relationships are long-term.
- *Values* are personal to you. They help guide how you want to be and what you want to do in your life.

A variety of programs engage youth in participatory action research to support community change (Ardoin et al., 2013; Fox et al., 2010; Shamrova & Cummings, 2017; Smith et al., 2010). However, there is only emerging evidence for the framework of engaging youth in the development, modification, analysis, and delivery of evidence-based practice to support IKT in clinical or counselling practices (Jaycox et al., 2012; L'Etang & Theron, 2012; Rickwood et al., 2019). This manuscript offers a potential approach to engaging youth in problem identification, program evaluation, and modification for their communities. The youth who participated in three or more sessions (including the workshop) all reported that they felt valued in the research collaboration process, that the process deepened their understanding of the concepts, and they felt a CBPR approach helped capture their lived experiences in the community. Recently Ballonoff Suleiman et al. (2021) presented a developmental framework for working with youth in community practices that could help inform the use of engaging youth in CBPR from a mental health intervention or prevention program approach. Furthermore, Mance et al. (2010) presented an approach to working with youth in delivering a modified EBP to their peers. Still, peer-led interventions are not always well received within schools and mental health

intervention clinics due to confidentiality concerns and adults' fears regarding whether youth can hold space for difficult emotions of their peers. Overall, this project presents an approach to working with youth in EBP modification, but future research that can engage in a long-term iterative modification and collaborative data analysis is essential.

Strengths and Limitations

This study's strength is that the interview data and engagement measures help explore the benefits of using a CBPR approach to the research process. Generally, the youth reported that the CBPR debriefing process helped deepen their learning. They felt there was a benefit to co-learning by hearing about how others understood and applied the practice. The group also reported the CBPR process created a safe space free from judgment, increased confidentiality in the group, and promoted comfort with the researcher. The group appeared to benefit from the CBPR process in a SC intervention because it helped deepen the teachings of common humanity by exploring how each participant applied the practices and the shared experience of pain.

The CBPR process helped to deepen understanding of the group's experiences and allows for further exploration for KT. The group felt that early introduction to these teachings in a school setting would support the development of a healthier relationship to self, help individuals learn to manage emotions and relational distress, and aid in goal attainment. The group recommended that the program (with their modifications) be delivered in a Grade 9 school setting. The school setting also allows for intervention without adding extra time constraints to youth schedules, supporting KT.

Though there are many strengths to this study, it is not without its limitations. Firstly, it was an exploratory study of the use of CBPR in the process of KT for clinical practice. Given this process's exploratory nature, it is difficult to discern which skills were developed explicitly

through the MSC process and which were developed through participation in empowerment research. A control group might have informed the study; however, the iterative changes to the intervention and CBPR process would have affected the outcomes.

Additionally, the measures were used to help inform the narratives, but there was not enough power for statistical analysis. Alex was the only person who participated in all four sessions and the workshop; hence, single-subject analysis would not reflect the overall experience of the group. Further, all the participants noted that they were involved in groups within their community. Engaged youth are more likely to agree to participate in other settings (Forneris et al., 2015). Trying to engage individuals who are disenfranchised from their community may help further understand the process's benefits.

Summary and Conclusions

Overall, this research offers a glimpse into participant experiences of modified MSC programs and adds to the literature an understanding of how youth respond to the intervention, how they conceptualize SC theory, and how these practices translate into daily living. The CBPR process outcomes led to a reconceptualized version of the program for Grade 9 youth in a school setting. The project's iterative nature allowed for ongoing changes in format, teachings, language, length of mediations, and group/pair discussions. This intervention was then presented in a local Grade 9 classroom (see Henson et al., 2020).

Additionally, very few qualitative studies have examined youth experiences in formal SC interventions. A large body of evidence highlights SC's benefits to mental health and well-being and a growing body of quantitative evidence supports the use of SC interventions. The current project hopes to help inform researchers about youth experiences in the program and highlight the importance of modifying programs for various settings.

Modification is important for implications in counselling settings. With the onset of COVID-19, the critical spotlight on social justice issues such as race relations and the MeToo movement, and the brutal bullying on social media, the importance of SC for youth communities has become crucial. SC helps young people, regardless of context, learn skills to notice their challenges, engage with discomfort, take care of themselves when they face distress, and clarify their values and individual goals. These skills lend support for facing personal issues and potentially becoming active and engaged community members and agents of change. Therefore, future research and practice from a prevention framework may be vital.

Finally, mental health practitioners must understand the communities in which they are practicing. In nonprofit youth mental health and education settings, there is a push for using evidence-based approaches to secure funding for these programs; however, these programs do not account for the community in which the program is delivered. Therefore, engaging the community in an ongoing modification of the program is essential.

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Table 1

Demographic Information and Attendance

Pseudonym	Age (years)	Grade	Mental health			Sessions attended
			Diagnosis	Support	In Treatment	
Alex	16	11	Yes	School, CMHC, hospital	No	WS, 1–4
Drew	16	10	No	CMHC	No	WS, 1–3
Taylor	16	11	Yes	School, CMHC	Yes	WS, 1–2
Jordan	17	12	No	CMHC	No	WS, 1–3
Parker	17	12	Yes	CMHC	Yes	WS, 1–3

Note. Diagnosis = received a mental health diagnosis; CMHC = Children's Mental Health; In treatment = currently participating in regular mental health treatment. Centre; WS = workshop.

The Link Between Manuscript 1 and Manuscript 2

I modified the SC program based on feedback from the CBPR team gathered during discussion via mind-mapping and memos, as well as discussion with the practitioners who delivered the intervention. The CBPR team made the iterative modifications each week during the delivery of the MSC intervention. Changes included the addition of art-based activities, more media and videos, shorter meditations (5-7 min), group warm-ups and check-ins, the importance of ambience (i.e., lighting, soft music, and room temperature), and the use of yoga. We also decided to focus each session on a specific topic (e.g., Session 1 focused on group development and the introduction to SC, Session 2 focused on mindfulness, Session 3 focused on self-kindness) to help clarify learning. After consulting with a local school board, I made the final modifications to ensure the program aligned with curriculum (Government of Ontario, 2015) and learning standards for health class (e.g., mental health, risk behaviours, bullying). This alignment was generally made via the use of examples of how SC can be used when managing bullies (e.g., common humanity), the need for acceptance and inclusion (e.g., loving-kindness), or substance use (e.g., values, goals and choices). It was to this school board that I then delivered the pilot intervention. The decision was made that I lead the intervention because I had modified the program and was familiar with leading psychoeducational and therapeutic groups, I had experience with the MSC material, and I had made the final modifications to the program that would be delivered.

The CBPR team decided that a school setting would be the desired location for delivering the modified SC program, for several reasons. First, school-based interventions are a primary location for an early point of contract (Kirby & Keon, 2006). Second, schools can be effective and innovative sites for health promotion and prevention (Ruglis & Freudenberg, 2010). The

youth wanted to focus on preventing mental health challenges before they began. Finally, youth living in small city centres without public transportation struggle to access services outside the school setting (Boydell et al., 2006). Therefore, the modified SC program was to be delivered during the transition to high school to help connect with youth during this often difficult transition.

Chapter 5: Manuscript 2

Self-Compassion for Youth in Small City Centres: A School-Based Pilot Project

Alisha Henson[1,2], Jessica Ruglis[1], Ada Sinacore[1], Marilyn Fitzpatrick[1] & Dianna Lanteigne[2]

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Self-Compassion for Youth in Small City Centres: A School-Based Pilot Project

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Alisha Henson (CCC, Ph.D. Candidate) is completing her doctorate at McGill University. Her research is focused on the intersection of self-compassion, youth advocacy, and psychotherapeutic practices. Alisha's research interests result from her years as a Child and Family Therapist and Youth Engagement Facilitator. Alisha works at Pembroke Psychological Services, an agency that offers a broad range of assessment and treatment services to a small city centre and the veteran community.

Jessica Ruglis (Ph.D., MPH, MAT) is an Associate Professor at McGill University. Dr. Ruglis's work centres on participatory, critical race/ethnic, social justice, feminist, and inclusive approaches to research and teaching in public education, public and community health, justice, policy, and youth development. Dr. Ruglis' research is organized around three main axes: 1) Contexts and institutions of youth development, health and wellbeing, 2) Social determinants of health (SDH) and education, 3) Participatory and community-engaged approaches to research, policy and professional training (e.g., participatory action research, PAR; youth participatory action research, YPAR; community-based participatory research, CBPR; community-engaged participatory action research, CEPAR; participatory policymaking).

Ada Sinacore (Ph.D.) is an Associate Professor in the Department of Educational and Counselling Psychology and the Director of the Social Justice and Diversity Research lab. Her research focuses on social justice and human rights and the role of psychology in addressing

societal problems emerging from these areas, such as: sexual violence, bullying and gender-based violence.

Marilyn Fitzpatrick (Ph.D., C. Psych) is a Professor Emerita at McGill University. Her research interests include psychotherapy processes with a particular focus on mindfulness-related processes such as self-compassion.

Dianna Lanteigne (Ph.D., C. Psych.) is a Clinical Psychologist who works with children, adolescents, and adults. She is the co-director of Pembroke Psychological Services, offering a broad range of assessment and treatment services. She also works for the Canadian Forces Mental Health Services, providing trauma-focused and other evidence-based treatments. Dr. Lanteigne studied developmental and clinical psychology at Queen's University in Kingston, ON. Her research interests include developing adolescent emotion regulation skills and the relationship with mental health and prevention programs for improving adolescent well-being.

Abstract

The purpose of this pilot study is to explore the benefits of a Self-Compassion intervention that was delivered in school to grade nine youth during their transition to high school in a small city centre in Ontario Canada. All participants were assigned female at birth. Self-compassion was identified as an important intervention for this population based on a Community-Based Participatory Research (CBPR) process that included youth living with mental health challenges, mental health practitioners, gatekeepers and academics. The CBPR process helped with problem identification and the modification of a self-compassion intervention for use in school for youth. The modified SC program was delivered in two physical-education classes, using a 2x2 crossover design (i.e., intervention or school-as-usual). Self-report measures focused on increasing mental health (e.g., wellbeing, values, self-compassion) and decreasing mental illness (e.g., depression, anxiety) were collected at baseline and pre-post intervention. Data analysed via ANCOVAs and non-parametric tests indicate no statistically significant results. At baseline, most students had relatively average scores for mental health and mental illness; therefore, floor and ceiling effects may have impacted measurable change. In this relatively healthy group, the benefits of the SC prevention program may be the capacity to continue to accept and support oneself in facing challenges, as is the overall goal of self-compassion. Future research may focus on using self-compassion interventions with youth in clinical settings or a longitudinal analysis with a comparison group.

Keywords: Self-compassion, the transition to high school, small city centre youth, mental health, wellbeing, community-based participatory research (CBPR)

Word Count: 7500

Self-Compassion for Youth in Small City Centres: A School Pilot Project

Global estimates indicate that 10 to 20% of young people have experienced mental health challenges and that three-quarters of all global adult mental illness has an onset before age 24 years (Kessler et al., 2007; Kessler et al., 2005). In Canada alone, the current economic burden of mental illness is estimated at $51 billion per year, and it is expected that by 2041, there will be almost 1.2 million Canadian children and adolescents living with a mental illness (Smetanin et al., 2011). These epidemiological statistics highlight that the onset of mental illness is increasing in adolescent populations and that intervention is vital. We need to arm our young people with skills to help navigate inevitable life struggles, boost their mental health, and potentially hinder the onset of mental illness via interventions that help youth (ages 14- 24 years) traverse this critical developmental period.

Youth mental wellness will be explored via two axes. One focused on *mental illness* (i.e., anxiety, depression, behavioural concerns) and the other on *mental health* (i.e., wellbeing and values). It is essential to understand that mental health and mental illness are not extremes of the same continuum but that they are two interconnected axes (Keyes, 2005); both of which are instrumental in a healthy transition to adulthood (Hides et al., 2020; O'Connor et al., 2017). One potential process for supporting a reduction in mental illness onset while supporting mental health development is self-compassion (Marsh et al., 2018).

Self-compassion (SC) is the internally motivated capacity to accept challenges and actively engage in empathy towards oneself (Neff, 2003b). SC helps youth endure emotional pain as inevitable, learn to experience emotions mindfully, allow individuals to recognize that they are not alone in their experiences, and engage oneself with kindness (Bluth & Blanton, 2014, 2015). SC offers more promising interventions for managing distress beyond other

mindful-based interventions because it goes beyond the simple awareness of thoughts, feeling, and sensations to actively engaging with discomfort (Neff & Dahm, 2015).

Developing from our early relationships with our primary caregivers (Pepping et al., 2015), high SC in youth has been found to negatively correlate with symptoms of mental illness, such as but not limited to anxiety, depression, substance use, non-suicidal self-injury, and to reduce the impact of trauma (Lathren et al., 2019; Tanaka et al., 2011; Wisener & Khoury, 2020; Xavier et al., 2016). SC has been found to play a role in offsetting the development of mental illness in youth. Alternatively, elevated SC levels have been correlated with factors that contribute to mental health, such as psychological wellbeing, self-determination, and satisfaction with life (Ferguson et al., 2014; Jeon et al., 2016). Through engagement with SC, youth will continue to experience daily life challenges associated with this transitional age. Still, they are less intertwined with the emotion and can potentially hold challenges (e.g., school, family, sport, academics) in balanced awareness. This capacity to not over-identify with challenges, self-soothe, and seek connections during difficulties creates space for persevering and focusing on engaging in life versus merely trying to survive it.

A growing body of literature indicates that SC decreases throughout adolescents, especially for individuals assigned female at birth (AFAB). Furthermore, SC acts as a safeguard for AFAB against the harmful effects of low self-esteem (Marshall et al., 2015). Bluth and Blanton (2015) found that during the transition to high school, students who were AFAB had significantly lower SC and life satisfaction and higher levels of perceived stress, negative affect, and depression, compared to the same age male peers or younger students. Consequently, adolescents who were AFAB are vulnerable to the onset of mental illness and challenges in engaged living for mental health. These findings have been replicated in many settings, including

a large sample of youth living within a population of approximately 15 000 people (Bluth et al., 2017).

Youth in small city centres are a unique demographic that is rarely targeted in research contexts. The youth that attend small city centre high schools may be bused for several kilometres, have little access to community resources, struggle with isolation or potential stigmas related to marginalization. This study focuses on small city centre youth as they are grossly underrepresented in clinical research. Highs schools in small city centres often become the meeting place for youth within the community and their rural counterparts. Furthermore, compared to large urban centres, rural youth are at an increased risk of poverty, dropping out of school, engagement in risk behaviours, lower life satisfaction, and increased mental health treatment barriers (Bowman et al., 2017; Pickett et al., 2018). However, little information is known regarding the differences in youth mental health in large city centres, small city centres and rural Canada locations. Therefore, interventions focused on SC for AFAB youth living in small city centres during the transition to high school may be essential to help these young people manage distress symptoms while focusing on personal goals and wellbeing.

A small but growing body of research explores SC interventions and their benefits in adults (Germer & Neff, 2013; Neff & Germer, 2013) and youth (Bluth et al., 2016). However, research on interventions for youth in small city centre settings remains unexplored. The Mindful Self-Compassion (MSC) program (Neff & Germer, 2013) was used because it is foundational manualized SC interventions. Modelled after the MSC program, Bluth and colleagues have since developed a SC program for community youth, which has produced promising results (Bluth & Eisenlohr-Moul, 2017; Bluth et al., 2016). However, youth living in small city centres benefit from school-based intervention because community resources can be challenging to access. School-based SC interventions have yet to be explored.

The current pilot study aimed to contribute to this gap in SC practice for youth living in small city centres. The goal of this pilot project was to understand if grade nine AFAB students who participate in a refined school-based SC program would experience an increase in mental health (i.e., wellbeing, self-compassion, and value based-living) and a reduction in symptoms of mental illness (i.e., depression, anxiety, anger, destructive behaviour, low self-concept).

Methods

Research Design

This 2 x 2 cross-over intervention design school-based pilot study was the final stage of a Community Based Participatory Research (CBPR, Isreal et al., 2005; Minkler & Wallerstein, 2011) project. The project study resulted from four years of consultation and collaboration with youth who have experienced the mental health care system, practitioners, and academics. CBPR offers co-learning, capacity building, and abolishes power differentials while intending to introduce long-term change and reduce health disparities within the community. The CBPR approach to program identification and refinement allowed partners to work collaboratively to ensure the research is rooted in individual experiences and needs, employs joint decision-making, and determines best practices for engaging and conducting research with youth in the community (Isreal et al., 2013; Jacquez et al., 2013), in this case, youth living in a small city centre. The process and results of the CBPR program (methodology and participant experiences) are presented in another manuscript.

The CBPR process identified that a SC approach would be the best intervention to best support an increase in mental health while reducing youth mental illness symptoms. Subsequently, the CBPR team refined the Mindful-Based Self-Compassion program (Neff & Germer, 2013) for youth living in a small city centre. The CBPR team also determined that maximum intervention benefit would be for youth undergoing the transition to high school, when

mental health symptoms increases (Mei et al., 2020), self-compassion decreases (Bluth et al., 2017), educational struggles amalgamate (Sutton et al., 2018) and academic disengagement intensifies (Olivier et al., 2020). Furthermore, a school setting was determined to be the desired location for the intervention because rural youth living on peripheries of small city centres struggle to access services outside the school setting (Boydell et al., 2006). See Benner (2011) for a review.

The school-based participants were recruited as a convenience sample since the school board's mental health lead desired to partner on this project, which is in line with best practices in CBPR (Isreal et al., 2013). Participants were recruited from their physical health and education (Phys. Ed) class because mental health is a unit within the current curriculum. In this local public school, Phys. Ed classes are taught in sex-specific classes, allowing the intervention to target AFAB youth. The high school where this study takes place has 700 students (grades 9 and 12) and is the only publicly funded anglophone high school in the city.

Following university and school board ethics approval, participants were recruited from two separate, all AFAB 9th-grade mandatory Phys. Ed classes (25-30 students enrolled in each class). I presented the same script to both classes. The interventions process and risks and benefits of participation were discussed. Benefits included the ability to participate in a local-peer refined SC pilot program that may increase wellbeing and reduce mental health symptoms, while respecting the rights and dignities of all those who participate. The risks regarding confidentiality in school-based settings were explored during the initial meeting. The youth were informed that there would be no effect on their grade regardless of their decision to participate or if they withdrew from the study. The youth were provided with an opportunity to ask questions, and all interested students took home parental consent and student assent forms.

Students were offered no incentive or compensation to participate beyond a new experience that may increase wellbeing and where they can learn about mindfulness. The students who elected not to participate engaged in curriculum-based health class. One week later, all students who returned their assent and consent forms completed their baseline questionnaire packages.

Participants. Prior to the intervention the school board randomly assigned each student to one of two classes (Group A or Group B). Group A consisted of 16 AFAB students ages 14 (n = 12) and 15 years (n = 4) (M = 14.25*, SD* = .45*)*, while Group B consisted of 17 AFAB students ages 14 (n = 16) and 15 years (n = 1) (M = 14.06*, SD* = .24). The number of students who opted out is unknown.

All of the students lived with their parents or a legal guardian, more than an hour away from a city with a population greater than 30,000. The public school has a catchment area for families from the city, farming, and military communities. Most of the participants identified as anglophone (85%), female (94%), heterosexual (85%), and white (79%). Although economics was not measured, the majority indicated that they "mostly or always" had enough money for basic needs (94%) and" "mostly or always" had the money for fun (69%). None of the students (100%) were currently engaged in therapeutic services and 75% indicated that they have never received a formal mental health diagnosis. Three students indicated that had anxiety, one with Attention Deficits Hyperactivity Disorder, one indicated anxiety-ADHD comorbidity and one student did not specify a diagnosis.

Intervention Design. For this pilot study, a 2 x 2 cross-over design was employed that consists of two-time treatment periods: students during the "SC intervention" (SCI) and students in "school as usual" (SaU), which is to say not participating in the intervention. The intervention was implemented in two sequences: Participants in Group A had the SCI first (February-April),

followed by SaU (April-June), while participants in Group B participated in SaU first (February-April), followed by SCI (April-June). The intervention took place for 75 minutes once a week in the morning for eight sessions. I facilitated all intervention sessions and data collection.

There was only a brief *washout period* between time points: (i.e., Group A ending the SCI and commencing the SaU), where participants had one week to complete the questionnaire package; hence evidence for residual benefits from participation in SCI are measured. The washout period is defined as the length of time between the two periods when the effects of the treatment can dissipate. There were two periods of measurement for each outcome measure, which are described in the results section. Furthermore, before the youth-friendly SCI was applied (the so-called run-in period), baseline measurements were taken.

During the SCI, students participated in brief self-compassion meditations (5-8 minutes) and psycho-education modified by the CBPR process from the original program (Neff & Germer, 2013), moving meditations, reflexive journaling and both dyadic and group discussions. Participants were given workbooks that contained activities related to the intervention, space for notes regarding the process, personal reflections, reflection of specific questions posed, and a place for artwork or personal expression. Recommendations were also made each week for home practice. Each week of the intervention focused on a specific self-compassion related topic.

Session 1: The *Introduction* focused on group norms, confidentiality and group cohesion. The session introduced self-compassion, components of SC (i.e., mindfulness, self-kindness and common humanity) and mediation.

Session 2*: Mindfulness* focused on learning to be mindful of difficult emotions) and how to use SC to manage distress.

Session 3: *Self-kindness* focused on learning to be your own best friend, identifying the inner critic and compassionately soothing the critic.

Session 4: *Common humanity* focused on the inevitability of life challenges and shared experience of not feeling "good enough."

Session 5: *Managing difficult emotions* focused on building a new relationship with difficult emotions.

Session 6: *Values and setting goals* was an exploration of personal values, identifying values, and utilizing SC when not living in congruence with values.

Session 7: *Embracing your life* highlighted negativity biases and taught how to savour goodness via gratitude and savouring.

Session 8: *Transforming relationship*s focused on a challenging interpersonal relationship and addressed cultivating forgiveness.

Data Collection Measures

All participants completed a questionnaire package that included six measures during three additional class sessions (baseline, post Class A intervention, and post Class B intervention). The baseline measure for both groups was utilized in the analysis and pre- and post-intervention measures. The students were sent email links to the Qualtrics survey program to complete a demographic questionnaire and the following measures.

Measures.

Demographic questionnaire. An 18-item questionnaire including information about age, caregivers, gender identity, sexual orientation, cultural identification, work, extra-curricular activities, financial comfort, and mental health.

Mental Health Continuum-Short Form (MHC-SF). The MHC-SF (Keyes et al., 2008) is a 14-item measure that assesses emotional wellbeing (e.g., happiness, satisfaction), psychological wellbeing (e.g. autonomy, environmental mastery, purpose in life, personal growth) and social wellbeing (e.g. social integration, social contribution, social coherence). The

items ask participants to rate how often they experienced the feelings of wellbeing in the last month on a 6-point scale (e.g., *never, 2-3 times a week, every day*). The measure can be scored categorically (i.e., flourishing, languishing or moderate) or continuously and has been found to have adequate test-retest reliability, good internal validity, and validated for adolescent populations (Keyes et al., 2008; Lamers et al., 2011).

Values Questionnaire (VQ). The VQ (Smout et al., 2014) is a brief ten-item instrument that measures perseverance towards (VQP, 5 items) or obstructions away from valued living (VQO, 5 items) on a scale ranging from 0 (not at all true) to 6 (completely true). Values are defined from an Acceptance and Commitment Therapy (Hayes et al., 2006) framework as self-determined principles that guide behaviour. This measure was developed with undergraduates and the only values measure that does not require defined values or assess domains of living. The measure is valid and reliable (Levin et al., 2018).

Self-compassion Scale–Short Form (SCS-SF). The SCS-SF (Raes et al., 2011) is a twelve-item measure that has a near-perfect correlation (0.98) with the original long measure (Neff, 2003a). Although traditionally a five-point scale (1=almost never to 5= almost always), a six-item scale was utilized in error. Statistical analysis was conducted to estimate the final scoring based on the original measure (1 = almost never to 6 = almost always). The total score was calculated for the scale with higher scores indicating greater self-compassion. The SC-SF represents the overall SC scores and has been found to have good internal consistency and test-retest reliability (Raes et al., 2011). In addition to a total SC score, the measure is utilized categorically (low, moderate and high self-compassion), adjusted for measurement error.

Multidimensional Student Satisfaction with Life Scale (MSSLS). The MSSLS is a 40-item, six-point scale used to assess students felt satisfaction in a variety of areas in their lives (Huebner, 1994). A robust body of literature indicates that the MSSLS is a valid and reliable

measure (see Veronese & Pepe, 2020 for a review). For this paper, the scale's total score will be utilized, with higher scores indicating greater satisfaction.

Beck Youth Inventory – Second Edition (BYI-II). The BYI-II (Beck et al., 2005) is a valid and reliable measure that consists of five scales: depression (BDP), anxiety (BANX), anger (BANG), disruptive behaviour (BDB), and self-concept (BSC). Each scale consists of twenty items that asks youth to rate how often they have felt or thought a certain way. The totals for each subscale are summed. High scores on the mental health measures indicate more significant concerns (Average - Extremely Elevated); while high scores on self-concept indicate a greater relationship to self (Much lower than average – Average).

Data Analysis

Statistical analysis. The demographic data were included in the initial analysis and assessed using SPSS software IBM SPSS Statistics for Windows, Version 21.0 to ensure no differences between groups. All other analyses were performed using SAS, version 9.4.

To determine whether or not there was an effect of the SC intervention (SCI) on each of the measures (in comparison to School as Usual, SaU), we used standard methods for a two-treatment, two-period cross-over design for continuous data. Since baseline measures were taken before the start of the experimental procedures, we performed a mixed Analysis of Covariance (ANCOVA) with random subject effects to consider the correlation between observations within-subject (Mehrotra, 2014). Degrees of freedom were adjusted using the Kenward-Roger correction (Kowalchuk et al., 2004) because the groups did not have the same number of subjects due to community sampling in the school and missing data.

Initial data analysis indicated that three students reported on the demographic questionnaire they were currently in crisis, and immediate follow-ups were made with the student and their families. Additionally, follow-ups were made with four additional students who

were either in the clinical range for depression or reported high scores on the depression crisis items on the BYI-II (Beck et al., 2005). These seven students were able to continue with the study, and a school support counsellor affiliated with the project engaged in ongoing monitoring with these students throughout the semester. Three students from Group A completed the Baseline questionnaire packages but then withdrew from the study. One student from both Group A and B completed the pre-intervention questionnaire but was absent for the post-intervention data collection. Therefore, the data for 29 students were included in the analysis.

Several participants missed one or two items on an individual measure, and the data appeared to *Missing Completely At Random* (Papageorgiou et al., 2018). The participant had to complete all the items for a specific measure at all three data points for their data to be included in the ANCOVA analysis. Subjects that had a missing data point were subsequently exclude from the analysis for that particular dependant variable. Consequently, the number of participants for each measure varies. According to Cohen (1992), to achieve a medium effect size ($\alpha = .05$), there would need to a minimum of 64 participants per group to run an ANCOVA. However, a small sample can be utilized in a within subject 2 x 2 cross-over interventions (Metcalfe, 2010).

The assumption of homogeneity of linearity for the ANCOVA model was checked by introducing and testing an interaction effect between treatment and baseline scores. The assumptions of normality and equal variances of errors and possible outliers were explored with analysis of residuals. We used visual or graphical methods to check the distribution of values: histogram, boxplot and, in particular, normal probability or QQ plot. All statistical tests of the hypothesis were two-sided and carried out at the level of significance of $p < 0.05$. Results of ANCOVA are reported as F-statistic with the numerator (*num*), the denominator (*den*), degrees

of freedom (*df*) (F (*num df, den df*)) and *p* values. We also report adjusted mean differences with 95% confidence interval (CI).

In the case where the assumptions of normality of the ANCOVA were not met, we performed a Wilcoxon-Mann-Whitney Ranked Sum (WRS) test for independent samples with exact p-values to test, in this order: 1) the carry-over effects of each, SCI and SaU, were different, 2) a treatment effect, under the assumption that the carry-over effects, were the same and 3) a period effect. However, it was impossible to adjust for baseline (Jones & Kenward, 2014).

Maxwell-Stuart Chi^2 test (Fleiss & Everitt, 1971) was used to analyse the frequency distribution of nominal data to determine if the participates remained in the same qualitative category from pre-SCI to post-SCI. The analysis was conducted on the clinical qualitative descriptors for both mental illness symptoms (i.e., BYI-II) and mental health (i.e., MHC-SF and SC-SF). The MLSS and VQ are not categorically scored and were not included in the analysis. Data from groups A and B was collapsed after t-tests determined no significant difference between groups. For this analysis, the missing data points (i.e., missing completely at random) were replaced with mean imputation for the individual scales, as noted as appropriate by authors of the measures (Papageorgiou et al., 2018). The data from the 29 students that had both pre- and post-SCI were included in the analysis.

Results

Results That Met the Assumptions of Normality

We tested for equality of 1) *carry-over effects* (sequences were SCI then SaU, Group A; or SaU then SCI, Group B), 2) *treatment effect* (intervention - SCI, versus no intervention - SaU) and 3) *period* when the intervention took place (Period One, February-April, versus Period Two, April-June) effect, adjusting for baseline for all measures. The *carry-over effect* is measured to

determine if the first intervention effect is persisting into the second treatment (e.g., SCI effect carry over to SaU, or SaU effect carry over to SCI). *Sequences* are defined as the treatment sequence in which the two classes received the intervention (e.g., SCI to SaU: Group A, or SaU into SCI: Group B).

Test for carry-over. The hypothesis that the carry-over effect from SaU to SCI is the same as from SCI to SaU was tested. The ANCOVA's for all measures showed no significant evidence that carry-over effects are different. Hence, any effect from the SCI did not appear to affect Group A SaU scores. There was a trend indicating carry-over effects from SCI to SaU for the MHC ($p = .10$) and SCS ($p = .07$), suggesting a longer washout may be needed in future implementations of this program (see Table 1).

Test for treatment effect by the intervention (SCI). Under the assumption that carry-over effects are the same, the ANCOVA for the measures that met normality assumptions (MHC, MLSS, VQO, SCS-SF, BSC, BANX, BANG) showed no significant treatment effect. In the 2 x 2 design, treatment refers to participation in the SCI or SaU (see Table 2, means by treatment effect). The results indicate that the SCI did not have a significant impact on wellbeing (MHC), life satisfaction (MLLS), reducing obstruction towards valued living (VQO), self-compassion (SCS-SF), self-concept (BSC), anxiety (BANX) or anger (BANG).

Test for period. We tested the period effect (i.e., is there a change in the mean in each outcome measure over time, irrespective of participation in SCI or SaU). The ANCOVA's for the MHC, MLLS, VQO, SCS-SF, BSC, BANX or BANG showed no significant evidence there was a period effect for any of the measures (see Table 3). Hence, it did not matter if the group participated in the SCI in the first or latter half of the semester; the results were the same.

Results That Did Not Meet the Assumptions of Normality

The Wilcoxon-Mann-Whitney Ranked Sum (WRS) test was used for outcome measures that did not meet the assumptions of normality. The three outcome measures were the VQP, BDP subscale and the BDB subscale. Jones and Kenward (2014) suggest that since these outcome measures did not meet the assumptions of normality and we cannot adjust for baseline measures, that the WRS is the best approach for interpreting the effects.

Test for carry-over for non-parametric tests. We tested if the hypotheses of that carry-over effect from SaU to SCI is the same as from SCI to SaU. The WRS test showed no significant evidence that the carry-over effects are different for any of the measures: VQP (S = 130, p = 0.2), BDP (S = 168, p = 0.5), BDB (S = 147.5, p = 0.8). Therefore, the effects of participating in the SCI did not affect the outcomes of participating in SaU.

Test for treatment effect by intervention (SCI). Under the assumption that the carry-over effects are the same, the WRS test (*see* Table 4) showed no significant evidence for any of the outcome measures: reducing depression (BDP: S = 136.5, p = 0.4), disruptive behaviours (BDB: S = 141.5, p = 0.5) or increasing action towards one's values (VQP: S = 132.5, p = 0.3).

Test for period. The WRS test for period effect (i.e., is there a change in the mean of each outcome measure over time, irrespective of treatment) showed significant evidence for all three outcome measures: VQP (S = 193.5, p = 0.05), BDP (S = 111.5, p = 0.03), BDB (S = 105.5, p = 0.01). These results highlight that regardless of the intervention (SCI or SaU), there was less depression and disruptive behaviour at the end of the study for Group B than group A. Alternatively, Group A had more progress towards values than Group B. These results may be due to a third variable such as adjustment to high school over the year or time of year effects (e.g., the upcoming summer months).

Maxwell-Stuart Chi-Square. The results of the Maxwell-Stuart test determined that there was no significant difference in any of the measures. The only measure approaching significance was the SC-SF (Maxwell-Stuart X^2 (2, N = 16) = 5.13, p = .07).

Discussion

This pilot project sought to explore if grade nine students AFAB in a small city centre who participated in a modified SC intervention (SCI) would experience an increase in mental health and a decrease in mental illness symptoms. The study results did not support either hypothesis that students would experience statistically significant mental health or mental illness changes due to participation in a SC intervention, as Bluth and Eisenlohr-Moul (2017) found with community youth. A growing and robust body of literature report the benefits of self-compassion for adolescents and adults' mental and psychopathology (Ferrari et al., 2019; Marsh et al., 2018). However, there are several potential reasons for the null results in this pilot study, which have implications for future research.

Floor and ceiling effects in participant data may have affected the ability to achieve significant results. The students that participated in this research project at baseline were relatively stable. The analysis indicated that both at pre-and post-intervention, 43% of all student's wellbeing was flourishing, 75% experienced average levels of anger, 89% had average disruptive behaviours, 43% average depression, and 46% average anxiety. Therefore, these already well-adjusted students remained relatively stable during their first year of high school.

Alternatively, the stance of mindful self-compassion intervention is to learn to become aware, accept difficulties as inevitable and learn to care for oneself to hamper suffering (Neff & Germer, 2013). The students participated relatively early in their high school careers and may have learned prevention strategies to help manage personal, interpersonal and academic distress. Therefore, participants could remain stable despite the onset of challenges that often occur

during this critical developmental stage (Lawrence et al., 2015). The current findings indicated that when the data from both groups were collapsed, the post-self-compassion scale was approaching significance; therefore, potential longitudinal data with a control sample may have further addressed possible stability or change. Future research addressing the longitudinal analysis of students who participate in a self-compassion intervention compared to peers will help determine if participation helps students navigate life stressors with greater ease. Additionally, more sessions may have resulted in a more significant impact.

Furthermore, living in a small city centre may buffer the onset of transitional distress. Many students living in small city centres transfer from a smaller elementary school (population 160 students, kindergarten to grade 8) to a larger high school (population 700, students grade 9 to 12). The high school is a feeder school for rural and small city youth; however, it is small compared to a large urban academic setting (possible enrolment 1000-1500 students). The students may not have experienced the transitional stressors related to reduced connection to school and peers often reported in larger urban centres (Benner, 2011; Lester et al., 2013). Further comparison research on mental health and mental illness in large, small, and rural centres is warranted. Finally, the CBPR approach to problem identification and intervention refinement with youth who struggle with mental illness may have not appropriately identified the needs of those amongst the general population.

Limitations. Firstly, the first author was instrumental in the CBPR process, recruitment, and delivering the intervention, which may have had the potential to influence the participant's perspectives of the outcome. Additionally, there is no comparison within the school to determine if the intervention impacted students differently from their peers or if this intervention is helpful from a prevention framework. Longitudinal data would help to determine the residual effects of the intervention. Finally, CBPR calls for iterative research, so the results should be reviewed

with the youth who participated in the refinement process to capture their perspectives of the null results.

Implications for Counselling Practice and Policy

This paper offers potential implications for counselling practice and policy. First, Ontario counsellors and psychotherapists employed at schools often work from an intervention or crisis model; adopting SC programming as a prevention program may impact a greater number of students.

Secondly, this pilot project offers the first attempt to engage high school students in an eight-week self-compassion program. SC may provide students with a unique way of managing difficult situations while learning to face adversity.

Thirdly, the collaborative approach to engaging youth in the remastering of the SCI offers clinically relevant insight into the challenges youth face in understanding the material, helped identify preferred techniques, and flagged challenges with this mindful-based approach.

Finally, regarding policy, process-based mental health prevention programming embedded into the academic curriculum may help youth learn vital strategies to traverse this difficult developmental period and learn to navigate personal, social, and community challenges with greater ease.

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Research Ethics Board Approval

This study received both university and local school-board human subjects research ethics approval.

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The authors have no conflicts of interest to disclose.

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Appendices

Table 1

Carry-Over for Effects of Self-Compassion Intervention (SCI) and School as Usual Sequence (SaU)

Outcome	Carry-over effect	*p value (p < .05)*
MHC	F (1, 25.5) = 3.51	0.07
MLSS	F (1, 24) = 0.75	0.39
VQO	F (1, 27.5) = 0.59	0.45
SCS-SF	F (1, 24) = 2.87	0.10
BSC	F (1, 25.7) = 0.82	0.37
BANX	F (1, 25.4) = 2.24	0.15
BANG	F (1, 27) = 0.28	0.60

Table 2

Treatment Comparisons and Changes, Baseline vs. Treatment Endpoints

Outcome	Changes between total scores from baseline and endpoint*		Treatment Comparisons† *p < .05*	
	SC Intervention	School as Usual	SC Intervention - School as Usual Difference	
MHC	56.5 (2.17)	57.99 (2.13)	-1.47 (2.11)	95% CI= (-5.85, 2.90)
	n = 10	*n* = 14	*p* = 0.50	
MLLS	56.52 (2.17)	57.99 (2.13)	-2.86 (4.35)	95% CI= (-11.96, 6.24),
	n = 10	*n* = 13	*p* = 0.52	
VQO	15.68 (1.02)	14.99 (1.02)	0.69 (0.72)	95% CI= (-0.79, 2.17),
	n = 11	*n* = 16	*p* = 0.35	
SCS-SF	42.68 (2.49)	43.06 (2.52)	0.38 (1.08)	95% CI= (-2.62, 1.87),
	n = 9	*n* = 14	*p* = 0.73	
BSC	57.74 (2.26)	57.38 (2.24)	0.36(1.22)	95% CI= (-2.16, 2.88),
	n = 12	*n* = 15	*p* = 0.77	
BANX	36.80 (2.17)	38.00 (2.38)	- 1.20 (1.34)	95% CI= (-3.97, 1.56),
	n = 12	*n* = 16	*p* = 0.38	
BANG	30.88 (1.77)	30.27 (1.76)	0.61 (1.08)	95% CI= (- 1.61, 2.83),
	n = 11	*n* = 16	*p* = 0.57	

Note. * Means (standard error). Adjusted for baseline values. † Least square mean difference (standard error)

Table 3

Period Effect Comparisons for All Measures That Met the Assumptions of Normality

Outcome	Test for period	*p value (p < 0.05)*
MHC	F (1, 23.5) = 0.86	0.49
MLLS	F (1, 18.9) = 0.90	0.35
VQO	F (1, 25.9) = 1.15	0.29
SCS-SF	F (1, 21.1) = 1.92	0.18
BSC	F (1, 23.2) = 1.11	0.32
BANX	F (1, 24.7) = 0.56	0.46
BANG	F (1, 25.6) = 1.61	0.22

Table 4

Results for Non-Parametric Tests by SCI and SaU

Outcome	Treatment	Median
VQP	SCI, n=26	20 (16-25)
	SaU, n=29	22 (18-26)
BDP	SCI, n=26	21.5 (20-24.5)
	SaU, n=29	21 (20-23)
BDB	SCI, n=26	21.5 (20-24.5)
	SaU, n=29	21 (20-23)

Chapter 6: General Discussion

This chapter focuses on three main components. First, I present a summary of the findings from Manuscripts 1 and 2. Second, I highlight the three essential learning outcomes that resulted from this dissertation process: (a) the role of SC in youth mental health and well-being promotion, prevention, and interventions; (b) further support for the individual but related continuums of mental health and well-being; and (c) adding to the limited literature on the process of YE via CBPR for IKT process in intervention research. The discussion concludes by highlighting the limitations of the current dissertation and my contributions to counselling psychology theory and practice.

Summary of Findings: Manuscript 1

The first manuscript examined the benefits for mental health and mental illness when engaging youth living with mental health challenges from a small city center as collaborators in a mixed-methods approach in evaluating the MSC (Neff & Germer, 2013) intervention. The youth documented their experiences in the MSC intervention via qualitative workbooks and interviews. Following the intervention, the youth qualitatively indicated in their workbooks and interviews that they developed a clearer understanding of their relationships with themselves and others, a better awareness of their present-moment living (i.e., present-moment awareness and awareness of difficulties), and a better sense of their values and goal-directed living. The quantitative outcomes for mental illness and mental health (i.e., well-being and values) indicated that all five youth reported decreased obstructions, whereas four out of five reported more progress toward value-based living. Additionally, four of five youth reported a decrease in depression and anger, two out of five reported anxiety reduction, and two out of five reported average disruptive behaviours. All five youth also experienced an increase in their SC scores, and their well-being

remained stable throughout the intervention. One youth reported stabilized above-average self-concept, and two others reported an increase in self-concept. Alex was the only participant to attend all five sessions. She reported a significant decrease in all mental health measures to average levels of concern, progress and less obstruction towards values, and consistent moderate well-being.

Although it is impossible to separate the CBPR benefits from the intervention benefits, four of the five youth (except Taylor, who only participated in two sessions and the workshop) reported additional benefits from the CBPR meetings. The youth indicated that they felt that the CBPR aspect deepened their understanding of the SC concepts, helped increased group cohesion and safety, helped them feel valued for their individuality, and increased feelings of commitment to help others who may struggle. The CBPR debriefing recommended iterative changes; combined with feedback from the MSC practitioners and school board, this led to a modified SC program for younger local high school students to engage in early intervention and help to address transitional distress.

Summary of Findings: Manuscript 2

Manuscript 2 presented the outcomes from the school-based modified MSC intervention pilot project. The goal of the pilot project was to understand if Grade 9 AFAB students who participated in the refined school-based SC program would experience an increase in mental health (i.e., well-being, life satisfaction, self-compassion, self-concept, and value-based living) and a reduction in symptoms of mental illness (i.e., depression, anxiety, anger, and destructive behaviour). The results from the pilot study were not statistically significant when using the 2 × 2 cross-over research design. However, many of the youth who participated in the project were relatively stable at the beginning of the study. For example, at the beginning of the intervention,

43% were in the flourishing range for well-being, 75% did not experience significant anger, and 89% did not engage in disruptive behaviour. Finally, in this cohort, approximately 54% reported average to mildly elevated anxiety or depression symptoms. Overall, this group reported experiencing stability in their mental health symptoms and well-being, which supported stability via the modified SC intervention. The findings from the school-based study and the CBPR study add to the literature of SC, mental health and well-being, and youth engagement via CBPR in the development and modification of evidence-based programs to support IKT. These conclusions will be highlighted as learning outcomes.

Learning Outcomes

Self-Compassion in Prevention and Intervention

SC interventions have the potential to play a pivotal role in youth mental health and mental illness programming. The findings from Manuscript 1 (CBPR group) indicated that well-being was stable with increased values progress and less value obstruction, while values, well-being, and life satisfaction remained stable in Manuscript 2 (school group). I measured well-being via the MHC-SF, which stabilized at moderate mental health for the CBPR group, and the majority of the school-based group stabilized at the flourishing level. These findings highlight the benefits of SC for stabilizing well-being. While the iteratively modified MSC (Neff & Germer, 2013) intervention helped reduce many of the mental health symptoms of those living with mental health symptoms in the CBPR group, the symptoms remained relatively low and stabilized for the school-based group. These findings highlight the benefits of SC for reducing symptoms for those with mental health challenges and stabilizing those who are managing the transition to high school and adolescence with greater ease. Overall, these findings highlight the

potential for SC programming, both in prevention and intervention, for schools, communities, and mental health agencies.

O'Connell et al. (2009) developed a mental health promotion spectrum that included aspects of Bronfenbrenner's social ecology model (Bronfenbrenner & Morris, 2006). The model highlighted the need for macro (community), mezzo (schools), and micro (individual) levels of support in youth mental health promotion, prevention, and treatment. The promotion model focuses on helping children and youth develop healthy life skills while building their sense of self, which includes aspects of PWB, SWB, and a capacity to cope with adversity (O'Connell et al., 2009, pg. 74). SC may be the ideal program for promotion and prevention, because of the interventions focus on awareness of difficult emotions, accepting these emotions without judgment, and then supporting oneself to manage challenges with resilience (Kotera et al., 2021; Neff & McGehee, 2010; Sünbül & Güneri, 2019).

O'Connell et al.'s (2009) model focus on four levels of programming: mental health and well-being promotion are at the community level (universal prevention), while prevention is either for specific at-risk targeted groups or individuals (selective preventions), or even higher risk individuals who show signs of mental health disorders but who do not meet diagnostic criteria (indicated prevention). Finally, treatment focuses on evidence-based treatments for targeted individuals identified as having challenges. Researchers have paired this continuum with models of CBPR for youth at risk (based on the social determinants of health) for the onset of mental health challenges (Ball et al., 2021; Haggerty et al., 2017; Harrop & Catalano, 2016). Based on the current findings, SC programming at a school-based level could meet the requirements for a selective prevention program for adolescents who are AFAB when SC and well-being decline and mental health challenges increase (Bluth et al., 2017). In contrast, SC can

also be used for a more targeted group or individuals in mental health programming for interventions, depending on the severity of needs for the individual or group. The indicated prevention program would pair a mental health provider with the group, as completed during the CBPR intervention, to help with individual questions, concerns, or triggers. Future research focusing on the differences in SC prevention and SC targeted interventions in communities and mental health centres is essential. Additionally, younger youth may benefit from SC promotion and prevention to help develop positive mental well-being attributes while reducing the onset of mental health symptoms. This project is also innovative in engaging youth living with mental health challenges in the use of MSC-based interventions. The findings on the mental illness and mental health indicators in this SC project also add to the current literature on well-being and mental illness being two individual but interrelated continuums.

SC's Role in the Continuum of Mental Health and Mental Illness

Several scholars have argued that mental health and mental illness are two interconnected but individual continuums (Greenspoon & Saklofske, 2001; Keyes, 2005, 2006; Moore et al., 2019; Westerhof & Keyes, 2010). The current dissertation supports this argument. As noted above, both groups' well-being stabilized throughout the intervention. Furthermore, the school-based group's mental health (e.g., depression, anxiety, and anger) was relatively stable, while there was evidence of symptom reduction in the CBPR group. Therefore, those who do not experience mental health challenges generally have flourishing well-being, while those with mental health concerns but are functioning in their communities and school have moderate well-being. Moore et al. (2019) found similar results in their analysis of high school students (Grades 9 through 11). They reported that four key classifications represent these continuums in youth in school: complete mental health represents those with high well-being and low mental distress,

moderate mental health represents those with high to average well-being and low mental distress, symptomatic but content reflects those who have high-average well-being and average to above-average distress, and finally, troubled represents those with below-average well-being and average to above-average distress. Neither Moore et al. nor I found a languishing group. These findings may have been because only a small group of adolescent languishers exists in most communities, especially those who continue in school or agree to participate in research processes. Future research should identify if languishers are more present in inpatient adolescent programs or in youth who have quit school, and researchers should attempt to engage these groups in research.

Furthermore, the current study lends additional support to the finding that although symptoms of mental illness and mental health are related constructs, they tend to decrease across adolescents (Moore et al., 2019), and SC may help in this continuum. SC helps youth overcome adversity and challenges related to the social determinants of health or trauma (Klingle & Van Vliet, 2019; Tanaka et al., 2011; Vigna et al., 2018, 2020). Grych et al. (2020) indicated that there is a need to promote emotional awareness, purpose in life, helping others (especially those who are younger), and the capacity to persevere in hopes of increasing well-being in youth who have experienced adversity, more so than the focus on mental health symptoms. Previous research highlighted the benefits of SC in the development of value-based living (Fitzpatrick et al., 2016), resilience (Marsh et al., 2018), and PWB (Zessin et al., 2015), primarily via interventions. Therefore, SC interventions can help to focus on well-being to thwart some increased distress in youth populations. The current research project also noted a dosing effect in the CBPR group. Alex had a substantial change in mental health symptom reduction and values-congruent behaviours. Therefore, further research is needed to help to clarify the role of SC

interventions, especially long-term interventions, in the development of well-being for youth and offsetting the onset of mental health challenges or school attrition. Schools and mental health programs have called for more youth representation in programming, but the process is rare in evidence-based intervention programming.

Using CBPR in Intervention Refinement for IKT

Educational settings (Chiodo & Kolpin, 2018) and children's mental health systems (Aarons et al., 2011; Steele et al., 2020) primarily use EBPs to allocate funds responsibly and to try to ensure best practices (Cook et al., 2017). However, the evidence in psychology intervention research often focuses on measured change and adult perspectives (e.g., practitioners or parents), even in programs focused on youth (Levac et al., 2019), and has rarely included voices of those in small rural areas or city centres not affiliated with universities. Regardless of the importance of EBP, researchers have also identified challenges in the practitioner's uptake of EBP in community settings (Malcolm et al., 2019; Novins et al., 2013). This research project focused on the inclusion of the voices of community practitioners and youth living with mental health challenges via YE principles (Heffernan et al., 2017; Pereira, 2007; Zeldin et al., 2013) to help answer the call for refining the research and delivery of EBP standards (Steele et al., 2020) for IKT (Jull et al., 2017). The current dissertation project used a CBPR (Israel et al., 2013) approach to engage youth living with mental health challenges to help with the IKT loop. YE inclusion in program design and evaluation is an emerging framework (see Rickwood et al., 2019) that has the potential to transform the youth mental health systems and the delivery of interventions.

The CBPR youth who participated in three or more intervention sessions in the iterative modification of the MSC (Neff & Germer, 2013) reported that they felt personal benefits from

participation in the CBPR debriefings. The youth said the CBPR debriefing helped deepen their experience and create safety and helped them feel valued for their individuality. The youth felt their input was respected, liked the idea of helping others, and were motivated to participate in groups or research in the future. The group modified the SC intervention process and highlighted the potential importance of learning these skills at a younger age and in a school setting to offset the struggles they currently experienced. I then delivered this program at the school. The project meets all of Levac et al.'s (2019) recommendations for engaging in CBPR in psychology: rigorous design (i.e., the use of mixed methods in the research project); community involvement at all stages (i.e., problem identification, research design, the research itself, and dissemination); and evidence that the research encourages trust (i.e., interviews with the youth and use of YE principles), promotes reciprocal capacity building (i.e., rewarding the youth for their time, the opportunity to learn new skills, the application of the program in a school, and benefits to my dissertation), and acknowledges power dynamics (i.e., awareness of my power as a practitioner, an adult, and a mental health provider). Therefore this project is novel and a template for including youth and practitioners in developing intervention research to help close the IKT research-to-practice gap as identified by Wathen and MacMillan (2018). Although the findings from the school-based intervention were null, this project is the first of its kind and may provide a template for future endeavours.

Limitations and Future Directions

There are several limitations to this dissertation process. Firstly, CBPR calls for an ongoing relationship with the community. Although I did my best to include the community in all stages of the process, I should have formed an advisory group that included youth, practitioners, and academics in overseeing the project. I should have continued to meet with

youth in the CBPR group to review the findings from Manuscript 1 and discuss the conclusions of the school intervention, possibly including a few school-based group representatives. Additionally, I could have met with a small subset of the school-based youth to discuss the outcomes and their experiences with the intervention. I also could have included one or two participants from the CBPR group as cofacilitators in the school group. Future research on the use of CBPR for IKT in community intervention research should include the community youth in all stages of the research process, especially in understanding the results. Additionally, the youth are keenly interested in participating as cofacilitators, and future researchers should explore the ethics of this endeavour more thoroughly.

Changes to the school-based SC intervention would include less writing, additional moving meditations, more art-based activities, and more time spent building group cohesion and safety. Someone with explicit MSC training should deliver future iterations of the program. The colleague who delivered the MSC program in the CBPR group had some MSC training but has never formally completed the training program. I have participated in the MSC program and modified the CBPR program with a MSC-trained facilitator, but I am not a trained MSC practitioner. Future SC intervention research should focus on the differences between psychological, social, and emotional well-being and symptoms of youth mental illness in community mental health agencies and schools and the importance of process-based learning versus psychoeducation in school settings.

Implications for Practice and Theory

My findings from these programs provide implications for the field of counselling psychology, as well as SC and YE for IKT practice and theory. Goodman et al. (2004) called for the importance of counselling psychology as an empowerment approach to psychotherapeutic

practices. This project is innovative in counselling psychology by engaging youth and community-based practitioners in a CBPR process for clinical practice to help support IKT. This project highlights the ethics of working with marginalized groups and applying manualized programs that may not capture the lived experience of the community. By engaging youth and practitioners in the research process, I was able to modify the program based on the community's needs. I was able to generate examples that fit with the youth experiences and highlight the use of SC in a relevant context (e.g., some community members experience rural isolation or military-related parental deployments). I aligned the curriculum to support integration into a school context without adding additional time stressors to the students. Finally, the dissertation highlights the ethical importance of engaging youth in EBP program design and evaluation for clinical uptake. The project also has implications for SC theory and practice.

Practitioners would benefit from learning the process-based application of SC for use in schools and mental health centres. The theory of SC is growing, and the application of MSC programs is emerging. Germer and Neff (2019) recently released *Teaching the Mindful Self-Compassion Program: A Guide for Professionals,* which documents the use of the initial 8-week intervention for adults. While Bluth and colleagues' refined MSC program *Making Friends with Yourself* (Bluth et al., 2016) has demonstrated effectiveness with community and university youth (Boggiss et al., 2020; Donovan et al., 2021). The current project further supports the use of MSC-based intervention and adds to the literature on the use of the program in schools and community mental health programs. The process also highlights the importance of long-term SC interventions and the benefits for stabilizing transitioning youth. This dissertation is innovative by exploring the use of the practice of SC in prevention and intervention programming. Using SC in prevention programming could have implications for engaging students in health

promotions by developing a capacity to manage difficult emotions and personal and social situations regardless of context. Adolescence is a time of critical emotional, social, familial, and cognitive change. This dissertation adds to the literature on the potential role of SC interventions for youth to thwart the onset of mental health challenges and have lifelong consequences for the capacity to manage distress.

Additionally, this dissertation adds to the SC theory by exploring how youth living with mental health challenges understand SC theory after the intervention. Including the youth's evaluations of the experience and their understanding of the three main components of SC and value-based living helps to clarify the importance of the theory to practice being explicit for youth. The youth understood the concepts but reported the need for additional focus on psychoeducation and embodied experiences. Finally, this project adds to the current body of literature highlighting the benefits of SC for marginalized groups. Youth living in small city centres are a rarely engaged population. This dissertation is unique in identifying this community as an outlier in research contexts. The rarely engaged voice of youth living in small city centres, especially those living with mental health challenges, should be involved in future research to understand their lived experiences. The project also adds to the literature on the practice and theory implication for YE in IKT.

The current dissertation emphasizes the importance of engaging youth voices in program design and evaluation in school and mental health agencies. Youth voices are rarely included in research processes in clinical and counselling mental health programming, despite the call for these practices to occur. The method of having youth as members on boards and advisory groups is growing, yet the practice of engaging youth living with mental health challenges in schools and community intervention evaluations is limited. Therefore, this project is innovative in adding

to the practice of engaging youth in counselling practices. This dissertation is also novel in adding to the IKT literature youth voices in program uptake. Including all youth regardless of status (e.g., youth living with mental health challenges, youth in small city centres) has the potential to engage individuals who are often marginalized or alienated in programs that affect them. These perspectives add the theoretical underpinnings of the benefits of youth engagement, IKT, and CBPR in mental health program interventions and EBP prevention programs.

Concluding Remarks

This study focused on the process of engaging youth living with mental health challenges in evaluating and modifying an SC program that was iteratively delivered to younger youth in a school setting. The overall findings of this project contribute to the body of literature on SC interventions and add the potential role of SC in prevention programs. Additionally, this program adds to the literature on engaging youth living with mental health challenges in program design and evaluation for systems that often rely on EBPs. This process may help engage youth, regardless of circumstance, in systems change. This process may also help with attrition and help reduce the disconnection that many youth struggling with mental health challenges experience. Finally, with the increasing distress related to COVID-19 and the spotlight on Black Lives Matter*,* the Canadian First Nations movement calling for Every Child Matters, and the Me Too movement, youth need the skills to manage distress and marginalization and advocate for systems change. SC can help youth take care of their emotional needs and become increasingly resilient, while YE in systems change may help critically analyze practice and create change for the next generation of researchers, practitioners, and youth.

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Appendix A

CBPR Study Ethics Approval

McGill

Research Ethics Board Office
James Administration Bldg.
845 Sherbrooke Street West. Rm 429
Montreal, QC H3A 0G4

Tel: (514) 398-6831
Fax: (514) 398-4644
Website: www.mcgill.ca/research/researchers/compliance/human/

Research Ethics Board III
Certificate of Ethical Acceptability of Research Involving Humans

REB File #: 294-1216

Project Title: Engaging Youth Mental Health Consumers in the Exploration and Evaluation of a Practice-Based Self-Compassion Program

Principal Investigator: Alisha Henson **Department:** Education and Counselling Psychology

Status: Ph.D. Student **Supervisor:** Prof. Marilyn Fitzpatrick

Funding: Social Sciences and Humanities Research Council of Canada: Doctoral award

Approval Period: January 27, 2017 – January 26, 2018

The REB-III reviewed and approved this project by delegated review in accordance with the requirements of the McGill University Policy on the Ethical Conduct of Research Involving Human Participants and the Tri-Council Policy Statement: Ethical Conduct For Research Involving Humans.

Lynda McNeil
Associate Director, Research Ethics

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* Approval is granted only for the research and purposes described.
* Modifications to the approved research must be reviewed and approved by the REB before they can be implemented.
* A Request for Renewal form must be submitted before the above expiry date. Research cannot be conducted without a current ethics approval. Submit 2-3 weeks ahead of the expiry date.
* When a project has been completed or terminated, a Study Closure form must be submitted.
* Unanticipated issues that may increase the risk level to participants or that may have other ethical implications must be promptly reported to the REB. Serious adverse events experienced by a participant in conjunction with the research must be reported to the REB without delay.
* The REB must be promptly notified of any new information that may affect the welfare or consent of participants.
* The REB must be notified of any suspension or cancellation imposed by a funding agency or regulatory body that is related to this study.
* The REB must be notified of any findings that may have ethical implications or may affect the decision of the REB.

Appendix B

Email to Gatekeepers

Dear Principle (principles name) or Cheryl Jensen (president of local college),

My name is Alisha Henson, and I am a PhD student at McGill University currently working towards my dissertation in counselling psychology. The focus of my PhD research project is to work collaboratively with youth to evaluate and remaster a current adult mental health program and make it more youth user friendly. This project has been approved by the McGill University Research Ethics board.

I work within the Pembroke community as a mental health therapist both for the Phoenix Centre and privately and believe that the youth in this community have something unique to offer this research project.

I am writing you today in hopes of gaining your approval to display a poster (see attached) advertising this project on your volunteer board at school. Youth who participate will be working collaboratively with adults to edit the mental health program over the course of five sessions, thus gaining not only skills related to mental health, but also leadership and research skills. For their participation, youth will be given volunteer hours or a small stipend.

Please, let me know if you have any questions or concerns.

Thank you for your consideration.

Alisha Henson (MA, CCC, PhD Candidate McGill University)

343-369-0603

Dear LGBTQQ group facilitator,

My name is Alisha Henson, and I am a PhD student at McGill University currently working towards my dissertation in counselling psychology. The focus of my PhD research project is to work collaboratively with youth to evaluate and remaster a current adult mental health program and make it more youth user friendly. This project has been approved by the McGill University Research Ethics board.

I work within the Pembroke community as a mental health therapist both for the Phoenix Centre and privately and believe that the youth in this community have something unique to offer this research project. I am reaching out to your organization to engage youth who often feel marginalized and face distress in rural communities.

I am writing you today in hopes of gaining your approval to display a poster (see attached) advertising this project in your group. Youth who participate will be working collaboratively with adults to edit the mental health program over the course of five sessions, thus gaining not only skills related to mental health, but also leadership and research skills. For their participation, youth will be given volunteer hours or a small stipend.

Please, let me know if you have any questions or concerns.

Thank you for your consideration.

Alisha Henson (MA, CCC, PhD Candidate McGill University)

343-369-0603

Appendix C

Recruitment Poster

Youth Community Meeting

Who: youth ages 16 – 20 years
*Only those who participated in mental health support services will be eligible to participate in the study

Where: Phoenix Centre 130 Pembroke Street West

When: March 1st 4:00 pm (snacks provided)

Why: A meeting to discuss an upcoming opportunity to participate in a collaborative research project focused on youth mental health.

Participation in the project can lead to volunteer hours OR a bit of cash!

The goal of the project is to edit an existing adult program focused on well-being and reducing distress for youth.

Alisha Henson (MA, PhD Candidate): alisha.henson@mail.mcgill.ca
Text/call 343-369-0603

McGill Psychotherapy Process Research Group

Social Sciences and Humanities Research Council of Canada | Conseil de recherches en sciences humaines du Canada

TALK: 03/01 @Phoenix
alisha.henson@mail.mcgill.ca

TALK: 03/01 @Phoenix
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Appendix D

Script for CBPR Study

Community Meeting Script

Thank you so much for coming, I appreciate it. Let me take a moment to introduce myself. My name is Alisha Henson, and I am a PhD student at McGill University currently working towards my dissertation in counselling psychology under the advisement of Dr. Marilyn Fitzpatrick. The focus of my PhD research project is to work collaboratively with youth to evaluate and remaster a current adult mental health program and make it more youth user friendly.

I want to do this because I believe that in working together, we can make programs more effective for your peers. This belief is rooted in my background in youth engagement. Youth engagement is focused on respecting the rights and dignities of young people and working together to change the systems that affect your day-to-day living (e.g. school and community programs). I want to bring you all together tonight to recruit youth collaborators for the project. The project has two main goals, 1) to evaluate and remaster the program and 2) to understand youth experience as collaborators in mental health research.

It is crucial that you understand that the goal is to work together. Therefore, I am recruiting youth who are willing to share their voices in how programs are created for youth. I understand this is a small community and there is risk in working collaboratively. I will follow the rules of confidentiality that are in line with my practice in mental health. I am also recruiting youth who are capable of being respectful of each other's confidentiality. This sense of safety in sharing is important to the process. Participants must also be comfortable respecting the principles of youth engagement.

Principles of YE that guide this project are: 1) to help youth develop *positive relationshi*p with adults through healthy collaborations and recognizing that youth are often not included in this process, but have the right to have a voice in the systems that affect them, 2) that youth deserve positive spaces where they can have healthy interactions free from physical, emotional, or psychological harm and be free to express themselves openly and authentically without fear of discrimination based on their gender, sex, sexual orientation, race, class, appearance, or other identifying factors, and 3) a space for you to develop life skills.

Finally, I am recruiting youth who will be available for the entirety of the project. Participants will be required to attend one two-hour pre-intervention workshop (10 am -12 pm) on TBD (Date) followed by a light lunch. They will also be required to attend four intervention sessions from 10 am – 3:30 pm on (date). Snacks and lunch will be provided. There will be minimal home practice between sessions. Finally, you will be asked to participate in an interview about your experience. Given that this a big commitment you can choose between two means of compensation 1) 20 volunteer hours 2) $50 cash.

Does anyone have any questions?

If you are interested in participating, I will ask you to stay behind and complete a brief recruitment package. If you need time to think or have any further questions, please take my card and call or email me.

Those who stay behind will be given the following directions.

1) There is a consent form that you will need to complete prior to completing the questionnaires. It is important that you understand all the information on the consent so

please let me know if you have any questions or need additional support regarding this consent.

2) Completing this package does not guarantee that you will be participating in the study. There may be many youth who want to participate and at this time we are only looking for 12-14 youth. If you are chosen, I will contact you to discuss the next steps. If your scores on the measures indicate that you are in crisis, I will again contact you to ensure you are currently working with a mental health provider or to connect you with local services.
3) If you are not chosen as a participant, your data will be destroyed.

Appendix E

CBPR Consent Form

Engaged Youth Mental Health Consumers in the Exploration and Evaluation of a Practice-Based Self-Compassion Program

Please read the information below carefully to ensure to allow you to make an informed decision about whether to collaboratively participate in this study on self-compassion.

Research Procedures

Objectives: The goal of this research project is to work collaboratively with youth to evaluate an existing self-compassion program for adults and modify the program for peers. The research will explore self-compassion and understanding the concepts of self-kindness, common humanity, and mindfulness. In addition, the research is focused on youth experiences as collaborators in mental health research.

Procedures: You will be asked to participate in one pre-workshop warm up session (10 am – 12 pm), four workshop/debriefing sessions (four consecutive Saturdays for four weeks from 10 am – approximately 3:30 pm). Lunch and snacks will be provided on all workshop days. The warm –up sessions will focus on activities for us to get to know each other and to complete pre-intervention questionnaires. During the workshops, you will be asked to participate in mindful activities and engaged in group discussions and discussions in pairs. You will also be asked to reflect in workbooks and complete small pieces of between session homework and record your thoughts in the workbook. The debriefing will focus on what worked and what did not work during the workshop sessions. You will be asked to share your experience from the workshop and make recommendations about how things could be improved. At the end of the four workshops, you will be asked to complete post-workshop questionnaires and the researchers

will make copes your workbooks. You may keep the original for your own use. The same questionnaires will be used throughout the intervention. The questionnaires will measure mental health symptoms (e.g. depression, anxiety, and stress), self-compassion, values, and your level of engagement.

Approximately one week after the final workshop, you will have an interview to discuss your experience of the workshop, as well as your experience as a collaborator in the research project. The length of this interview will be approximately 30- 45 minutes. The interviews will be audio-recorded and will take place in private rooms at the Phoenix Centre. Once transcription has occurred, you will be given the opportunity to read the transcript of your interview and clarify the information you provided.

Dissemination of Results: As per the theory of Knowledge Mobilization, the results will be shared in three separate areas of mental health. First the results will be shared with the academic community via the principal research dissertation, academic journals, and scholarly presentations. Secondly, the data will be shared with the children's mental health community to address standards of engaging youth in mental health research for program development and evaluation. Finally, as part of the collaborative process, we will make a joint decision about ways to share our findings with your peers. The researcher hopes to engage youth in disseminating the research to their peers in a form fitting to youth (e.g. mixed media, pamphlets, group intervention).

Confidentiality

All the questionnaire and interviews data will be identified with a number assigned to you at the beginning of the study. The information linking your name to a tracking number will be kept in a digital file on a password-protected computer separate from the data. Only the principal

investigator will have the data linking the participant ID to the individual. The principal research and her team (academic advisor, dissertation committee, and research assistants) will be responsible for transcribing the interviews, analyzing data, and disseminating results and only these people will have access to your de-identified data. Your identifying information will never be associated with the responses during data analysis or in the dissemination of results. All research assistants will be required to sign a confidentiality agreement, which will give them access to your de-identifiable data.

Data Storage

Questionnaire responses will not be associated with your name. All paper-based data will be safely stored in locked cabinets in locked rooms of the researcher's office, and only researchers have the key to access this cabinet. All digital data and will be stored on a password-protected computer only accessible to the researcher team. The interviews will be audio-recorded solely for analyzing data.

Compensation

During the project you can be compensated in one of two ways: 1) receive 25 volunteer hours or 2) a $50 stipend which will be dispersed with $5 for the pre-intervention workshop, $5 for the first intervention session, $10 for the subsequent intervention sessions (session 2-4), and $10 for the follow-up interview. Participation in this research completely voluntary and you can choose to withdraw at any time. If withdraw from the study at any point and receive volunteer hours for the time you spent participating or cash based on the schedule listed above.

Potential Benefits

By participating in this project, you could experience an increased awareness of the challenges you have previously or currently are facing in life; as well as insight into your own

experience of self-compassion, values, and well-being. The benefit for your participation is to learn a new and healthy way to manage difficult moments, which can be beneficial to your mental health and well-being. You may also learn valuable research skills.

Potential Harm

You may experience some emotional discomfort because of exploring the ways in which you cope with difficult moments in life. There will be several mental health professionals available to consult with during this process. You will be provided with referral resources if you need additional support, after participating in the study.

Questions about the study may be addressed to Alisha Henson (McGill University), by phone 343-369-0603 or by email alisha.henson@mail.mcgill.ca or my academic advisor Dr. Marilyn Fitzpatrick at 514-398-3476 or marilyn.fitzpatrick@mcgill.ca.

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca.

Thank you for your consideration of this study.

Alisha Henson, PhD Candidate

alisha.henson@mail.mcgill.ca

Please check the box below if you agree to participate in the study:

- ❑ I AGREE to take part in this research project. I have been informed of the project's procedures. I understand that I can withdraw from the project at any time and that I can refuse to answer any question.

Please check ONLY ONE of the boxes below regarding use of data:

- ❑ I agree to allow this data to be used ONLY for this research project.
- ❑ I agree to allow this data to be used in FUTURE related research projects conducted by Alisha Henson. These projects may use only de-identifiable data: transcripts of the post-intervention interviews, workbooks, and questionnaire data collected throughout this study.

To ensure the study is being conducted properly, authorized individuals such as a member of the Research Ethics board, may have access to your information. By signing this consent form, you are allowing such access. Agreeing to participate in this study does not waive any of your rights or release the researchers from their responsibilities. A copy of this consent form will be given to you and the researcher will keep a copy

Appendix F

About Me Questionnaire

*****If you are younger than 16, please do not complete this questionnaire*****

Name: _____

Date of birth: _____Month/Day/Year

Email address _____ Phone number: _____

Would you preferred method of contact (please circle): email phone

What gender do you identify with? (Please choose all that apply)

☐ Boy/Man ☐ Girl/Woman ☐ Genderqueer ☐ Gender-Neutral
☐ Trans ☐ Third Gender ☐ Two-Spirit ☐ I prefer not to say
☐ My gender does not fit into any of these check boxes
If you'd like to, please describe your gender identity in your own words: _____

Do you consider yourself to be:

☐ Bisexual (attracted to more than one gender)
☐ Heterosexual/Straight (attracted to others of the opposite gender)
☐ Homosexual/Gay (attracted to others of the same gender)
☐ Lesbian (woman attracted to other women)
☐ Queer (anyone who does not identify as only heterosexual)
☐ Questioning (someone exploring their sexual orientation)
☐ I prefer not to say
☐ My sexual orientation does not fit into any of these check boxes. If you'd like to, please describe your sexual orientation in your own words:

_____

What cultural/racial group(s) do you identify with?

African Arab Black Chinese Filipino
First Nations Inuit Japanese Korean Latin
Metis White
South Asian (e.g. Indian, Pakistani, Sri Lankan etc…)
Southeast Asian (e.g. Cambodian, Laotian, Indonesian, etc…)
West Asian (e.g. Afghan, Iranian, Turkish etc…)
Other: _____
If you'd like to, please describe your cultural/racial group in your own words _____

Were you born in a country other than Canada?

☐ Yes ☐ No ☐ I don't know ☐ I would prefer to not say

Were your parents born in a country other than Canada?

☐ Yes ☐ No ☐ I don't know ☐ I would prefer to not say

Do you live in a town or community that is smaller than 20,000 people?

☐ Yes ☐ No ☐ I don't know ☐ I would prefer to not say

Do you live more than an hour's drive from a city?

☐ Yes ☐ No ☐ I don't know ☐ I would prefer to not say

When you are at home or with your family, what language(s) do you usually speak? (Please choose all that apply)

☐ I prefer not to say ☐ English ☐ French ☐ First Nations Language

☐ Speak another language (Please specify) _____

Are you currently in school: Yes No (circle one) Grade: _____

If yes, how many hours a week are you in school? _____

Are you currently working: Yes No (circle one)

If yes, how many hours a work do you usually work? _____

Do you have enough money to meet your basic needs (food, housing, clothing, health care)?

☐ Always ☐ Mostly ☐ Sometimes ☐ Hardly ever ☐ Not at all

☐ I prefer not to say

Do you have enough money (from a job, parents/guardians, etc.) to do the fun things you'd like to do?

☐Always ☐ Mostly ☐ Sometimes ☐ Hardly ever ☐ Not at all

☐ I prefer not to say

Who do you live with? (Please choose all that apply)

☐ Birth/Adoptive Mom ☐ Birth/Adoptive Dad ☐ Step Mom ☐ Step Dad

☐ Guardian ☐ Foster Parents ☐ Other Relatives

☐ Brothers/Sisters ☐ Girlfriend/Boyfriend ☐ Partner/Spouse

☐ My Child/Children ☐ Roommates/Friends ☐ Live on my Own

☐ Staff/Residents of Group Home ☐ Staff/Residents of Closed Custody Facility

☐ I prefer not to say

☐ Other (Please describe)_____

Do you currently belong to any clubs or groups? If yes, which one's _____

Have you ever sought mental health support? Yes No (circle one)

If yes, where did you receive services: _____

Do you have a mental health diagnosis? Yes No (circle one)

Are you currently working with a mental health professional? Yes No (circle one)

Are you currently in crisis? Yes No (circle one)

Appendix G

Participation Invitation Email

Hello,

Thank you for attending the community information session and applying to be a participant in a collaborative mental health research project. I am contacting you today to inform you that you have been selected to be a participant and to confirm that you are available to participate in the pre-intervention workshop and all four workshop sessions of the program. The pre-intervention workshop will be held on (TBD) from 10:00 am till 12:00 pm (light lunch will be provided). The workshop sessions will be held on four consecutive Saturday's from 10:00 am – 3:30 pm.

As highlighted at the community information session, the main goal of my research project is to modify an existing adult mental health program for youth in hopes of increasing well-being and reducing symptoms of distress. One immensely important part of this process is to work collaboratively with youth (age 16 -20 years) to help evaluate and modify this program for peers.

During the sessions, you will be asked to participate in a mindful-based program focused on developing compassion for yourself and then engage in discussion about the benefits and pitfalls of the program. In appreciation for your participation and collaboration in my research, you have the option of receive 25 volunteer hours or to receive a $50.00 stipend for your time.

Space is limited so please let me know as soon as possible if you are still interested in participating so I can reserve a spot for you.

If you wish to participate or if you have questions, please send an email to Alisha Henson (alisha.henson@mail.mcgill.ca) or contact my academic advisor Dr. Marilyn Fitzpatrick (marilyn.fitzpatrick@mcgill.ca). Please put *SC Project* in the subject line. You are also welcomed to call me at (343) 369 -0603.

Thank you again and I look forward to working together,

Alisha Henson

MA, CCC, PhD Candidate McGill University

Appendix H

CBPR Group Demographics

Table H1

*CBPR Group: Baseline Demographic and Clinical Characteristics by Sequence and Total, Categorical Data (*N = *12)*

Characteristic	Participants *n* (%)	Withdrawers *n* (%)	Total *n* (%)
Age			
16	3 (25.00)	0 (0.00)	3 (25.00)
17	2 (16.67)	3 (25.00)	5 (41.67)
18	0 (0.00)	2 (16.67)	2 (16.67)
19	0 (0.00)	1 (8.33)	1 (8.33)
20	0 (0.00)	1 (8.33)	1 (8.33)
Gender identity			
Woman	4 (33.33)	5 (41.67)	9 (75.00)
Man	1 (8.33)	2 (16.67)	3 (25.00)
Other	0 (0.00)	0 (0.00)	0 (0.00)
Sexual orientation			
Bisexual	1 (8.33)	1 (8.33)	2 (16.67)
Heterosexual	4 (33.33)	5 (41.67)	9 (75.00)
Gay/Lesbian	0 (0.00)	0 (0.00)	0 (0.00)
Questioning	0 (0.00)	1 (8.33)	1 (8.33)
Cultural identification			
White	5 (41.67)	3 (25.00)	8 (66.67)
Metis	0 (0.00)	1 (8.33)	1 (8.33)
Multiracial Metis/White	0 (0.00)	2 (16.67)	2 (16.67)
Multiracial Black/White	0 (0.00)	1 (8.33)	1 (8.33)
Language spoken			
English	4 (33.33)	7 (58.33)	11 (91.67)
English/French	1 (8.33)	0 (0.00)	1 (8.33)

Characteristic	Participants *n* (%)	Withdrawers *n* (%)	Total *n* (%)
Money for basic needs			
Always	1 (8.33)	4 (33.33)	5 (41.67)
Mostly	3 (25.00)	2 (16.67)	5 (41.67)
Sometimes	1 (8.33)	1 (8.33)	2 (16.66)
Money for fun			
Always	0 (0.00)	2 (16.67)	2 (16.67)
Mostly	1 (8.33)	1 (8.33)	2 (16.67)
Sometimes	4 (33.33)	3 (25.00)	7 (58.33)
Hardly ever	0 (0.00)	1 (8.33)	1 (8.33)
Current mental health support			
Yes	2 (16.67)	5 (41.67)	7 (58.33)
No	3 (25.00)	2 (16.67)	5 (41.67)
Mental health diagnosis			
No diagnosis	2 (16.67)	1 (8.33)	3 (25.00)
Yes diagnosis	3 (25.00)	6 (50.00)	9 (75.00)
Participates in groups			
Yes	5 (41.67)	2 (16.67)	7 (58.33)
No	0 (0.00)	5 (41.67)	5 (41.67)

Appendix I

School Board Ethics Approval

Administrative Procedure 290

Access to RCDSB Operations by Research Personnel

Background

The Renfrew County District School Board supports excellence in teaching and learning and recognizes the value of research projects being carried out to further our collective understanding. This procedure outlines the application process, approval criteria and communication for a proposed study that has the potential to directly benefit the school system.

Procedure

The staged process:

Stage 1:

1. The applicant will submit F-290-1, Application to Conduct Research in the RCDSB, to the Director's Office (contact information available via RCDSB website). Email/electronic submissions are preferred.

2. The application will be evaluated by the Operations Steering Committee which meets at least three times in each year. The criteria used to evaluate the application is as follows:

   a) protection of student/staff rights when students/staff are subjects. When data are collected from students/staff, their rights and those of parents are not to be infringed upon. Conditions to be met include:
      - approval in writing from parents or the adult student or staff member;
      - assurance that information is given voluntarily without any special form of reward;
      - all rights are explained to participants in advance of data collection; and
      - there is no denial of learning opportunity.
   b) protection of the rights and well-being of the subjects in accordance with accepted research ethics;
   c) minimal or non-existent distress on students;
   d) no use of violent materials for students;
   e) consideration of political issues and consulting with the applicable Superintendent(s);
   f) consideration of any researcher bias or conflict of interest situations that may arise;
   g) a design that does not permit evaluation of an individual, and ensures that anonymity of participants and confidentiality of data are protected and consistent with the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA);
   h) clear procedures for obtaining informed consent (as required for application form completion);

Appendix J

McGill Ethics for School Study

McGill

Research Ethics Board Office
James Administration Bldg.
845 Sherbrooke Street West. Rm 325
Montreal, QC H3A 0G4

Tel: (514) 398-6831

Website: www.mcgill.ca/research/researchers/compliance/human/

Research Ethics Board III
Certificate of Ethical Acceptability of Research Involving Humans

REB File #: 356-0118

Project Title: A self-comparison program for youth in a school setting: a feasibility study

Principal Investigator: Alisha Henson

Department: Educational & Counselling Psychology

Status: Master's Student

Supervisor: Prof. Marilyn Fitzpatrick

Co-Investigator(s): Dr. Jessica Ruglis, McGill University; Dr. Lynette Monteiro, University of Ottawa; Dr. Purnima Sundar, Ontario Centre of Excellence in Child and Youth Mental Health

Approval Period: February 3, 2018 to February 2, 2019

The REB-III reviewed and approved this project by full review in accordance with the requirements of the McGill University Policy on the Ethical Conduct of Research Involving Human Participants and the Tri-Council Policy Statement: Ethical Conduct For Research Involving Humans.

Deanna Collin
Ethics Review Administrator, REB I, II, III & FAES

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* Approval is granted only for the research and purposes described.
* Modifications to the approved research must be reviewed and approved by the REB before they can be implemented.
* A Request for Renewal form must be submitted before the above expiry date. Research cannot be conducted without a current ethics approval. Submit 2-3 weeks ahead of the expiry date.
* When a project has been completed or terminated, a Study Closure form must be submitted.
* Unanticipated issues that may increase the risk level to participants or that may have other ethical implications must be promptly reported to the REB. Serious adverse events experienced by a participant in conjunction with the research must be reported to the REB without delay.
* The REB must be promptly notified of any new information that may affect the welfare or consent of participants.
* The REB must be notified of any suspension or cancellation imposed by a funding agency or regulatory body that is related to this study.
* The REB must be notified of any findings that may have ethical implications or may affect the decision of the REB.
* The REB must be notified of any suspension or cancellation imposed by a funding agency or regulatory body that is related to this project.
* The REB must be notified of any findings that may have ethical implications or may affect the decision of the REB.

Appendix K

Script for School Recruitment Script

Thank you so much for allowing me to come and speak with you today, I appreciate it. Let me take a moment to introduce myself. My name is Alisha Henson and I am a PhD Candidate at McGill University currently working towards my dissertation in counselling psychology under the advisement of Dr. Marilyn Fitzpatrick and Dr. Jessica Ruglis. The focus of my PhD research project is to work collaboratively with youth to evaluate and remaster a current adult mental health program and make it more youth user friendly. I also hope to create intervention that can be taught to youth at school to help increase well-being and decrease potential mental health challenges.

I want to do this because I believe that in working together, we can make programs more effective for your peers. This belief is rooted in my background in youth engagement. Youth engagement is focused on respecting the rights and dignities of young people and working together to change the systems that affect your day to day living (e.g. school and community programs). For the last several months I have been working with a group of youth to explore a Self-Compassion program that was developed for adults and to modify it for use with your peer group. My goal is to now take the findings of that project and engage your classroom in the re-mastered intervention in hopes of continue to explore the benefits and to get your feedback on the process.

It is crucial that you understand that the goal is to work together. I understand this is a small classroom and community and there is risk in working collaboratively. I will follow the rules of confidentiality that are in line with my practice in mental health. I am recruiting youth who are capable of being respectful of each other's confidentiality. This sense of safety in

sharing is important to the process. Participants must also be comfortable respecting the principles of youth engagement.

Principles of YE that guide this project are: 1) to help youth develop positive relationship with adults through healthy collaborations and recognizing that youth are often not included in this process, but have the right to have a voice in the systems that affect them, 2) that youth deserve positive spaces where they can have healthy interactions free from physical, emotional, or psychological harm and be free to express themselves openly and authentically without fear of discrimination based on their gender, sex, sexual orientation, race, class, appearance, or other identifying factors, and 3) a space for you to develop life skills.

Finally, I am recruiting youth who will be available for the entirety of the project. Participants will be required to attend one hour session that will take place once a week during your physical education for a period of eight weeks. They will also be asked to complete a pre-questionnaire one week before the intervention, mid-intervention and a post- intervention. The questionnaires will take approximately 50 minutes. There will be minimal home practice between sessions. Home practice will take approximately 5-10 minutes.

The decision to participate or not participate in this project will have no effect on your physical education grade. Those who choose to not participate will learn about mental-health and well-being through traditional processes while those who chose to participate are engaging in the project. Does anyone have any questions?

If you are interested in participating, I will ask you to add your name to this list. If you need time to think or have any further questions, please take my card and call or email me. If you do not wish to participate, you will engage in regular physical education with your teacher. Your

decision to not participate will have no effect on your overall grade in your physical education class.

Finally, if you wish to participate, I also ask you to take a consent form home to your parent/guardian. You will not be able to participate in this project without your signed consent. You will also be asked to sign an assent form indicating your desire to participate. Both must be returned to your teacher this week. Your teacher and/or school support counsellor will follow-up with you, but please do not forget.

Appendix L

School Consent and Assent Forms

Parent Consent Form

A Self-Compassion Program for Youth in a School Setting: A Feasibility Study.

Please read the information below carefully to ensure you have the necessary information to make an informed decision about whether to all your child's participate in this study on self-compassion.

Hello parent/guardian,

Alisha Henson, a McGill University PhD candidate and the Renfrew County District School Board are collaborating on a research project focused on mental health and well-being. The project will take place during your daughters grade nine physical education class. Your decisions regarding participation in this project will have no effect on your child's physical education grade. Those who choose to not participate will learn about mental-health and well-being through traditional processes while those who chose to participate are engaging in the project.

Objectives: The goal of this research project is to evaluate an existing self-compassion program for adults and modify the program for youth in a school setting. The intervention will take place once a week during your child's physical education class for a period of eight weeks. The program will explore self-compassion and understanding the concepts of self-kindness, common humanity, values, and mindfulness and how these concepts help youth to better cope with mental health challenges, to live a value directed life, and increase their psychological well-being.

Procedures: All youth that gain parental consent and personally assent to participate will be assigned to either the intervention group or a school-as-usual control group. These two groups will alternate after eight-weeks of the program. During the intervention, your child will be asked to participate in a series of self-compassion based interventions and to engage in group discussions, discussions in pairs, and to work individually. Youth will also be asked to reflect in workbooks and complete brief between-session home practice. Home practice will take 5-10 minutes a week and is strictly voluntary.

All youth will be asked to complete a questionnaires package at three times points (pre-mid-point and post-intervention) during the winter semester of 2017-2018 school year. The same questionnaires will be used throughout the intervention. The questionnaires will measure mental health symptoms (e.g., depression, anxiety, and stress), well-being, self-compassion, and values. During the questionnaire sessions, youth who do not participate will engage in their usual physical education class with their teacher. At the end of the workshops, the principal researcher (Alisha Henson) will make copies of your child's workbook and the youth will keep the original for personal use. All workbooks will be kept confidential.

Participation in this research is completely voluntary and the decision to not participate will not affect your child's grade. You can choose to withdraw your child from the project at any time. If you chose to not allow your child to participate, they will engage in school as usual. If you choose to withdraw your youth at any time, for any reason, and all data relating to their name will be destroyed unless they indicate otherwise.

Dissemination of Results*:* As per the theory of Knowledge Mobilization, the results will be shared in three separate areas. First, the results will be shared with the academic community via the principal researcher's dissertation, academic journals, and scholarly presentations. Secondly, the results of this research will be shared with the school board to address standards of engaging youth in self-compassion practice as part of the school curriculum. Finally, the data will also be used to inform the continued development of a new self-compassion intervention program.

Confidentiality: All the questionnaires and workbook data will be confidential. All the questionnaire and workbook data will be identified with a number assigned to the student at the beginning of the study. Only the principal researcher will have the data linking the participant ID to the individual. The information linking the student to a tracking number will be kept in a digital file on a password-protected computer separate from the data. All research assistants will be required to sign a confidentiality agreement, which will give them access to your non-identifiable data. The principal researcher and her team (academic advisor, dissertation committee, and research assistants) will be responsible for transcribing the workbooks, analyzing data, and disseminating results. Student identifying information will never be associated with the responses during data analysis or in the dissemination of results.

Data Storage: Questionnaire responses will not be associated with your youths name. All paper-based data will be safely stored in locked cabinet in locked rooms of the principal researcher's office, and only researchers have the key to access this cabinet. All non-identifiable digital data and will be stored on a password-protected computer only accessible to the research team.

Potential Benefits: By participating in this project, your child could experience an increased awareness of the challenges they have previously or currently are facing in life; as well as insight into their own experience of self-compassion, values, and well-being. The benefit for your child's participation is to learn a new and healthy way to manage difficult moments, which can be beneficial to your mental health and well-being.

> Potential Harm: Your child may experience some emotional discomfort because of exploring how they cope with difficult moments in life. There will be several school and community based mental health professionals available to consult with during this process. All youth will be provided with community referral resources if additional support is needed at any time during the study.

Questions should be addressed to Alisha Henson by phone 343-369-0603/alisha.henson@mail.mcgill.ca or my academic advisors Dr. Marilyn Fitzpatrick (514-398-3476/ marilyn.fitzpatrick@mcgill.ca) or Dr. Jessica Ruglis (514-398-2418/Jessica.ruglis@mcgill.ca).

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca.

Thank you for your consideration of this study.
Alisha Henson, Ph.D. Candidate (343-369-0603/alisha.henson@mail.mcgill.ca)

After reading the information about participating in the study, please complete the section below to proceed with consent for participation.

Please check ALL the boxes below if you agree to allow your child to participate in the study:

- ❑ I AGREE with my child's participation in this research project.
- ❑ I have been informed of the project's procedures.
- ❑ I understand that I can withdraw my child's participation and their data from the project at any time without affecting their physical education grade.

Please check ONLY ONE of the boxes below regarding use of data:

- ❑ I agree to allow this data to be used ONLY for this research project.
- ❑ I agree to allow this data to be used in FUTURE related research projects conducted by Alisha Henson. These projects may use only non-identifiable data: workbooks, and questionnaire data collected throughout this study.

Please be advised that your child's confidentiality will be broken and you will be contacted if there is reasonable cause to believe your child is at risk of harming herself or someone else.

Please be advised that your child's confidentiality will be broken and Family and Children Services will be contacted if your child discloses that they previously or currently have been subject to any form of abuse.

To ensure the study is being conducted properly, authorized individuals such as a member of the Research Ethics board may have access to your information. By signing this consent form, you are allowing such access. Agreeing to participate in this study does not waive any of your rights or release the researchers from their responsibilities. Please keep a copy of this consent form for your records, and sign and return one copy to the school and principal researcher.

Child Name (printed): _____ Parent Name (printed):_____

Parent Signature: _____ Date:_____

SSHRC CRSH
Social Sciences and Humanities Research Council of Canada
Conseil de recherches en sciences humaines du Canada

McGill

RCDSB
Renfrew County
District School Board

Student Assent Form

A Self-Compassion Program for Youth in a School Setting: A Feasibility Study

Please read the information below carefully to ensure you have the necessary information to make an informed decision about whether to participate in this study on self-compassion.

Hello student,

Objectives: The goal of this research project is to evaluate an existing self-compassion program for adults and modify the program for youth. The program will explore self-compassion and understanding the concepts of self-kindness, common humanity, values, and mindfulness and how these concepts help youth to better cope with mental health challenges, to live a more value directed life, and increase their psychological well-being. Your decisions regarding participation in this project will have no effect on your physical education grade. Those who choose to not participate will learn about mental-health and well-being through traditional processes while those who chose to participate are engaging in the project.

Procedures: You are being asked to participate in an intervention that focuses on mindfulness, values, and self-compassion based activities. This intervention will take place once a week during your physical education class for a period of eight weeks. In the beginning, you will be assigned to either the intervention group or the control group. After eight weeks, the groups will alternate. At the beginning, mid-point, and end of the workshop, you will be asked to complete a questionnaires package. The same questionnaires will be used throughout the intervention. The questionnaires will measure mental health symptoms (e.g., depression, anxiety, well-being, and stress), self-compassion, and values. During the questionnaire sessions, youth who do not participate will engage in their usual physical education class with their teacher. During the intervention, you will be asked to engage in group discussions and discussions in pairs. You will also be asked to reflect in workbooks and complete brief home practice between sessions. At the end of the workshops, the primary researcher will make copies of your workbook. All your information will be kept confidential. You may keep the original for your personal use.

Participation in this research is completely voluntary and you can choose to withdraw at any time without it affecting your physical education grade. If you chose to not participate, you will engage in school as usual. If you choose to withdraw at any time, for any reason, and all data relating to your name will be destroyed unless you indicate otherwise.

Dissemination of Results: As per the theory of Knowledge Mobilization, the results will be shared in three separate areas of mental health. First, the results will be shared with the academic community via the principal researcher dissertation, academic journals, and scholarly presentations. Secondly, the data will be shared with the school board. Finally, the data will be used to inform the continued development of a new self-compassion intervention for your peers.

Confidentiality: All the questionnaire and workbook data will be identified with a number assigned to you at the beginning of the study. The information linking your name to a tracking number will be kept in a digital file on a password-protected computer separate from the data. Only the principal researcher (Alisha Henson) will have the data linking the participant ID to the individual. Your identifying information will never be associated with the responses during data

analysis or in the dissemination of results. All research assistants will be required to sign a confidentiality agreement, which will give them access to the non-identifiable data. The principal researcher and her academic team at McGill (academic advisor, dissertation committee, and research assistants) will be responsible for transcribing the non-identifiable workbooks, analyzing data, and disseminating results. These team members will only have access to your non-identifiable data.

Data Storage: Questionnaire responses will not be associated with your name. All paper-based data will be safely stored in a locked cabinet in a locked room of the principal researcher's office, and only she will have the key to access this cabinet. All non-identifiable digital data and will be stored on a password-protected computer only accessible to the researcher team (principal researcher and her academic team).

Potential Benefits: By participating in this project, you could experience an increased awareness of the challenges you have previously or currently are facing in life; as well as insight into your own experience of self-compassion, values, and well-being. The benefit for your participation is to learn a new and healthy way to manage difficult moments, which can be beneficial to your mental health and well-being.

Potential Harm: You may experience some emotional discomfort because of exploring how you cope with difficult moments in life. There will be several school and community based mental health professionals available to consult with during this process. You will be provided with referral resources if you need additional support at any time during the study. Please be sure to review confidentiality in the statements below.

Questions about the study may be addressed to Alisha Henson (343-369-0603/alisha.henson@mail.mcgill.ca) or one of my academic advisors Dr. Marilyn Fitzpatrick (514-398-3476/marilyn.fitzpatrick@mcgill.ca) or Dr. Jessica Ruglis (514-398-2418/jessica.ruglis@mcgill.ca).

If you have any questions or concerns regarding your rights or welfare as a participant in this research study, please contact the McGill Ethics Officer at 514-398-6831 or lynda.mcneil@mcgill.ca.

Thank you for your consideration of this study.

Please complete the section below to proceed with assent for participation.

Please check the box below if you agree to participate in the study:

- ❑ I AGREE that, with my parent's consent, I am choosing to participate in this research project.
- ❑ I have been informed of the project's procedures.
- ❑ I understand that I can withdraw from the project at any time, to withdraw my data, and that I can refuse to answer any question.

Please check ONLY ONE of the boxes below regarding use of data:

- ❑ I agree, with my parent's consent, to allow this data to be used ONLY for this research project.

- ❑ I agree, with my parent's consent, to allow this data to be used in FUTURE related research projects conducted by Alisha Henson. These projects may use only non-identifiable data: transcripts of the post-intervention interviews, workbooks, and questionnaire data collected throughout this study.

Please be advised that your confidentiality may be broken, and your parents/guardian and the school will be informed if there is reasonable cause to believe you are at risk of harming yourself or others.

Please be advised that your confidentiality will be broken and Family and Children Services will be contacted, if you at any point during the study discloses previous or current physical or sexual abuse.

Please check ONLY ONE statement below that reflects your understanding about the potential risk and your subsequent decision about participating in the research project.

☐ I understand the risk and want to continue to participate.
☐ I understand the risk and no longer want to participate.

To ensure the study is being conducted properly, authorized individuals such as a member of the Research Ethics board may have access to your information. By signing this consent form, you are allowing such access. Agreeing to participate in this study does not waive any of your rights or release the principal research and academic team from their responsibilities. Upon request a copy of this consent form can be provided to you and the researcher will keep a copy.

Student Name (printed): _____ Date: _____

Student Signature: _____

Appendix M

Crisis Contact Information

Call Hotlines:

Mental Health Helpline
MHH provides free, anonymous, confidential information and referral services and supports for people experiencing mental health issues or to their families,
ON, CA
1-866-531-2600
www.MentalHealthHelpline.ca

Kids Help Phone
Kids Help Phone is Canada's only bilingual phone and on-line counselling service for youth. It's free, anonymous and confidential.
439 University Avenue, Toronto, ON, M5G 1Y8
416-586-5437
www.kidshelpphone.ca

Walk-in Crisis Counselling:

Phoenix Centre for Children and Families
Accredited mental health agency that provides treatment for children, youth and families in Renfrew County.
130 Pembroke Street West, Pembroke, ON, K8A 5M8
613-735-2374
1 800 465 1870
www.phoenixctr.com

Pembroke Regional Hospital
Regional community hospital which delivers a wide range of quality health and mental health services. Mental health programs include adult mental health.
705 Mackay Street, Pembroke, ON, K8A 1G8
613-732-2811
www.pemreghos.org/

Appendix N

School Study Demographics

Name: _____

Date of birth: _____Month/Day/Year

Email address _____ Phone number: _____

Would you preferred method of contact (please circle):
Email_____ phone _____

What gender do you identify with? (Please choose all that apply)
☐ Boy/Man ☐ Girl/Woman ☐ Genderqueer ☐ Gender-Neutral
☐ Trans ☐ Third Gender ☐ Two-Spirit ☐ I prefer not to say
☐ My gender does not fit into any of these check boxes
If you'd like to, please describe your gender identity in your own words: _____

Do you consider yourself to be:
☐ Bisexual (attracted to more than one gender)
☐ Heterosexual/Straight (attracted to others of the opposite gender)
☐ Homosexual/Gay (attracted to others of the same gender)
☐ Lesbian (woman attracted to other women)
☐ Queer (anyone who does not identify as only heterosexual)
☐ Questioning (someone exploring their sexual orientation)
☐ I prefer not to say
☐ My sexual orientation does not fit into any of these check boxes If you'd like to, please describe your sexual orientation in your own words:_____

What cultural/racial group(s) do you identify with?

African	Arab	Black	Chinese	Filipino
First Nations	Intuit	Japanese	Korean	Latin
Metis	White			

South Asian (e.g. Indian, Pakistani, Sri Lankan etc…)
Southeast Asian (e.g. Cambodian, Laotian, Indonesian, etc…)
West Asian (e.g. Afghan, Iranian, Turkish etc…)
Other: _____
If you'd like to, please describe your cultural/racial group in your own words _____

Were you born in a country other than Canada?
☐ Yes ☐ No ☐ I don't know ☐ I would prefer to not say

Were your parents born in a country other than Canada?
☐ Yes ☐ No ☐ I don't know ☐ I would prefer to not say

Do you live more than an hour's drive from a city?
☐ Yes ☐ No ☐ I don't know ☐ I would prefer to not say

When you are at home or with your family, what language(s) do you usually speak? (Please choose all that apply)
☐ I prefer not to say ☐ English ☐ French ☐ First Nations Language
☐ Speak another language (Please specify) _____

Are you currently in school: Yes No (circle one) Grade: _____
If yes, how many hours a week are you in school? _____

Are you currently working: Yes No (circle one)
If yes, how many hours a work do you usually work? _____

Do you have enough money to meet your basic needs (food, housing, clothing, health care)?
☐ Always ☐ Mostly ☐ Sometimes ☐ Hardly ever ☐ Not at all
☐ I prefer not to say

Do you have enough money (from a job, parents/guardians, etc.) to do the fun things you'd like to do?
☐Always ☐ Mostly ☐ Sometimes ☐ Hardly ever ☐ Not at all
☐ I prefer not to say

Who do you live with? (Please choose all that apply)
☐ Birth/Adoptive Mom ☐ Birth/Adoptive Dad ☐ Stepmom ☐ Stepdad
☐ Guardian ☐ Foster Parents ☐ Other Relatives
☐ Brothers/Sisters ☐ Girlfriend/Boyfriend ☐ Partner/Spouse
☐ My Child/Children ☐ Roommates/Friends ☐ Live on my Own
☐ Staff/Residents of Group Home ☐ Staff/Residents of Closed Custody Facility
☐ I prefer not to say
☐ Other (Please describe)_____

Do you currently belong to any clubs or groups? If yes, which one's _____

Have you ever sought mental health support? Yes No (circle one)
If yes, where did you receive services: _____
Do you have a mental health diagnosis? Yes No (circle one)
If yes, what diagnosis:_____

Are you currently working with a mental health professional? Yes No (circle one)
Are you currently in crisis? Yes No (circle one)

Appendix O

Depression, Anxiety and Stress Scale (DASS-21)

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**.

There are no right or wrong answers. Do not spend too much me on any statement.

The range scale is as follows:
0 Did not apply to me at all – NEVER
1 Applied to me to some degree, or some of the me – SOMETIMES
2 Applied to me to a considerable degree, or a good part of me - OFTEN
3 Applied to me very much, or most of the me - ALMOST ALWAYS

	N	S	O	A
1. I found it hard to wind down	0	1	2	3
2. I was aware of the dryness of my mouth	0	1	2	3
3. I couldn't seem to experience any positive feeling at all	0	1	2	3
4. I experienced breathing difficulties (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5. I found it difficult to work up the initiative to do things	0	1	2	3
6. I tended to over-react to situations	0	1	2	3
7. I experienced trembling (in the hands)	0	1	2	3
8. I felt that I was using a lot of nervous energy	0	1	2	3
9. I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10. I felt that I had nothing to look forward to	0	1	2	3
11. I found myself getting agitated	0	1	2	3
12. I found it difficult to relax	0	1	2	3
13. I felt down-hearted and blue	0	1	2	3
14. I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15. I felt I was close to panic	0	1	2	3
16. I was unable to become enthusiastic about anything	0	1	2	3
17. I felt I wasn't worth much as a person	0	1	2	3
18. I felt that I was rather touchy	0	1	2	3
19. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20. I felt scared without any good reason	0	1	2	3
21. I felt that life was meaningless	0	1	2	3

Appendix P

Beck Youth Inventory–2nd Edition (BYI-II)

Examples:

	0: Never	1: Sometimes	2: Often	3: Always
Self-concept				
1. I work hard	Never	Sometimes	Often	Always
7. I am a good person	Never	Sometimes	Often	Always
Anxiety				
30. I worry about my future.	Never	Sometimes	Often	Always
38. I get shaky	Never	Sometimes	Often	Always
Depression				
41. I think that my life is bad.	Never	Sometimes	Often	Always
58. I feel sad.	Never	Sometimes	Often	Always
Anger				
69. I get mad at other people.	Never	Sometimes	Often	Always
74. I feel mean.	Never	Sometimes	Often	Always
Disruptive Behaviour				
81. I steal.	Never	Sometimes	Often	Always
96. I like to bully others.	Never	Sometimes	Often	Always

Appendix Q

Self-Compassion Scale–Short Form (SCS-SF)

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

Almost Never				Almost Always
1	2	3	4	5

____ 1. When I fail at something important to me I become consumed by feelings of inadequacy.

____ 2. I try to be understanding and patient towards those aspects of my personality I don't like.

____ 3. When something painful happens, I try to take a balanced view of the situation.

____ 4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

____ 5. I try to see my failings as part of the human condition.

____ 6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

____ 7. When something upsets me I try to keep my emotions in balance.

____ 8. When I fail at something that's important to me, I tend to feel alone in my failure.

____ 9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

____ 11. I'm disapproving and judgmental about my own flaws and inadequacies.

____ 12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Appendix R

Mental Health Continuum–Short Form (MHC-SF)

Please answer the following questions are about how you have been feeling during the past month. Place a check mark in the box that best represents how often you have experienced or felt the following:

During the past month, how often did you feel…	Never	Once or Twice	About Once a Week	2 or 3 Times a Week	Almost Every Day	Every Day
1. Happy						
2. Interested in life						
3. Satisfied with life						
4. That you had something important to contribute to society						
5. That you belonged to a community (like a social group, your school, or your neighbourhood)						
6. That our society is a good place, or is becoming a better place, for all people						
7. That people are basically good						
8. That the way our society works made sense to you						
9. That you like most parts of your personality						
10. That you are good at managing the responsibilities of your daily life						
11. That you had warm and trusting relationship with others						
12. That you had experiences that challenged you to grow and become a better person						
13. Confident enough to think or express your ideas and opinions						
14. That your life has a sense of direction or meaning to it						

Appendix S

Valuing Questionnaire (VQ)

Please read each statement carefully and then circle the number which best describes how much the statement was true for you DURING THE PAST WEEK, INCLUDING TODAY.

0 1 2 3 4 5 6
Not at all true Completely true

1) I spent a lot of time thinking about the past or future, rather than being engaged in activities that mattered to me
0 1 2 3 4 5 6

2) I was basically on "auto-pilot" most of the time
0 1 2 3 4 5 6

3) I worked toward my goals even if I didn't feel motivated to
0 1 2 3 4 5 6

4) I was proud about how I lived my life
0 1 2 3 4 5 6

5) I made progress in the areas of my life I care most about
0 1 2 3 4 5 6

6) Difficult thoughts, feelings, or memories got in the way of what I really wanted to do
0 1 2 3 4 5 6

7) I continued to get better at being the kind of person I want to be
0 1 2 3 4 5 6

8) When things didn't go according to plan, I gave up easily
0 1 2 3 4 5 6

9) I felt like I had a purpose in life
0 1 2 3 4 5 6

10) It seemed like I was just "going through the motions", rather than focusing on what was important to me
0 1 2 3 4 5 6

Appendix T

Multidimensional Student Satisfaction With Life Scale

	Never	Sometimes	Often	Always
I enjoy being at home with my family.	1	2	3	4
My family gets along well together.	1	2	3	4
I like spending time with my parents.	1	2	3	4
My parents and I doing fun things together.	1	2	3	4
My family is better than most.	1	2	3	4
Members of my family talk nicely to one another.	1	2	3	4
My parents treat me fairly.	1	2	3	4
My friends treat me well.	1	2	3	4
My friends are nice to me.	1	2	3	4
I wish I had different friends.	1	2	3	4
My friends are mean to me.	1	2	3	4
My friends are great	1	2	3	4
I have a bad time with my friends.	1	2	3	4
I have a lot of fun with my friends.	1	2	3	4
I have enough friends.	1	2	3	4
My friends will help me if I need it.	1	2	3	4
I look forward to going to school.	1	2	3	4
I like being in school.	1	2	3	4
School is interesting.	1	2	3	4
I wish I didn't have to go to school.	1	2	3	4
There are many things about school I don't like.	1	2	3	4
I enjoy school activities.	1	2	3	4
I learn a lot at school.	1	2	3	4
I feel bad at school.	1	2	3	4
I like where I live.	1	2	3	4
I wish there were different people in my neighborhood.	1	2	3	4
I wish I lived in a different house.	1	2	3	4
I wish I lived somewhere else.	1	2	3	4
I like my neighborhood.	1	2	3	4
I like my neighbors.	1	2	3	4
This town is filled with mean people.	1	2	3	4
My family's house is nice.	1	2	3	4
There are lots of fun things to do where I live.	1	2	3	4
I think I am good looking.	1	2	3	4
I am fun to be around.	1	2	3	4
I am a nice person.	1	2	3	4
Most people like me.	1	2	3	4
There are lots of things I can do well.	1	2	3	4
I like to try new things.	1	2	3	4

I like myself.	1	2	3	4

Appendix U

Youth Engagement Sheet

What did you learn about today?

What will you do with what you learned today?

How did you feel about the sessions today? (circle one)




Is there anything specific that made you feel this way?

How did you connect today? (did you feel heard; did you get a chance to share your thoughts/feeling?)

Did you feel like there was space to share your thoughts, feelings, experiences? If yes, was there anything specific that made you feel that way?

What did you want to share but you did not get a chance?

Did you feel meaningfully engaged? If yes, what does it feel like when you are being meaningfully engaged?

What do you need to feel safe when sharing your perspectives?

Appendix V

Example of Workbooks

From Session One

Self-Compassion Break:

Goal: Practice a quick and efficient self-compassion practice that can be applied through the day wherever you feel pain and suffering. Think of a situation in your life that is difficult that is causing you stress, something that sucks and is bugging you.

- Now say to yourself "this is a moment of pain and suffering."
  - That is *mindfulness* → other options are:
    - This hurts
    - This is frustrating
    - Ouch
    - This is stressful
- Now say to yourself "suffering is a part of life," it is part of being human, it is especially hard to be a teen.
  - This is *common humanity*→ other options are:
    - Other people feel this way too
    - I am not alone
    - We all struggle
    - Everyone at some point feels these feelings.
- Now ask yourself "what do I need to hear right now."
  - This is *self-kindness* → other options are:
    - May I forgive myself
    - May I be strong
    - May I be safe
    - May I be peaceful
    - May I learn to accept myself as I am

Now please spend a moment writing about what this experience was like for you:
What is it like to stop and notice your suffering?

_____
_____
_____

What phrase you would like to hear?

_____
_____

Give a few details on how it feels to know you are not alone?

_____
_____

What did you think of this exercise? (Circle one)

Very Poor	Poor	Moderate	Good	Very Good

From Session Three

Session 3: Focus on self-kindness: learning to understand and practice being your own best friend, learning about backdraft, identifying one's inner critic and soothing the critic with one's compassionate voice.

Mindful: Welcoming your present feelings VS Self-kindness: Taking care of your feelings

Before: On a scale of 1-10, how comfortable are you with being kind to yourself?_____

Loving Kindness Phrases:
May I …

accept myself	I be free from fear	feel like I am enough
appreciate myself	feel loved	be at peace
know that I belong	be healthy	I accept myself just as I am
be calm	honour myself	be free from harm
I be free from shame	be kind to myself	be brave
be happy	know I am loved	Other:_____

After: On a scale of 1-10 how likely comfortable is it for you to be kind to yourself?_____

Moment to reflect in your journal. How do you feel about loving kindness phrases? Was it weird to think that everyone needs to hear these things? We others needing similar phrases to you? Would you change yours?

_____
_____
_____
_____
_____

What did you think of this exercise? (Circle one)

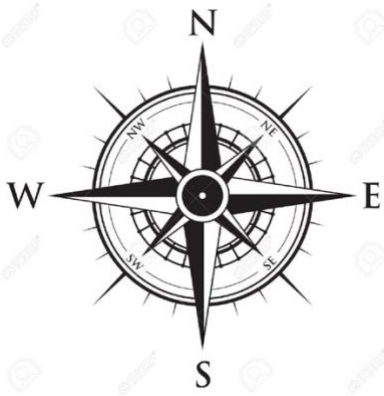
Very Poor	Poor	Moderate	Good	Very Good

From Session Six:

Session 6: Discover your core values addressed what gives our lives meaning. The goal is to focus on values to reorient ourselves to a purpose in life and ways to set goals and make decisions moment to moment. Finally, how to use self-compassion for value incongruence or when we struggle to attain our goals

We have learned that when we resist pain, we sometimes avoid what is important to us or through isolation and avoidance we do not engage in the life we want or we make choices (drugs, alcohol, running away, isolation, and skipping school) in order to avoid pain. The goal of this process is to help us persevere through times of pain, but also to help clarify the path we want to be on and the pain of when we stray from the path.

Values versus Goals



Values orient our lives in a certain direction/ Goals are specific and have a clear end.

- Goals are part of the journey of values. Example, growing and learning as the value (this will never be fully achieved, we can learn and grow as a person for the rest of our lives), but graduating high school may be part of that journey
- Value are discovered, we create, edit and rediscover our values throughout life
- Goals are destinations along the way while values are life directions.

Discovering your values:

1) _____	**1)** _____	**1)** _____
2) _____	**2)** _____	**2)** _____
3) _____	**3)** _____	**3)** _____
4) _____	**4)** _____	
5) _____	**5)** _____	
6) _____		
7) _____		
8) _____		
9) _____		
10) _____		

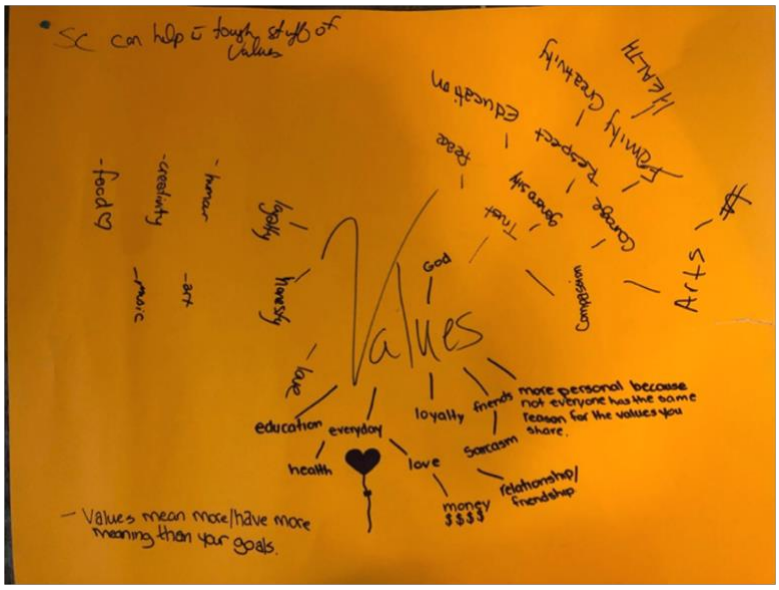
Appendix W

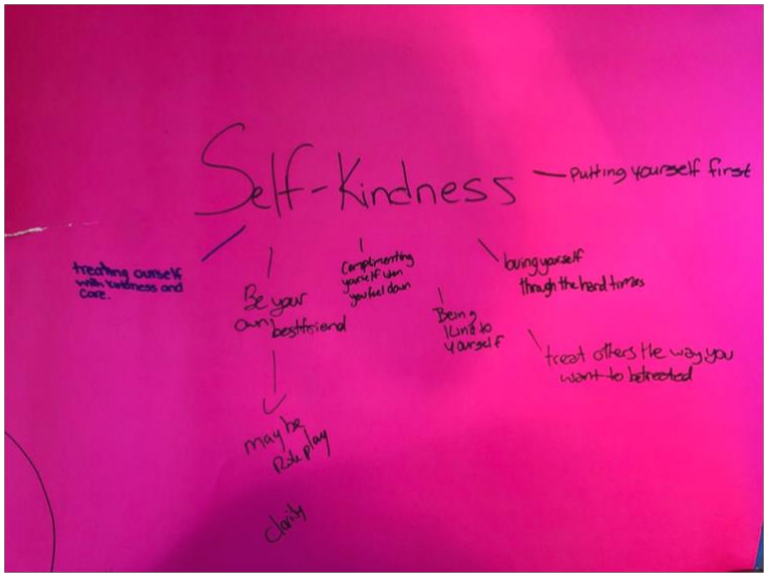
Interview Questions Template

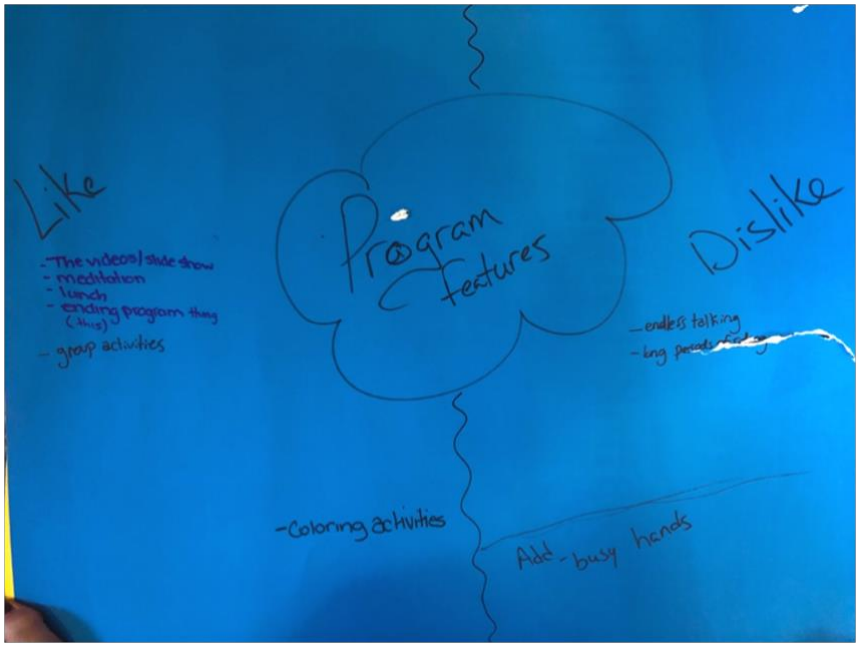
1. Please state first letter of your first name.
2. This interview will be transcribed and analyzed for themes. Do you wish to review your transcript and identified themes at a later date? How should I contact you to arrange this review?
3. What brought you to collaborate on this research project?
4. What were the barriers to contributing?
5. What aspects of the project helped you to feel like you could contribute?
6. What do you feel were the personal benefits to participation?
7. How do you feel participation has affected your mental health and well-being?
8. How do you feel the collaboration has changed how clear you are about your values/goals?
9. How has your participation helped or not helped you to live in a more valued way? If it has not, what would you change to help this process?
10. What was your overall experience of the collaboration in research?
11. Can you in your own words define self-compassion?
    a. Mindfulness
    b. Common humanity
    c. Self-kindness
12. Is there anything else you would like to contribute to this interview?

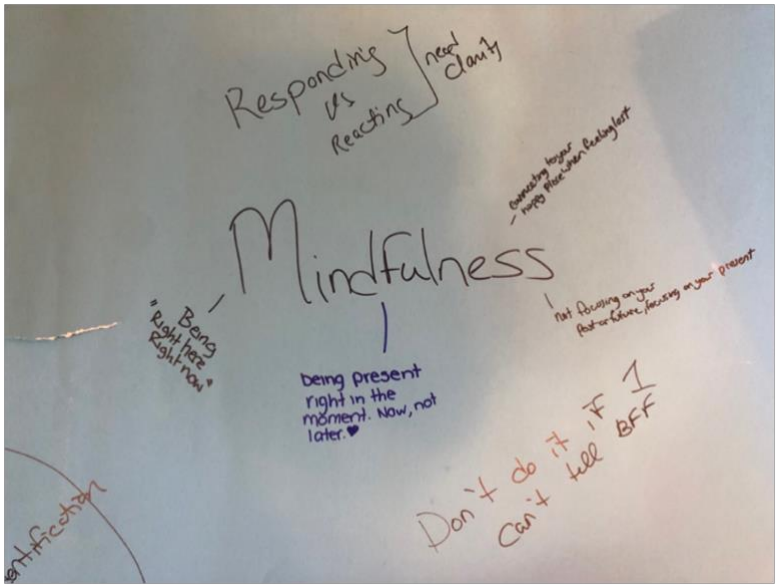
Appendix X

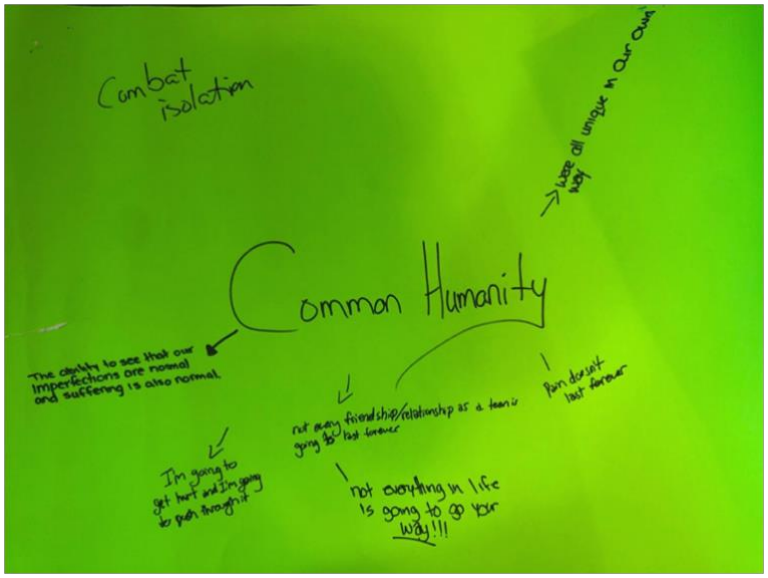
Mind Maps From Group






Like
- The videos/slide show
- meditation
- lunch
- ending program thing (this)
- group activities
Program features
Dislike
- endless talking
-Coloring activities
Add - busy hands

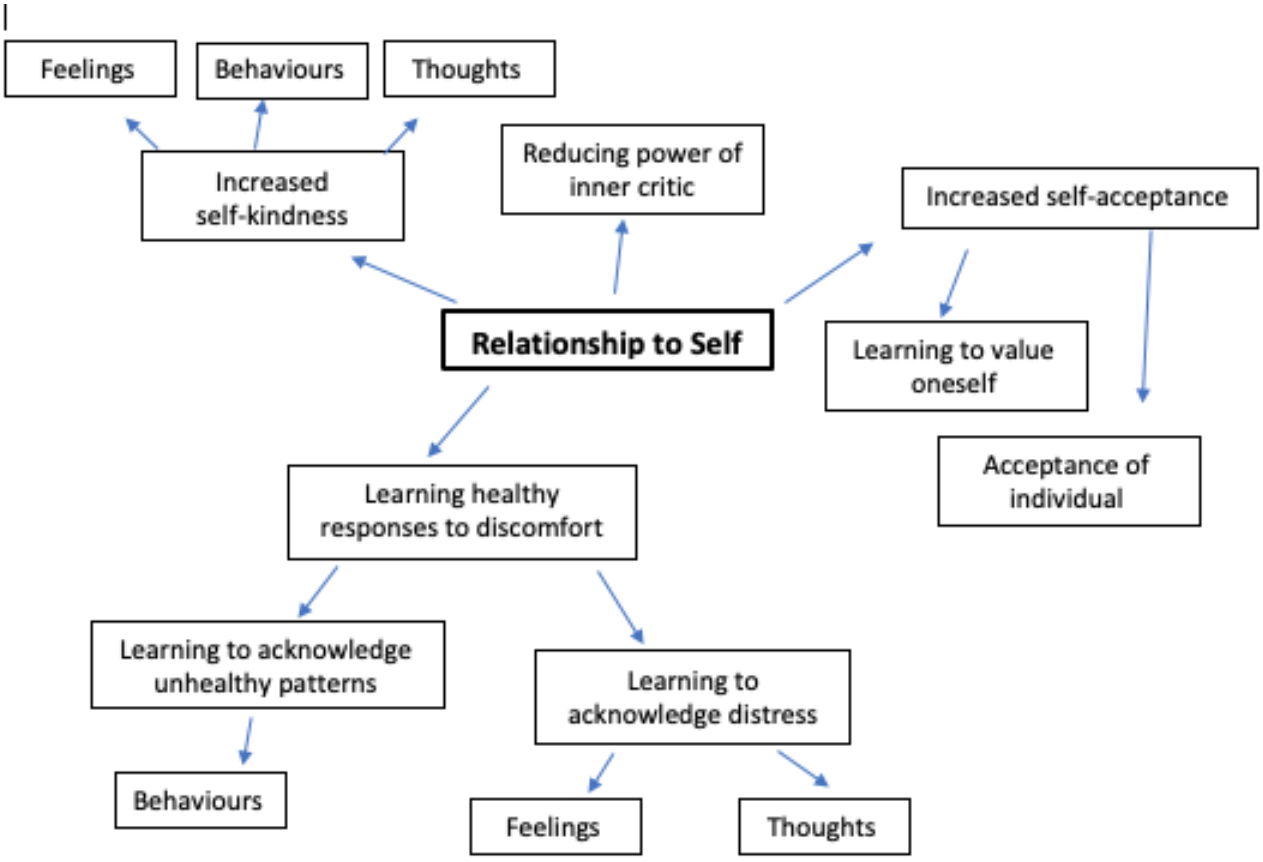

Responding vs Reacting
need clarity
Mindfulness
Being "Right here Right now"
being present right in the moment. Now, not later.
not focusing on your past or future, focusing on your present
Don't do it, if I can't tell BFF

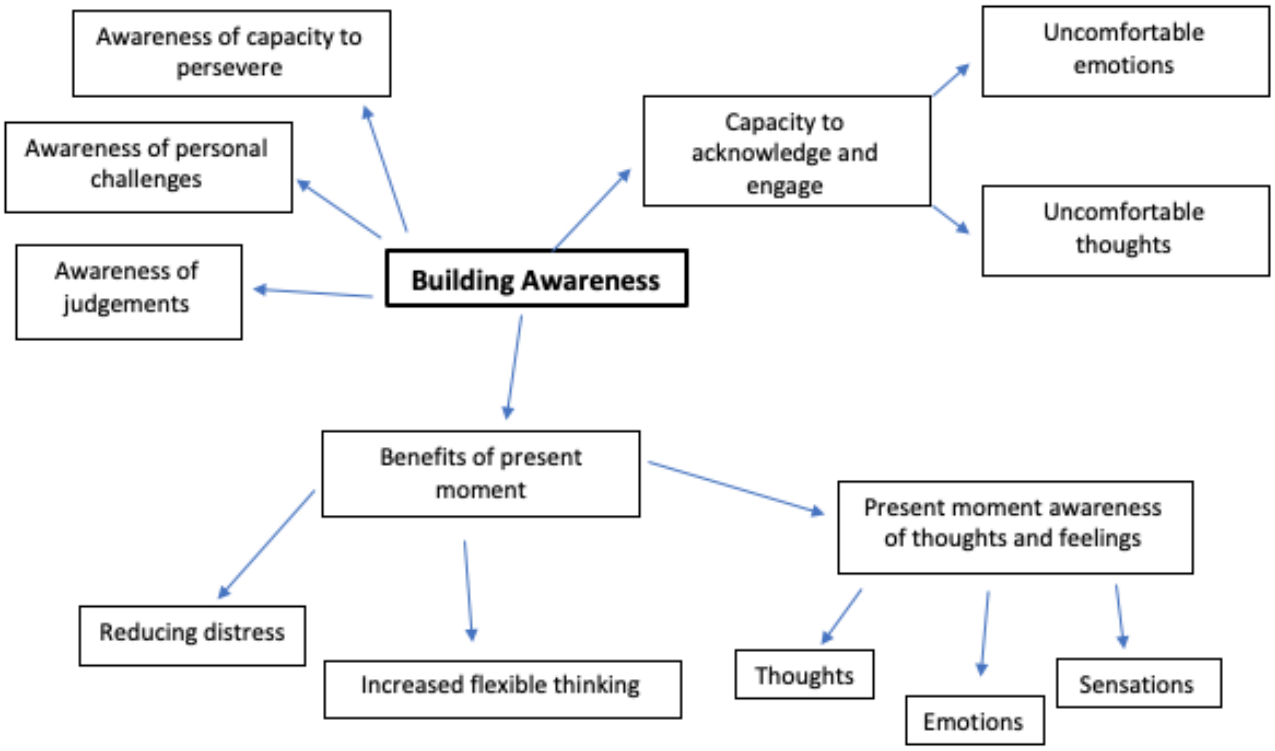

Combat isolation
We're all unique in our own way
Common Humanity
The ability to see that our imperfections are normal and suffering is also normal
not every friendship/relationship as a teen is going to last forever
Pain doesn't last forever
I'm going to get hurt and I'm going to push through it
not everything in life is going to go your way!!!

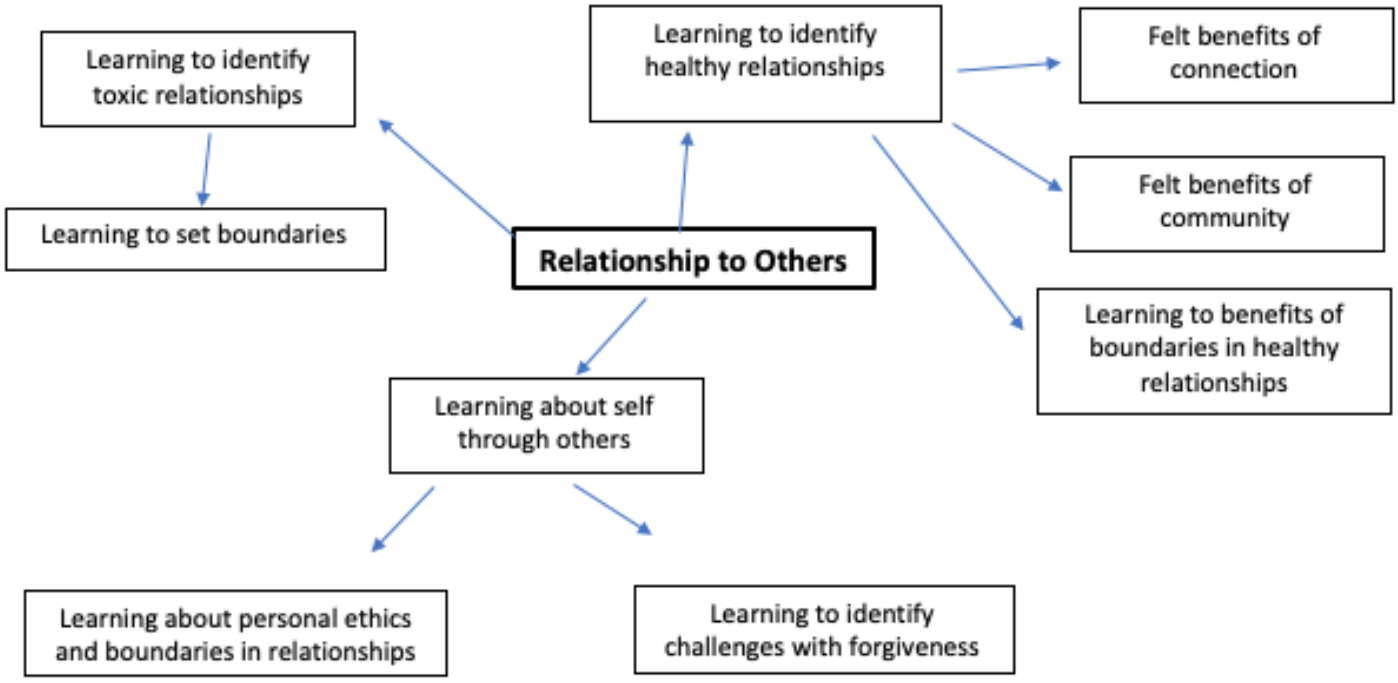

Self-Compassion
Is...
recognizing our own suffering and trying to relieve it
- getting help when you're struggling
- Trying to better yourself, for yourself
Is not...
- Suffering by yourself
- ignoring your pain
- taking out your emotions on yourself

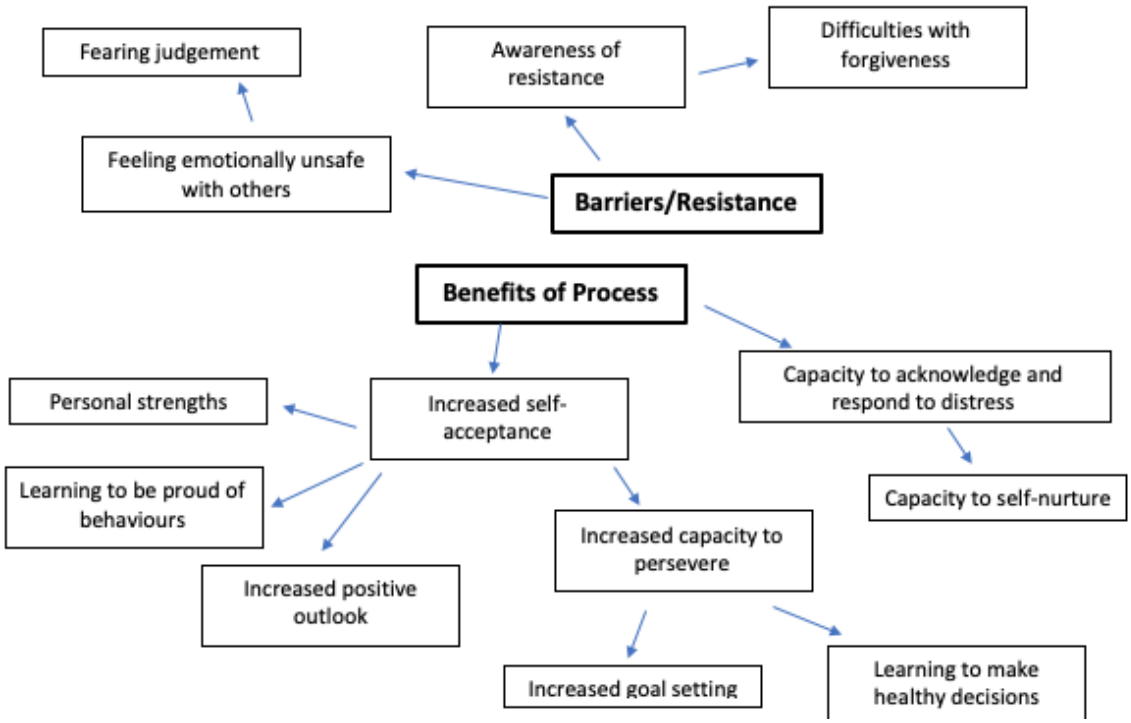
Appendix Y

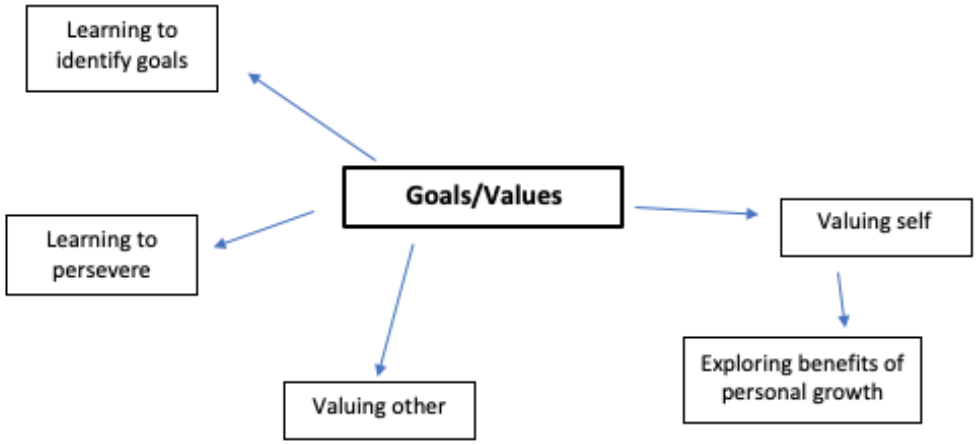
Thematic Analysis Maps




Awareness of capacity to persevere
Awareness of personal challenges
Awareness of judgements
Building Awareness
Capacity to acknowledge and engage
Uncomfortable emotions
Uncomfortable thoughts
Benefits of present moment
Reducing distress
Increased flexible thinking
Present moment awareness of thoughts and feelings
Thoughts
Emotions
Sensations


Learning to identify toxic relationships
Learning to identify healthy relationships
Felt benefits of connection
Felt benefits of community
Learning to benefits of boundaries in healthy relationships
Learning to set boundaries
Relationship to Others
Learning about self through others
Learning about personal ethics and boundaries in relationships
Learning to identify challenges with forgiveness


Fearing judgement
Awareness of resistance
Difficulties with forgiveness
Feeling emotionally unsafe with others
Barriers/Resistance
Benefits of Process
Capacity to acknowledge and respond to distress
Personal strengths
Increased self-acceptance
Capacity to self-nurture
Learning to be proud of behaviours
Increased capacity to persevere
Increased positive outlook
Increased goal setting
Learning to make healthy decisions


Learning to identify goals
Goals/Values
Learning to persevere
Valuing self
Exploring benefits of personal growth
Valuing other

Appendix Z

Manuscript 1 Quantitative Descriptions for Pre- and Post-Intervention Data

Table Z1

Pre-Post Qualitative Descriptors of Data, Mental Health Continuum (MHC)–Short Form

Participant	Pre MHC	Post MHC	Change
Alex	Moderate	Moderate	Same
Drew	Moderate	Languisher	Lower
Taylor	Moderate	Moderate	Same
Jordan	Moderate	Moderate	Same
Parker	Moderate	Moderate	Same

Table Z2

Pre-post Qualitative Descriptors of Data, Self-Compassion–Short Form (SC-SF)

Participant	Pre SC-SF	Post SC-SF	Change
Alex	Low	High	Higher
Drew	Low	Moderate	Higher
Taylor	Low	High	Higher
Jordan	Low	Moderate	Higher
Parker	Low	Moderate	Higher

Table Z3

Pre-Post Qualitative Descriptors of Data, Beck Youth Inventory–2nd ed. (Self-Concept)

Participant	Pre Self-Concept	Post Self-Concept	Change
Alex	Lower than average	Average	Increase
Drew	Much lower than average	Lower than average	Increase
Taylor	Much lower than average	Much lower than average	Same
Jordan	Much lower than average	Much lower than average	Same
Parker	Above average	Above average	Same

Table Z4

Pre-Post Qualitative Descriptors of Data, Beck Youth Inventory–2nd ed. (Depression & Anxiety)

Participant	Pre Anxiety	Post Anxiety	Change	Pre Depression	Post Depression	Change
Alex	Extremely elevated	Average	Decrease	Extremely elevated	Average	Decrease
Drew	Extremely elevated	Extremely elevated	Same	Extremely elevated	Moderately elevated	Decrease
Taylor	Extremely elevated	Extremely elevated	Same	Extremely elevated	Mildly elevated	Decrease
Jordan	Mildly elevated	Mildly elevated	Same	Mildly elevated	Average	Decrease
Parker	Mildly elevated	Average	Decrease	Average	Moderately elevated	Increase

Table Z5

Pre-Post Qualitative Descriptors of Data, Beck Youth Inventory–2nd ed (Anger & Disruptive Behaviour)

Participant	Pre Anger	Post Anger	Change	Pre DB	Post DB	Change
Alex	Moderately elevated	Average	Decrease	Moderately elevated	Average	Decrease
Drew	Extremely elevated	Moderately elevated	Decrease	Extremely elevated	Extremely elevated	Same
Taylor	Extremely elevated	Moderately elevated	Decrease	Extremely elevated	Extremely elevated	Same
Jordan	Mildly elevated	Mildly elevated	Same	Moderately elevated	Moderately elevated	Same
Parker	Moderately elevated	Average	Decrease	Average	Average	Same

Note. DB = Disruptive Behavior.

Table Z6

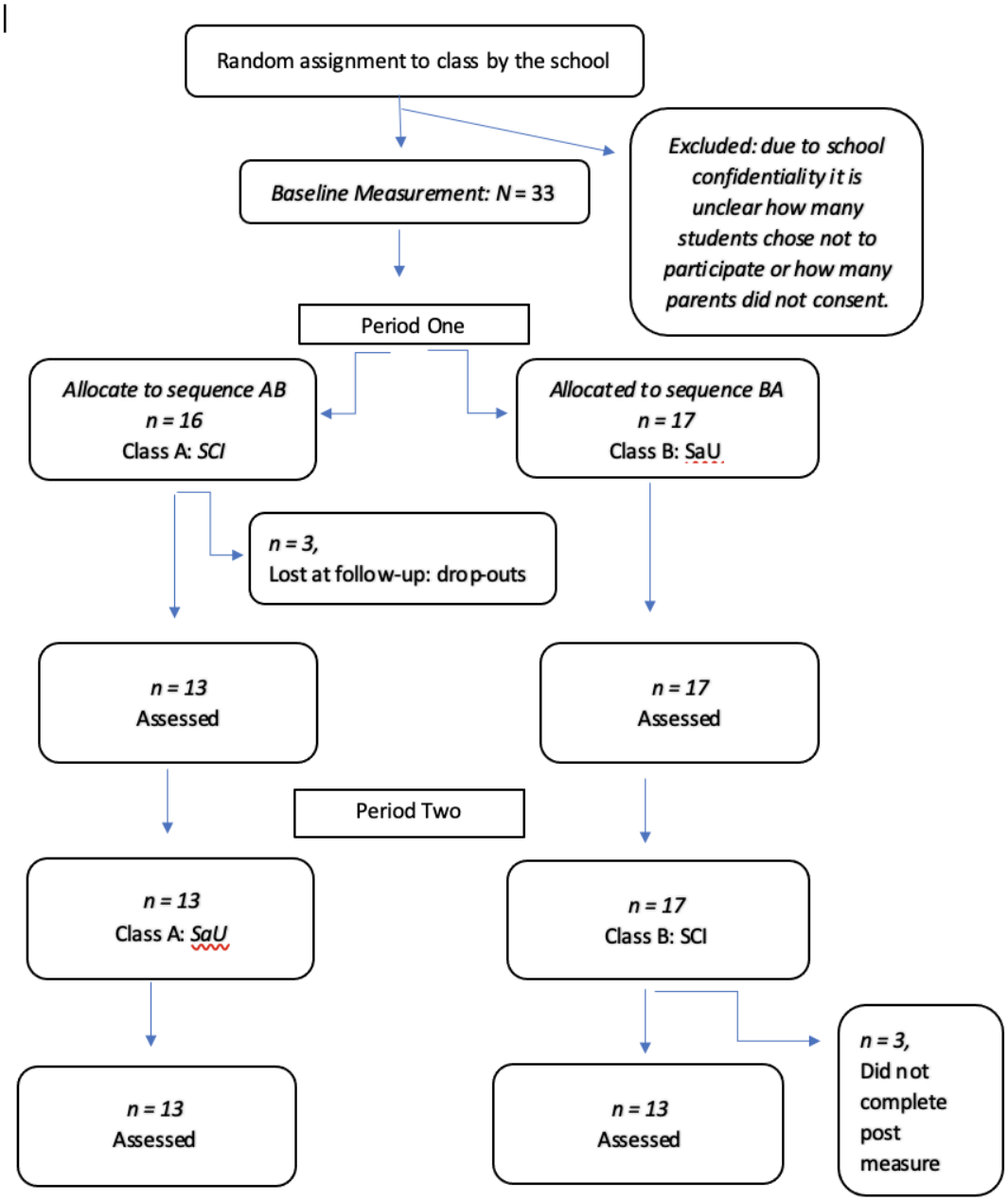
Pre-Post Qualitative Descriptors of VQ Data (VQProgress & VQObstruction)

Participant	Pre VQP	PostVQP	Change	PreVQO	PostVQO	Change
Alex	22	26	Increase	24	13	Decrease
Drew	15	18	Increase	16	7	Decrease
Taylor	16	16	Same	26	18	Decrease
Jordan	10	13	Increase	17	16	Decrease
Parker	14	23	Increase	16	10	Decrease

Note. VQP = VQProgress; VQO = VQObstruction.

Appendix AA

Participant Map School Study



Flow diagram for crossover trail. A = SCI; B =SaU

Appendix BB

Demographics Table From School Study

Table BB1

School Study: Baseline Demographic and Clinical Characteristics by Sequence and Total, Categorical Data

Characteristic	Treatment sequence		Total ($N = 33$)
	Group A ($n = 16$)	Group B ($n = 17$)	
Age			
14	12 (75.00)	16 (94.1)	28 (84.80)
15	4 (25.00)	1 (5.90)	5 (15.20)
Gender identity			
Woman	15 (93.80)	16 (94.1)	31 (93.90)
Man	0 (0.00)	0 (0.00)	0 (0.00)
Other (trans, third-gender)	1 (6.3)	1 (5.90)	2 (6.10)
Sexual orientation			
Bisexual	1 (6.30)	1 (5.90)	2 (6.10)
Heterosexual	13 (81.30)	15 (88.20)	28 (84.80)
Gay/Lesbian	0 (0.00)	0 (0.00)	0 (0.00)
Other (e.g., prefer to not identify, pansexual)	2 (12.5)	1 (5.90)	3 (9.10)
Cultural identification			
White	14 (87.50)	12 (70.60)	26 (78.79)
First Nations	0 (0.00)	1 (5.90)	1 (3.03)
Southeast Asian	1 (6.25)	1 (5.90)	2 (6.06)
Other/did not identify	0 (0.00)	3 (17.60)	3 (9.09)
Arab	1 (6.25)	0 (0.00)	1 (3.03)
Language spoken			
English	13 (81.3)	15 (88.20)	28 (84.80)
English/French	2 (12.50)	1 (5.90)	3 (9.10))
English/other	1 (6.30)	1 (5.90)	2 (6.10)
Money for basic needs			

Always	10 (62.50)	13 (76.5)	23 (69.70)
Mostly	5 (31.25)	1 (5.90)	6 (18.20)
Sometimes	0 (0.00)	1 (5.90)	1 (3.00)
Prefer to not say	1 (6.25)	2 (11.80)	3 (9.10)
Money for fun			
Always	6 (37.50)	6 (35.30)	12 (36.40)
Mostly	6 (37.50)	5 (29.40)	11 (33.30)
Sometimes	3 (18.75)	5 (29.40)	8 (24.20)
Hardly ever	0 (0.00)	1 (5.90)	1 (3.00)
Prefer to not say	1 (6.25)	0 (0.00)	1 (3.00)
Current mental health support			
Yes	0 (0.00)	0 (0.00)	0 (0.00)
No	16 (100.00)	17 (100.00)	33 (100.00)
Mental health diagnosis			
Yes	4 (25.00)	2 (11.76)	6 (18.20)
No	12 (70.00)	15 (88.24)	27 (81.80)
Type of mental health diagnosis			
No diagnosis	12 (75.00)	15 (88.24)	27 (75.02))
Anxiety	1 (6.25)	2 (11.76)	3 (12.50)
ADHD	1 (6.25)	0 (0.00)	1 (4.16)
Comorbid	1 (6.25)	0 (0.00)	1 (4.16)
Did not report	1 (6.25)	0 (0.00)	1 (4.16)
Current crisis			
Yes	2 (12.50)	1 (5.90)	3 (9.10)
No	14 (87.50)	16 (94.10)	30 (90.90)

Note. ADHD = attention deficit hyperactivity disorder.

Appendix CC

Icebreakers and Introduction to Mind Mapping

Where the Wind Blows

Description: Have everyone stand in a circle. Have one volunteer stand in the middle of the circle. The volunteer in the middle begins with the statement "the wind blows to anyone who…" the volunteer shares something about themselves. It can be a unique fact, life experience, quality or something about their appearance, which would also apply to others in the group. For example, "the wind blows to anyone who has a pet cat", the volunteer and everyone else who identifies with this statement (in this case, everyone who has a pet cat) is asked to scramble and find a new spot in the circle. The person left standing without an assigned spot goes to the middle of the circle and is asked to continue with another statement.

Purpose: This game is great as an energizer to get everyone moving and laughing together. It allows the group to learn about each other.

Desert Island

Description: Instruct the group to imagine they are stranded on a desert island with no hope of rescue, and they can only bring three items. Give participants time to think of which items they would bring. One by one, ask participants to introduce themselves and share their items.

Purpose: This activity can be used as an icebreaker. As participants share what they would like to bring, the group learns a little bit about the likes, dislikes and personality of each person.

Mind Mapping

Description: This activity will be completed in a group. The leader will draw in the middle of

the page, one main image, concept or idea. The group will choose a topic to use as the theme of the mind map. The leader will then draw major branches reaching out from that central image, inserting a new idea on each branch that are generated by the group. Then, draw sub-branches that reach out from those branches, inserting sub-themes. The ideas can be drawn, written, sketched, etc.

Purpose: It is a creative outlet, allowing participants to see how their ideas connect and stem from other ideas. This process will be used as part of the group debriefing at the end of each session.

Give's and Get's

Description: Ask participants to take a few moments to write what they will bring to the research (gives) on one card and what they hope to get out of the research (gets) on another. If participants can't think of any right away, no problem, participants can share their gives and gets throughout the activity. Once they have their ideas, ask participants to post their gives and gets on the wall and for those who are comfortable doing so, to read and reflect on what other people have written. Participants can share their answers with their neighbour.

Closing Circle:

Description: The circle is a place where youth, adults and facilitators are equals. No one is higher or lower and everyone respects the voices of the others. Facilitation of the circle should rotate. There are several components to keep in mind when conducting an activity in a circle, participants should: listen without judgment, maintain confidentiality (whatever is said in the circle stays in the circle), and offer what they can and ask for what they need. Silence can also be

part of the conversation. Ask each person to answer: How did you feel about the session today and how are you feeling about moving forward?

Appendix DD

Mid-Week Reminder Email and Homework

Hi Youth Collaborator,

This is your mid-week reminder to take a few minutes to complete your homework for the week. Ideally the homework is done 2-3 times between sessions. It is extremely helpful if you take a few minutes to write about these experiences in the space provided in your workbook.

If you at any time this week feel triggered and need to talk to someone, please reach out to one of the crisis lines provided.

Thank you again for all your amazing work.
I look forward to chatting with you on Saturday about your experience.

Take care
Alisha

Kids Help Phone
Kids Help Phone is Canada's only bilingual phone and on-line counselling service for youth. It's free, anonymous, and confidential.
439 University Avenue, Toronto, ON, M5G 1Y8
416-586-5437
www.kidshelpphone.ca

Phoenix Centre for Children and Families
Accredited mental health agency that provides treatment for children, youth and families in Renfrew County.
130 Pembroke Street West, Pembroke, ON, K8A 5M8
613-735-2374
1 800 465 1870
www.phoenixctr.com

Session 1 Homework:

Neff:
Self-compassion break:
http://self-compassion.org/category/exercises/#guided-meditations

Affectionate breathing:
http://self-compassion.org/wpcontent/uploads/2016/11/affectionatebreathing_cleaned.mp3

Here and Now stone
or
Mindfulness in daily life:
e.g. when you receive a text message, when you are about to get a test back in class, take a moment to breathe before doing something

You will receive an email mid-week from Alisha reminding you to practice these things.

Session 2 Homework:

Compassionate letter to myself

Goal to write a compassionate letter to yourself as a helpful way to continue the practice of speaking to oneself in a compassionate voice.

- During the week when you are struggling or feeling bad about yourself, write a letter to yourself from this compassionate self-perspective.
- The idea is to think of an aspect of yourself that you beat yourself up over and wish you could change.
- Than think of an imaginary friend who is unconditionally wise, loving, and compassionate and write a letter to yourself about the issue you criticize yourself for, but form that compassionate friend's perspective.
- After writing the letter, you can put it down for a while then read it again letting the words soothe and comfort you.

Think about what you can do to take care of yourself when backdraft occurs. Think of a song or an activity you could do to offer kindness to yourself.

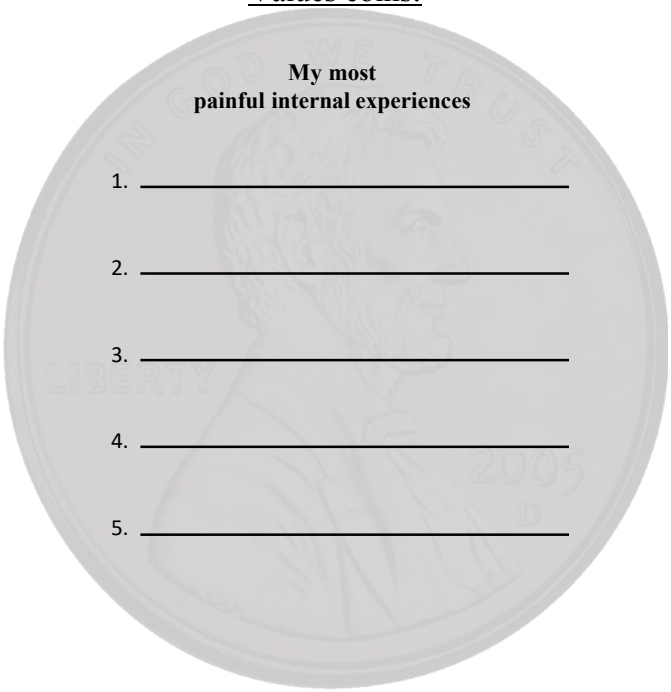
Think of each of the techniques for "what can be done when difficult emotions arise" and find a new image that can inspire you to try each approach. Which one are you likely to try?

You will receive an email mid-week from Alisha reminding you to practice these things.

Session 3 Homework

Germer: loving-kindness for a difficult person:
http://www.mindfulselfcompassion.org/audio/LovingKindnessfortheDifficultPerson.mp3

Values coins:



Set a short-term goal that you can work on this week.

Appendix EE

MPPRG Lab Confidentiality Agreement

1. DISCLOSURE OF INFORMATION. The researchers, collaborators and staff members acknowledge that involvement with this project will result in having access to confidential information. Those involved agree that they will not disclose any information obtained through the work on this project to anyone and will not disclose information that could permit anyone to identify the individuals in the study. Unless authorized to do so by the Directors of Research, it is strictly forbidden to discuss any material with non-members of the MPPRG.

2. MATERIALS. It is strictly forbidden to take material (e.g., transcripts, audio, or video recordings, etc.) out of the laboratories. Those involved agree to turn over all research materials at the end of the project, or at the request of the Directors of Research. Hard and electronic copies of any document must be destroyed once a copy is given to the Directors of Research.

3. ETHICAL STANDARDS AND MPPRG HANDBOOK. Those involved will conduct themselves in accordance with the Ethical Standards of their profession. For students in Psychology, the Code of Ethics of the Ordre des Psychologues du Québec will apply. McGill regulations also need to be respected always. Students have the responsibility of knowing and understanding the content of the MPPRG handbook. The instructions contained in the handbook must be respected always.

4. INDEMNITY. If anyone involved breaches any terms of this Agreement, she or he will pay any cost, expense -including legal and attorney fees-, and/or liability incurred or imposed upon by the MPPRG. All lab privileges will be suspended.

5. GOVERNING LAW AND JURISDICTION. This Agreement shall be governed by the laws of Québec, and McGill policies.

Initials: _____

Initials of witness: _____

I _____ agree to the terms of the Agreement.
(Print name)
Signature: _____ Date: _____

Witness: Marilyn Fitzpatrick,

Other _____
(Print name)

Signature: _____ Date: _____