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Opening a Crack to let the Light in: An Exploration of an Online Group Adolescent Compassion Focussed Therapy Intervention

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Abstract

The current study's goal is to expand the adolescent compassion focused therapy (CFT) literature by exploring participant experiences of a novel CFT protocol which was delivered in an online group therapy format. This study is a mixed methods approach using surveys, open-ended questionnaires, and interviews to explore participants' experience and expression of feelings of inadequacy (FOI) and self-compassion. Thematic analysis findings revealed that participants struggled primarily with FOI relating to evaluative contexts such as school and sports and that these FOI also carried with them implications of self-worth and perfectionism. Through participating in the program, participants were able to de-shame their struggles by experiencing and understanding the struggle of their fellow peers, acquired assertiveness skills to set healthy boundaries and express needs adaptively and learned how to effectuate compassionate self-support in moments of difficulty and suffering.

Keywords

Summary for Lay Audience

Self-criticism is a detrimental aspect of human psychology that has been implicated in causing and maintaining anxiety and depression. Self-criticism is made up of two parts, self-hatred and feelings of inadequacy (FOI), the focus of this study. FOI have implications for goal setting, self-worth and perfectionism. Compassion focused therapy (CFT) is a treatment style designed to help clients overcome their self-criticism by shifting into a caregiving and care-receiving motive-oriented state of mind. This translates to an individual learning to meet their emotional and psychological needs in an adaptive manner; whether that is through self-soothing, self-encouragement or setting appropriate and attainable standards for one's behaviour and the manner in which the individual relates to themself. In doing so, clients learn to interrupt corrosive cycles of self-attack and move towards self-support and compassionate self-correction. The current study examined an online group CFT program for adolescents to better understand adolescents' experience of FOI and the development of compassion. Participants' reported FOI were primarily concerned with evaluative contexts such as school and sports and were felt as harsh and berating voices or as their own self-chastising. Adolescents reported several gains as a result of participating in the program such as learning skills of assertiveness, normalizing and de-stigmatizing their mental health struggles and helping them to effectuate self-support in times of need and struggle.

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1   **Literature review**

Adolescence is a time in life characterized by a marked development of self-identity and an increased focus on the politics of social hierarchies (Gilbert & Irons, 2009). During this period of rapid and complex development, there are innumerable opportunities for mental health disturbances and maladaptive psychological patterns to emerge that can lead to lasting adverse outcomes (Gilbert & Irons, 2009; Shahar et al., 2004; Xavier et al., 2016). Recent studies have shown that adolescent mental health issues are on the rise, with a growing prevalence of depression, anxiety and suicide, trends that have only been further compounded by the Covid-19 pandemic (Flatt, 2013; Magson et al., 2021; Weinberger et al., 2017; Wiens et al., 2020). Adolescent mental health is subject to a variety of compounding stressors such as mounting academic pressure in an increasingly competitive scholarly environment, pandemic isolation, and the realities of navigating a highly connected online social landscape (Flatt, 2013; Weinberger et al., 2017; Wiens et al., 2020).

While the emotional outcomes associated with each of these stressors varies across individuals, unresolved feelings of inadequacy (FOI) may exacerbate the deleterious effects of those stressors (Gilbert et al., 2004; Gilbert & Irons, 2009; Thomson & Zuroff, 2004; Zuroff et al., 2005). FOI in this context refer to more than simply feeling not good enough, they are a multifaceted mentality that involve feelings of low self-worth that arise as a result of an individual attempting to generate motivation to improve or be accepted by others (Gilbert et al., 2004). This self-motivation is done by continuously highlighting one's own perceived faults and shortcomings making the

individual constantly aware of their inadequate status and the need to improve (Gilbert et al., 2004).

FOI is one of the components that form the higher order construct of self-criticism (the other component being self-hatred) (Gilbert et al., 2004; Kopala-Sibley et al., 2013). Self-criticism is a developmentally influenced personality orientation that can be described as the internalization of shame and is characterized by an individual's harsh self-scrutiny, depression in the face of failure, and feelings of inadequacy and guilt (Ahmad & Soenens, 2010; Bleys et al., 2018). The current project focuses specifically on the inadequacy aspect of self-criticism (FOI) due to its negative implications regarding a variety of important adolescent developmental factors such as perfectionism, low self-esteem, coping with social rejection, goal setting and mastery experiences (Bandura, 1997, 2006, 2010; de Vries & Kühne, 2015; Gilbert et al., 2004; Gilbert & Irons, 2009; Lup et al., 2015; Mehr & Adams, 2016; Radovic et al., 2017; Schunk & Meece, 2006).

A significant contributor towards adolescent FOI is social comparisons in the context of social media. One of the primary ways we process information concerning others is by relating it to ourselves, making a relational value judgement (Feinstein et al., 2013). Adolescents who compare themselves unfavourably against others on social media are engaging in what is known as negative social comparison, a contributor to depression, low self-esteem and most relevant to this study, FOI (de Vries & Kühne, 2015; Lup et al., 2015; Radovic et al., 2017). Social media use amongst all age categories is on the rise and expected to continue growing in the foreseeable future (Pew Research Centre, 2021; Statista, 2020), a trend that has been further compounded by the Covid-19 pandemic (Drouin et al., 2020; Magson et al., 2021; Singh et al., 2020). Social media use has been

shown to be both advantageous and detrimental to mental health (Chae, 2018; Drouin et al., 2020; Feinstein et al., 2013; Lup et al., 2015; Meier & Schäfer, 2018; Singh et al., 2020; Radovic et al., 2017; Uhls et al., 2017). However, since the arrival of the pandemic, maladaptive and compulsive social media use has risen significantly, increasing the likelihood that adolescent mental health will be further impacted (Drouin et al., 2020; Magson et al., 2021; Singh et al., 2020).

In opposition to the impacts of FOI, it has been shown that acts of kindness, affiliation, and compassion towards oneself may be able to interrupt the adverse outcomes of FOI through effectuating self-support in moments of failure in place of critically highlighting one's own faults (Gilbert et al., 2004, Gilbert, 2009). One promising approach to youth mental health treatment that utilizes compassion and self-affiliation is Compassion Focused Therapy (CFT). CFT helps youth navigate the challenges of adolescence by facilitating the development of important emotional regulation and self-support skills (Bratt et al., 2020a, b; Carona et al., 2017; Gilbert, 2009, Xavier et al., 2016). CFT is an emerging treatment method specifically designed to treat FOI and self-criticism and has shown to be effective at increasing emotional regulation in adult populations (Craig et al., 2020; Gilbert, 2009; Gilbert & Procter, 2009; Leaviss & Uttley, 2015).

A recent meta-analysis by Craig and colleagues (2020) of 29 CFT interventions demonstrates that CFT is a viable treatment method that is on par and, in some cases, exceeds more widely used treatment methods such as cognitive behavioural therapy. Interest in adult CFT is steadily growing and receiving increasing clinical attention, whereas CFT for adolescents is still in its nascent stages, with only a small handful of

studies catering specifically to this population (Bratt et al., 2020a, b; Carona et al., 2017; Craig et al., 2020). In case studies and small pilot evaluations, CFT for adolescents has been shown to be effective in the treatment of disruptive behaviours (Ribeiro da Silva et al., 2019) and trauma relating to sexual assault (Bowyer et al., 2014). Furthermore, CFT for adolescents is effective at decreasing self-stigma and shame and fostering self-acceptance, a mindset with numerous positive psychological qualities (Bratt et al., 2020a). While these initial studies have shown promise for CFT's usefulness with adolescents, further research is required to assess CFT's effectiveness with this age group (Bratt et al., 2020a, b; Carona et al., 2017). The proposed study will expand the adolescent CFT literature by studying a pilot of an online adolescent CFT group intervention developed by Dr. Eli Cwinn, titled the "I Have my Back" (IHMB) program. The study's principal goals are to explore participant experiences in the IHMB program, examine participant's experience of FOI and self-compassion and how participation in the program has influenced these factors.

1.1 Overview and implications of feelings of inadequacy

Feeling inadequate at times is a normal aspect of human experience, signaling to ourselves that we have failed to meet an internal or external standard of performance. However, FOI in a clinical context reflect pervasive, internalized self-beliefs about the inadequate nature of an individual's overall ability and worth (Gilbert & Irons, 2009; Thomson & Zuroff, 2004). In addition to feelings of low self-worth and insufficiency, FOI are characterized by a self-critical process where an individual self-shames by ruminating over their faults and shortcomings in an attempt to abrasively generate motivation to improve (Gilbert et al., 2004; Kopala-Sibley et al., 2013). FOI are a type of

self-critical motivation which is often done with the aim of conforming socially or adhering to high external (ex. parental, societal) or internal standards (Bleys et al., 2018; Gilbert et al., 2004; Kopala-Sibley et al., 2013).

While self-shaming associated with FOI has been shown to have numerous deleterious effects in modern times, the tendency to turn conflict and castigation inwards is theorized to have been an adaptive survival strategy for early humans (Gilbert & Irons, 2005). Our emotional systems are primed to operate with a "better safe than sorry" approach to mitigate risk and increase our chances at reproduction (Gilbert & Irons, 2005). Thus, defensive strategies such as shame, self-monitoring and withdrawal are an adaptive evolutionary strategy that helped maintain inclusion and social harmony at the expense of personal wellbeing (Gilbert & Irons, 2005). This is contrasted with riskier strategies such as assertion and confrontation that carry with them the possibility of retaliation or exclusion (Gilbert & Irons, 2005). Individuals who conceptualize themselves as inadequate are often highly preoccupied with exterior assessment, living with a heightened sensitivity towards social threats and are more likely to attribute neutral comments as hostile or judgmental (Mehr & Adams, 2016; Thomson & Zuroff, 2004). A constant alertness to social threats and turning conflict inward is an adaptive set of behaviours if a primary concern is social exclusion, which could prove potentially fatal to ancient humans (Mehr & Adams, 2016; Thomson & Zuroff, 2004).

1.2 **Development of FOI**

FOI and the resulting maladaptive perfectionism are well-documented, cross-cultural phenomena associated with psychological turmoil and distress (Ahmad & Soenens, 2010; Bleys et al., 2018; Hong et al., 2017; Mehr & Adams, 2016; Thomson &

Zuroff, 2004). The orientation towards self-critical and perfectionistic behaviour is done with the hope of motivating positive change to win the love and respect they crave, which can prove to be quite difficult in situations where parental standards are unreachable or continuously receding (Gilbert et al., 2004). Conversely, in moments of success when the child performs adequately, parents' contingent affection comes into effect and the child learns that performing to others' standards is one path towards achieving and being worthy of love and acceptance (Gilbert et al., 2004).

A core sense of being inadequate can develop when an individual lives in social context that is evaluative and judgemental or where love and acceptance are contingent on meeting certain standards of achievement (Ahmad & Soenens, 2010; Bleys et al., 2018; Gilbert et al., 2004; Gittins & Hunt, 2019; Kopala-Sibley et al., 2015). Children reared in critical environments are less likely to receive warmth and positive attention outside of performative or interpersonally pleasing interactions and, as a result, are believed to have less access to internal working models of unconditional warmth and support (Gilbert & Irons, 2009; Kirby et al., 2019). Contingent parenting such as this originates from parent's desires to have their children succeed by using behaviours such as intrusive psychological control to increase the chances of their children adopting their standards of performance (Gittins & Hunt, 2019; Hong et al., 2017). In circumstances such as these, it is theorized that children have less access to unconditional models of support to effectuate their own self-reassurance at times when they fail to meet their standards. Children will instead manage their persistent FOI and negative emotions with self-attack (self-directed loathing, self-debasement, self-harm), unrelenting self-standards, and perfectionism (Gilbert et al., 2004; Goldblatt et al., 2014; Kopala-Sibley et

al., 2013; Thomson & Zuroff, 2004). To offer another perspective, it may be possible that even partially contingent parenting or excessive praise and attention in moments of success could lead to the development of self-criticism and FOI, depending on the child's temperament and how they respond to the attention and affection. Indeed, clinical anecdotes in the CFT community suggest that adolescents and adults can develop chronic FOI in supportive family environments. In these cases, it is suggested that an individual's biological temperament makes them sensitive to compounded micro-invalidations and rejection from both parents and peers (Harvey & Penzo, 2009; Henderson, 2011).

Children who experience parental or peer expectations as high or unachievable can internalize these standards, leading the individual to place very high standards on themselves, which, if not met, result in FOI and harsh self-criticism (Bleys & Soenens, 2018; Thomson & Zuroff, 2004). Even in moments of success, perfectionists' standards tend to rise above what has been achieved, leaving them unable to feel accomplished and negating any positive impact of achievement (Thomson & Zuroff, 2004). The cycle of failure to achieve unrealistic internal standards followed by self-shaming perpetuates negative affect and leads to deep feelings of worthlessness and failure (Blatt, 1974; Mongrain & Leather, 2006).

1.2.1 *Adolescent self-criticism and feelings of inadequacy*

Adolescent self-criticism is characterized by two key processes: the degree of self-directed hostility, contempt and self-loathing and a relative inability to generate feelings of self-directed reassurance, warmth and soothing (Gilbert & Irons, 2009). One important characteristic of adolescence is an increased focus on peer groups and an individual's place within social hierarchies (Stott, 2007). The centrality of peer group

interactions and perceptions in an adolescent's life has been further amplified by the increasing levels of pressure to have a "branded" public persona and to present themselves in a socially desirable light in person and on social media (Gilbert, 2010; Johnson, 2017). The increased focus on social groups creates further avenues for the development of self-criticism, as a result of peer rejection, social shaming and peer victimization (Gilbert & Irons, 2009; Kopala-Sibley et al., 2013). Adolescents who perceive themselves to be viewed negatively in the minds of their peers are at greater risk of developing self-criticism, particularly the FOI half of self-criticism (the self-hatred half being related to the most severe forms of bullying and harassment) (Gilbert, 2010; Gilbert & Irons, 2009; Tangney & Dearing, 2002). External threats such as social shame, combined with self-attack and self-criticism leave adolescents in a state of heightened threat awareness, triggering the release of stress hormones such as cortisol and adrenaline (Dickerson & Kemeny, 2004; Gruenewald et al., 2004). This perpetual guardedness has been suggested to be the cause of a multitude of issues such as anxiety, paranoia, social difficulties, and depression (Cheung et al., 2004; Gilbert, 1998; Rosen & Schulkin, 1998; Shahar et al., 2004; Zuroff et al., 1994).

1.3   Negative social media comparisons and their relationship with FOI

Another influence on the development of FOI is social media. Negative comparisons on social media are a form of contrasting upwards comparison, where an individual is made aware of their own deficits in comparison to a perceived superior target (Meier & Schäfer, 2018). The FOI brought about by contrasting upwards comparisons have been shown to cause a decrease in positive affect and self-esteem and an increase in negative affect and depressive symptomatology (Lup et al., 2015; Steers et

al., 2014; Vogel et al., 2015). One pertinent factor to the perpetuation of FOI is the phenomenon known as "highlight reels," where social media users tend to display only their greatest achievements and moments of joy producing a rosy and distorted social media personality (Steers et al., 2014). Negative comparisons on social media can be understood through the metaphor of "Keeping up with the Joneses", where users are perpetually dissatisfied chasing unobtainable and unrealistic standards of beauty, health, fulfillment, and success. In the context of social media, the comparisons to others are far more chronic and pervasive, as instead of occasional brushes with neighbours' affluence adolescents are exposed to a constant stream of potential comparisons. In addition to the FOI fuelled by internal social comparisons, social media can be a prominent source of peer harassment and victimization in the form of online harassment/cyberbullying (Beran et al., 2012; Kwan et al., 2020). With the pervasive nature of adolescent online access, cyberbullying can act as a powerful contributor to FOI by acting as a potentially continuous source of peer victimization (Gilbert & Irons, 2009; Kopala-Sibley et al., 2013; Kwan et al., 2020).

Social media usage is almost ubiquitous amongst adolescents, with 95% of youth owning a smartphone and 45% reporting to be online on a nearly continuous basis (Pew Research Centre, 2018). Repeated exposure to highlight reels has been shown to be a driving factor for depression as individuals continuously fail to form a favourable comparison between their own life and a tailored media product designed to project success and happiness (Steers et al., 2014). With rising rates of social media use further strengthened by the pandemic, negative comparisons and the drain of highlight reels are likely to continue contributing to adolescent FOI and disrupting adaptive social media use

(Chae, 2018; Drouin et al., 2020; Feinstein et al., 2013; Lup et al., 2015; Radovic et al., 2017; Singh et al., 2020).

It is worth noting that the impact of social media use on mental health is multi-faceted and not uniformly detrimental or conducive to mental health. A recent study has demonstrated the positive side of social media comparisons where they can contribute to wellbeing and act as a source of motivation (Meier & Schäfer, 2018). In some cases, upwards social comparisons have been shown to be beneficial when the individual seeks to assimilate in some manner to gain the strengths of the superior target (Meier & Schäfer, 2018). An example where an upward social comparison could be beneficial would be a scenario such as an adolescent being inspired by a fitness personality to start eating healthier and exercising, improving their life and wellbeing, rather than using the comparison as a means to further focus on their inadequacies. According to Meier and Schäfer (2018), the factor that determines whether a comparison will be beneficial or not is levels of positive affect, something that may be lacking in adolescents who already struggle with mental health symptomatology.

1.4   Developmental implications of chronic FOI

Continued self-emphasis and shaming of an individual's own shortcomings that accompany FOI create a stable, internal conflict where the individual becomes demoralized and submissive towards their own internal badgering or pushes them into anxious, perfectionism in the continuous task of attempting to satisfy their own high internal standards (Gilbert et al., 2004; Gilbert, 2009). This internal conflict is psychologically taxing, leading to a variety of mental health issues such as anxiety and depression (Gilbert et al., 2004; Gilbert, 2009). FOI can also have serious implications

for motivation and self-worth which can negatively impact an individual's goal setting ability, attainment, and wellbeing (Bandura, 2010; Gilbert et al., 2004; Sheets et al., 2014).

One highly pertinent example of the effects of FOI is its negative impact on self-efficacy (Bandura, 2010). Self-efficacy is our personal belief regarding our ability to accomplish a given task and influence the events that impact our lives (Bandura, 1997, 2006). Self-efficacy is based on our subjective assessment of our own capabilities and the difficulty of the task; with a greater belief in our own abilities, we are subsequently motivated to attempt greater challenges (Bandura, 2010). However, when hampered with chronic feelings of inadequacy, and no ability to access internal self-support, the threat of even mild challenges can be overwhelming (Bandura, 2010). Even when an individual can engage with the chosen task, their feelings of dread at potential failure can result in stress and lowered performance, increasing the chances of realizing the feared failure (Pajares, 2006). When this pattern of challenge avoidance and lowered performance is established, it creates a cycle where an individual will experience a deficit of mastery experiences, further hampering self-efficacy and maintaining FOI (Bandura, 2010). Self-efficacy is an important determinant of human motivation, emotional wellbeing and can be the deciding factor in whether a person is successful in a goal -or if they even decide to attempt the challenge in the first place (Bandura, 2010). Individuals who consistently judge themselves as inadequate to accomplish a task or pursuit suffer many detriments to functioning across a wide scope of measures, from poorer attainment, decreased wellbeing, greater risk of depression and ruminative thoughts, and greater incidences of

internalizing and externalizing behaviours in adolescents (Bandura, 1986; 1997; Di Giunta et al., 2018; Kavanagh & Wilson, 1986).

FOI can also have a deleterious effect on our sense of self-worth (Crocker & Wolfe, 2001). Self-worth (and the related concept self-esteem) is a global judgement of the worth or value of the self and plays a significant role in our happiness, success, and social attractiveness (Crocker & Wolfe, 2001; Sargent et al., 2006). Low self-worth has been shown to be nearly inseparable from depression and is recognized by the DSM-5 as a core feature of the disorder (American Psychiatric Association, 2013; Burwell & Shirk, 2006). An individual's self-worth is particularly vulnerable when it is highly contingent on external factors such as academic achievement, social status, and physical appearance (Burwell & Shirk, 2006). Without sufficient intrinsic self-worth and compassionate self-support, FOI in a contingent domain can directly hamper an individual's self-worth (Burwell & Shirk, 2006; Gilbert et al, 2004; Gilbert, 2009). Individuals with high contingent self-worth are not only at risk of developing depression as the result of falling short against external criteria, but their ability to productively engage with their domains of contingency can be disrupted (Burwell & Shirk, 2006; Crocker & Knight, 2005). Individuals with highly contingent self-worth will pursue tasks that validate those domains to which their esteem is contingent on (Crocker & Knight, 2005). The caveat to the pursuit of contingent domains however is that their self-assessment must be judged adequate to justify threat to self-esteem resulting from the possible failure (Crocker & Knight, 2005). In this manner, contingent self-worth acts as a motivator, based on a positive self-assessment and a belief that, in the face of failure, the individual can gather their strength and remount a goal pursuit (Crocker & Knight, 2005). However, in cases

when an individual feels inadequate to succeed, the individual is at risk of engaging in avoidance behaviours rather than attempting the task directly (Crocker & Knight, 2005). Adolescents are particularly vulnerable to the negative effects of contingent self-worth due to normative developmental increases in self-consciousness and adolescents' tendency to base their self-worth on external feedback (Harter, 1999). Furthermore, as children age into adolescents and their peer group takes on a more central role in their lives, they experience a disruption in the structure of their external feedback systems putting adolescents with highly contingent self-worth at greater risk of depression (Burwell & Shirk, 2006; Steinberg, 2002).

1.5   **Compassion is an ameliorative skill**

Compassion can be conceptualized as the ability to detect and understand suffering in self or others and subsequently respond to alleviate it (differentiated from sympathy or empathy in that there is an action-oriented element) (Kirby et al., 2019). Compassion exists in three varieties known as "flows:" self-to-other, other-to-self, and self-to-self (Gilbert, 2009). The focus of the current study is on self-compassion, the self-to-self flow, where an individual perceives their own pain and suffering and takes steps to alleviate it and improve their lives. Kristin Neff (2016) defines self-compassion as "How we relate to ourselves in instances of perceived failure, inadequacy, or personal suffering." Neff (2016, p.265) further describes self-compassion as being composed of three main components coupled with self-critical polar opposites: self-kindness versus self-judgment, a sense of common humanity versus isolation (e.g., "I am not alone in my suffering"), and mindfulness versus over-identification (e.g., "One instance of inadequacy or failure does not mean I am a failure overall"). The development of self-

compassion has been shown to be an effective antidote to FOI and self-criticism (Bluth &

Blanton, 2014; Hoffmann et al., 2011). Self-compassion is a potent contributor to youth

wellbeing, helping to alleviate the symptoms of depression, social anxiety, interpersonal

problems, and cognitive-behavioural avoidance (Bluth & Blanton, 2014; Hoffmann et al.,

2011; Karimi et al., 2020). Furthermore, self-compassion has been shown to increase

self-efficacy across multiple contexts such as university student wellbeing, health-related

behaviours in emerging adults and goal mastery (Babenko & Oswald; 2019; Manavipour

& Saeedian, 2016; Sirois, 2015; Smeets et al., 2014).

Despite the benefits of compassion, individuals often espouse several fears and

apprehensions about using and receiving compassion in times of difficulty (Gilbert &

Mascaro, 2017; Kirby et al., 2019). Compassion is often erroneously viewed as a source

of weakness or indulgence and carries with it apprehensions of its usefulness (Gilbert &

Mascaro, 2017). Fears of compassion can take many forms such as a worry of being

overwhelmed by the distress of self or others or that engaging in compassion may be

viewed as manipulative (Gilbert & Mascaro, 2017; Vitaliano, et al., 2003). Of particular

relevance to this study is the fears of compassion as they relate to feeling inadequate.

Individuals often fear that if they relent in their self-criticism, they will lose motivation

and fail external standards of achievement and progress (Gilbert & Mascaro, 2017; Kirby

et al., 2019). Many individuals are prevented from acting compassionately towards others

as they fear their efforts will be insufficient and they will be seen as incompetent,

unhelpful or risk having their good intentions rejected (Gilbert & Mascaro, 2017). CFT is

a formal psychotherapy that trains the skills and attributes of compassionate responding

while using process-based interventions to help individuals work through their fears and

resistances to allowing compassion to flow-in or -out depending on the client's individual needs (Craig et al., 2020; Hoffmann et al., 2011).

1.6   **Compassion as treatment: Compassion focused therapy**

CFT is a treatment approach that incorporates elements from Buddhist psychology, attachment theory, affective neuroscience, and social psychology for the purpose of alleviating shame and self-criticism (Gilbert, 2014). CFT and compassionate mind training (One of CFT's primary methods to develop compassion in therapy clients) have demonstrated promise in alleviating the issues of a variety of treatment resistant populations such as adults struggling with treatment resistant depression, psychosis (Beaumont et al., 2012; Braehler et al., 2013; Gilbert & Procter, 2006; Judge et al., 2012; Laithwaite et al., 2009; Lucre & Corten, 2012; Shapira & Mongrain, 2010) and adolescent self-injury (Van Vliet & Kalnins, 2011) .

Many self-critical, treatment resistant populations often internally relate to themselves in a cold, hostile, and shaming manner (Gilbert, 2014; Pauley & McPherson, 2010; Stott, 2007). Persistent negative self-relations result in a decreased ability to effectuate self-directed positive emotion, perpetuating mental health pathologies such as depression and eating disorders (Gilbert, 2014; Pauley & McPherson, 2010; Stott, 2007). CFT addresses client's feelings of self-criticism, shame and inadequacy by developing their ability to effectuate self-compassion and positive self-affiliation to increase adaptive motivation and emotional regulation (Gilbert, 2009; 2014). The CFT clinician works with the client to overcome their barriers to compassion, conceptualized as fears (e.g., if I am kind to myself I won't work as hard and will fail; concerns about the practical sequalae of using compassion), blocks (e.g., I don't know *how* to do it or what to say; skills or

fluency deficits in using compassion effectively) and resistances (e.g., I don't deserve compassion; emotional and caregiving/receiving learning histories lead compassion to be experienced as aversive in some way; Kirby et al., 2019). CFT trains skills such as distress tolerance, self-kindness, sensitivity, nonjudgment, empathy, compassionate self-correction, radical self-acceptance, and mindfulness to facilitate a client's ability to respond in a warm, compassionate manner towards their failure, inadequacies and setbacks (Gilbert, 2009; 2014). Clients are taught how to internalize their own compassionate intentions, allowing them to effectuate self-support in moments of difficulty and inadequacy as an alternative to emotion avoidance, self-shaming and self-criticism (Gilbert, 2014; Neff, 2016).

Two recent case studies have provided optimistic support for CFT's role as a promising treatment option for adolescents (Bowyer et al., 2014; Ribeiro da Silva, et al., 2019). The first case study examined an adolescent female undergoing a CFT intervention to treat trauma resulting from sexual assault. The intervention showed a clinically significant reduction in shame, self-attacking cognitions and PTSD symptoms that remained sub-clinical after treatment completion (Bowyer et al., 2014). CFT's de-shaming and acceptance-based methods proved to be highly effective in soothing and processing the shame and disgust-based flashbacks that often occur in survivors of sexual assault. The second case study explored the efficacy of CFT with a 16-year-old Portuguese youth with dozens of assault charges. The study found that the CFT intervention resulted in a significant reduction in antisocial traits and disruptive behaviour measured using the Youth Psychopathic Traits Inventory Sheet (YPI-S) and number of recorded disciplinary infractions respectively (Ribeiro da Silva, et al., 2019).

Furthermore, the 3-month follow-up provided similarly positive results, the youth had committed no disciplinary infractions, and it was recorded that he experienced further significant reductions in the overall YPI-S score and its sub-factors (grandiose/manipulative; callous/unemotional; impulsive/irresponsible).

In two recent studies, CFT has demonstrated its effectiveness in adolescent group-based interventions (Bratt et al., 2020a, b). The first study by Bratt and colleagues (2020a) conducted a qualitative investigation of the experiences of six adolescent girls between the ages of 15 to 17 undergoing group CFT treatment at a Swedish psychiatric outpatient program. This program was facilitated alongside an optional, parallel parental CFT program where the adolescent's parents could address their own struggles and learn to relate to their children compassionately. The experiences of the six adolescent girls were collected and analyzed using what is known as a "Reflective Lifeworld Approach," a qualitative investigation format that stresses openness, flexibility, and self-restraint against hastily coming to conclusions (Bratt et al., 2020a; Dahlberg & Dahlberg, 2019). The results of the analysis demonstrated that participants' key takeaways from the intervention were the development of a sense of calm and clarity in regard to their struggles, being more effective at setting boundaries and asserting themselves and increasing their experience of connectedness with their peers. Overall, the intervention was a positive and constructive experience for participants, allowing them to develop a sense of common humanity in their shared struggles, gaining a greater understanding of their emotions and how to navigate them and learning how to ask for help and adaptively communicate their distress to others (Bratt et al., 2020a). A quote from one participant

regarding her experience with common humanity (as conceptualized by Neff (2019) is

relayed below (Bratt et al., 2020a):

> *"Meeting others who are also suffering, and who, because they seem okay and look fine, you would not think are suffering, has made a great difference. I think that if other people feel bad, then there is nothing wrong with me just because I suffer, so I can talk about it, too. Admitting to others that I suffer was like admitting it to myself, and we were able to talk and understand each other." (p.916)*

One participant however, experienced a negative outcome relating to the

intervention. After gaining the ability to assert herself and set boundaries when being

mistreated, her friend group abandoned her, unwilling to accept her newly developed

self-advocacy. The participant expressed confidence in her decision to self-advocate but

reflected that she now felt quite isolated. Future CFT interventions can learn from this

account in that it highlights the importance of communicating and preparing clients for

the unexpected life changes that may occur in the process of developing compassionate

self-support skills.

The second study was a non-randomized controlled trial that's design

incorporated both adolescents and their parents (Bratt et al., 2020b). A total of 43

adolescents (83.7% female) and 77 parents (61% female) underwent treatment, with 19

adolescents participating in the CFT intervention and 24 receiving cognitive behavioural

therapy (CBT) with parents attending the corresponding parallel interventions. No

significant differences in terms of perceived stress and self-compassion were found

between the CFT intervention and CBT intervention for either the parents or adolescents. This was accounted for by the fact that the treatment was relatively short (8 weeks) and the mental health issues the adolescents were coping with were highly complex. Another possible factor to consider is the changes may not have been observable on quantitative measures as they acted on the process level rather than the outcome level. For example, teaching someone a skill such as assertiveness may not be reflected in self-report measures of mood or self-criticism until they have had multiple opportunities in life to effectuate this skill and for it to eventually translate into a shift in mood. Additionally, it is important to consider the possibility of a response shift bias in that adolescents may overestimate the status of their mental health at the start of the program, especially because the CFT teaches clients to become attuned to their own distress and engage with it in an open manner.

Furthermore, some of the adolescents found the visualizing and mentalizing exercises involved in CFT treatment difficult, potentially highlighting an element to tailor or remove in future adolescent CFT treatments. In contrast, a qualitative analysis of the study found that the CFT treatment was able to develop parents' ability to care for their own needs which in turn helped developed their agency and confidence in caring for their children (Bratt et al., 2019). These studies point towards CFT's potential as an alternative adolescent/parent group treatment method to CBT, however further studies need to be conducted to further explore its viability.

1.7   **Viability of online group therapy**

The study of online group therapy is a field that has drawn little research in preceding years and is still a relatively understudied therapy format (Weinberg, 2020).

With the arrival of Covid-19, online therapy's viability and acceptance steadily grew throughout the pandemic as in person meetings became a challenge posing not only a health risk but also a financial burden of needing to retrofit office with protective barriers for the small windows of time where face-to-face meetings are legally permitted (Barker & Barker, 2021; Situmorang, 2020). Since the first recorded teletherapy session in 1961 (Wittson et al., 1961) remote therapy has been steadily increasing in its acceptability as a viable treatment delivery method (Békés & Doorn, 2020).

Several studies and meta-analyses have shown online therapy to be an effective alternative to face-to-face therapy for treating a variety of different disorders such as PTSD, eating disorders, panic disorders and depression, producing comparable outcome measures and client amelioration (Norwood et al., 2018; Skinner & Zack, 2004, Sloan et al., 2011; Stamm, 1998). Those same studies on the effectiveness of group therapy also found that while results were comparable, patients rated the therapeutic bond and therapist's presence as being of a lower quality (Weinberg, 2020). In addition to this, maintaining group focus can be a greater challenge online as when clients are contained within the same room the therapist can easily monitor participants engagement and make use of co-regulation to keep participants on track. In an online landscape, participant distraction and disengagement can be difficult to detect, masked through participants muting their audio input, turning off their cameras or opening browsers so their gaze is still on the camera, but their attention is elsewhere. Weinberg (2020) suggests that therapists should accordingly increase their presence by employing self-disclosure to increase the intimacy of the experience along with encouraging participants to imagine the group as if everyone were in a circle to promote participants to actively think about

their relations in the group and who they might want to sit next to or maintain some distance from. One other drawback of online therapy is that clients with acute suicidality cannot be immediately tended to through a screen as they would in person. This factor informed an exclusion criteria for the formation of the current study's groups that necessitated sufficient support outside of the program to manage the participant's suicidality.

2   **Current study**

With the increase in adolescent mental health challenges and the deleterious effects of social media becoming more prevalent, there is a continued need for the development of effective treatment methods catered to the needs of this population (Flatt, 2013; Weinberger et al., 2017; Wiens et al., 2020). CFT's ability to address the transdiagnostic factors of FOI and self-criticism make it a promising tool for ameliorating adolescent mental health (Bowyer et al., 2014; Bratt et al., 2020a, b; Ribeiro da Silva, et al., 2019). The current study expands the CFT literature by exploring the benefits of an online pilot CFT adolescent therapy group titled the I Have my Back program (IHMB). This was accomplished through a mixed methods approach analyzing pre and posttest survey responses and data acquired from post-test semi-structured interviews. Participants' experiences and perceptions of the group were collected along with several mental health measures assessing anxiety, depression, self-criticism, and self-compassion. Furthermore, participants were questioned regarding their feelings of inadequacy and how these have changed over the course of the group. The current study's aims were to:

>**Aim 1**: Explore participants' experience of the IHMB program and assess the viability of further adolescent group CFT programs.

>**Aim 2:** Explore the participants' understanding and experience of FOI, self-criticism and self-compassion and how those understandings and their mental health were influenced by participating in the IHMB program.

2.1   Participants

Participants were adolescents who participated in the IHMB CFT intervention and completed at least the pre-post measures or either post-test interview (written or verbal) and consented to have their data used for research purposes. The program is hosted through Western University's Child and Youth Development Centre (CYDC) in London, ON and is being facilitated independent of the current study. At the time of writing, a total of 25 adolescents have participated in the IHMB program with 10 consenting to research (3 completed the pre-post measures, 1 completed the post-test interview and 6 completed both). The participating adolescents are between the ages of 13-17 (M=14.25, SD=1.28 min:13, max: 17) with n=5 identifying as cis male, n=3 identifying as cis female and 2 identifying as gender minorities (one participant identified as both female and a gender minority). The majority of participants identified as white (n=8) and n=2 participants identified as mixed race. Pre-test overall depression anxiety stress scales-short form scores (DASS-21) were very elevated (m=94.67, SD=31.13) indicating extremely severe mental health difficulties.

2.2   Procedure

The IHMB intervention consists of 13 weekly 1-1.5 hour Zoom sessions delivered to groups of approximately 3-4 adolescents who are experiencing mental health difficulties (see table 1 for program outline). The goal of the IHMB program is to develop adolescents' self-compassion through skills-building to help increase emotional regulation and wellbeing. This is accomplished through a variety of exercises and group activities such as situational roleplay, psychoeducation, and compassion and assertiveness training. Through these sessions, adolescents are taught the skills necessary

to effectuate self-support in response to moments of struggle and difficulty which often prompt feelings of self-hatred and inadequacy. Furthermore, the IHMB program is designed to promote an open, playful, and non-judgemental environment crafted by each facilitator with the aim of giving participants a space where they can take risks and make mistakes without severe consequences or punishment to encourage growth and experimentation with new coping skills.

Participants in the IHMB program were invited to participate in a one-month follow-up interview in exchange for a 30$ Amazon gift card. The interview occurs outside of their participation in the CYDC programming and pertains to this study only and is optional. Participants are also offered to alternatively complete a series of open-ended questions based on the interview questions with the same level of compensation. The interview takes approximately 60 minutes to complete while the survey takes approximately 20 minutes to complete. Compensation was initially based on a fair rate for the online interview and was not lowered for the questionnaire to avoid coercing participants to participate in a format they were uncomfortable with.

Table 1

Summary of the content and activities of the IHMB program

Session number and title	Content	Specific activities
1. Introduction, Building Cohesion, and Setting Group Rules	Build a sense of group cohesion and a social climate that is supportive, non-judgmental, playful, and helpful.	Meet and greet, get to know you/ icebreaker games. Establish collaborative group rules of conduct.
2. The Matrix	Discussing goal setting in framed as pursuing a rewards rather than avoiding punishment.	Acceptance and commitment therapy matrix (Polk et al., 2016)
3. Becoming the Caption of Your Mind and Listening to Your Emotions	Provide psycho-education on emotions, frame emotions as perceptual faculties that need to be felt, and to introduce the idea of part-selves and the polyphonic discourse of the mind	Psycho-education on emotions, needs and sources of information. Captain of the mind metaphor to represent part selves (i.e., Self-critic, inner caregiver)
4. Self-Validation and the Tripartite Model of Affect Regulation	Psycho-education on the Tripartite Model of Affect regulation, teaching youth to validate their own emotions and experiences	Psychoeducation on affect regulation and self-validation.
5. Qualities of Compassion and Compassionate Other Imagery	Define the qualities of compassion and introduce the Compassionate Other Imagery	Guided meditation and compassion psycho-education
6. Self-Attack versus Compassionate Self-correction	Bolster skills related to compassionate reasoning, further develop "scripts" for patterns of compassionate self-relating, begin discussing fears of using compassion as a means of relating to oneself and others, and differentiating between self-attack and compassionate self-correction	Psychoeducation on self-attack and compassionate self-correction
7. Functional Analysis of Self-Criticism	Bolster skills related to compassionate reasoning, and to introduce functional analysis of self-criticism	Functional analysis of self-criticism
8. Attentional Shifting and Compassionate Goal Setting	Review goals from week 2 and break down into smaller pieces, training compassionate self-correction as an alternative to self-criticism, and shaping out-of-session practice	Attentional shifting exercise and compassionate goal setting (setting realistic goals based on values rather than harsh self-critical goal adherence)
9. Assertiveness	Fostering strength and authority and agency	Psycho-education on assertiveness Bill of rights activity (what are your rights, when do they apply?) Shaping assertiveness roleplay
10. Assertiveness and Part-selves	Learning to apply assertiveness to part selves	Assertiveness roleplay with part selves
11. Low-Bar problem solving	Teaching problem solving from a lens radical self-acceptance and non-condemnation to encourage youth to act in a manner consistent with "I am not the problem, the problem is the problem".	Low-bar problem solving: **L** – Look at the Problem from the outside **O** – Objective: what are you aiming for **W** – walls: what are the walls or barriers you need to consider **B** – Brainstorm **A** – Arrive at a solution you are willing to try **R** – Review what worked and revisit if needed
12. Radical Self-Acceptance	Teach and practice radical self-acceptance, to identify and own character strengths and values publicly, and to practice savoring pleasurable or meaningful experiences	I am not good enough story, Dove inner thoughts video (Dove, 2015), discussion on difficulties of self-acceptance
13. Graduation	Reflect on skills learned and growth, to continue allowing compassion and kindness flowing in, and to have fun and celebrate all the hard work youth did over the past 12 weeks.	Post-test survey completion, introducing teens to post-test interviewer, celebration decided upon by adolescents and facilitators.

2.3   **Measures**

Post-test verbal interview. This interview (Appendix A) is a semi-structured verbal interview designed to assess adolescent's group experiences and their subjective experience of self-criticism, inadequacy, and self-compassion. The questions have been formulated based on the conceptualizations of inadequacy and self-judgement by Gilbert and colleagues (2004) and Neff and colleagues (2021), respectively. Example items on the interview include, "Before the CFT intervention, did you ever feel bad or not good enough when comparing yourself to others online? (Y/N) <If yes> What thoughts would go through your head when you were feeling this way?" and "What are some of the blocks, barriers, or difficulties you have experienced in compassionately responding to your feelings of not being good enough?" The semi-structured interview also asks participants about their experience of the group, the activities in the group, and other program evaluation relevant areas.

Written open-ended post-test questionnaire. The written post-test questionnaire (Appendix B) is an online form with a series of open-ended questions with text entry boxes available to participants. This questionnaire was designed to give participants an alternative method to share their group experiences. During the course of study, the open-ended interview received very low response rates and the questionnaire was devised as a method to collect participants experiences in a less intimidating manner that could be completed at their convenience and did not require scheduling an online meeting. The questionnaire is a shortened version of the post-test verbal interview (appendix A) that encapsulates core questions such as: "What do you say to yourself when you are being self-critical? Did this change since you attended the CFT group? If so, in what ways?".

Post-test survey group feedback section (appendix C). This section of the post-test interview is designed to survey participant's experience of the group using multiple choice questions asking which activities they found helpful, harmful or neutral/useless along with text entry questions such as "If you were going to recommend this program to a friend, what would you say?".

Post-test survey subjective experiences section (appendix D). This section of the post-test interview is designed to survey participant's subjective experience of their mood and feelings after having completed the group. This survey section includes multiple choice questions rated from 1 (strongly disagree) to 5 (strongly agree) such as "the program helped me stand up for myself" and "the program helped me feel like I matter".

Behavior and feelings survey (Youth). The behaviour and feelings survey youth (BFS-Y) (Weisz et al., 2019) (appendix E) is a 12-item survey designed to assess a youth's difficulty with feelings and disruptive behaviours. Each item is rated on a scale of 0-4, 0 being not a problem and 4 being a very big problem. One example of the thoughts and feelings subscale is "I think sad or scary thoughts over and over" and one example item from the behaviour subscale is "I talk back or argue with my parents or other adults". A higher score indicates more issues with feelings and disruptive behaviours.

Depression, anxiety & stress scales- short form. The depression, anxiety and stress scales (DASS-21) (Lovibond & Lovibond, 1995) (appendix F) is a 21-item questionnaire created to assess levels of depression, anxiety and stress using items such as "I was unable to become enthusiastic about anything" rated on a scale of 0-3, 0 denoting did not apply to me at all and 3 denoting applied to me very much or most of the

time. A higher score on the survey or any subscales indicate higher levels of anxiety, stress or depression respectively.

    Self-Compassion scale youth. The self-compassion scale youth (SCS-Y) (Neff, 2021) (appendix G) is a 17-item survey that assesses different self-compassionate and self-critical qualities in youth. An example of a self-compassionate statement in this survey is "I try to be kind and supportive to myself when I'm having a hard time" and an example of a self-critical statement is "I'm really hard on myself when I do something wrong.". Each item is rated on a scale of 1-5, 1 representing almost neve and 5 representing almost always. The items that pertain to self-criticism subscales are reverse coded and thus the higher an individual scores on this survey the greater their self-compassion is determined to be. There are currently no well-established norms for what is considered high, medium or low levels of compassion (Neff, 2016). Neff (2016) expressed that this scale is primarily useful for facilitating research, helping clinicians in their efforts to teach their clients self-compassion and to track those changes over time.

2.4   Data analysis

    Quantitative multiple-choice survey data was analyzed using a paired samples t-test examining participant scores pre and post-test. Due to the small sample size, effect sizes was determined using Hedge's G, a more conservative effect size compared to Cohen's D. Hedge's G uses pooled weighted standard deviations versus Cohen's D which uses pooled standard deviations.

2.4.1   *Thematic analysis of open-ended interview and open-ended questionnaire data*

    The thematic analysis of the qualitative data used the framework outlined by Braun and Clarke (2019). Braun and Clarke (2019) recommend a six-step process for

engaging in thematic analysis that consist of firstly familiarizing oneself with the data, second, creating initial codes (in this case the initial codes agreed upon by the researchers is FOI, online FOI and group helpfulness themes), third search for themes, fourth, review themes, fifth, define themes and lastly write up results and interpretations.

2.4.2   *Positionality of author and second coder*

In line with best practice for reflexive research methodology, it is important to make note of the positionality of the author and the author's supervisor who fulfilled the role of the second coder. Firstly, it is important to denote the categorial positionality of both coders being white, cis males of European descent. This privileged positionality inherently makes the researchers more sensitive to themes and ideas that pertain to our own categorical identifiers and potentially leaves us with a lesser ability to understand themes and ideas that pertain to groups that are not our own. Secondly, both coders have an active investment in the success of the IHMB program due to both being facilitators of the program and having a personal ideological investment in the success of compassion-focussed material. Additionally, both have been trained in a manner that is consistent with Western psychological understandings and carries with it expectations of measurable change brought about by a clearly identifiable mechanism or tool. These biases necessitate that coding and interpretation will need to be methodical in its attempt to not overly emphasize the helpfulness and gains of the program and equally bring to light any detrimental or lack of findings to develop a balanced representation of the data.

2.5   **Ethical considerations**

Participants might have experienced discomfort at being asked about their subjective experiences with feeling inadequate and memories of negative social

comparison. Participants were informed that their participation in the post-test interview is entirely voluntary and will in no way affect their programming with the CYDC. The IHMB CFT intervention has been approved by the Western Non-Medical Research Ethics Board (WNMREB). Furthermore, The WNMREB approved our request to contact program attendees for the purpose of recruiting participants for the research involved in this study. The IHMB program ensured to directly ask potential participants beforehand if they were struggling with active suicidality or eating disorders as both of those factors would necessitate specialized support that could not be offered in the program.

3   **Results**

Data were collected from n=9 participants who completed both the pre and post-test surveys. A total of 7 participants completed the qualitative measures, n=3 participants agreed to participate in the semi-structured post-test interview and n=4 completed the open-ended questionnaire.

Table 2

Pretest-Posttest Paired Samples T-test Results

Paired differences	Mean Change	SD	t	df	Sig. 2 (tailed)	Effect Size
BFSY total	1.33	9.95	0.4	8	0.7	0.13
DASS-21 Total	-16	35	-1.37	8	0.21	-0.44
SCS Total	0.13	0.35	1.15	8	0.282	0.37

All effect sizes are measured using Hedge's G due to small post-test samples size

3.1   **Quantitative data overview**

No paired samples t-tests were significant and effect sizes were relatively small, the largest amongst them being -0.44 for the Depression Anxiety Stress Scale (Lovibond & Lovibond 1995) indicating a medium sized, non-significant decrease in average depression, anxiety, and stress levels. In order to better understand why pre- post differences were not found, post-hoc analyses were conducted at the individual level.

Using the reliable change index (RCI) (difference between pre and posttest scores divided by the standard error of the difference; 1.96< indicates a reliable difference), it was determined that two participants showed improvement on the DASS-21, BFSY (Teens 2 and 7). Three participants reported an increase in self-compassion (Teens 3, 4 and 8). Three participants (Teens 2, 4 and 5) reported a deterioration on the internalizing

subscale of the BFSY and an amelioration on the DASS-21. As the DASS-21 and BFSY are parallel measures this may suggest the presence of measurement error.

3.2   **Participant group experiences feedback**

As part of the post-survey participants were provided with quality improvement questions concerning group feedback which they rated on a scale from 1 (strongly disagree) to 5 (strongly agree; see figure 1). Most participants found the program helpful, agreed that the program was fun, and they would recommend the program to a friend. Furthermore, most participants strongly disagreed that the program was a waste of time and disagreed that program made things worse.

Figure 1
Multiple-choice group feedback, post-test questionnaire
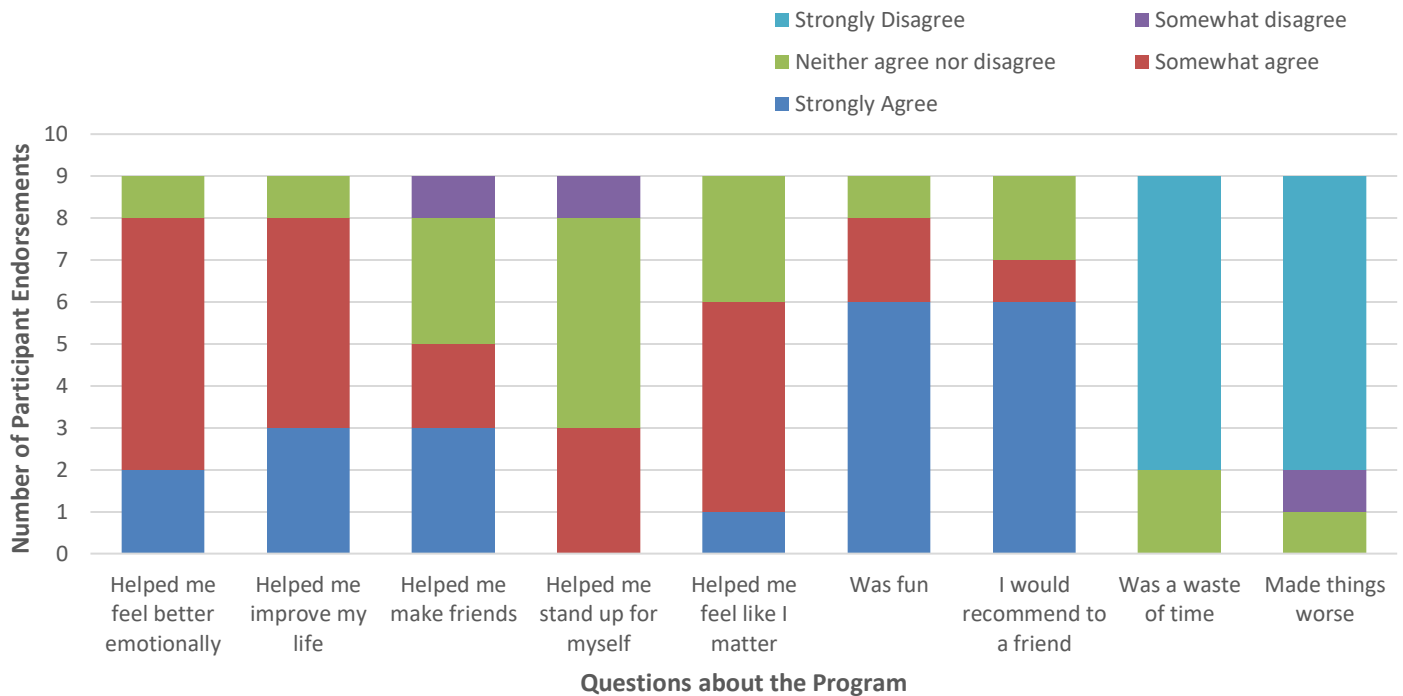
In addition to the group feedback segment of the post-test survey (see figure 1), participants were also provided with a subjective experiences feedback survey (see figure

2). While there was not a significant difference between pre and post-test group differences in the objective measures described above, most participants do report positive changes on the feedback survey. The majority of participants agreed that their mood got slightly to much better and that their anxiety got slightly to moderately better. Participant's ability to be kind to themselves also increased. Two important factors related to mental health showed improvement, nearly all participants expressed that their self-criticism got slightly to moderately better, and more than half of participants felt that their feelings that they matter got slightly to much better.

Figure 2
Participant's subjective experience post-test multiple choice feedback
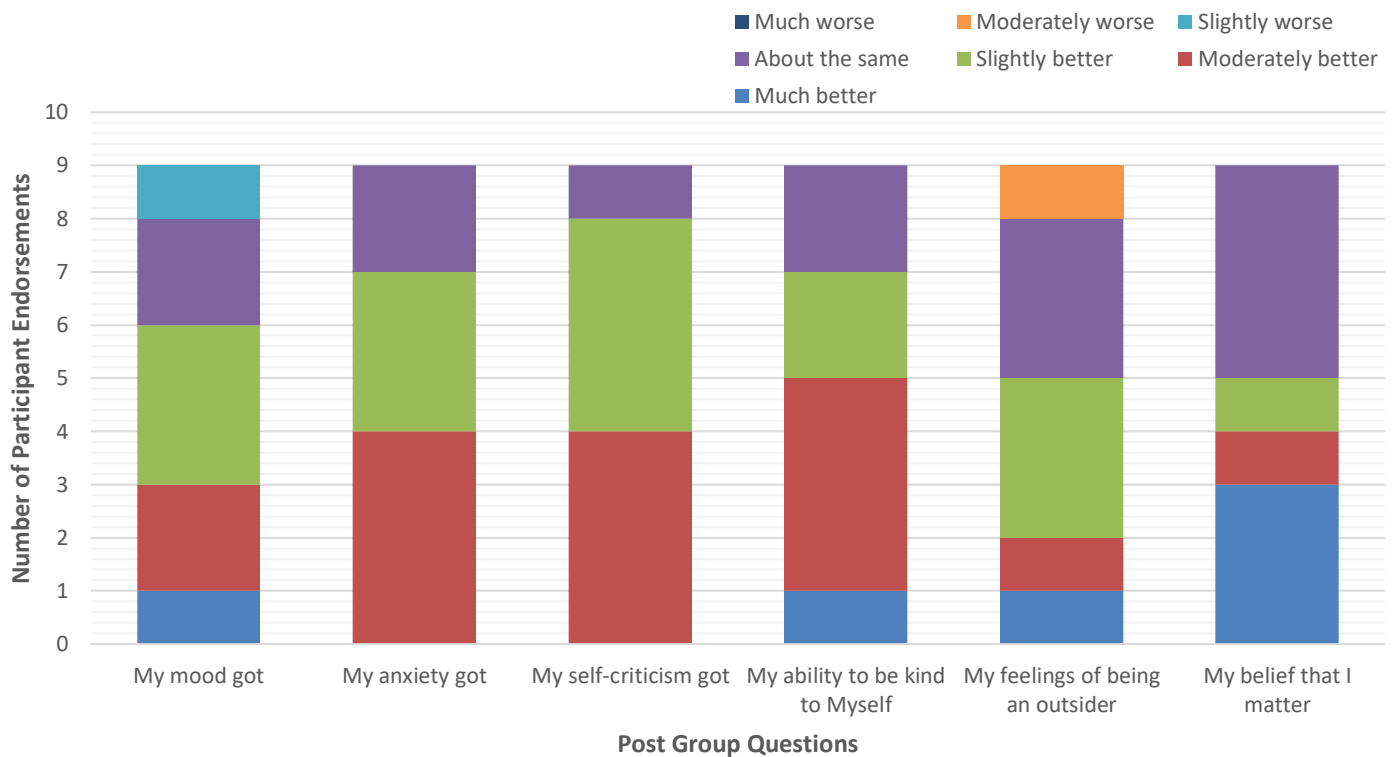
As part of the post-test survey a quality assurance segment was presented to participants inquiring about program aspects and activities (see table 3). Participants were asked to endorse items as either helpful, unhelpful, or harmful. Overall, participants

found the activities associated with the program to generally be helpful to them with few endorsements of activities being unhelpful or harmful. All activities were endorsed as helpful by at least one participant and the three most helpful activities (minimum majority endorsement; 5/9) were practicing breathing at home, learning about assertiveness, and learning about the emotional regulation triangle. Activities that were endorsed as unhelpful were talking to other teens, thinking about part selves, and practicing breathing at home. Only one activity was endorsed as being harmful, talking with other teens.

Table 3

Participant group activity ratings

Activity	Helpful	Unhelpful	Harmful
Talking with other teens	5	2	1
Doing home challenges	5	0	0
Thinking about my emotions as part selves or crew members on a ship that I am the captain of	4	1	0
Practicing breathing in group	5	0	0
Practicing breathing at home	8	2	0
Practicing moving my attention around in group	3	0	0
Doing imagery in group	4	1	0
Doing imagery at home	1	1	0
Learning about assertiveness	7	0	0
Learning about emotion regulation triangle	6	0	0

Scores represent number of participants that endorsed this activity as the top row of descriptors. 0 represents no endorsement

3.3   **Thematic analysis results**

During the third step of the Braun and Clarke's (2019) thematic analysis, the coders examined 6/7 transcripts (3 verbal interviews and 3 written responses) and confirmed two initial codes developed in step 2 (FOI, group helpfulness (renamed explicit group feedback). Online FOI was not prevalent enough to justify its own theme and was subsumed as a subtheme of FOI. Steps 4 and 5 were applied and re-applied each time a new theme arose until a concrete definition and justification as a distinct theme was agreed upon by the coders. In some cases, the validity and definition of a theme necessitated further clarification and exploration of a documented process that ultimately resulted in 100% agreement on inclusion and definition of all themes and subthemes. Upon completion of the coding process, the final rendition of the themes were grouped into two sections to reflect the initial research aims. The first research aim, explore participant's experience of the IHMB program and assess the viability of further adolescent group CFT programs, is represented by the program related themes section (see table 4). The program-related themes category contains the themes of explicit group feedback, emotion processing and wellbeing, skills acquisition and responsive use, therapy tasks or activities, self-compassion as an outcome, FOI reduction as an outcome (as it relates to program involvement), interpersonal changes and group dynamics. Themes relating to the second research aim are expanded on in section 3.5 below. The complete set of themes and subthemes was then used to code the 7th transcript (a written response) that was collected at a later date. The coding of the 7th interview corresponded to the existing themes and subthemes and did not necessitate any further changes to the coding structure.

Table 4
Thematic code definitions for program related themes

Theme	Definition	Examples
Explicit group feedback	*Explicitly state or respond using words likes helpful, harmful, neutral, unhelpful or other comments regarding the group's overall helpfulness or as an agent of change*	*"Did you find the group helpful?"- "Yes"-Teen 8* *"Do you think your relationship with self-criticism has changed since the program?" –"Yes, 100 percent" -Teen 2* *"I think that there was there was a lot of skills that I learnt while doing it that helped me make progress" – Teen 3*
Emotion processing and wellbeing	*Reporting overall increase or decrease in distress* *Dispositional relation to self and emotion* *Reporting a shift in how they understand, relate to, and regulate their emotions*	*"The group helped me communicate my emotions a lot better" -Teen 11* *(Referring to calling on inner caregiver) "that kind of helps me out with calming myself down and relaxing, it was before I go to bed so it kind of helped me sleep well." -Teen 2* *(Referring to relating to inner caregiver) "you had to tell them what you needed and if you need help" -Teen 3*
Skills acquisition and responsive use	*Learning coping skills* *Reporting the use of specific coping skills* *Immediate and in response to a situation* *Reporting that they handle difficult situations with more ease, containment, fluency, or agency*	*"I definitely feel less anxious and more relaced when it comes to anxiety provoking scenarios…"-Teen 6* *"I can control myself better, I know that much." -Teen 2* *"It has helped a little bit because, especially before, it was harder with boundaries, I wasn't as good with them." -Teen 3*
Therapy tasks or activities	*Naming a specific exercise, task or activity and describing it as somewhere on the continuum of harmful to helpful*	*"What was your experience doing the roleplays? Were they helpful, if so, how?" "They weren't really, mainly because I was struggling to get into character I guess" -Teen 11* *"I did the one exercise that they told me about, like going in and talking to somebody in your head (inner caregiver)"-Teen 2*

		"Do you remember any of the activities that you found were helpful?" "Yeah, the assertiveness one"-Teen 4
Self-compassion as an outcome	*Participants describe a shift in the frequency, intensity, or quality of their self-compassionate responding*	*(Relating to inner caregiver) "it helped me figure out when I needed help, what I needed to hear and what I needed to say to help myself comfort myself" -Teen 3* *"I think that I will try harder to improve and not everyone is perfect." -Teen 8, In response to "When you just don't feel good enough, what do you say to yourself? (ex. do you criticize and attack yourself or try to support yourself?) Has this changed since the program?"* *"Sometimes I feel like if I get a bad grade on a test the teacher and my parents will think poorly of me. I now know that one bad grade doesn't mean anything if I do good on the rest of the assignments and tests." -Teen 6*
FOI reduction as an outcome	*Reporting reductions in self-criticism, FOI, or contingencies of worth*	*"It (conversing with inner caregiver) helped me figure out when I needed help, when I needed to hear and what I needed to say to myself to help myself comfort myself which has helped a lot and actually comforting myself through those instead of just sitting there and looping through (self-critical thoughts)-Teen 3* *'It doesn't hurt as less and it happens less (FOI)" – Teen 2*
Interpersonal changes	*Changes in the goal, pattern, intensity or frequency of interpersonal aggression, compassion, or assertiveness*	*"So once I had boundaries in place, it was easier to, like just calm down and be OK with it, with the fact that she (mother) needed help." -Teen 3* *"Have you found that you've been able to be more assertive?" "Yeah before I was more aggressive…I had no different way of doing things." -Teen 4*
Group dynamics	*Statements relating group dynamics including feelings of inclusion, non-judgment, playfulness, facilitator stance, interpersonal support/interactions*	*"What skills or activities from the group were most helpful to you?" "Hearing that people had the same struggles as me." -Teen 8* *"Just having people around me that I can share my stuff with and have people that will support me" -Teen 2*

3.4   **Program-related themes**

As noted above, the program related themes identified are explicit group feedback, emotion processing and wellbeing, skills acquisition and responsive use, therapy tasks or activities, self-compassion as an outcome, FOI reduction as an outcome (as it relates to program involvement), interpersonal changes and group dynamics. This section describes the themes and provides quotes from youth exemplifying each theme.

Emotional processing and wellbeing. Participants reported that they had experienced an increased ability to identify and meet their emotional needs, whether that need was self-soothing, clear emotional expression or gaining the knowledge to understand what they were feeling and how to subsequently act to meet this need. Several participants expressed that they previously did not have the ability to respond actively to identify or meet their emotional needs and would be "stuck" in cycles of negative emotionality.

"It (conferring with inner caregiver) has helped me figure out how to respond to myself in a way that actually helps me because when the person who was being your inner caregiver was talking to you, you had to tell them what you needed and if you needed help.". -Teen 3

"The group helped me learn to communicate my emotions a lot better." -Teen 11

"That kind of helps me out with calming myself down and relaxing, it was before I go to bed so it kind of helped me sleep well." -Teen 2 Referring to calling on his inner caregiver

Skills acquisition and responsive use. More than half of the participants expressed active use and different response patterns to emotionally challenging situations post-group participation. These participants demonstrated a greater ability to reflect on their emotional state and manage their choices and influence outcomes to a greater degree as opposed to reacting impulsively or without an awareness of how their emotional state was guiding their decisions. This took a variety of forms from choosing to avoid harassing individuals rather than entering into direct conflict, predicting possible outcomes and choosing the best solution as a result of roleplaying or being better able to manage the emotions and needs of others after erecting healthy barriers to protect one's own needs.

"I get picked on at school a lot, so I've stayed away from the people now. So what I do is I choose to just focus on whatever I'm doing and tune them out, and I just tune them out, like can't hear them…you can't retaliate if you can't hear them, keeps me from retaliating." -Teen 2

"I definitely feel less anxious and more relaxed when it comes to anxiety provoking scenarios that I am put into."-Teen 6

"It has helped a little bit because especially before It was harder with boundaries, I wasn't as good with them." -Teen 3

Therapy tasks or activities. Nearly all participants expressed that they found a specific activity helpful. Roleplaying was the most endorsed activity for a variety of reasons, one example being that it helped them better predict and choose situational outcomes in their lives.

Q. "What was your experience of doing the roleplays? Were they helpful? If so, how?"

A. "Not right away but as time went on, I was able to predict outcomes and choose more positive results." -Teen 8

Another example of the benefits from roleplaying was its ability to give an interpersonal context to intrapersonal forces (ex. participants acting out different "part selves" to practice managing their inner critics and calling upon support from their inner caregiver).

"There was one activity where you had one person who was your inner-caregiver, the other person who was your inner-critic. And then they'd go back and forth, and you'd have to respond to it. I felt that was extremely helpful." -Teen 3

One participant found it difficult to benefit from the roleplaying exercises due to a difficulty getting into character.

"They (roleplaying exercises) weren't really (helpful), mainly because I was struggling to get into character I guess." -Teen 11

Another participant reported that they were reticent about roleplaying exercises but found the exercises preformed in group to be useful due to their applied nature in

helping them manage their anxiety (also conceptualized as the "inner worrier" part self) Two adolescents endorsed the guided imagery exercises due to its calming effects and the inner caregiver exercise for its ability to help provide them with a confidant to aid in personal needs-meeting.

Self-compassion as an outcome. Nearly all participants expressed developments along several facets of compassion. The common humanity dimension of compassion (according to Neff's (2016) model) was found to be an important element of several participants experiences. Responses indicated a shift from the opposite pole of isolation in their struggles and suffering towards a sense of camaraderie and communion in their suffering. The majority of participants were able to connect their struggles and suffering to the greater experience of human suffering, understanding that other teens experience difficulties and not everyone is perfect or lives a life without issues.

> *"I try to think that everyone has these thoughts from time to time, it is normal."*
> *-Teen 8*

> *I'm allowed to make mistakes because I'm human and I just like comfort, whatever*
> *I need to hear in the moment really." -Teen 3*

Other adolescents experienced a development in their overall understanding of compassion, their ability to notice suffering and a commitment to help relieve it. This took several forms from gaining the ability to notice their emotional state and needs in the moment to actively interrupting the cycle of self-critical attack as described by Teen 6 below:

"Before the program I would usually just attack myself but now I usually criticize myself but then I catch myself saying these things and then I make myself feel better by saying things like "It's okay, no one noticed" or "It's not that big of a deal we will overcome this". -Teen 6

Teen also demonstrated an ability to compassionately respond to her online FOI by engaging in radical acceptance:

"When I compare myself to other people online I usually think that I'm not skinny enough or that my life isn't as glamorous as theirs. Now I know that everybody's life is different and I was meant to look this way and that I don't need to change anything about myself because I am content." -Teen 6

Another element that is worth noting is Teen 3's expression of her difficulties utilizing compassion in the past. The following account represents an expression of barriers to compassion but was not sufficiently prevalent to warrant its own theme.

"It was a mix of not knowing what I needed at the time and not believing that I should be able to get help, thinking that I shouldn't be getting help or giving myself any compassion because I didn't deserve it. So, it was a mix between not really knowing what I needed or when I needed it, and not being able to pinpoint where I was at or

where my feelings were coming from and not believe that I deserve to know that and to

actually listen to it."-Teen 3

FOI reduction as an outcome. Half of the participants reported experiencing small decreases in their FOI in terms of frequency and intensity of the feelings. They described these reductions in FOI as the feelings and internal narratives as being less harsh and hurting less. It was clear that participants still actively experienced FOI but some of the burden had been alleviated post-group participation.

'It doesn't hurt as less and it happens less (FOI)" – Teen 2

"These thoughts (FOI) have decreased slightly after the program" -Teen 8

"It (conversing with inner caregiver) helped me figure out when I needed help, when I needed to hear and what I needed to say to myself to help myself comfort myself which has helped a lot and actually comforting myself through those <u>instead</u> <u>of just sitting there and looping through (self-critical thoughts)</u>" -Teen 3

One participant experienced small reductions in their overall experience of FOI but did not experience any decreases in their comparisons to others online as it related to their feelings of body dysphoria:

"*Yes I did compare myself (to others online). I still do. I've struggled with body dysphoria for so long that it's hard to not look at those and judge myself still."*
-Teen 11

Interpersonal changes. Post group participation some participants found themselves experiencing improved interpersonal relationship patterns. 2 of those participants were able to better interpret and respond to the emotions of others. Teen 2 reported that after the program he was better able to listen to and contribute to the needs of others, exemplified when his cousin and their partner were experiencing a conflict and Teen 2 asked how they were feeling and actively listened to their struggles. Prior to the program, Teen 2 said he would have likely not taken the time to listen to them and would have simply expressed his frustration at their conflict:

> *[The participant notes that before the group they would have said:] "What are you idiots doing? You love each other? Go!" -Teen 2 when asked how his pre-group self would have handled the situation*

> *[After the group they report responding in the following way:] "I like make sure their needs, like they're OK. And because I saw my cousin and his girlfriend weren't happy with each other today, I went over to both of them and because we're both friends and I went over to my cousin, I said, you good? Like, are you two OK?"-Teen 2*

Teen 3 expressed that her interpersonal patterns had ameliorated with her mother as a result of erecting healthy emotional barriers described in the following passage:

> *"When I'm trying to accept a shortcoming it's mostly with my mom because she's stressed out and she's frustrated and living in the house, a house with someone and having completely no boundaries is difficult because you're living with them. You need to have boundaries and you need a mutual respect and things like that. So, before I put*

any boundaries in place, almost anything she did would make me mad, let alone

something that she needed compassion for, so once I had boundaries in place it was

easier to like just calm down and be ok with it, with the fact that she needed help. So,

it was easier to help I wasn't so angry and bitter about everything else that I wasn't

setting boundaries for."-Teen 3

Group dynamics. The non-judgmental and communal environment created throughout the program proved to be a major theme in participant's experiences. The group dynamic promoted an environment where participants could freely share their experiences and reflect on those of their peers to help normalize and de-stigmatize their own struggles. This non-judgemental de-stigmatization created an atmosphere conducive to change and learning where participants would not be punished or mocked for making mistakes or expressing their struggles. Two of the participants expressed that they wanted more exposure to fellow group members or additional members to increase the experience of community.

"It was a really open space, and it wasn't judgmental, it was just like somewhere

where you could like yourself and it was OK." -Teen 3

"I'm still quite self-conscious, but being supported by people who I'm not that close

with was quite nice honestly. It didn't feel forced." -Teen 11

"Just having people around me that I can share my stuff with and have people that

will support me"-Teen 2

"What skills or activities from the group were most helpful to you?" "Hearing that

people had the same struggles as me." -Teen 8

"Just having people around me that I can share my stuff with and have people that

will support me"-Teen 2

3.5   FOI related themes

The second research aim - to explore the participants' understanding and experience of FOI, self-criticism, and self-compassion and how those understandings and their mental health were influenced by participating in the IHMB program - is represented by the themes FOI content domain and manifested FOI (see below, table 5). FOI content domain theme refers to which topic/activity they felt inadequate about. The manifested FOI theme covers how their FOI were manifested or instantiated; descriptors, resulting feelings and action impulses relating to FOI. The FOI content domain theme contains the subthemes of scholarly/academic, social, body image/appearance, online FOI and hobby activities. The manifested FOI theme is further divided into the self-attacks/thoughts, and behavior subthemes.

Results suggest that most participants had multiple triggers and targets for their FOI, usually with one topic in particular that was the prime incitement for FOI. Participants also often described other subtopics that additionally incited FOI. Participants expressed a wide variety of manifested FOI including overt self-attacks, constant comparison to others and expressions of lament for missing what made them

feel inadequate. Participants experienced the manifested FOI as painful and demoralizing internal forces.

Table 5
FOI related themes and subthemes

Theme	Subthemes	Definition	Examples
FOI Content Domain	Scholarly/Academic	*Content relating to test performance and public speaking through presentations*	*"School, sports and social activities" -Teen 8* *"Performances and presentations" -Teen 11*
	Social	*Content relating to socialization*	*"The way I look, my social skills"-Teen 6*
	Body Image/Appearance	*Comments concerning feelings of inadequacy relating to physical appearance or traits*	*"Physical looks, like anything like that that I feel like people could judge me on" -Teen 3*
	Online FOI	*Relating to online content generating FOI*	*"I did compare myself (to others online) and I still do. I've struggled with body dysphoria for so long that it's hard to not look at those and judge myself still." -Teen 11* *"When I compare myself to other people online I usually think that I'm not skinny enough or that my life isn't as glamorous as theirs." -Teen 6*
	Hobby Activities	*Extracurricular pursuits, sports, interests*	*"School, sports and social activities" -Teen 8*
Manifested FOI	Self-attacks / thoughts	*Specific thoughts or critical statements identifying the ways in which one is not good enough*	*"Oh God damn, like, like I suck and stuff and I'm the worst human being ever" -Teen 2* *"I'm not smart enough, I'm not pretty enough, I'm not fit enough, I'm not good enough in general." -Teen 3*

Behavior	*The actions of outcomes of having FOI (e.g., procrastination, cutting, suicide)*	*"And it makes you want to like sit down and do nothing." -Teen 2* *"It did however used to just be me beating myself down without caring." -Teen 11*

3.5.1 *Manifested FOI*

Self-Attacks/Thoughts. Adolescent's expression of self-attack/thoughts fell into three broad categories. The first was general self-attacks and thoughts that did not express an overt motivational component, the second included an overt motivational component and the third related to teens expressing concerns with contingent value. The first category consisted of self-directed statements such as:

"I'm not skinny enough, My life isn't as pleasurable as theirs." -Teen 6

Or

"I'm not smart enough, I'm not pretty enough, I'm not fit enough, I'm not good enough in general, just like full on...I'm not talented enough, not motivated enough, it's just a full on. I'm not enough in general for anyone."-Teen 3

In the second category of self-attacks a more salient motivational component can be observed:

"So if I'm like pissed at myself and I'm in a hockey game in a stressful situation, then I'll be like "Oh damn it, get your shit together bro!"-Teen 2

Or

"You need to get better or you aren't going anywhere." -Teen 3

Lastly, three adolescents expressed contingent value, where their performance is related to their value as a person and regulates the esteem of important people in their lives.

"Sometimes I feel like if I get a bad grade on a test the teacher and my parents will think poorly of me." -Teen 6

"I'm a straight-A student and it's both unfortunate and fortunate for me because I need to be a straight-A student for university and everything like that, because I need to get scholarships because money is expensive. I don't have that. My family doesn't have that. So, it's kind of always been a thing like you need to be better, you need to be the best or you aren't going to get anywhere. And then after a while, it stopped becoming like this thing that I would be praised for, and it started becoming this thing that everyone expected. So, it wasn't like this thing that I could be happy or proud of anymore. It was just this thing that everyone expected me to be doing. And it, it just it sucked because I didn't if I wasn't good enough, then I was letting everyone down and everyone was looking at me as if I wasn't good enough as well as myself. So, it just kind of sucked."-Teen 3

"I feel worth less in society occasionally and I try way too hard to belong even though according to others I already belong."-Teen 9

Behaviour. Three participants expressed their behavioural impulses associated with FOI; procrastination, succumbing to their own self-critical harassment and perpetuating the cycle of self- critical attacks.

"Yeah, a lot of the time, like, say you're trying to do a school project or something like that, like the minute you start to think to yourself constantly, I'm not good enough at this. I'm not good enough at this. Like it brings it for me. It brings my motivation to do the project in the first place down. So, when I'm instead of doing the project to my full capabilities, I'll put off the project and put it off and put it off and procrastinate in it, doing the last minute and not do as well as I could of if I actually put all my effort in. And it's all because I didn't think that I was good enough at it. So, I shouldn't have tried person. Similarly, to try new things like it makes it harder to try a new thing because I'm so scared that I won't be good enough at that new thing and everyone will just judge me." -Teen 3

"It makes you want to like sit down and do nothing." -Teen 2

"It did however used to just be me beating myself down without caring." -Teen 11

4   Discussion

The current study set out with the aims of exploring participant's experiences in the IHMB program, assessing the future viability of such groups, and exploring participant's experience of FOI, self-criticism and self-compassion within the context of the IHMB program. Participants offered a wealth of detailed feedback describing their experiences in the IHMB program and their personal navigation of mental health struggles and the intricacies of adolescent life. To summarize the findings, participants entered the program with heterogeneous needs and issues ranging from bullying, high parental expectations, anxiety, gender identity struggles and much more. Each participant found something in the program that was useful to them, gains which were not strictly limited to the development of self-compassion but included learning assertiveness, experiencing feelings of acceptance and camaraderie and normalization of their struggles and mental health difficulties. While the quantitative data presents some indication of individual directional change, statistical significance was not found, and the quantitative results may have been subject to measurement error related to inconsistent responding. Upon examination of the qualitative data, the benefits of the program became far clearer and thus the discussion will be focussed on the qualitative data.

4.1   Detailed exploration of participant experiences

All activities in the program were considered helpful to some degree. The two most helpful activities were practicing breathing at home and assertiveness training in the group (see table 5). In comparison, to practicing breathing at home the other home practice exercise, imagery at home, was endorsed at a noticeably lower rate (8/9 vs. 1/9 respectively). One possible explanation for this disparity in home practice helpfulness

could be because other home practice exercises may have required more effort and focus, one example being practicing imagery at home, which was the least endorsed home exercise (n=1). Mindful breathing exercises are likely to be simpler to practice as the only requirement is using the experience and motion of breath to ground one in the present moment to regulate emotional arousal levels. Imagery exercises on the other hand, are not rooted in an involuntary, consistent biological function, and require both the imaginative capacity to build and focus on an image of a compassionate caregiver, along with the cognitive flexibility required to refocus on this imagery in the event of distraction. For future iterations of the program and other CFT groups, it may be advantageous to assign low-complexity home practice exercises to give adolescents greater access to feelings of mastery and successful independent practice. Adolescents can benefit from imagery exercises but perhaps the most effective way to implement these exercises is in a group setting where participants have the additional support and co-regulation of their cohort mates and the facilitators to aid in attempting more complex exercises (Cheung, 2014).

The assertiveness training being rated as the other most helpful exercise may hint at a need for additional assertiveness training for future groups and adolescents overall. Assertiveness is an important developmental skill that has been shown to decrease self-criticism and promotes an internal locus of control (Çeçen-Eroğul & Zengel, 2009). Assertiveness training focusses on socially acceptable and adaptive methods of sharing thoughts, emotions and other expressions that occupy a balance between excessive passivity and shyness versus lacking sensitivity to others needs or bullying others in conversation and interaction (Parray & Kumar, 2017). Assertiveness training has been shown to benefit not only unassertive individuals but also adolescents with average levels

of assertiveness and has been shown to play a role in regulating aggressive behaviours

(Parray & Kumar, 2017). This finding was echoed by Teen 4 (male, age 13) who found

they were less aggressive after engaging with the assertiveness training session, stating

that they simply weren't aware of another option rather than outright social

aggressiveness.

Per the CFT literature, the way in which we relate to ourselves (self-to-self

behaviour) is informed by our interpersonal behaviour (Gilbert, 2014). Training a skill

interpersonally can act as a model to help shape self-to-self behaviour, in this case

interpersonal assertiveness training being used to inform more adaptive self-to-self

relation. Self-assertion is a valuable tool that allows a person to resist some of the

negative effects of a berating inner critic by neither relenting to its attacks nor

aggressively trying to silence or fight this part self (Gilbert, 2014). Using assertion to

hold ground against the inner critic interrupts the cycle of self-attack and submission

(described as anger turned inwards by Freud (1900)) implicated in the maintenance of

depression and anxiety (Blatt, 1974; Mongrain & Leather, 2006). Interpersonal

assertiveness also implicitly involves an affirmation that "I matter" or "my needs matter"

which can shift one's intrapersonal sense of being worthy of belonging or adequate in a

core sense. Adolescents raised in homes that promote self-criticism (unrelenting parental

standards, psychological control, or parental rejection) or that experience peer harassment

are likely to benefit from learning to express their emotions and needs in an assertive

manner. Developmentally, many children may not have had access to models of healthy

assertiveness or the space to learn this skill due to navigating environments where

acceptance is contingent or withheld and non-compliant behaviours jeopardize this

acceptance. In such environments, children can resort to attention seeking social strategies such as passiveness, over-compliance, or destructive behaviours. These behaviours are done with the goal of securing love and acceptance or at the very least attention (Gilbert & Irons, 2005; Gilbert & Irons, 2009; Kopala-Sibley et al., 2013).

As assertiveness is such an important skill and has been reported to be one of the most useful aspects of the program, it could be advantageous for future iterations to include more material and exercises based around assertiveness such as challenging participants to speak up as to how they feel their needs are being met by the group or by strategizing and roleplaying where they could apply assertiveness in their lives in an adaptive manner. CFT's focus on intrapersonal forces and self-to-self dialogue present a valuable opportunity to augment interpersonal assertiveness training by facilitating its ability to shape the self-to-self relation. The IHMB program incorporated roleplaying exercises that focused on interpersonal assertiveness and other scenarios playing a participant against their inner critic to help improve internal relations. The exercise incorporating the inner-critic was not explicitly focused on assertiveness, but perhaps this could be an element that could be tuned towards being more explicitly about practicing assertiveness with the inner-critic to maximize internal and external benefits.

Participants endorsing items as unhelpful occurred at far lower rates when compared to participants endorsing items as helpful (56 total helpful endorsements vs. 13 total unhelpful endorsements). The item that was most frequently endorsed as being unhelpful was talking with other teens. While this is a small portion of the group it provides information that the qualitative gains in common humanity and the positive regard towards being in a non-judgmental group are not unilateral. An explanation of

these endorsements can possibly be found in one piece of written feedback we gathered concerning participant's experiences in the group. Teen 7 (female age 14), who started the program in a group format and later transitioned to 1 on 1 sessions due to attrition said, "I have social anxiety and it was hard for me to open up and I often felt either put on the spot (or) excluded.". This response would suggest that in future iterations screening procedures may have to be additionally explicit about the nature of the exercises and the discomfort they may generate. There is also potentially a case to be made for excluding adolescents with social anxiety without a prior commitment or goal to improve upon socially anxious behaviours in a group context. In addition to endorsing talking with other teen's as being unhelpful, Teen 7 also endorsed talking with other teens as harmful. This was the lone harmful endorsement and can be understood that participating in a group format caused them some distress that could be interpreted as harmful.

One interesting finding was that the assertiveness training received no endorsements as harmful. This differs from the Bratt and colleague's (2020a) participant that experienced negative peer reactions to her asserting herself and setting protective boundaries. As this program was facilitated during various stages of lockdown it is possible that the participants may not have had ample opportunity to "test drive" their growing assertiveness skills with their peers at the time of data collection. An aspect of assertiveness training that CFT is well suited to augmenting is learning to deal with the potential fallout or drawbacks of learning assertiveness, in the case of Bratt et al., (2020a), friend abandonment and loneliness. As Gilbert (2017) said, self-compassion is not merely soothing and being nice to ourselves, it is concerned with reducing our suffering. Assertion through setting boundaries against unacceptable behaviour is one

such avenue. CFT can offer training in the skills to effectuate the assertiveness and also manage the emotional and social consequences through self-support and the self-kindness aspect of compassion.

4.2   **FOI content domains explored**

All the FOI content domains recorded reflected contexts that are inherently evaluative. This reflects the nature of FOI firstly being a preoccupation with the assessments and judgements of others that serve to shape an individual's internal model for self-acceptance and worth (Gilbert & Irons, 2009; Thomson & Zuroff, 2004).

4.2.1 *Academic/Scholarly*

The emergence of academic subtheme category being a strong FOI content domain is expected as academic performance is a common determinant of conditional parental acceptance (Scharf et al., 2016). The prevalence of academic/scholarly FOI is consistent with findings that adolescent experiences with education are becoming increasingly more competitive, playing a contributing role in adolescent depression (Weinberger et al., 2017). When a child performs poorly at school, they may face the ire of their teachers, the failure to reach academic standards required for post-secondary success and the possible threat of the perceived removal of love and acceptance from their parents. This dynamic may be distressing and a creates opportunities for the adoption of strategies such as perfectionism (Gilbert et al., 2004). It is however important to note that feeling inadequate and engaging in self-criticism is a normal, human experience and does not in and of itself necessitate clinical intervention. FOI in a domain of goal pursuit can act as a reminder to maintain focus and improve said domain and when balanced out with self-compassion can result in a sustainable, goal-driven mindset.

Issues arise when there exists an insufficient self-compassionate buffer and the self-attacks are vicious and chronic, leading to an erosion of wellbeing (Mehr & Adams, 2016)

    While teaching self-compassion skills to adolescents can generate a variety of benefits, academic/scholarly content appearing in most participants highlights the importance of engaging adolescents' parents in any compassion focussed therapy process or intervention (Bluth & Blanton, 2014; Hoffmann et al., 2011; Karimi et al., 2020). The reason behind the imperative for parental inclusion is that cultivating an outlook of intrinsic value and self-support in the face of failure is difficult to maintain when your primary caretakers continue to critically enforce that your value is directly related to your output. With parents involved this creates a greater opportunity to examine and change the critical patterns that maintain the worst of FOI and perfectionism (Bratt et al., 2020b; Psychogiou et al., 2016).

4.2.2 *Online FOI*

    The impact of social media was apparent in four cases amongst the post-test open-ended surveys. Teen 6 offered up a detailed account of their experiences with online FOI, previously quoted in section 3.4:

"When I compare myself to other people online I usually think that I'm not skinny enough or that my life isn't as glamorous as theirs. Now I know that everybody's life is different and I was meant to look this way and that I don't need to change anything about myself because I am content." -Teen 6

This quote represents a powerful shift in self-relating, where we can see how previously Teen 6 had many markers of online comparison, falling for the illusion of highlight reels (Steers et al., 2014). The manner in which the participant decided to support themselves when dealing with these difficult feelings was by radically accepting and affirming their own appearance as being acceptable and somewhat destined. From his quote the participant appears to, rather than challenge the illusory nature of the highlight reels, accept them as they are, representations of other people living completely separate lives from hers.

One of the four adolescents experiencing online appearance-based FOI reported a phenomenon pertinent to transgender individuals known as body dysphoria, not be confused with the term body dysmorphia. Body dysphoria is a state of distress and disconnection from their bodies that transgender people experience due to their physiology not matching with their felt sense of gender and has been implicated in harsh self-criticism (Martin & Coolhart, 2019; McGuire et al., 2016).

4.3   **FOI manifested**

4.3.1   *Self-attacks/thoughts*

The FOI data collected only reflected the FOI facet of self-criticism with little to no content that could be justified as self-hatred (Gilbert, 2004). This is a curious finding as several participants expressed suicidality and high pre-test scores indicating heightened mental distress. This finding created the expectation that there would have been some self-hatred content as it is correlated with suicidal ideation (Gilbert et al., 2004; Kopala-Sibley et al., 2013). The lack of self-hatred content could be a result of the questions not explicitly asking after this facet of self-criticism. Another possible

explanation for this lack of self-hatred in the findings is that FOI may over time evolve into self-hatred. Hatred is anger or disgust sustained over a long period of time, distinct from bursts of anger or other more temporary emotions. Much in the same manner, the sustained self-directed anger, shame, and disgust at one's inadequacy could feasibly evolve into self-hatred. It's possible that without intervention many individuals who struggle with FOI in their youth may eventually grow to develop self-hatred. This suggestion however would need to be substantiated with a sufficiently powerful longitudinal investigation.

According to the self-criticism literature, FOI can act as a source of maladaptive motivation which can lead some individual's towards developing positive associations towards their FOI as being a "necessary evil" (Ahmad & Soenens, 2010; Bleys et al., 2018; Hong et al., 2017; Mehr & Adams, 2016; Thomson & Zuroff, 2004). This affiliation with FOI and belief that an individual needs to be hard on themselves in order to perform at their highest capacity is a form of fear of compassion; that letting go of their inner critic or embracing compassion will lead to an unpleasant outcome such as lost productivity (Gilbert & Mascaro, 2017). This fear of compassion did not appear in this study and participants experienced their FOI solely as a negative phenomenon. Quoted in results section 3.7.2, Teen 3 offers a highly detailed account of a self-critical cycle. This is the most fleshed out and reflective account of self-criticism that was collected. This quote reflects many key facets of FOI, preoccupation with performance leading to perfectionism and an inability to feel pride and joy at accomplishments as one's internal standard is continually out of reach (Gilbert et al., 2004; Thomson & Zuroff, 2004).

Other participant's accounts of their experiences with FOI were not as extensive as Teen 3, yet were clear in their conceptualization of FOI as a negative motivator, whether it was providing a reminder that a teen may be viewed poorly socially for not being attractive enough or not performing adequately at sports or hobbies. A salient aspect across the FOI self-attacks/thoughts theme was how many of the statements reflected concerns of self-worth. Statements concerning their intrinsic worth, worth to their parents and worth to society all tie into a key aspect of depression, low self-worth (American Psychiatric Association, 2013; Burwell & Shirk, 2006). As this is a strong commonality amongst this sample, it may be advantageous for future groups to consider a greater degree of focus towards soothing some of the harsher self-worth beliefs that can result from chronic FOI. The belief in intrinsic human value being separate from our productivity can be considered a countercultural and counter-capitalist value. Due to its cultural entrenchment, it may prove to be a significant challenge in transmitting this ideal to participants thus requiring a multi-faceted approach, harnessing multiple aspects of CFT's toolbox. One exercise that could aid the goal of developing intrinsic self-worth could be performed through compassionate roleplaying exercises where a person acts out another's self-worth FOI, as another individual provides compassionate support and reassurance.

4.3.2 *Behaviour*

In the data collected, most participants readily shared the content domains and thoughts associated with their FOI, but a minority communicated the behavioural impulses associated with FOI. This could be a result of the interview questions being more concerned with the emotions associated with FOI rather than the resulting actions

or impulses. One example of this is that the writer was able to observe participants in group discussing procrastination issues, a common FOI-fuelled behaviour (Ferrari, 2005; Hawkins, 2016; Sirois, 2014), yet those struggles did not appear in any qualitative data except for Teen 3's account. This may also indicate that more emphasis needs to be put on helping adolescents make the connection between the FOI and how it drives behaviour that may be maladaptive or lead to counterintuitive cycles (e.g., I feel bad, so I shame myself for feeling bad, making me feel worse). With a greater understanding of these cycles of behaviour there is an increased chance that adolescents will be able to attend to their needs in the moment and interrupt these cycles.

4.4   Participants development of self-compassion

The two most prevalent avenues for the development of self-compassion in this sample was through participants crafting statements of self-support and destigmatizing their struggles by being amongst their peers. What was noticeable about the nature of the self-support statements was they were based around what the participant needed to hear in the moment, rather than blithe platitudes. Examples such as "I try to think that everyone has these thoughts from time to time, it is normal." (Teen 8) and "I'm allowed to make mistakes because I'm human and I just like comfort, whatever I need to hear in the moment really." (Teen 3) demonstrate an active response to their in-the-moment needs. This is a salient example of what defines CFT as being more than just being nice to yourself, in that it helps to cultivate responsivity and the will to act rather than just applying general self-directed positivity to struggles.

Similar to Bratt (2020a), strong themes of common humanity and normalizing mental health struggles were present in the findings. Self-stigmatization is strong aspect

of struggling with mental health issues and can lead to isolation and FOI when compared to their peers (Kranke et al., 2015). Bratt (2020a) discussed how CFT has the potential to empower youth with mental health struggles through normalization and de-shaming through candid conversation. The results of this study suggest participants gained measures of empowerment by engaging with the group and learning to accept that their struggles are one piece of a greater whole shared by their age group peers. Teen 11's expression of desire to have more group interaction and the strong support for the roleplays gives credence towards the importance of continuing to give adolescents opportunities in group to share their struggles and form bonds amongst each other.

Teen 3's self-compassion development is worth expanding on further due to it being a good example of a prototypical CFT client. Teen 3 was able to effectively describe her FOI, the impact it had on her life and then post-participation make effective use of the inner caregiver metaphor to soften the impact of FOI. Teen 3 also demonstrated strong gains across all three quantitative measures, demonstrating the 2nd highest reduction on the BFS scale (34 to 22), Third highest reduction on the DASS-21 (128 to 84) and demonstrated the largest gain in self-compassion according to the SCS-Y (3.25 to 3.89). The primary explanation for Teen 3's success in the program is likely because her primary issues were perfectionism and FOI compared to other participants whose concerns were issues such as peer harassment or gender dysphoria. One advantage that could explain Teen 3's benefits from the program is that she is the oldest participant at 17 years of age which gives her a greater chance of having more developed metacognitive abilities (Van der Stel & Veenman, 2014). In the context of CFT, having strong metacognitive abilities may help facilitate exercises such as tuning into the inner

caregiver and the functional analysis of self-criticism. Both of these activities require

thoughtful reflection on one's own internal motivations, thoughts and desires,

necessitating a certain degree of mental flexibility and metacognition. While this

reasoning is based on only one participant it does pose the question of whether

adolescents without sufficient metacognitive ability can fully reap the benefits CFT has to

offer.

4.4.1 *Emerging theme: fears, blocks, and resistances*

It was expected that more participants would express their difficulties and barriers

towards accepting compassion as these barriers often accompany self-criticism and FOI

(Kirby, 2019). In a larger sample size, it is likely that further accounts of barriers to self-

compassion would be expressed, the fact that Teen 3 was able to offer the account of her

difficulties (see results section 3.4) is concurrent with her reflective ability and reported

gains in the program. In Teen 3's account there are two barriers to compassion expressed.

The first is found in the segment *"So, it was a mix between not really knowing what I*

needed or when I needed it, and not being able to pinpoint where I was at or where my

feelings were coming from". This segment is consistent with a block to compassion, a

lack of knowledge regarding what is needed or how to act compassionately (Kirby,

2019). There is also an expressed lack of emotional awareness, in that Teen 3 was not

able to interpret their feelings moment to moment and thus hindered from responding

adaptively. The second barrier to compassion is found in the segment "*thinking that I*

shouldn't be getting help or giving myself any compassion because I didn't deserve it".

This segment demonstrates a resistance to compassion as it is an expressed or felt belief

that they do not deserve compassion as a result of being not good enough or an adverse

history with compassion that give it negative association (Kirby, 2019). This segment

also demonstrates self-judgement, a self-critical opposing pole to self-kindness in Neff's

definition of compassion (Neff, 2021).

4.4.2   *Concluding discussion of results*

Overall, this research provided preliminary evidence that the IHMB program was

able to offer a variety of helpful factors to participants with varied needs and gave

participants an opportunity to reflect on their FOI and how they relate to this mindset.

Participants' FOI were concerned contexts and activities that included competition and

evaluation by others. Most participants experienced FOI as a negative phenomenon with

some expressing a motivational component such as Teen 2 abrasively encouraging

themselves to try harder during a stressful moment in a game of hockey. Participants

were able to successfully develop self-compassion by primarily offering themselves

tailored statements of self-support during times of struggles and reflecting on the

common humanity of their issues in order to reduce self-judgment. In the following

section the discussion will explore the barriers and challenges experienced during the

effectuation of the IHMB program and this study. Following that, suggestions for future

iterations of the IHMB program and other comparable CFT groups will be made.

4.5   **Adapting to Zoom fatigue and use of cameras in session**

Over the year and a half since the IHMB program begun in 2020, there have been

many challenges in navigating the realities of facilitating an online group therapy session

during the Covid-19 pandemic. In the writer's own experience facilitating the groups, one

common trend that emerged was the reality of "Zoom fatigue" (Bailenson, 2021;

Wiederhold, 2020). Zoom fatigue has been described as a novel variety of social

exhaustion, anxiety, and irritability from over-use of online telecommunication platforms (Bailenson, 2021; Wiederhold, 2020). Bailenson (2021) has suggested that this type of social exhaustion could be caused by factors such as restraint on physical mobility, heightened self-monitoring due to a user's own video being displayed to them, increased cognitive load and excessive close eye gaze. Others have suggested this phenomenon is caused by microsecond moments of desynchronization between communicating parties that cumulatively create a cognitive burden as we mentally compensate for the tiny delays in information transmission which would otherwise be absent in person-to-person speech (Wiederhold, 2020). The exact cause of this phenomenon aside, in addition to navigating the regular challenges of maintaining a group, such as building rapport, trust, therapeutic presence and engagement, facilitators had to additionally mitigate the realities of Zoom fatigue in not only their participants but themselves.

In the writer's experience of facilitating two groups, it was often difficult to ensure participants kept their cameras and microphones active throughout the session. During the course of the second group, the facilitators decided to address this issue by employing a flexible approach, allowing for concessions on group norms during weeks where adolescents felt particularly burdened with the shifting realities of online schooling. This flexibility of expectations regarding communication granted adolescents further autonomy in their choice to participate in group matters, which coincided with the ideals of the IHMB program that include mindfulness and adaptive communication of their needs. This flexible approach to the use of cameras did not seem to disrupt the delivery of the material as participation was much the same regardless. Additionally, it did not impede the formation of bonds amongst the participants as all participants readily

shared their contact information amongst each other at the end of the program. For the
foreseeable future of online group therapies, it would seem to be adaptive to allow similar
levels of flexibility regarding video camera use, particularly in the context of added stress
during the pandemic.

4.6   **Future recommendation**

Future iterations of the program and other online CFT interventions could
potentially benefit from a fine tuning of the homework assignments, titled as home
practice assignments by the IHMB program. Research has shown that the assignment of
homework in psychotherapeutic practices has become accepted as a key tool in
psychotherapeutic progress (Miller, 2010). Without home practice to reinforce and
generalize the learned skills, the expectation is that the bulk of therapeutic gains will
happen during the session. The completion of homework is a goal which is subject to the
influence of various factors such as therapist presence and influence, matching the
assigned work to client needs and client buy-in to the therapeutic process (Miller, 2010).

The home practice assignments in the IHMB program are varied and designed to
reinforce in-session learning, encourage self-development, and further emphasize
compassion as an ameliorative skill. Home practice assignments consisted of activities
such as home guided meditations to explore mindfulness and feeling of self-compassion,
compassionate problem solving and practicing effectuating self-support in moments of
difficulty. Weekly trackers were provided to the adolescents as part of their program
workbook and homework would be debriefed at the beginning of each weekly session.
Careful attention was paid to not shame the adolescents for missing the homework as this
would be counter the ideals of the program. Instead, a structure of curious problem

solving was recommended to facilitators to direct focus away from ideas of failure or non-compliance and instead co-problem solve with the adolescents to strategize as to how they could overcome barriers towards completing the tasks.

Despite this adaptive and compassion-oriented homework delivery method, adolescent homework completion was very low. Frequently, (for the two groups that the author facilitated) during the homework re-cap queries about completion or attempts would be met with stark silence or reports of having too much schoolwork or not having enough time, despite many of the practices asking only five or ten minutes of their time. This difficulty could be the result of a few potential factors. The first amongst them being the difficulty that facilitators may have had in establishing social influence and a strong enough therapeutic presence (Miller, 2010; Weinberg, 2020).

The second possible explanation could be the lack of participant buy-in to the home practice assignments. Without the extrinsic motivation that is associated with school homework assignments participants would need to rely on intrinsic motivation to complete the homework. Without sufficient buy-in participants may have found it difficult to access the sufficient intrinsic motivation to complete the homework. For future iterations of this program and other online CFT interventions, a promising suggestion could be incorporating collaborative formulation in the assignment of home practice, in line with current therapeutic homework literature (Miller, 2010). To simplify facilitation, participants could possibly pick from a premade list of assignments or offer their own curriculum consistent suggestions. This will hopefully increase participant buy-in and completion as instead of the home practice being another academic assignment handed down to them it can hopefully be framed as a choice to grow and explore.

5   **Conclusion**

This pilot program was able to meet a diverse mix of emotional needs in its participants. Adolescents experienced a variety of benefits from participating in this program from learning the skills to shift the conversation with your inner critic, practicing healthy assertion or learning to have their own back through self-support. Many participants benefitted from sharing their experiences amongst peers who know what it is like to struggle in the navigation of adolescence. FOI were prevalent amongst surveyed participants and acted as impediments to goal pursuit and recovery after adverse events. Many participants learned how to adaptively respond to their needs in the moment, gaining a further ability to interrupt corrosive cycles of self-attack.

CFT has much to offer adolescents and youth and it would appear from the data gathered that most participants were able to absorb these lessons and apply them to their lives, gaining greater mastery over decision making in stressful situations and strategizing for improved interpersonal relationships. Those who struggle most with FOI have the most to gain from CFT, but as the data has shown, CFT can offer useful skills and experiences to participants navigating a variety of issues.

This study has been successful in illuminating a sample of struggles with FOI adolescents face today. Self-compassion has been instrumental in helping this sample improve their intra-and interpersonal relationships and demonstrates the potential of compassion as an ameliorative skill. While the field of adolescent CFT is still in its opening stages, this modality continues to show it has much to offer teens in their pursuit of healthy development, growth, mistakes, and recovery.

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Appendix A:

Post-test verbal interview

Introduction

Welcome to the interview. The purpose of our meeting today is to discuss your experiences of the CFT group and the impacts it may have had on you. Just like the CFT group, we are hoping that this space can be open and non-judgemental. Feel free to answer or pass any questions you want. We are hoping to have a good discussion about the group and your experiences of it. Do you have any questions before we start?

Experience of the group

1. *What was your overall impression of the program, did you like it, not like it?*

2. What skills or activities from the group were the most helpful to you?

3. Where there any activities from the group that you found unhelpful or harmful?

4. Did you find the imagery tasks helpful? Were you able to come-up with any images that were meaningful or emotionally activating? If you were going to change the imagery activities, what should be done differently/ For example were they too short, too long, too cheesy, to hard to vague?

5. Do you think you made progress on any of the top 3 problems you identified at the start of the group? If so what lead to the change?

Experience of self-criticism and self-compassion

Everyone is hard on themselves from time to time. We all say self-critical things to ourselves.

6. What situations are most likely to elicit self-criticism for you? What do you say to yourself when you are being self-critical? Did this change since you attended the CFT group? If so, in what ways?

7. Do you ever respond to difficulties, set-backs, or challenges using self-compassion? If so what do you say to yourself when you are being self-compassionate?

8. Since attending the group have you related to your emotional needs differently? For example, noticing your emotional needs and expressing them or trying to meet them?

9. Is there anything else you think the researchers should know about your experience of the group, your opinion about how the intervention might be helpful, or anything else at all?

Self-Criticism Scale

Now we are going to talk about that self-criticism scale you completed at the start and end of the group. I will put it in the chat so you can take a look at it on your own computer but I will also put it on my screen and share my screen so you can read it from there.

Take a moment and read all the questions. Let me know if there are any words you don't understand or any questions you don't understand. You can use the emoticon feature to give a thumbs-up when you are done. Take your time, its not a race.

We made this survey to try and understand teen experiences of self-criticism.

10. Are there any questions you think we should take out?

11. Are there any questions you think we should add?

12. Do you think these questions capture your experiences of being hard on yourself? If not, what are we missing?

Adolescent Inadequacy and Self-Compassion Interview

For the last part of the interview, we're going to talk about moments in your life when you just don't feel good enough or when you have to achieve something to be important or matter to others. This is part of feeling self-critical and we're hoping to understand what it's like to have these feelings as a teenager. Just like all the other questions, you can answer as many as you want or skip if you don't feel like answering the question for any reason.

1. In the program we discussed the "I'm not good enough" story (remind if necessary) and spoke about moments when we just don't feel good enough. When

you just don't feel good enough, what goes through your head, what thoughts come up?

2.

  -Follow-up Prompts:

  -Sometimes we feel as though we aren't able to do something, aren't strong enough, smart enough to do something we want, do you ever doubt yourself in this way and has this changed since the program? How so?

  - Some people can feel like because they can't do certain things, they are worth less or feel like they don't have value. Some also feel like they have to do really well at achieving or doing something to matter. Do you ever feel like this, and has it changed since the program? How so?

  -Before the CFT intervention, did you ever feel bad or not good enough when comparing yourself to others online? (Y/N) what context does this occur in, streaming, Facebook, Instagram?

-<If yes> What thoughts would go through your head when you were feeling this way?

<If no> What helped you overcome these feelings or avoid comparing yourself to others?

2. After undergoing the CFT intervention, are you able to better deal with feeling not good enough? (Y/N)

-<If yes> In your words, what changed in how you handle not feeling good enough? What helped you in that change?

<If no> Ask for elaboration on their coping or what makes it hard to deal with those feelings

2.b) is that also true for your online life?

3. Do you remember when we spoke about the flows of compassion (giving compassion to others, receiving compassion from others, and giving yourself self-compassion)? Have any of those flows changed since the program/ become easier or harder?

-<If easier> What are you doing differently now? Does it feel different?

<Harder or no change> What makes it hard to allow those flows? What do you think could be changed in the group if anything to make it easier?

4. Compared to before the program, do you feel more able to accept those you care about and their shortcomings?

6. Since the program, are you better able to stand up for yourself, take up space, or express needs?

7. What was the most useful aspect of the CFT intervention that helped you address your feelings of not being good enough?

8. What are some of the blocks, barriers, or difficulty you have experienced in

   compassionately responding to your feelings of not being good enough?

9. Is there anything else you want to tell us about your experience with the program, the

   skills or anything else in general?

Ending

So that wraps up the focus group. Thank you so much for your participation. The gift

cards will be emailed to the address you provided. If you have any questions or concerns,

feel free to get in touch with us by email and we will be happy to help.

Bye for now and thanks again!

Appendix B:

Written open-ended post-test questionnaire

1. Did you find the group helpful? Y/N?

2. How did the group help? For example, are you less depressed, less anxious, feel less alone, have more self-compassion and coping skills, have a different perspective, etc. Please write out any benefits you got from the group

3. What do think contributed to that change? Were there certain perspectives or skills you found helpful? What skills or activities from the group were the most helpful to you?

4. What was your experience of doing the role plays? Were they helpful? If so, how?

5. Was there something that you didn't like or that made it hard to benefit from the group?

6. Were there any difficult thoughts or feelings that made it hard to benefit from the group?

7. What would you add or change about the group to make it better?

8. Everyone is hard on themselves from time to time, What situations are most likely to bring up self-criticism for you?

9. What do you say to yourself when you are being self-critical? Did this change since you attended the CFT group? If so, in what ways?

For the last part of the questionnaire, we're going to talk about moments in your life when you just don't feel good enough or when you have to achieve something in order to

be important or matter to others. This is part of feeling self-critical and we're hoping to understand what it's like to have these feelings as a teenager.

10. In the program, we discussed the "I'm not good enough" story (We all say things to ourselves like I'm not smart enough, pretty enough, I'm not popular enough etc..) and spoke about moments when we just don't feel good enough. When you just don't feel good enough, what do you say to yourself? (ex. Do you criticize and attack yourself or try to support yourself?) Has this changed since the program?

11. Some people can feel that because they can't do certain things, they are worth less or like they don't have value. Some people also feel like they have to do really well at achieving or doing something to matter. Do you ever feel like this? Has it changed since the program? How so? Before the CFT intervention, did you ever feel bad or not good enough when comparing yourself to others online?

12. If yes, what thoughts would go through your head when you were feeling this way? Has this changed since participating in the program?

13. If you did not feel bad when comparing yourself to others online, was there anything that helped you or anything you said to support yourself?

14. Is there anything else you think the researchers should know about your

experience of the group, your opinion about how the intervention might be

helpful, or anything else at all?

Thank you so much for your participation. Your gift card will be emailed to you

shortly. If you have any questions or concerns, feel free to get in touch with us by email

and we will be happy to help. Bye for now and thanks again!

Appendix C:

Post-test survey group feedback section

This next set of questions asks about your experience of the I Have My Back Group.

Please answer honestly so that we can fine-tune the group to be as helpful to other teens

as possible

What activities from the group did you find helpful? Click all that apply:

- o   Talking with the other teens (1)

- o   Doing home challenges to "Have my back" (2)

- o   Thinking about my emotions as 'part selves' or crew members on a ship and that I

   am the captain   (3)

- o   Practicing breathing during the group   (4)

- o   Practicing breathing at home   (5)

- o   Practicing moving my attention around in the group   (6)

- o   Doing imagery in the group (7)

- o   Doing imagery at home (8)

- o   Learning about assertiveness   (9)

- o   Learning about the emotion regulation triangle   (10)

- o   Other: (11)

What other parts of the program did you find helpful? _____

What activities from the group did you find unhelpful, useless, or neutral?

Click all that apply:

- o   Talking with the other teens (1)

- o Doing home challenges to "Have my back" (2)

- o Thinking about my emotions as 'part selves' or crew members on a ship and that I am the captain   (3)

- o Practicing breathing during the group   (4)

- o Practicing breathing at home   (5)

- o Practicing moving my attention around in the group   (6)

- o Doing imagery in the group (7)

- o Doing imagery at home (8)

- o Learning about assertiveness   (9)

- o Learning about the emotion regulation triangle   (10)

- o Other: (11)

What were the other activities did you find to be unhelpful, or useless?

_____

What activities from the group did you find harmful?

- o Talking with the other teens (1)

- o Doing home challenges to "Have my back" (2)

- o Thinking about my emotions as 'part selves' or crew members on a ship and that I am the captain   (3)

- o Practicing breathing during the group   (4)

- o Practicing breathing at home   (5)

- o Practicing moving my attention around in the group   (6)

- o Doing imagery in the group (7)

- o Doing imagery at home (8)

o   Learning about assertiveness   (9)

o   Learning about the emotion regulation triangle   (10)

o   Other: (11)

What were the other activities did you find to be harmful?

_____

If you were going to recommend this program to a friend, what would you say?

_____

Would you want to rename the program? If so, what would you call it?

_____

Is there anything else about the program you think the program facilitators should know? For example other things you liked, didn't like, or should get changed? If so, please let us know:

_____

Appendix D:

Post-test survey subjective experiences section

This next set of questions asks about your experience of the I Have My Back Group.

Please answer honestly so that we can fine-tune the group to be as helpful to other teens

as possible

Rate the following statements based on how much you agree with them:

Strongly disagree (1); Somewhat disagree; (2) Neither agree nor disagree (3); Somewhat

agree (4);Strongly agree (5)

The program helped me feel better emotionally (1-5)

The program helped me improve my life (1-5)

The program helped me make friends (1-5)

The program helped me stand up for myself (1-5)

The program helped me feel like I matter (1-5)

The program helped my relationship with my parents / caregivers (1-5)

The program was fun (1-5)

I would recommend the program to a friend (1-5)

The program was a waste of time (1-5)

The program made things worse (1-5)

Please rate how much the following changed for you over the course of the group:

Much worse (1); Moderately worse (2); Slightly worse (3); About the same (4); Slightly

better (5); Moderately better (6); Much better (7)

Over the course of the group my mood got (1-7)

Over the course of the group my anxiety (1-7)

Over the course of the group my self-criticism (1-7)

Over the course of the group my ability to be kind to myself (1-7)

Over the course of the group my feelings of being an outsider (1-7)

Over the course of the group my belief that I matter: (1-7)

Appendix E:

Behaviour and Feelings Survey Youth (Weisz et al., 2019)

How much have you had each of the following problems during the past week?

Rate each item based on how much of a problem its been for you; 0= not a problem 4= a very big problem.

Not a Problem (0); Barely a Problem (1); Somewhat of a Problem (2); A Problem (3);A Very Big Problem (4)

My Thoughts and Feelings Rating (internalizing subscale)

I feel sad. (0-4)

I feel bad about myself, or don't like myself. (0-4)

I feel down or depressed. (0-4)

I feel nervous or afraid. (0-4)

I worry about bad things happening(0-4)

I think sad or scary thoughts over and over again. (0-4)

My Conduct and Behavior (externalizing subscale)

I talk back or argue with my parents or other adults. (0-4)

I refuse to do what adults tell me to do. (0-4)

I do things I am not supposed to do. (0-4)

I am rude or disrespectful to people. (0-4)

I argue with people. (0-4)

I break rules at home or at school. (0-4)

Appendix F:

Depression Anxiety Stress Scale Short Form (DASS-21)

How often has each of the following statements applied to you over the past week?

Did not apply to me at all (1); Applied to me to some degree, or some of the time (2);

Applied to me a considerable degree, or a good part of the time (3); Applied to me very

much, or most of the time (4)

I found it hard to wind down. (1-4)

I was aware of dryness of my mouth. (1-4)

I couldn't seem to experience any positive feelings at all. (1-4)

I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the

absence of physical exertion). (1-4)

I found it difficult to work up the initiative to do things (1-4)

I tended to over-react to situations (1-4)

I experienced trembling (e.g., shaky hands). (1-4)

I felt that I was using a lot of nervous energy. (1-4)

I was worried about situations in which I might panic and make a fool of myself. (1-4)

I felt that I had nothing to look forward to. (1-4)

I found myself getting agitated. (1-4)

I found it was difficult to relax. (1-4)

I felt down hearted and blue. (1-4)

I was intolerant of anything that kept me from getting on with what I was doing. (1-4)

I felt I was close to panic. (1-4)

I was unable to become enthusiastic about anything. (1-4)

I felt I wasn't worth much as a person. (1-4)

I felt I was rather touchy. (1-4)

I was aware of the action of my heart in the absence of physical exertion (e.g. sense of

heart rate increase, missing a beat) (1-4)

I felt scared without any good reason. (1-4)

I felt that life was meaningless. (1-4)

Appendix G:

Self-Compassion Scale Youth (Neff et al., 2021)

SCS-Y Please rate each item below based on how often it occurs to you.

Almost Never (1); Not Very Often (2); Sometimes (3); Very Often (4); Almost Always (5)

I try to be kind and supportive to myself when I'm having a hard time. (1-5)

When I feel sad or down, it seems like I'm the only one who feels that way. (1-5)

When I notice things about myself that I don't like, I get really frustrated. (1-5)

When I feel I'm not "good enough" in some way, I try to remind myself that other people sometimes feel this way too. (1-5)

When I feel frustrated or disappointed, I think about it over and over again. (1-5)

When something upsetting happens, I try to see things as they are without blowing it out of proportion. (1-5)

I get mad at myself for not being better at some things. (1-5)

When I'm sad or unhappy, I remember that other people also feel this way at times. (1-5)

I'm kind to myself when things go wrong and I'm feeling bad. (1-5)

When I feel bad or upset, I tend to feel most other people are probably happier than I am. (1-5)

When something difficult happens, I try to see things clearly without exaggerations. (11) (1-5)

I'm really hard on myself when I do something wrong. (1-5)

When things aren't going well, I keep in mind that life is sometimes hard for everyone. (1-5)

When I'm feeling bad or upset, I can't think of anything else at the time. (1-5)

I try to be understanding and patient with myself even when I mess up. (1-5)

When I'm really struggling, I tend to feel like other people are probably having an easier time of it. (1-5)

When something upsets me, I try to notice my feelings and not get carried away by them. (1-5)

SCORING KEY Self-Kindness Items: 1, 9, 15 Self-Judgment Items (reverse scored): 3, 7, 12 Common Humanity Items: 4, 8, 13 Isolation Items (reverse scored): 2, 10, 16 Mindfulness Items: 6, 11, 17 Over-identified Items (reverse scored): 5, 14 To calculate a total score, take a grand mean of the six subscale means after reverse-coding.

7   Curriculum Vitae

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**Post-secondary
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Western University
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