An examination of self-compassion among Canadian youth with and without a caregiving role

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Submitted in partial fulfillment
of the requirements for the degree

Doctor of Philosophy

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DEDICATION

I dedicate this PhD dissertation to my one and only mother, Maria Deich, who has fought to give her family the best life possible and who has instilled passion, creativity, and hard work in every core of my being. My mother, who left this physical world suddenly, was the best, brightest, and loudest cheerleader that anyone could ever ask for. Just know that you will forever be in my heart and my mind, always here with me, and that I will use every ounce of self-compassion to deal with losing you.

It is only fitting that I add here the one and only Russian phrase that she would have yelled out to me: "*NE PUHA, NE PERA*", to which I would have proudly yelled back "*K CHORTU!*" [literal meaning: "Neither down nor feathers". Equivalent to the English phrase: "BREAK A LEG!"].

ABSTRACT

Self-compassion occurs when people apply the same compassion towards themselves as they would towards others (Neff, 2003a, 2003b). Self-compassion has been shown to relate to positive mental health outcomes, such as reduced depression and lower anxiety (Neff 2003a), as well as increased happiness and optimism (Neff et al., 2007), but has yet to be studied with young carers (YCs), who provide significant care and compassion to family members due to various circumstances (e.g., illness, disability, substance use, language barriers, and age-related needs; Bleakney, 2014; Charles, 2011; Charles et al., 2009), leaving limited time for other activities, friends, or self-care (Sexton, 2017; Stamatopoulos, 2018; Szafran et al., 2016). This dissertation examined 1. Self-compassion in youth ages 12-18 years, by exploring its potential correlates; 2. Self-compassion in the context of caregiving for others via focus groups with 33 YCs; and 3. Self-compassion and Subjective Well-Being (SWB) among YCs (n = 55) in comparison to non-caregiving youth (n = 107). Study 1 found that while sex and age did not relate to self-compassion, positive affect, life satisfaction, honesty and humility, and agreeableness were positively related to self-compassion, and negative affect and emotionality were negatively associated with it. Study 2 revealed that caregiving for others may have reduced YCs' time for self-compassion, thereby possibly showing lower self-compassion. Finally, Study 3 found that YCs and non-YCs showed similar levels of self-compassion and SWB, which suggested that even though caregiving responsibilities may come in a way of self-compassion, it did not do so significantly. YCs' SWB was also not any lower than their non-caregiving peers, which could be indicative of some hidden protective

mechanism at play, such as resiliency. Implications for interventions and program modifications were discussed.

Keywords: Self-compassion, young carers, subjective well-being, caregiving, youth

ACKNOWLEDGEMENTS

To my biggest supporter, advisor, and mentor, Dr. Heather Chalmers, I just want to say THANK YOU, from the bottom of my heart. It has been such a fun ride, with you on my side, always looking out for me and taking care of me. I truly appreciate all of our moments together the past seven years at Brock. I came into Brock University, not knowing what it would be like, and since day one, you made it feel like home. Thank you for your efforts to make me a better person, writer, researcher, and a colleague.

I want to extend my gratitude to my committee members, Dr. Danielle Molnar and Dr. Heather Ramey, who have always given me such thoughtful comments that made me realize I have many more things to learn and to consider, to question and to wonder about. I really value how you made this process so enjoyable for me. You were incredible supporters and you have helped me grow as a young scholar!

I want to thank my external examiner, Dr. Tricia van Rhijn, and my internal examiner, Dr. Priscilla Burnham Riosa, who have made my PhD defence very exciting and have made me think of future projects. Dr. van Rhijn, I really valued your report and the questions that you asked me. Dr. Burnham Riosa, thank you for your thoughtful input regarding culture. I look forward to examining it in the future.

Of course, I would not have been able to do anything without my wonderful husband, Michael Berardini, who, believe it or not, used to help me with my English (back in grade 10 when I first came to Canada), and now I help him with his… YES, we have come full circle! You have been and will continue to be my ride or die for life! Thank you for holding the fort while I finished this PhD and always covering me, without questions asked.

To Victoria, my little angel. Thank you for always behaving for daddy, when mommy needed some time to write her chapters; thank you for sleeping from 7:30pm, so that mommy can write her dissertation at night; and thank you for sleeping through the night, because you probably knew, mommy needed her sanity! You are an absolute joy!

Sending huge thanks to my dear family and friends, daycare workers, and neighbours for taking such good care of Victoria, when I needed the extra time to work. I am so grateful to have had all this support during this process. I could not have done this without you.

To my department professors, colleagues, and administrative staff, you have always been there for me and it did not go unnoticed. Thank you so much for all your continual support. I will always cherish our conversations in the hallways or at your offices. I am forever grateful for the courses I took during this PhD journey, because without them, I wouldn’t have had the breadth of knowledge that I have today.

Of course, this experience was that much sweeter because of my incredible cohort, friends, and colleagues along the way. I won't name anyone in particular out of fear of missing someone, but please know that if I still keep in touch with you today, you mean the world to me and you have made this ride very enjoyable, so thank you.

Finally, this dissertation would not have been possible without the amazing community organizations along the way, who worked with me from the beginning by letting me use their facilities for data collection, talk to their youth, and schedule meetings. Special thank you to the Young Caregivers Association (Formally known as Powerhouse Project, specifically, Michelle Lewis, Cayleigh Sexton, and the St. Catharines and Haldimand-Norfolk crew and staff) and to Toronto Hospice for getting me connected with young carers.

And of course, to all the great participants: I am so appreciative of your time and efforts you put into being a part of my focus groups or answering my questionnaire. Your input was invaluable, and this study would be nothing without you. THANK YOU for your participation.

One final note: To 'COVID-19', you got nothing on me! I finished even when the odds were stacked against me, and you made me stronger, but please END, so that peace finally comes to those who have been affected.

Off to my next chapter now…

"Sometimes you get to what you thought was the end
and you find it's a whole new beginning" [Anne Tyler]

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CHAPTER 1: GENERAL INTRODUCTION

A Canadian survey on disability estimated that 3.8 million Canadians (or 13.7%) identified themselves as disabled in 2012 (Social and Aboriginal Statistics Division, 2013). When asked who provided care for them, individuals reported receiving ongoing support from family members, friends, neighbors, organizations or paid employees (Employment and Social Development Canada, 2011). This suggests that these individuals may receive some help from their own children within the family. Young people who provide care for family members because of specific circumstances (e.g., illness, disability, addiction, language barriers, age-related needs, and parental absence) are referred to as "Young Carers" (YCs) (Bleakney, 2014; Charles, 2011; Charles et al., 2009; Stamatopoulos, 2015). As awareness, identification, and support for YCs in Canada is still lagging (Waugh et al., 2015), YCs often represent a hidden, vulnerable group of children and youth. The purpose of the current series of studies was to expand the Canadian knowledgebase, by empirically testing YCs' self-compassion in hopes obtaining a better understanding of how it unfolds within young people who provide care for others. As such, the following section contains information about who YCs are and what they do, followed by sections on self-compassion and subjective well-being, as they are the main constructs in this dissertation.

1. The Story of Young Carers

Examination of international prevalence rates revealed that cumulatively, there are approximately 4-7% of YCs under the age of 25 who provide regular care to their family members (Banks et al., 2002; Becker, 2004 as cited in Smyth et al., 2011; McDonald et al., 2009; Nagl-Cupal et al., 2014). The last known Canadian provincial

prevalence study in 2012 revealed that 12% of high school youth (ages 12-17 years) self-identified as YCs in British Columbia (Charles et al., 2009). Two years later, data from the 2012 General Social Survey (GSS) on caregiving and care receiving showed that approximately 1.9 million (or 27%) of Canadians between the ages of 15-29 years were YCs (Bleakney, 2014). The first and only Canadian-based study based on census data, covering the years of 1996 to 2006, showed that 28.2% of children and youth, between the ages of 15 and 24, identified as YCs as they provided unpaid care to their family member(s) (Stamatopoulos, 2015). Overall, it is important to note that Canada's prevalence rates are much higher than other places in the world. This, of course, could be attributed to differences in how the question of 'who is a YC' was asked as well as how researchers defined YCs (e.g., age restrictions, caregiving tasks). It could also indicate differences in social service provision and beliefs about role of children in society.

The lack of consensus about YCs' definition and age range make it very difficult to identify and support all YCs. Whereas some researchers focus on the reasons that increase the need for YCs' such as family members' disability, illness, drug or alcohol problems (Banks et al., 2002; Nagl-Cupal et al., 2014; Remtulla et al., 2012), others have expanded the definition by looking at the unpaid nature of this work (Stamatopoulos, 2015). The underlining fact that is inherent to the definition is that the caregiving tasks often exceed what is considered 'normal' for the young people's developmental age (Charles, 2011; Miller, 2012; Smyth et al., 2011). Within Canada, results showed that the YC label was uncommon, but much needed for better identification (Waugh et al., 2015). Moreover, the age criterion has also been fluctuating throughout the years. Past literature on YCs used to include youth under the age of 18 years, but currently contains those

under the age of 25 years (Stamatopoulos, 2015). In some cases, it is even more inclusive (e.g., under the age of 30 years) (Bleakney, 2014). In the context of the present studies, the targeted sample of YCs included children and youth between the ages of 12 to 18 years, who provided unpaid care to family members for a variety of reasons (e.g., disability, illness, addiction, parental absence, and language barriers). This age range was chosen for several reasons: 1. Middle childhood has been a common onset for caregiving (Fives et al., 2013; Kavanaugh et al., 2014; Lakman, 2015; Marote et al., 2012; Shifren & Kachorek, 2003). 2. The self-compassion scale is most reliable for ages 14 years and older (Neff, 2003a), however, since previous studies have suggested that YCs may be more mature for their age (Chalmers & Lucyk, 2012; Nagl-Cupal et al., 2014), age 12 seemed reasonable. 3. From age 12 years and onwards, the formal operational stage begins, where children and youth show increases in their cognitive capacity and use more self-regulation and self-reflection (Bjorklund & Blasi, 2012). 4. Beyond 18 years of age represents the start of post-secondary education, which might be restricted for some YCs (Hamilton & Adamson, 2013; Warren, 2007) or might result in a change in how care is provided (if at all), given they might leave their homes, thus the chosen cut-off of 18 years of age seemed more appropriate to ensure some homogeneity with middle and high school mandatory school experiences and greater likelihood of living at home.

As awareness of YCs has grown, researchers have begun to explore YCs' caregiving role and its potential impacts. A profile of a YC has started to emerge (Lakman & Chalmers, 2019). A number of studies have revealed that some YCs begin caregiving around middle childhood (e.g., 12-13 years of age; Lakman, 2015; Marote et al., 2012). Of course, it has to coincide with a "need", which is often the reason for such

care. Some studies that examined reasons for care found that it could include (but not be limited to) disabilities, physical/mental illness, and other health or age-related conditions (Banks et al., 2002; Fives et al., 2013; Nagl-Cupal et al., 2015). Their responsibilities included household tasks, general care, sibling care, medical/nursing care, financial care, and emotional support (Fives et al., 2013; Joseph et al., 2009; Lackey & Gates, 2001; Marote et al., 2012; McDonald et al., 2009; Nagl-Cupal et al., 2014). With regards to who is more likely to be a caregiver, some studies found that YCs are overrepresented by the female gender (Fives et al., 2013; Kavanaugh et al., 2014; Marote et al., 2012; Stamatopoulos, 2015). Moreover, the need for YCs is higher among those who live in single-family households, where no one else is able to accomplish some of the responsibilities (Fives et al., 2013; Ireland & Pakenham, 2010; Lakman & Chalmers, 2019; Metzing-Blau & Schnepp, 2008).

This knowledgebase has generated a few comparative studies that examined how many responsibilities YCs completed in relation to their non-caregiving peers and their potential impact. One common finding is that YCs often completed more chores and spent more time on caregiving tasks than other children their age (Becker, 2007; Nagl-Cupal et al., 2014; Warren, 2007). Many qualitative and quantitative studies, and only a handful of comparative ones, have suggested that caregiving has been reported to be associated with various emotional, psychological, social, and educational disadvantages (Chalmers & Luyck, 2012; Lakman & Chalmers, 2019; Lakman et al., 2017; Metzing-Blau & Schnepp, 2008; Moore et al., 2009; Nagl-Cupal et al., 2014). A literature review revealed that many YCs experienced stigma, bullying, social isolation, health problems, restricted futures and other limitations (Marote et al., 2012). A recent article noted a

‘caregiving penalty’ (Stamatopoulos, 2018), where YCs showed disadvantages in areas of social engagement, education, and family life, which illustrated just how serious the negative impact can be.

Much less is known on the positive outcomes that YCs experience. From what is known, some YCs have recalled positive consequences from their caregiving role. In a review of the literature, Marote and colleagues (2012) found that many YCs developed responsibility, maturity, better attachments, self-efficacy, feelings of belongingness, and intelligence. Other positive outcomes included feeling more useful, brave, capable, and proud (Bolas et al., 2007) or feeling needed, appreciated, and important, while also becoming more caring and nurturing (Lackey & Gates, 2001). A Canadian study of former YCs noted that they became more responsible, independent, gained a sense of community responsibility, developed better relationships, and became more compassionate and sympathetic (Szafran et al., 2016).

These positive outcomes were related to several important factors. When YCs focused on the positive side of their situation and believed that they could do it, they experienced more positive outcomes (Doutre et al., 2013). When they valued their caregiving role and found benefits in it, they were less likely to experience negative outcomes and distress (Cassidy & Giles, 2013). When they had a balance and support from their parents, they did not report severe impact on education and social lives (McDonald et al., 2010) and less distress (Pakenham et al., 2007). Finally, when they felt they had a choice in caring, they had greater life satisfaction, positive affect, and lower distress (Pakenham et al., 2007). Therefore, it is possible that with some positive outlook or some inner strength, some YCs are able to thrive.

The limited exploration of positive constructs creates a large gap in the literature. Thus, the present studies examined two constructs that yet to be addressed in the YC literature, as far as I know. The following section elaborates on constructs of self-compassion and subjective well-being (SWB) and establishes the link to YCs' caregiving, pointing out where further research is needed.

2. Self-Compassion

2.1. Compassion versus Self-Compassion

Compassion can be understood as an affective state, in which a person is showing concern and care for others and feeling for another person's state, thereby getting motivated to help them (Goetz et al., 2010; Singer & Klimecki, 2014). Importantly, it is an 'other-oriented' or 'other-focused' response (Goetz et al., 2010). It is related to other terms, such as sympathy, empathic concern, and pity (Goetz et al., 2010). Neff (2003a) wrote that whereas "compassion involves being open to and moved by the suffering of others, so that one desires to ease their suffering…self-compassion involves being open to and moved by one's own suffering…" (p. 224). Self-compassion is a reciprocal golden rule, where people reciprocate the compassion that is usually directed at others towards themselves (Neff, 2003a, 2003b; Reyes, 2012). Self-compassion is a healthy attitude or an emotional regulatory strategy that is applied to the self (Neff, 2003a). Upon experiencing something negative that yields suffering, a person who applies self-compassion can maintain self-kindness, keep negative emotions at a mindful state, and get reassured that others may go through similar experiences, thus having the aspect of 'common humanity', instead of isolating themselves from others, self-criticizing themselves, or getting overidentified with emotions (Neff, 2003a, 2003b). For self-

compassion to exist, a state of suffering or a negative situation must precede it (Reyes, 2012). Self-compassion is different from other constructs such as self-pity, self-indulgence, and self-esteem as it is neither about over identifying with one's own negative emotions, nor about evaluating oneself in comparison to others (Neff, 2003a, 2003b, 2004). It is more related to self-empathy or emotional regulation, and is rooted in humanistic psychology (Neff, 2003b). Overall, self-compassion can be understood as a state (e.g., healthy attitude, an emotional regulation strategy) and as a coping mechanism (e.g., skill) (Neff, 2003a, 2003b, 2019; Neff et al., 2005).

2.2. Self-Care versus Self-Compassion

When examined separately, self-care and self-compassion represent two separate constructs. The World Health Organization (WHO) defines self-care as one's ability to promote health by using factors or processes (behaviours) to obtain hygiene, nutrition, and lifestyles that are conducive to maintaining health (WHO, 2020). Self-care includes practices (e.g., behaviours) that individuals engage in to obtain a better overall well-being and health (e.g., healthy eating, sleeping, exercising) (Coleman et al., 2016).

Despite self-care and self-compassion constructs representing distinct areas (a behaviour versus an attitude, respectively), the two terms get used together because they are related, as they both represent one's need to care for the self (Andrews et al., 2020). The similarity between them is rooted in the fact that self-care and self-compassion are both directed inwards and hence contrasted from outward compassion (Andrews et al., 2020). Moreover, two recent dissertations concluded that not only are the two terms related (Mills, 2018), but that self-care also predicted self-compassion (Macedonia, 2018). This is in line with other studies that suggested that self-care is a broader term that

encompasses ‘self-compassion’ as a strategy to increase self-care, making it essential for it (Coleman et al., 2016; Mills et al., 2018).

2.3. The Relationship between Self and Other-Oriented Compassion

Recent studies have explored the relationship between self and other-oriented care. In the self-care literature, some studies found that people who provided care for others may be in danger of ‘compassion fatigue’ (e.g., job-related stress) (Coleman et al., 2016; Figley, 2002; Mills et al., 2018). Consistently, research findings have suggested that caring for others (as informal or formal caregivers) can burden people and increase their own levels of stress (Sawatzky & Flower-Kerry, 2003; van Groenou et al., 2013; Williams et al., 2014). Moreover, Acton (2002) reported that in comparison to non-caregiving individuals, those who took care of family members practiced less self-care and had fewer opportunities (e.g., more barriers) for health-promoting behaviours.

Likewise, in the self-compassion literature, Neff’s (2003a) study found a relationship between outward and inward compassion. Her study showed that higher self-compassion was associated with having higher inward and outward compassion. However, low levels of self-compassion were associated with only outward compassion (Neff, 2003a). In other words, people had lower self-compassion when they only took care of others, but higher self-compassion when in addition to caring for others, they also took the time to care for themselves (Mills, 2018; Neff, 2003a). Overall, recent research has suggested that it was imperative to enhance and promote self-care in formal (e.g., health care providers, counsellors) and in informal (e.g., family members) caregivers (Coleman et al., 2016; Mills et al., 2018). It is believed that by increasing self-care practices via self-compassion, many people could benefit from having higher well-being

and becoming better caregivers (Acton, 2002; Boellinghaus et al., 2013; Nelson et al., 2017).

For the purposes of the current studies, I define self-compassion as an individuals' capacity, which indicates an individual difference (e.g., between those high or low on self-compassion), and as a skill or a strategy that they can learn and apply when they experience negative circumstances. In YCs' worlds, where they show daily other-oriented care, I wanted to assess their self-reported self-compassion and whether they had time for self-care.

3. Subjective Well-Being (SWB)

According to the World Health Organization, well-being is defined as a person's state, in which they live fulfilled lives, work well, and adequately cope with life's stressors (World Health Organization, 2004). In other words, living up to one's potential can mean "living a life of meaning, purpose, and virtue" (Maddux, 2017, p. 8).

There are different areas of well-being (e.g., psychological, emotional, physical); they can all be assessed via different measures but underlining each is how one evaluates their own life experiences. SWB is described as an umbrella term that describes how people subjectively evaluate their own well-being (Diener & Ryan, 2009), "based on their values, goals, and life circumstances" (Diener et al., 1998, p. 35), or how they feel or think about their lives (Maddux, 2017). In other words, SWB is about how people think they experience life, and whether they think that they are leading a life that they are satisfied with and that makes them feel generally good or happy (Maddux, 2017). This corresponds with the tripartite formulation of SWB, measured by affective (e.g., positive

and negative affect) and cognitive (e.g., life satisfaction) constructs (Diener, 2000; Schimmack et al., 2008).

SWB is a multidimensional concept, but many researchers choose to examine it differently. Research by Busseri and colleagues suggested different conceptualizations of this construct, and variations in implications based on which model researchers would use (Busseri & Sadava, 2011; Busseri, 2015). For example, among many different conceptualizations, SWB can be split into its separate indicators whereby creating a separate examination of positive and negative affect and life satisfaction or SWB can measured as a single composite variable (Busseri, 2015; Busseri & Sadava, 2011).

Although considered a stable construct (Busseri & Sadava, 2013; Suh et al., 1996), an important question to consider is whether SWB is a state or a trait? "Bottom-up'' and "top-down" theories clarify this. Bottom-up theories suggest that SWB is a process made up of experiences or events (Diener & Ryan, 2009). SWB fluctuates accordingly, where positive events can improve well-being, and negative events can diminish it. Top-down theories claim that SWB is instilled within each person. In other words, people have an "inherent propensity to experience the world in a certain way" (Diener & Ryan, 2009, p. 394). As a result, they may see some experiences in a better light than others. Moreover, it becomes clear that SWB can also fluctuate as a result of a dramatic or long-term life event (Busseri & Sadava, 2013; Lishner, & Stocks, 2017). In fact, past studies have shown that SWB can be influenced by environmental events, but also largely by personality traits (Schimmack et al., 2008; Suh et al., 1996). In other words, even if personality traits can impact a person's SWB at baseline, if someone becomes sick or experiences a stressful life event (just as YCs might on a daily basis),

their SWB could change to a newer state, before going back to their baseline (Lishner, & Stocks, 2017). Moreover, people can have different configurations of SWB (Busseri et al., 2009; Diener et al., 1999). For example, a person could be high on life satisfaction and positive affect and low on negative affect, whereas another could be low on life satisfaction and positive affect, but high on negative affect (Busseri et al., 2009). Busseri and colleagues (2013) also found that usually, those who displayed lower life satisfaction were more likely to be influenced by dramatic life events.

In this study, SWB was defined as a state that could change based on experiences, which reflected the unique living circumstances and context of YCs. YCs are a heterogeneous group of children and youth, with varying degrees of caregiving hours and responsibilities, and unique set of familial expectations and needs.

4. Theoretical Frameworks

In this dissertation, I used two overarching theoretical frameworks. 1. Positive psychology; and 2. Family systems theory. Positive psychology is the scientific study of "positive human functioning and humans' flourishing" (Seligman & Csikszentmihalyi, 2000, p. 13), which is differentiated from clinical psychology which typically emphasizes the need to fix what is wrong (Compton & Hoffman, 2019; Hart, 2020; Snyder & Lopez, 2005). Positive psychology is about "building what is right. Psychology is not just about illness or health; it also is about work, education, insight, love, growth, and play" (Snyder & Lopez, 2005, p. 4), with specific attention to the positive notions in people (Hart, 2020). It fits as a framework for my dissertation because of its focus on examining positive emotions, behaviours, and states and traits (Compton & Hoffman, 2019), such as I am doing by examining self-compassion and SWB. In fact, in the past, the study of self-

compassion has been tied to the movement of positive psychology, as it was shown to be related to positive mental health (Neff, 2003a). Moreover, SWB can also be described under the positive psychology paradigm, as it encompasses greater positive affect, greater life satisfaction, and limited negative affect.

This dissertation also adopted the family systems theory, because young caregiving is a product of a family need; it is a response to a family condition (i.e., illness, disability, ageing, addiction, etc.) that affects the entire family. Family systems theory was created by Bowen in 1974 in an attempt to incorporate the family into therapy, realizing that any problem affects everyone within (Brown, 1999). Bavelas and Segal (1982) defined a family more than a simple unit that is made up of individuals in relationships. For them, family illustrates a system that is "established, maintained, and evidenced by the members communicating with each other" (Bavelas & Segal, 1982, p. 101-102). This suggests that any issue, such as young caregiving, may be understood by understanding its members (Bavelas & Segal, 1982). Metzing-Blau and Schnepp (2008) noted that "for most of the families it is important to organize everyday life with the illness- without letting it dominate their life" (p. 7). This suggests that while an illness could have tremendous effects on everyone within the family, and especially on YCs with added responsibilities, family members come together to adjust to the change and organize their new roles (Metzing-Blau & Schnepp, 2008). Moreover, this framework incorporates the 'family' within interventions, which focuses on strength-based approach to support all members of the family (Dunst & Trivette, 2009). One approach is called 'Capacity-building', in which interventions orient towards promoting competence and positive functioning, realizing assets rather than limitations, empowering family

members, and strengthening relationships within the family (Dunst & Trivette, 2009). This reinforces the positive psychology paradigm, where the focus is on positive constructs, denoting some form of resilience.

Together, these two approaches were utilized as one lens by showing that the stress that caregiving might produce may affect everyone within, and not just YCs. And while there is a strong need to learn what YCs experience with respect to self-compassion and attempt to translate the findings to future interventions, it might be essential to include the entire family in the discussion of how to best promote self-compassion, which may contribute to better well-being.

Overview of Current Studies

By examining self-compassion literature, it was very clear that the majority of findings are derived from adult samples. Very few adolescent studies existed and those studies (e.g., Neff & McGehee, 2010) showed inconsistencies with adult's findings regarding how age and sex was related to self-compassion. Moreover, much remained unknown about how personality and SWB related to self-compassion among youth. Thus, before understanding self-compassion in YCs, it was beneficial to first understand which factors correlated with self-compassion in youth. Hence, the first study included an exploratory and descriptive study that examined how individual and demographic factors correlates of self-compassion in youth. It was important to conduct this research because adolescence can evidently be an uncertain period, with increased risk to mental health (Arnett, 1999; WHO, 2019), and findings factors that correlated with self-compassion could be used in intervention and prevention plans to enhance their positive trajectories.

The big question still remained: where does this leave us with respect to YCs, who evidently show compassion towards others while possibly supressing their own needs for self-care and/or self-compassion? To the best of my ability, I did not identify any studies that have investigated the construct of self-compassion in youth with a caregiving role, thus their current levels of self-compassion remain unknown. It was vital to understand YC's self-compassion levels with respect to their context of caregiving for others and in relation to their self-care, especially in light of recent findings that showed they may have limited time for self-care or other activities (Sexton, 2017; Stamatopoulos, 2018; Szafran et al., 2016). Therefore, the purpose of the second study was to establish what YCs thought about compassion, self-compassion, and how they saw it fitting within their lives as they provided care for others. This study was qualitative, because it used focus groups to obtain a better understanding of self-compassion in YCs' lives. Finally, the last study was a comparative and exploratory. Based on previous studies' inconsistencies and gaps, it was imperative to understand whether YCs' self-compassion and SWB were comparable to youth without the caregiving role. The results could be used to modify existing programs that support YCs and to enhance self-compassion, if needed, among YCs.

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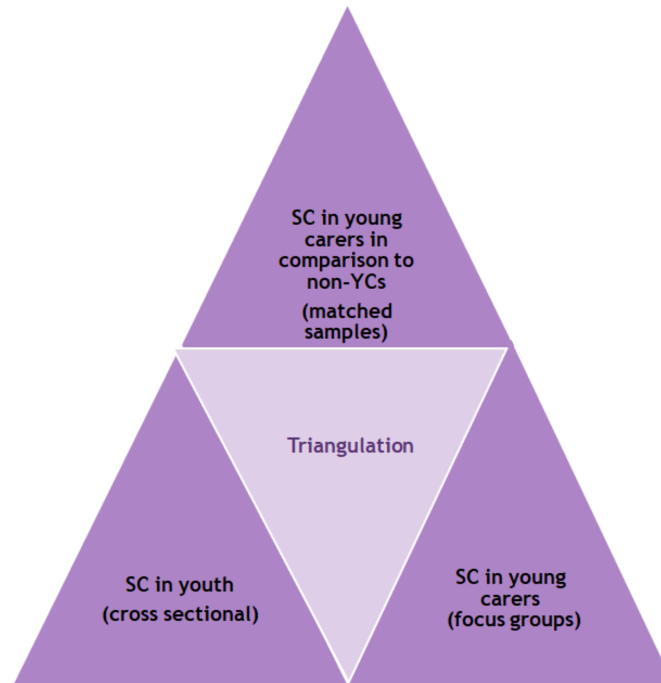
CHAPTER 2: GENERAL METHODOLOGY

This dissertation included a mixed methodology of both quantitative and qualitative techniques to attain a more comprehensive understanding of self-compassion among YCs. This was done for the purpose of "triangulation". Triangulation is used in research when more than one approach, method, or theory is used to understand the phenomenon at hand or to answer specific research questions for the purposes of completeness, confirmation, added depth, and comprehensiveness (Bekhet & Zauszniewski, 2012; Heale & Forbes, 2013; Hussein, 2009). While there are many forms of triangulation (e.g., data, methods, theoretical, investigator, analysis, and multiple), this dissertation used the methods triangulation (Bekhet & Zauszniewski, 2012; Hussein, 2009; Kimchi et al., 1991). More specifically, because I used both qualitative and quantitative methods to understand the same construct (i.e., self-compassion) among youth, and especially in the YC sub-group, I used the between-method triangulation technique (see Figure 2.1).

Figure 2.1

Triangulation of Methods



Note. SC = self-compassion. The triangle on the left is study 1; the triangle on the right is study 2; the triangle on top is study 3.

In that way, both approaches complemented and triangulated with one another, where qualitative measures were able to provide a more complete picture of the quantitative results, especially since the topic was minimally explored with youth, and to the best of my knowledge, remained unexplored in YCs (Given, 2012; Hussein, 2009).

As previously mentioned, I aimed to first find which factors correlated with self-compassion in youth in Study 1, based on the fact that previous studies were inconclusive or there was absence of knowledge in this area. For this, I used a quantitative approach, where I developed a questionnaire that addressed participants' self-reported self-compassion rates, personality traits, and SWB. I utilized various Likert scales, specifically, the self-compassion scale (SCS; Neff, 2003a), personality subscales (e.g.,

Honesty/Humility, Agreeableness, and Emotionality) (HEXACO–60; Ashton & Lee, 2009), and measures of SWB (positive and negative affect scale (PANAS-C; Laurent et al., 1999), and life satisfaction scale (SWLS-C; Gadermann et al., 2010), all of which represent positive constructs. I administered these surveys at various youth clubs in the community. While this enabled me to understand which factors correlated with youth in general, my main aim was to understand how a more vulnerable youth, such as young carers, present on self-compassion.

For study 2, since I could not identify any studies that have investigated the construct of self-compassion in youth with a caregiving role, and their current levels of self-compassion remained unknown, I wanted to explore what it means to them in a conversation, rather than a survey. Hence, in Study 2, I used a qualitative approach, via focus groups, that enabled me to have rich stories of how YCs felt about compassion and self-compassion (and self-care) in the context of caregiving for others. This clearly showed me how YCs practice compassion and how self-compassion unfolds in their lives. Moreover, I inquired about whether they thought their parents promoted it and how, to enable me to further understand how it is experienced within the family unit. However, Study 2 did not provide any information on how relatable these experiences were to youth without the caregiving role.

Given previous studies have noted that youth in general may have trouble with self-compassion (e.g., Neff & McGehee, 2010) and YCs continue to report caregiving penalties (e.g., Stamatopoulos, 2018), it was important to examine how similar or different YCs' self-compassion rates and SWB were in relation to youth without the caregiving role. In study 3, I aimed to find out whether results of study 2 hold when

comparing YCs to non-YCs. I approached a local organization that supports YCs to have YCs complete the same survey as non-YCs in Study 1 and relied on quantitative data analyses to assess this comparison. Hence, Study 1 and 3 were cross-sectional, descriptive studies, but Study 3 used a comparative analysis to answer the research question.

Overall, the methods were triangulated to attain a more comprehensive assessment of self-compassion in caregiving and non-caregiving youth. Results not only showed the factors that contributed to self-compassion in youth, but also revealed what self-compassion meant in youth who spends much of their time caregiving for others. Finally, when comparing the two samples, a clearer picture of self-compassion emerged, in which case, the triangulation occurred for the purposes of confirming results of previous studies, and also providing more in-depth understanding of the topic of self-compassion among youth. Using mixed methods also showed that qualitative accounts might benefit from quantitative analyses when examining the same construct in this dissertation.

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CHAPTER 3: STUDY 1

Exploring Demographic, Personality, and Subjective Well-Being Correlates of Adolescents' Self-compassion[1]

The way in which people cope and respond to life's hardships will vary. Some may be highly judgmental of themselves, others may become very emotional and withdrawn, while others may be kinder toward themselves and more understanding of their circumstances. It is during negative life events that self-compassion can act as an emotional regulation strategy or a coping strategy (Neff, 2003a, 2003b). Self-compassion is a kindness that is directed towards oneself, especially when one is experiencing suffering (Neff, 2003a, 2003b). Self-compassion is believed to be comprised of three integral concepts: self-kindness (i.e., establishing a positive attitude that protects self-concept instead of judging themselves), mindfulness (i.e., becoming aware and reflective of the negative emotions and experiencing them fully instead of dwelling on them), and common humanity (i.e., understanding that these experiences shared with and common to other human beings instead of thinking that it is unique to them) (Neff, 2003a, 2003b). The purpose of the present study was to apply this construct to adolescents and explore what factors may be associated with it in youth.

Self-compassion research has commonly been conducted with adults (e.g., Neff & Germer, 2012; Neff & Pommier, 2013; Neff & Vonk, 2009) and undergraduate samples (e.g., Neff, Rude, et al., 2007; Neff, Kirkpatrick, et al., 2007; Neff & McGehee, 2010; Neff & Pommier, 2013). Findings have suggested that higher self-compassion was related

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[1] A version of this chapter is under review for publication. Berardini, Y., Chalmers, H., & Ramey, H. (under review). Exploring Demographic, Personality, and Subjective Well-Being Correlates of Adolescents' Self-compassion.

to better mental health, and higher psychological functioning (e.g., decreased depression and anxiety), quality of life (e.g., social connectedness), and well-being (Neff & Germer, 2012; Neff, Kirkpatrick, et al., 2007; Neff & McGehee, 2010; Neff, Rude, et al., 2007). Research with undergraduate students found that having self-compassion acted as a protective factor against anxiety in self-evaluative situations within a North American sample (Neff, Kirkpatrick, et al., 2007) and predicted positive mental health in Korean young adults (Shin & Lim, 2019).

Research on self-compassion in adolescents seems to be far less common, thus our understanding of youths' self-compassion rates remains very limited, and non-existent in Canada. Adolescence is marked by a great deal of uncertainty, increased attention to peer evaluations, more abstract self-concept, hormonal changes, and identity formation, all of which could impact well-being (Arnett, 1999; Steinberg & Morris, 2001). A fact sheet from the World Health Organization (WHO; 2019) on adolescent mental health reported that globally, depression is one of the leading public health issues among adolescents, and suicide was adolescents' third leading cause of death, supporting the need for further research. In Canada alone, a population-based survey revealed that suicide is the second leading cause of death among adolescents aged 15-18, with a prevalence rate of 13.5% and 7.6% for depression (Cheung et al., 2006). Among the studies that have examined adolescent self-compassion, a number of key findings resemble those of adults. For instance, in United States, youth with higher self-compassion showed better well-being and mental health (Neff & McGehee, 2010; also see Bluth et al., 2017). In Spain, self-compassion acted as a protective factor in cases of victimization and psychological maladjustment in youth (Jativa & Cerezo, 2014), and in

Israel, self-compassion protected against depression, panic, suicidality, and posttraumatic stress in at-risk youth ages 15-19 years (Zeller et al., 2015). In the UK, adolescents with higher self-compassion scores scored lower on social anxiety (Gill et al., 2018), and in Australia, results showed that youth with higher self-compassion may have good mental health, despite having low self-esteem (Marshall et al., 2015). These studies commonly show that self-compassion is related to well-being in adolescence and adulthood. What is missing from the literature is examination of subjective well-being in the Canadian context.

Although the research literature has pointed to connections between self-compassion and well-being, it has been operationalized very narrowly as the absence of mental health concerns. In two recent meta-analyses of the relationship between self-compassion and well-being (as indexed by psychological distress (Marsh et al., 2018) and psychopathology (MacBeth & Gumley, 2012), well-being was assessed via measures of anxiety, depression, and stress. Results yielded a number of studies that showed a large effect size, concluding that higher self-compassion was related to lower psychological distress or lower psychopathology (MacBeth & Gumley, 2012; Marsh et al., 2018). Despite the fact that self-compassion is highly related to positive psychology (Neff, 2003a), in some studies, only one positive construct was explored (e.g., life satisfaction with anxiety and depression (Neff, 2003a) or social connectedness with anxiety and depression (Neff & McGehee, 2010)). With only three studies that have explored whether positive states (e.g., happiness, positive/negative affect, life satisfaction, optimism) contributed to self-compassion (Bluth & Blanton, 2015; Neff, Rude, et al., 2007; Neff & Vonk, 2009), more research is needed to examine whether a person's cognitive and

affective evaluations of their lived experience may be related to self-compassion. These aspects of subjective well-being (SWB) are closely related to ‘happiness’ (Diener, 2000). Diener (2000) has argued that people with higher SWB may be happier, enjoy their experiences more, have higher life satisfaction, and have more positive emotions (Diener, 2000). Presently, I am not aware of any studies that investigated this construct in relation to self-compassion. Thus, to better understand the relationship between well-being and self-compassion, within the positive psychology paradigm, the current study aimed to examine the construct of SWB, and more specifically its individual subsets: positive and negative affect, as well as life satisfaction.

In addition to problems operationalizing well-being, it is also paramount to consider how individual differences might play a role in people’s perception and interpretation of their lived experiences, and hence how these individual differences are connected to self-compassion. The relationship between personality traits and self-compassion has only been addressed in one study with adults from North America, finding that higher self-compassion was related to lower neuroticism, and higher agreeableness, extroversion, and conscientiousness, but was unrelated to openness to new experiences (Neff, Rude, et al., 2007). In addition to specific traits, other-oriented concern or altruistic tendency may contribute to self-compassion (Neff, 2003a; Neff & Pommier, 2013). Interestingly, this relationship only existed among adults; for college students, self-compassion did not relate to empathetic, other-oriented tendencies, suggesting a possible developmental influence. Given no other studies to the best of my knowledge have examined altruistic tendencies as part of personality traits, I aimed to fill

in this important gap to further our understanding of self-compassion in youth ages 12-18 years.

Sex and age differences in self-compassion have also been reported. Women showed lower self-compassion than men in adult and young adult samples (Gill et al., 2018; Lockard et al., 2014; Neff, 2003b; Neff & Beretvas, 2013; Neff & McGehee, 2010; Yarnell et al., 2015). However, in adolescents, results remain inconsistent. While Cunha and colleagues (2016) found that in Portugal, boys scored higher than girls on self-compassion, in the United States, no sex differences were found in an adolescent sample (Neff & McGehee, 2010). With respect to age, a common finding was that adults reported higher self-compassion rates than younger people and that the rates of self-compassion increased with age, again supporting a possible developmental connection (Neff, 2003b; Neff & Pommier, 2013; Neff & Vonk, 2009). Interestingly, among adolescents in both the USA and Portugal, self-compassion did not differ by age (Cunha et al., 2016; Neff & McGehee, 2010). To replicate and address these inconsistencies, I examined age and sex as potential correlates of self-compassion in this youth sample.

Therefore, the purpose of conducting Study 1 was to determine what correlated with self-compassion among youth. I hypothesized that: 1. Sex and age would not be related to self-compassion; 2. Higher levels of self-compassion would be associated with higher levels of all subscales of SWB; and 3. Altruistic traits, namely agreeableness, honesty and humility, and emotionality, would be related to self-compassion. A clearer understanding of which factors correlate with self-compassion may assist in more targeted interventions and prevention programs to increase self-compassion among youth. It is imperative more studies investigate self-compassion among adolescents, given this

vulnerable phase of development and self-compassion's relation to improved overall mental health and well-being.

Methods

Participants

Participants (*N* = 170) were between 12-18 years of age from Southern Ontario, with 57.6% girls (*n* = 98) and 41.2% boys (*n* = 70); one participant indicated a non-binary status, and another did not disclose their sex. The average age was 15 years (*SD* = 1.67). Of the entire sample, 7.6% self-identified as young carers from the community (*n* = 13). Of the total sample, the majority (88.2%) indicated that they were born in Canada. Twenty-five participants (14.7%) self-classified as being Canadian and 83.5% (*n* = 142) reported having another ethnicity: British (14.1%, *n* = 24), Italian (14.1%, *n* = 24), Dutch (12.9%, *n* = 22), French (12.4%, *n* = 21), German (11.1%, *n* = 19), Polish (4.1%, *n* = 7), Chinese (4.1%, *n* = 7), East Indian (4.1%, *n* = 7), Native Aboriginal (4.1%, *n* = 7), Ukrainian (2.9%, *n* = 5), American (2.9%, *n* = 5), African (2.9%, *n* = 5), Hungarian (1.8%, *n* = 3), West Indian (1.8%, *n* = 3), Latin American (1.8%, *n* = 3), Russian (1.2%, *n* = 2), Greek (1.2%, *n* = 2), Korean (.6%, *n* = 1), and other (34.5%, *n* = 59; e.g., Scottish, Irish, Indonesian, Egyptian, Icelandic, Lebanese, and others).

The vast majority (72.9%, *n* = 124) lived with both birth parents, 14.7% (*n* = 25) lived with birth mother, 9.4% (*n* = 16) lived with birth mother and stepfather, 3.5% (*n* = 6) lived with birth father and stepmother, 2.9% (*n* = 5) lived with birth father, 2.4% (*n* = 4) lived with grandparents, .6% (*n* = 1) lived with legal guardians, .6% (*n* = 1) lived with other relatives, and .6% (*n* = 1) lived with their brother.

Measures

Demographics. The participants responded to questions regarding their sex, age, ethnicity, whether they have been born in Canada, and with whom they lived.

Screening for Young Carers. Three questions were used to screen for potential young carers in this community sample (e.g., 1. Do you live with an immediate family member(s) who is ill, has a disability, or other special needs? 2. If so, do you help on a daily basis with responsibilities such as cooking, cleaning, dressing, supervising siblings, etc.? 3. Are you a part of Powerhouse Project, a support program for young carers?). The third question was only required for ethics, to ensure I do not get duplicated survey completions from youth in the support group who may also be engaged in another community club.

Self-Compassion. Self-compassion was measured using the 26 item Self-Compassion Scale (SCS; Neff, 2003a), using a 5-point Likert Scale (1 = *Almost never* to 5 = *Almost always*). This scale was validated on adolescents (ages 12-19) in Portugal (Cunha et al., 2016) and in North America it was validated with undergraduate students (Neff, 2003a). Neff and McGehee (2010) applied this scale to adolescents aged 14-17 and their self-compassion rates were comparable to other studies (Cunha et al., 2016), showing good psychometric properties with strong construct, content, and convergent validity and internal consistency (Cronbach's alpha α = .90 (Neff & McGehee, 2010) and α = .88 (Cunha et al., 2016)). In this study, the 26 items were combined to form an overall self-compassion score (α = .91). Higher scores indicated higher self-compassion. To increase comprehension due to the age of the sample, some wording was simplified, for example, 'disapproving and judgmental' was revised to 'negative and critical'.

Subjective Well-Being. A combination of cognitive and affect measures comprise Subjective Well-Being (SWB) (Diener, 2000; Seligman & Csikszentmihalyi, 2000). I explored subscales of SWB (i.e., positive and negative affect, satisfaction with life) separately to obtain a better understanding for which indicator related to overall self-compassion.

Positive and Negative Affect. Feeling and emotions were assessed using the Positive and Negative Affect Scale for children (PANAS-C; Laurent et al., 1999). This scale measured 30 feelings/emotions (e.g., sad, energetic, afraid, lonely, proud, strong) that ranged from 1 (*Very slightly or not at all*) to 5 (*Extremely*). This scale has been validated for children with an average age of 11. This scale showed good convergent and discriminant validity. The scale was administered to two samples of youth and showed strong internal reliability for Negative Affect (NA) and Positive Affect (PA) (ranging from .92-.94 and .89-.90, respectively). In this sample, Cronbach's alphas for positive and negative affect were $\alpha = .90$ and $\alpha = .92$, respectively.

Satisfaction with Life. The participants completed the 5-item Satisfaction with Life Scale for Children (SWLS-C; Gadermann, Schonert-Reichl, & Zumbo, 2010), measured on a 5-point Likert scale (1 = *Disagree a lot* to 5 = *Agree a lot*), where higher scores indicated higher satisfaction with life (example item: "My life is close to the way I want it to be"). The five items were combined to form a total life satisfaction score that ranged from 5-25. This scale has been validated for Canadian children ages 9-14 years. The scale showed evidence for convergent and discriminant validity, as well as strong internal reliability (Cronbach's alpha ranged from $\alpha = .75$ - .87). This sample's derived reliability was $\alpha = .88$.

Personality. The 60 item HEXACO scale was employed (HEXACO–60; Ashton & Lee, 2009). This scale was comprised of six broad domain scales: Honesty/humility, Emotionality, eXtraversion, Agreeableness, Conscientiousness, and Openness to experience. This scale ranged from 1 (*Strongly disagree*) to 5 (*Strongly agree*). Studies have shown that the Honesty and Humility dimension, together with Agreeableness and Emotionality, made up an altruistic tendency and empathy (Ashton & Lee, 2007), therefore, only Honesty/humility (e.g., "I wouldn't use flattery to get a raise or promotion at work, even if I thought it would succeed"), Emotionality (e.g., "I sometimes can't help worrying about little things") and Agreeableness (e.g., "My attitude toward people who have treated me badly is 'forgive and forget'") were used for this study.

This scale has been applied to a college student sample (N = 1126; Ashton & Lee, 2009). These three subscales showed high internal reliabilities (Honesty/humility α = .76, Emotionality α = .80, Agreeableness α = .77). These are highly linked to self-compassion, because altruism (or helping others) has been found to be associated with self-compassion (i.e., helping oneself) (Neff, 2003a; Neff & Pommier, 2013). Although it has not been validated for younger age groups, a study by Farrell, Brook, Dane, Marini, & Volk (2015) used the 100 item HEXACO Personality Inventory–Revised (HEXACO PI) scale on adolescents between the ages of 11-17. In this study, Cronbach's alphas for the three subscales (e.g., Honesty/humility, Emotionality, and Agreeableness) were .71, .75, .67, respectively.

Procedure

This study was approved by Brock University's Research Ethics Board (REB #18-294, Appendix A). I contacted several organizations supporting young people (e.g.,

YMCA, Big Brother Big Sister, Boys and Girls Clubs, Youth Advisories Committees, a local summer camp). Following meetings with executive directors and program managers, a date for data collection was set. Participants with signed parental consent and assent forms were directed to a designated area where they filled out paper and pencil questionnaires, in group settings during regular program hours. They were instructed to complete surveys independently and ask for any clarifications or assistance with comprehension. The survey took approximately 30 minutes to complete. Upon completion, participants were compensated with pizza and drinks or a healthy snack of their choice. For the questionnaire, please see Appendix B.

Data Screening and Analyses

Data was initially screened to verify statistical assumptions. To test for univariate normality, all variables were assessed by examining skewness, kurtosis, histograms, and pp-plots. Two univariate outliers were identified affecting normality (Field, 2017; Tabachnick & Fidell, 2001). The two univariate outliers (one on total self-compassion and one on negative affect) were Winsorized to minimize impact (Tabachnick & Fidell, 2013). Next, various scatterplots were inspected, meeting the assumptions of linearity, independence, and homoscedasticity. Two multivariate cases were identified via Mahalanobis Distance (D^2) and deleted from further analyses. Analyses were conducted with and without the outliers, ensuring integrity in case of changes to result patterns. There were no problems with multicollinearity as there were no extremely high correlations (i.e., > 0.7, 0.9) and all values were within the VIF (<10) and tolerance ($> .2$) limits (Field, 2017; Tabachnick & Fidell, 2001).

Missing Value Analyses (MVA) were conducted and revealed that there were no variables with 5% or more missing values. In this case, no actions were implemented as missing data was deemed as non-problematic (Tabachnick & Fidell, 2001).

Using SPSS IBM statistics 22, a Simultaneous Multiple Regression was conducted where self-compassion was regressed on status, sex, age, personality traits, and the three subscales of SWB. Because some of the youth could have been young carers (YCs), I accounted for the role of status to ensure that it would not confound results. I chose not to run a hierarchical regression because there was no previous theoretical explanation to control for any of the variables, nor there was a need to see which factor would explain more variability in self-compassion over and above others, as this was an exploratory study, thus a more conservative approach. Simultaneous regression's results were further complimented by adding a discussion on unique variances (sr^2), which would be identical to what a hierarchical method would produce.

Results

Descriptive statistics for all variables in the model can be seen in Table 3.1. Bivariate correlations revealed that self-compassion was positively associated with life satisfaction, positive affect, honesty/humility, and agreeableness and negatively associated with negative affect and emotionality (see Table 3.2). Furthermore, girls reported higher negative affect and higher rates of emotionality than boys. Finally, age was negatively associated with life satisfaction and with positive affect, which meant that older age was related to lower life satisfaction and fewer feeling of happiness and positive affect.

Table 3.1

Descriptive Statistics for All Model Variables

Variable	Mean (*M*)	Standard Deviation (*SD*)	N	Min	Max	Range	Skew (SE)	Kurtosis (SE)
Age	15.02	1.67	170	12.00	18.00	6.00	-0.04 (0.19)	-0.98 (0.37)
Total Self-Compassion	2.90	0.68	170	1.08	4.95	3.87	-0.08 (0.19)	-0.22 (0.37)
Positive Affect	3.23	0.77	168	1.40	4.86	3.46	-0.10 (0.19)	-0.67 (0.37)
Negative Affect	2.32	0.85	168	1.00	4.47	3.47	0.68 (0.19)	-0.43 (0.37)
Honesty/ Humility	3.53	0.64	170	1.80	5.00	3.20	-0.28 (0.19)	0.11 (0.37)
Emotionality	3.36	0.64	170	2.00	4.90	2.90	-0.01 (0.19)	-0.56 (0.37)
Agreeableness	3.17	0.56	170	1.44	4.56	3.11	-0.35 (0.19)	0.09 (0.37)
Life Satisfaction	17.58	4.57	167	5.00	25.00	20.00	-0.58 (0.19)	0.08 (0.37)

Note: Overall N = 170; for all variables, higher numbers represent more of this state/trait.

Table 3.2

Zero-Order Correlations between the Tested Variables

Variable	1	2	3	4	5	6	7	8	9	10
1.Self-Comp	-	.10	-.06	-.07	.31***	-.22**	.46***	.58***	.47***	-.60***
2. YC status		-	-.00	.03	.12	.08	.07	.07	.09	-.10
3.Age			-	-.05	-.07	.01	.04	-.22**	-.16*	.10
4.Sex				-	.10	.42***	-.04	-.01	.06	.19**
5.Honest/ Humility					-	.14*	.40***	.09	.08	-.14*
6. Emotion						-	.07	-.08	-.23**	.20**
7. Agree							-	.32***	.17*	-.31***
8. LS								-	.59***	-.61***
9. PA									-	-.35***
10. NA										-

Note. N = 165; self-comp = Self Compassion; YC status = Young carer status (coded 0 = ycs, 1 = non); Sex coded 0 = male, 1 = female; Emotion = Emotionality; Agree = Agreeableness; LS = Life Satisfaction; PA = Positive Affect; NA = Negative Affect. All variables are coded in the direction that higher scores

reflect higher self-compassion, life satisfaction, more positive/negative affect, and higher honesty/humility, emotionality, and agreeableness, as well as older age. *$p < .05$, **$p < .01$, ***$p < .001$.

Regression Analyses

A Simultaneous Multiple Regression was conducted to determine whether self-compassion was associated with sex, age, personality traits, positive/negative affect, and life satisfaction, while accounting for status in the model. Results revealed that the overall model was statistically significant, $F(9, 155) = 22.72$, $p < .001$, explaining 56.9% of variance in self-compassion[2]. Demographic variables, such as YC status, sex and age were not related to self-compassion (see Table 3.3). Further, honesty and humility shared 2.19% unique variance with self-compassion, after considering all other variables in the model. Agreeableness shared 3.42% unique variance with self-compassion, after accounting for all other variables in the model. Emotionality shared 1.93% of unique variance with self-compassion, after all other variables were considered (see Table 3.3).

Examination of SWB showed that life satisfaction shared 2.07% unique variance with self-compassion, after accounting for all other variables in the model. Positive affect explained 1.35% of unique variance of self-compassion, after considering all other variables in the model. Finally, negative affect shared 5.29% unique variance with self-compassion, after all other variables were considered.

[2] The model with the two multivariate outliers explained overall 55.5% of variability in self-compassion and PA was not a statistically significant predictor ($p = .073$). The two multivariate outliers were removed from all further analyses.

Table 3.3

Results of Regression Analyses in which Self-Compassion was Regressed on Status, Age, Sex, Personality and SWB

	B	*SE B*	*β*	95% CI [LL, UL]
Model 1				
constant	1.22	0.56		[0.12, 2.32]
YC status	0.04	0.13	.02	[-0.22, 0.31]
Age	0.02	0.02	0.04	[-0.02, 0.06]
Sex	0.06	0.08	0.05	[-0.10, 0.22]
Honesty/Humility	0.18	0.06	0.16**	[0.05, 0.31]
Emotionality	-0.17	0.07	-0.16*	[-0.30, -0.04]
Agreeableness	0.26	0.07	0.22**	[0.11, 0.41]
Life Satisfaction	0.03	0.01	0.22**	[0.01, 0.05]
Positive Affect	0.13	0.06	0.15*	[0.01, 0.25]
Negative Affect	-0.24	0.05	-0.31***	[-0.35, -0.13]

Note. *N* =165; YC status = young carer status (coded 0 = yc, 1 = non); Sex 0 = male, 1 = female; *p < .05, **p < .01, ***p < .001; CI = confidence intervals; LL = lower limit; UL = upper limit; Outcome = self-compassion.

Discussion

Considering research on self-compassion among youth has been limited and most studies were conducted with adults, the purpose of Study 1 was to examine self-compassion and its correlates among a youth sample. In this model, YC status was accounted for in the analyses to eliminate any confounding possibilities that YC's identification could be related to self-compassion. As expected, sex and age did not relate to self-compassion. This finding complemented a North American sample of youth, in which sex and age did not relate to self-compassion (Neff & McGehee, 2010). Neff and McGehee (2010) concluded that developmental trends may only show up when comparing youth to older adults. They also claimed that adolescents might not be capable of self-compassion due to their cognitive advancements, various pressures, evaluations, higher emphasis for self-esteem (Neff, 2003b), as well as states of 'personal fable' or 'egocentrism' (e.g., thinking their situation is unique to them) (Neff & McGehee, 2010).

Thus, it could be that self-compassion is a complex construct for youth, which then might validate that it increases with age and truly forms in adulthood (Neff & Pommier, 2013; Neff & Vonk, 2009). Interestingly, when Neff and McGehee (2010) examined sex differences in the older group of young adults, women showed lower self-compassion than men (Neff & McGehee, 2010). This could indicate a sex by age interaction. In fact, Bluth and colleagues (2015, 2017), who tested these interactions, found that certain stages of adolescents (older/younger) mixed with sex (male/female) contributed to self-compassion. Future studies could examine whether such interactions exist among North American youth. Another possible explanation for the lack of age and sex associations is that this only exists on specific subscales of self-compassion. Bluth and Blanton (2015) claimed that although older girls showed lower self-compassion scores than boys, the decline in self-compassion was driven by the fact that girls scored lower than boys on the negative subscales of self-compassion (i.e., self-judgement, isolation, and overidentification with emotions). Because the current study only assessed self-compassion's total score, it could be that the role of sex as a correlate was masked. Future studies could examine whether sex or age correlated with self-compassion's individual subscales.

The current findings yielded a better understanding of the relationship between SWB and self-compassion. As hypothesized, life satisfaction was associated with self-compassion. This was in accordance to Bluth et al.'s (2017) findings, where higher levels of life satisfaction predicted higher self-compassion. In addition, self-compassion was related to youth's affect. This extended studies with young adults that examined happiness, optimism, and positive mood correlates (Neff & Germer, 2012; Neff, Rude, et

al., 2007). Given that negative affect was the strongest negative correlate in the model, this could suggest that those with a pessimistic, more depressed mood were less likely to be kind to themselves, may instead focus too much on their negative emotions, and isolate themselves from others. This was supported by previous research that found depressive symptoms, distress tolerance, anxiety, and perceived stress contributed to lower self-compassion (Bluth et al., 2017).

Furthermore, sex played a role in the relationship between adolescents' affect and self-compassion. Bluth and colleagues (2017) found that only when stress was high, girls showed lower self-compassion rates than boys. Given that the current study found that girls had more negative affect, complementing other studies with similar results (Bluth & Blanton, 2015; Forbes et al., 2004), it may suggest that sex could act as a moderator of the relationship between affect and self-compassion. Future studies could further explore whether the relation between affect and self-compassion is different for boys than for girls.

Finally, examination of personality traits yielded interesting findings with regards to youth's self-compassion rates. Previous literature noted a relationship between outward compassion and self-compassion (Neff, 2003a), as well as between altruism and enhancement of self-regulation (DeSteno, 2015). The current results shed a light on which personality traits were related to self-compassion. The third hypothesis was supported by the fact that all three personality traits were associated with self-compassion, with agreeableness being the strongest correlate in the model. These results replicated Neff, Rude, and Kirkpatrick's study (2007), finding that higher agreeableness levels were related to higher self-compassion. Interestingly, this study extended the

previous knowledgebase regarding personality traits, by also including the trait for honesty/humility, which was associated with self-compassion. Taken together, results suggested that people who were more tolerating, forgiving, patient, modest, neither manipulative nor entitled (Ashton et al., 2014), were more likely to have higher self-compassion. That was not surprising, considering that having a strong sense of self-importance, being quick tempered, or pretentious is theoretically counterintuitive to self-compassion (e.g., superiority, self-indulgence, self-promotion; Ashton et al., 2014; Neff, 2003a, 2003b).

On the contrary, emotionality was associated with lower self-compassion rates. This was again not surprising, given its resemblance to one of the negative subscales of self-compassion: 'overidentification with emotions' (Neff, 2003a). Theoretically, higher emotionality is counterproductive as it would make people dwell on negative emotions and make them be highly sensitive, vulnerable, anxious, and sentimental (Ashton et al., 2014; Neff, 2003a, 2003b). The fact that the current results found that girls had higher emotionality trait could indicate a 'sex by personality' interaction. The link between being a girl and scoring high on the emotionality trait is well researched (Ashton & Lee, 2007; Ashton & Lee, 2009), however, the link between personality and self-compassion is relatively new. Future studies could benefit from examining how personality can shape self-compassion for girls and for boys, longitudinally.

Limitations and Implications

This study was cross-sectional, precluding any inferences regarding effects of directionality or causation. Future studies could benefit from collecting longitudinal data to determine temporal precedence of well-being with respect to self-compassion in youth

samples and possible developmental impacts. Moreover, despite the fact that this study was based on youth in Southern Ontario, Canada, who were recruited from diverse community organizations, such as camp settings, youth advisories, clubs, and tutoring/private school, it still limits generalizability. Moreover, due to power constraints, post-hoc tests for interactions were not attainable. Future studies could explore whether such interactions exist among larger youth samples.

Given that self-compassion is a dose-dependent, teachable skill that enhances quality of life (Neff & Germer, 2012), it could be beneficial to begin promoting this favourable skill at age 12, because developmentally, it coincides with significant life events (e.g., transition to middle school, a new peer group, changes to body and puberty). Additionally, in this study, emotionality and negative affect related to lower self-compassion rates. Negative mood could act as an "early sign" in prevention efforts, especially since it has been implicated in overlapping with anxiety and depression (Forbes et al., 2004; Joiner et al., 1996). Given that girls showed higher emotionality and worsen mood, intervention and prevention programs could target these early "signs" in adolescent girls to develop more tailored ways to increase their self-compassion rates. Finally, service providers could use the finding that certain altruistic personality traits were associated with self-compassion to educate the public about the importance of finding a balance between caring for others and caring for oneself to prevent the risk of burnout and compassion fatigue.

Overall, this study examined whether age, sex, personality traits, and subjective well-being were associated with self-compassion in youth ages 12 to 18 years. Results showed that while age and sex did not relate to self-compassion rates, higher life

satisfaction and better mood (in contrast to negative mood) were associated with higher self-compassion. Negative affect could be seen as a risk factor for lower self-compassion. Moreover, all personality traits that were related to an 'altruistic tendency' predicted self-compassion. While this study extended knowledge on adolescents' self-compassion, future studies could examine this construct in more vulnerable youth like the young carers, who show significant levels of compassion towards their loved ones, perhaps compromising their own well-being.

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CHAPTER 4: STUDY 2

Unfolding What Self-Compassion Means in Young Carers' Lives[3]

Study 1 examined self-compassion in youth, and while it replicated and expanded research in the field of self-compassion, one gap still persisted. To my knowledge, no studies have examined self-compassion in Young Carers (YCs), who provide a significant amount of care to others and show continuous compassion by seeing and supporting their loved ones vulnerabilities, showing sensitivity, and attending to their needs (Berardini et al., *in press;* Dewar et al., 2014; Sahoo & Suar, 2010). These young people provide care for family members due to specific circumstances in their family (e.g., illness, disability, addiction, language barriers, age-related needs, and parental absence) (Bleakney, 2014; Charles, 2011; Charles et al., 2009; Stamatopoulos, 2015). While YCs are slowly gaining recognition in North America, the impact of this caregiving role and how it manifests in their lives has yet to be fully understood.

In general, caregiving seems to be associated with some costs or, as Stamatopoulos (2018) described it, 'a young carer penalty', which can include emotional, psychological, social, and educational disadvantages (Lakman & Chalmers, 2019; Lakman et al., 2017; Metzing-Blau & Schnepp, 2008; Moore et al., 2009; Nagl-Cupal et al., 2014). Previous studies showed that some YCs experienced depression, low self-esteem, poorer health, as well as lower levels of life satisfaction, happiness, and well-being (Banks et al., 2001, Banks et al., 2002; Chalmers & Lucyk, 2012; Collins & Bayless, 2013; Hamilton & Adamson, 2013; Lakman & Chalmers, 2019; Lloyd, 2013;

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[3] An abstract of this chapter has been accepted; a full paper has been sent and currently under review. Berardini, Y., Chalmers, H., & Ramey, H. (under review). Unfolding What Self-Compassion Means in Young Carers' Lives.

Thomas et al., 2003). Yet, when taking into consideration YCs' outlook on life, some positive outcomes become noteworthy. When YCs found benefits in their role as a carer, they experienced more positive outcomes (e.g., in their social lives, with their family, and in their education) and less burden from care, thus more resilience (Areguy et al., 2019; Cassidy & Giles, 2013; Gough & Gulliford, 2020). Moreover, having practical coping strategies (Doutre et al., 2013; Polkki et al., 2004) or a strong sense of agency and connectedness (Gough & Gulliford, 2020) also promoted better outcomes for YCs.

One factor that has not yet been explored in caregiving youth is self-compassion. In this study, self-compassion is a kindness that is directed inwards and could be seen as a healthy attitude or a coping strategy used when life becomes difficult (Neff, 2003a, 2003b, 2019; Neff et al., 2005). Self-compassion involves people showing kindness toward the self (self-kindness), becoming mindfully aware of negative emotions (mindfulness), and understanding that experience is not unique, but common to all human beings (common humanity) (Neff, 2003a, 2003b). What makes self-compassion relevant to caregiving is its relationship to other-oriented care. Neff (2003a) found that those who provide care for others might have low levels of self-compassion, whereas people who tend to care for others, while also caring for themselves, may have higher self-compassion (Andrews et al., 2020). This other-oriented caregiving has been found to relate to 'compassion fatigue' (e.g., job-related stress) (Coleman et al., 2016; Figley, 2002; Mills et al., 2018), as well as burden and stress (Sawatzky & Flower-Kerry, 2003; van Groenou et al., 2013; Williams, Wang et al., 2014). In many cases, those who care for others do not have many opportunities to self-care (Acton, 2002).

In YCs' situations, although the relationship between inward and outward compassion has not yet been directly examined, some evidence points to their limited ability to self-care. Past studies have shown that self-care was the least engaged in activity by YCs (Lakman, 2015) and that caregiving for others was a major stressor in that YCs had little time to themselves and had few breaks from the caregiving role (Sexton, 2017; Stamatopoulos, 2018; Szafran et al., 2016). Some YCs reported to suppressing their own emotions while showing compassion towards their loved ones (Ali et al., 2012; Chan & Chau, 2010). A study by Nagl-Cupal and colleagues (2015) found that only after YCs exited their role as a caregiver, did they notice that their own needs had been set aside for a long time. This suggests that YCs may not have time nor the opportunity to be compassionate towards themselves due to the needs of their loved ones. Therefore, in the context of caregiving for others, in which YCs spend numerous hours (Banks et al, 2001; Moore et al., 2009; Nagl-Cupal et al., 2014; Warren, 2007), they might have limited time to self-care or show self-compassion.

Lower self-compassion may have some impact on YCs' lives. Having the ability to learn and show self-compassion has been associated with many benefits, such as increased social connectedness (Neff & McGehee, 2010), greater life satisfaction (Neff, 2003a), as well as higher optimism and happiness (Neff et al., 2007). Thus, it is vital to understand YCs' perception of themselves with respect to self-compassion in the context of caregiving for others and in relation to self-care. Since YCs' current levels of self-compassion remain unknown, the current study's objectives were three-fold: 1) to gain a better understanding of what compassion means for YCs and 2) to examine what self-compassion means to YCs and 3) to explore whether YCs saw themselves as self-carers

in addition to being caregivers. This information could be used to enhance some services and programs directed to improving YCs' well-being.

Methods

Participants

Participants were self-identified as YCs by family members or professionals (i.e., service providers). Overall, there were $N = 33$ participants ages 12 to 18; 16 participants ($n = 2$ male, $n = 14$ females) were 12 to 14 years of age and 17 participants ($n = 6$ male, $n = 11$ female) were 15 to 18 years of age. For more specific age and sex composition across the focus group, please see Appendix C.

Procedure

Design and Sampling

This study was approved by Brock University's Research Ethics Board (REB #18-295; Appendix D). By using purposive sampling techniques, executive directors and staff at the two YC organizations in Southern Ontario, Canada were contacted. Participants who attended their programs, were recruited because they self-identified as YCs. Once signed parental consent forms returned to staff members, a focus group session was scheduled. Focus groups were chosen instead of one-on-one interviews because it was believed that participants would discuss the topic with greater ease in front of some of their friends from the program, thereby feeling peer support and comfort (Kitzinger, 1994; Smyth & Michail, 2010). The participants signed an assent form and were encouraged to ask for clarifications at the start of the focus group. All participants provided informed assent and gave permission to be audio recorded. At the end of each focus group, participants were provided with pizza and soft drinks.

Between August 2019 and November 2019, a total of six focus groups, two in each of the three locations (St. Catharines/Niagara Region, Haldimand-Norfolk, and Toronto) were conducted. To ensure rigour and data saturation, four to seven participants were in each of the six focus groups (Kitzinger, 2005; Liamputtong, 2011). Focus groups were divided into younger and older groups to offset any possible developmental differences within one group, where older participants may dominate the conversation (Krueger, 1994).

At the beginning of each focus group, the researcher introduced the topic and defined the main construct of self-compassion as aligned with Neff's (2003a, 2003b) conceptualizations. On average, the focus groups ran for approximately 40 minutes, with a range of 30 minutes to approximately one hour. Semi-structured questions pertained to what YCs thought about their role as caregivers, how they defined 'compassion' and 'self-compassion', what minimized self-compassion, how it tied to well-being, and parents' role in promoting it. For specific focus group questions, see Appendix E.

Data Analysis

I transcribed verbatim and analyzed the focus groups for common themes by utilizing the thematic analysis (Braun & Clarke, 2006), specifically constant comparison analysis (Onwuegbuzie et al., 2009). First, data was chunked into smaller units, representing a code. Then, codes were grouped under similar categories. Finally, themes were created to encompass the categories (Onwuegbuzie et al., 2009). Then there was a comparison of the first group to the rest, to see if the themes in the first group were also observed in subsequent focus groups (Onwuegbuzie et al., 2009). Coding for themes was done following a hybrid approach that included both deductive and inductive thematic

analysis (Fereday & Muir-Cochrane, 2006). For instance, some themes (e.g., theme 1: Characteristics of compassion) were formed deductively, which means that they emerged from the questions that were asked during the focus groups (e.g., How do you show compassion towards others? How does showing compassion towards others make you feel?). Other themes (e.g., theme 3: Supports for self-compassion) were formed inductively, which means that they emerged from the data as a repeated code (e.g., conveying how parents and programs promoted self-compassion) (Creswell, 2007). The groups were also analyzed in an aggregate form, while still paying close attention to any potential developmental differences between younger and older youth. Any findings regarding group differences were discussed in each theme, when it was relevant and noteworthy.

By getting familiar with the transcripts, I created a codebook with main themes. To ensure inter-coder agreement, which is a code cross-checking approach to rigour, I elicited the assistance of four research team members (all of whom are PhD graduate students). Each of them was instructed to review the codebook, which consisted of main themes, codes, and quotations that best explained that code and theme. They were instructed to star the quotes that they disagreed with representing the codes/themes. I met each of them separately to discuss which codes they did not agree upon. Overall, there were 195 codes. A total of seven disagreements between two of the four research team members was evident. Specifically, one research member had five disagreements and the other research member had two, which overlapped with the first research member's disagreements. After compiling a list of disagreements among the four raters, we met together to discuss my solutions and clarify any further discrepancies. Any discrepancies

were resolved by full discussions between all the four research members. This showed an agreement of 188 quotes (96.4%).

Results and Discussion

This study examined whether YCs saw themselves as self-carers in addition to being caregivers and whether they engaged in self-compassionate behaviours in the context of providing care to others. The results revealed three main themes: Characteristics of compassion, self-compassion in YCs, and supports for self-compassion.

Characteristics of Compassion as a Function of Being a YC

Although it is a common practice to categorize YCs' daily tasks into household tasks, medical care, sibling care, personal care, and emotional care (Chan & Chau, 2010; Fives et al., 2013; McDonald et al., 2009; Sahoo & Suar, 2010; Sexton, 2017; Warren, 2007), this study revealed that YCs spoke about their responsibilities in task-oriented versus affect-oriented compassion. Furthermore, compassionate care promoted positive self-regard and regard for others (see Table 4.1).

Table 4.1

Example Quotations for Theme A: Characteristics of Compassion

Themes	Subthemes	Example Quotes
A. Characteristics of compassion	1. Task-oriented	"When my father is feeling down, I play chess with him" [focus group 1, younger male]
	2. Affect-oriented	"When my older sister feeling down, I try to cheer her up" [focus group 1, younger female].
	2.1 Empathy	"…I can also have empathy for them and give them advice. I can be like 'okay, I kind of went through something similar, last year, and for me, this really helped', you know?" [focus group 4, older female]
	3. Contributes to positive self-regard	"It makes me feel good because it lets me know that I did a good thing" [focus group 2, younger female]
	4. Promotes regard for others	"My sister is upset a lot, so it makes me happy to see her happy" [focus group 1, younger female]
	5. A normal action, not special	"…but you did it everyday so its not really something you notice... you are just like 'okay, take your medicine'. And you don't really feel for that anymore cuz you have done it for flipping 16 years, right?" [focus group 4, older female]

The task-oriented compassion included any behaviours that were intended to solve a problem, such as helping others with speech, lifting, doing groceries, and completing household tasks. The affect-oriented compassion comprised any behaviours that were specific to showing emotional care, such as giving someone a hug, being there for their loved ones, and emotionally checking in on them. Affect-oriented compassion included acts of empathy. When asked what compassion meant for the participants, a younger female participant noted that for her, it was about "putting yourself in someone else's shoes and letting yourself feel what they are feeling" [focus group 2]. However, the role of empathy should be explored in future studies, since it may be either a trait that

could predict compassion and caregiving (Lim & DeSteno, 2016), or be the product of such caregiving (Stamatopoulos, 2018)

Further, compassionate actions contributed to positive self-regard, or an improved internal state. As one participant commented: “It [providing care] makes you feel more mature. It makes you feel like smarter, more mature, cuz you are helping someone out” [focus group 3, younger female]. All younger participants (and none of the older ones) gave an adjective to describe how helping others made them feel (e.g., happy, excited, good, amazing). These findings were congruent with previous studies that found that caregiving contributed to some YCs feeling happier, becoming stronger, as well as becoming more considerate, mature, compassionate, proud, capable, and useful (Bolas et al., 2007; Chan & Chau, 2010; Sahoo & Suar, 2010; Smyth, Cass et al., 2011; Szafran et al., 2016). It seems that this was consistent across age groups, as some of these studies included former YCs or youth that were younger and older than the current study’s sample (e.g., some were 7 or 11 years old and up to 25 years of age). However, it should be noted that in the current study, the older youth were far more reflective about how these actions made them feel, which could simply be due to developmental differences. This was illustrated as one older male [focus group 5] stated:

> “… it [showing compassion] can be very stressful but at the same time, it can be a very good thing cuz it’s one of those things that pushes me to be more optimistic towards others and help others…you just feel like you [are] doing something for the best of the world… helping other people and make sure they are not in the same spot that you were kind of makes you feel good”.

This suggests that for this older individual, compassion not only enhanced their self-regard (e.g., made them more optimistic, made them feel good), but it also promoted regard for others (e.g., become optimistic to help others, making sure others are doing well). This was also the case in Bolas, Wersch, and Flynn's (2007) study, where interviews with older youth (aged 14 to 18) showed that their sense of self-esteem was tied to feelings of being useful and capable of helping others. Thus, in addition to gaining a more positive state of self, compassionate actions elicited regard for others, as many more participants reported caregiving because it made the other person feel good. As one younger, female participant stated [focus group 1]: "[caregiving makes me] happy to see my brother happy even though it bugs me a lot, I still want to see my brother happy".

Showing empathy, self-regard, and regard for others could all be motivators for caregiving. Berardini, Volk, Chalmers, and Kalkman (*in press*) have suggested that some YCs could be motivated by evolutionary mechanisms (e.g., kin selection, altruism, attachment, and temperament) to care for others in the family. The motivator may be as simple as loyalty and love for family members (Earley et al., 2007), but it could also be self-serving (Berardini et al., *in press*). However, it must be noted that in many cases, YCs do not have a choice when it comes to caring for their loved ones (Bolas et al., 2007; Parveen et al., 2011; Sawatzky & Fowler-Kerry, 2003; Smyth, Cass et al., 2011). Therefore, future studies could further explore this "involuntary" nature of compassion.

Finally, for some of the older youth (and none of the younger participants), compassion was not a special act at all (see Table 4.1). In fact, older YCs talked about how for them it was a normal, "natural" act, as one participant described:

> "It's just like… for me… I dunno if it's for the others, but like doing the things that you need to do for the person you care for is just natural, right? Like by now, at the stage we are at [mumble], it's kind of a fluid motion. It's like muscle memory. You just go with it or whatever. I know when I was younger and when I first started putting this extra step, you kind of feel good about yourself, you feel like 'oh, I helped someone out today' or whatever…" [focus group 6, older male].

This suggested that doing it for longer (as a function of being older) makes acts of compassion less noticeable with time, and thus more normalized. These results complemented a study by McDonald, Dew, and Cumming (2010) who found that for some YCs, caregiving became a natural behaviour, and with time, both parents and children have gotten used to it. However, it should be noted that habituating to the caregiving role could just be a function of how they have entered the role and the length of time they care for. In other words, those who reported it was normal for them could have been socialized into the role (e.g., have been born into it), and since they started caregiving at an earlier age, it was all they knew (Hamilton & Adamson, 2013; McDonald et al., 2010). The ability to provide caregiving "naturally" could also indicate temperamental differences that other children and youth may not possess (Lakman & Chalmers, 2019). Another potential explanation, and perhaps a more problematic view, is that with time and increased complexity of the caregiving situation, these children may think more and more about their family member(s)' needs and less and less of their own (Nagl-Cupal et al., 2015).

Self-Compassion in YCs

The paradox and the struggle with self-compassion

In the current study, YCs understood self-compassion as being an essential part in their caregiving identities (see Table 4.2). For instance, one participant said: "I mean self-caring makes me feel like a better person because I became kinder and more accepting [towards her brother] by self-caring" [focus group 6, older female]. This suggested that there was a relationship between caregiving for others and for oneself. This quote showed that this YC saw how self-compassion was tied to the potential enhancement of their caregiving role. The relationship between self-compassion and caregiving was confirmed by other studies who noted that increasing self-care via self-compassion could benefit one's well-being and caregiving abilities (Acton, 2002; Boellinghaus et al., 2013; Nelson et al., 2017). Moreover, when asked how they showed self-compassion or self-care, many YCs were able to list self-caring practices. They shared how they watched TV, surfed the Internet, hang out with friends, took baths, and relaxed.

Despite verbally stating its' essential role and bringing up self-caring ideas, a contradiction appeared when they identified that the caregiving role was their main barrier to self-compassion as one participant commented:

> "You have to take some time out of your day. It can be very time consuming and energy consuming and emotionally consuming… just like very consuming everything… even if you might not notice it. Because what if this person [the person they care for] wasn't this way, like you would maybe have more time for other things" [focus group 3, younger female].

It was not surprising that YCs experienced time constraints (Banks et al., 2002; Stamatopoulos, 2018; Warren, 2007), but these results have expanded previous studies because these results point to the relevance of time availability in relation to self-compassion and the ability to self-care. In this context, it created a paradox: YCs knew that self-compassion was important to their caregiving role, were able to list self-care practices, but reported that their caregiving role is one barrier to self-compassion and self-care. This yielded some serious tensions.

Some tensions related to confusion or lack of understanding of self-compassion (see Table 4.2). When asked whether they had time to care for themselves or show self-compassion, some simply nodded in agreement. When asked to elaborate on how they did it, a younger female participant responded: "I don't really make… I don't know… I just… it's… I don't know" [focus group 1]. This indicated that some YCs could not explain how they showed self-compassion, either because they never thought of it before or because they experienced difficulty with the term. The silence of the rest of the participants could suggest that they did not understand the topic, were uncomfortable with the topic, or wanted to avoid answering the question.

Moreover, further conversations with YCs revealed that it was very hard for some older YCs to accept the need for self-care or self-compassion. Older YCs spoke about how it would make them feel selfish if they took the time away from their loved ones to care of themselves. To truly understand the tensions between being a YC and having time to self-care, an older female participant said: "It's difficult to care for yourself" [focus group 4]. To which, another member of the group added: "Yea, cuz there is a very fine line between self-compassion and selfishness…very fine line and I don't want to cross

it… I rather not have self-compassion than be selfish" [focus group 4, older male]. This showed how for them, caring for oneself might represented a character flaw. It should be noted that developmentally, older youth were in the stage of being highly concerned with how others might perceive their behaviours, and as a result they might have been more concerned with how it would look if they cared for themselves instead of for their loved ones. Even though previous research noted that self-compassion did not relate to narcissism (Mills et al., 2018; Neff, 2003a; Neff & Vonk, 2009) and did not entail selfishness or self-centredness (Mills et al., 2018; Neff, 2003a), a few YCs continued to struggle with distinguishing between self-compassion and selfishness.

Finally, some tensions grew out of sense of guilt for taking time for themselves instead of helping others. These tensions were further explained by a participant who said: "You have the ability to care for yourself but you do feel kind of slightly selfish or self-centred so then you kind of lay back and you care for yourself but not as much as you thought you could" [focus group 6, older male]. This was in accordance with previous studies that showed the role that guilt plays in caregiving (Bolas et al., 2007; Doutre et al., 2013; Earley et al., 2007; Stamatopoulos, 2018). The following exchange with participants [focus group 5] and the researcher helps to show how difficult it could be for some YCs to take time during their day for self-care:

> "I probably do [have time to self-care], I just don't take it though… you can and you know how to, but you just don't feel you need it. You just want to 'save it for another time'" (older female). To which another participant added, "yea that is what I was just thinking, more than likely a lot of people have time but choose not to use it … probably the feeling of you can't". (older male).

In a recent study, Stamatopoulos (2018) found that several older YCs (ages 15 to 19) reported that it was difficult to secure "free time" and even if they were successful, they felt guilty for taking it. These feelings and tensions were not unique to YCs. For example, informal and formal adult caregivers also noted similar tensions, and feelings of being selfish or feeling guilty (Gonyea et al., 2008; Mills et al., 2018; Tate, 2015). Future studies could further explore how the existence of these tensions, especially guilt, can minimize one's self-compassion.

Pointers of lower self-compassion

Results from the focus groups indicated that YCs' self-compassion was notably low (see Table 4.2). Based on Neff's studies and conceptualizations (Neff, 2003a, 2003b), self-compassion is comprised of three main dimensions, specifically self-kindness, mindfulness, and common humanity, that are contrasted with self-judgement, over-identification with emotions, and isolation, respectively. It is also lower in people who direct their attention towards meeting other's needs and the current study found that YCs showed more "other-oriented" tendencies, were more self-judgemental as opposed to self-kind, were more overidentified with emotions rather than mindful, but nonetheless experienced the component of common humanity, instead of isolation.

'Other-Oriented' tendencies. YCs' responses were extremely 'other-oriented'. In line with previous research findings (Neff, 2003a), regard for others was related to low self-compassion rates. In this study, some quotes illustrated that for them, even self-care was rooted in other-oriented care. A younger female participant [focus group 1] said that self-compassion is "that you love yourself, doing the best you can for anyone" and an older, male participant [focus group 6] responded: "hmm care for myself, I'd say its

caring for them too”. These ‘other-oriented’ responses suggest that some YCs were oriented towards helping others more so than helping themselves, thereby diminishing their self-compassion. Further, all older YCs (and none of the younger ones) reported concealing their ‘need for self-care’ from their parents. As one participant reported:

> “I think my parents think… yea... they think that I take care of myself a lot, right? But I don’t... my parents are like ‘how has your day been [participant’s name]?’ and ‘are you taking care of yourself and stuff?’ and I’m like ‘yes, of course I am!’, but that’s A BIG FAT LIE [emphasized and pronounced louder]. And I just don’t want them to worry cuz they already have enough to worry about” [focus group 4, older female].

This shows that they actively concealed their hardships as an attempt to protect their parents from added stress, reinforcing again their ‘other-oriented’ tendencies, where they are doing it to better others, despite the potential costs to themselves. This tendency was also evident in other studies who found that YCs suppressed their needs to ensure others’ needs were met first (Ali et al., 2012; Nagl-Cupal et al., 2015). Moreover, Stamatopoulos (2018) found that their needs were secondary to the needs of their family member(s). Thus, this inclination of thinking about others first before meeting their own needs reinforced just how potentially low their self-compassion level was.

Self-judgement. YCs in the current study did not show self-kindness. In fact, when they were asked whether they were good carers, some narratives pointed to self-judgement, as participants said ‘no’ and one participant reported: “they [grandparents with whom he lived] kicked me out so I couldn’t have been that good” [focus group 4, older male]. Although the researcher did not want to further explore which behaviours

might have contributed to the grandparents asking him to leave, the YC might have thought that if he would have been a better carer, they would not have kicked him out. This self-criticism may hinder YC's ability to be kind to themselves, thereby lowering their levels of self-compassion.

Another example came from a female participant, who distinguished between feeling good about herself physically versus mentally, as she responded: "…because physically I would…I do take care of myself. I like makeup and everything but like mentally, I'm not really nice to myself" [focus group 3, younger female]. This indicated that some YCs struggle with being kind to themselves and can be critical of themselves at times. Similar findings were reported in a study by Ali and colleagues (2012) who found that some YCs felt that they were hindering the situation with their care-recipients, especially when they felt that the person for whom they cared for resented them. All in all, this self-judgement (e.g., feeling as inadequate caregivers or thinking that they have failed to meet one's needs, or not being nice to themselves) could be associated with one's guilt (Gonyea et al., 2008; Losada et al., 2010), thereby pointing again to its' potential influence over self-compassion. It might also relate to low self-esteem, where they are evaluating themselves in a negative light (Banks et al., 2001; Lakman & Chalmers, 2019).

Overidentification with emotions. YCs' quotes exhibited the consequences for lacking time to self-care, which suggested overidentification with emotions. Both younger and older participants reported negative affect when they sensed that they did not have time for self-care (please see Table 4.2 for example quotes). Interestingly, the younger participants reported externalizing behaviours (e.g., getting upset, yelling, and

freaking out), while the older participants reported more internalized stress. Similarly, Szafran and colleagues (2016) found that YCs acted out and engaged in illegal activities to cope with their stress. Moreover, Bolas and colleagues (2007) found that some expressed anger and frustrations, much like the youth in the current study who reportedly yelled and became angry when they did not have time for themselves (see also Moore et al., 2009). Moreover, this study showed some evidence for internalized stress as did other studies with YCs (Bolas et al., 2007; Cree, 2003; Early et al., 2006; Stamatopoulos, 2018). Each these aspects of overidentification with emotions were indicative of low self-compassion.

Meanwhile, some participants reported accepting the fact they had no time for self-care or self-compassion. Sometimes, instead of overidentification with emotions, the lack of time was manifested through some level of understanding and coping with their situation, as was the case when an older female participant responded [focus group 6]: "I try to think that its okay sometimes if I miss one time with my friends, sometimes I'll see them at school the next day and we will be fine". This response was very similar to what other YCs from another study did when they were probed about their social lives (or lack thereof) (Stamatopoulos, 2018). This specific participant validated that she was fine and would see her friends at school, much like YCs' in Stamatopoulos' study (2018) who chose to use other setting (like school) to gain back some social opportunities when they were anxious about "missing out" (in this case, hanging out with friends, which was a self-caring opportunity). Hence, accepting the fact that sometimes there would not be time for self-care could be their way of coping with the demands of their everyday lives. Although acceptance with one's caregiving role has been established in previous studies

(Pakenham et al., 2007; Smyth, Blaxland et al., 2011), there are no studies, to my knowledge, that have examined this sense of 'acceptance' for lacking the time to self-care. Thus, this study expanded current literature on YCs, by findings that some might accept the fact they do not have time for self-care. Future studies could explore whether this acceptance is used as a coping strategy or may be a protective factor against 'compassion fatigue'.

Common humanity. Being a part of a support program engendered a sense of belongingness, rather than isolation. For so many YCs, who are not a part of a program, caregiving can become an isolating experience (Ali et al., 2012; Bolas et al., 2007; Szafran et al., 2016). Yet, many participants in the current study talked about the importance of having friends who shared their experiences, as one participant noted: "I think coming here also takes off of the stress at home so we just have fun hanging out with people who are going through the same thing as us" [focus group 1, younger female]. By becoming a part of a support group, it was not a surprise that YCs received a safe space, validation, and support (Richardson et al., 2009; Smyth, Blaxland et al., 2011). With that, they also sensed right away that they were not alone and that others experienced the same hardships as them. This was in line with Neff's (2003a, 2003b) 'common humanity' facet of self-compassion. These results paralleled the experiences of older informal caregivers who said that they have gained comfort and understanding that others went through similar situations, reassuring to them that they were not alone (Williams, Morrison et al., 2014).

Table 4.2

Example Quotations for Theme B: Self-Compassion in YCs

Themes		Subthemes	Example Quotes
B. Self-compassion in YCs	1. The relationship between self-compassion and caregiving- The paradox	1.1. Self-compassion is essential to be a good caregiver	"If you are feeling bad it would be pretty hard to help other people, because how can we care for other people if you are not caring for yourself?" [focus group 2, younger female]
		1.2. Self-compassion via self-care practices	"I sometimes like to draw so I would draw" [focus group 1, younger female]
		1.3. YCs' caregiving responsibilities directly minimize self-compassion	"For me, its hard to find the time because my brother, he doesn't communicate like others do so it gets tough to like stay on top of school and I sort of fear for my future like university… like how am I going to help my parents but typically, I try to find the time. Sometimes I just don't have the time" [Focus group 6, older female] "I don't have any self-compassion" [focus group 4, older male]
	2. The struggles and tensions	2.1. YCs did not think about or understand the term	"I never actually even thought of that-wow!" [focus group 4, older female]
		2.2. YCs worried that it may reflect selfishness	"I would consider myself selfish if I did that. Oh, it's like 'am I allowed to do all of this for me?'. It's for me… it's not for someone else… if I pay attention to them [family member], am I allowed to give this much attention to me?" [focus group 6, older female]

Themes		Subthemes	Example Quotes
		2.3. YCs felt torn	"For me, its like, I guess its like stress. Like I'm stressed… my brother is growing up and… he needs more help right now to become more independent and stuff, as he gets older, its going to get worse. And I'm like 'but I have my own stuff in life that I also have to care for'" [focus group 4, older female]
		2.4. YCs felt guilty	"I guess if you don't care for them I guess its in the back your mind, there is a little tick that kind of reminding you but yea, you know, there are times where us, as caregivers, we should be able to have a little bit of time alone, or not time alone, time away from having that responsibility.. but yea" [focus group 6, older male]
	3. Pointers for lower self-compassion	3.1. Increased self-judgement	"…Even if I facetiming…they are like 'oh [name] you seem like such a good sister', but like I don't see it.. I don't know if its just me" [focus group 4, older female]
		3.2. Increased overidentification with emotions Externalization/ internalization versus acceptance	"I go outside and yell" [focus group 2, younger female] "I get stressed out because sometimes when I'm working too hard, some days I kind of run myself to the ground and then I get really tired and my emotions are all over the place. I dunno… it stresses me out most of the time" [focus group 5, older female]. "Just go on with life and just not do it [self-care]. You live and you will be fine eventually at some point…. Hopefully" [focus group 4, older male].

Themes	Subthemes	Example Quotes
3. Pointers for lower self-compassion	3.3. Increased compassion for others	"No [don't have time to self-care]. If I do have any free time, I immediately ask if anybody needs help, cuz I know they need help more than I do" [focus group 4, older male] "yea I don't tell my parents when things get hard. I don't …" [focus group 6, older female]
	3.4. Decreased isolation via common shared experiences	"…Of course we go through different situations at home and you have some similarities, they won't find it in a school building necessarily" [Focus group 5, older female]

Supports for Self-Compassion

It was imperative to examine what the parents' and a support programs' role was with respect to self-compassion (see Table 4.3). Some participants spoke about their parents' ability to encourage and promote self-compassion in them. For example, an older female participant said "My parents sometimes when I'm doing too much, they will be like… they will say that its not all my responsibility to take care of everything and that if I want to go away to some place, yea that's fine" [focus group 5]. This statement showed that her parents might encourage them to be kinder to themselves. Yet, others shared that their parents disapproved when they took time for themselves. The following exchange between the researcher and two participants showed that some parents were unable to give YCs the break that they were looking for:

Researcher: "Have they [parents] ever come to you and said 'listen, I know you are going through a lot, have a little break'".

Participant [focus group 5, older female]: "oh no, they will add stuff on my plate and expect me to be done in two hours". To which another participant [older male] exclaimed: "precisely!"

Other participants noted how their parents expected things to get done or assumed they were okay, as one participant reported: "my parents care about me, but most of the time they spend on my sister, especially my mom. She does the cooking and work so she doesn't have a lot of time to check up on me and she assumes I'm very independent" [focus group 6, older female]. This, of course, could be seen as a coping strategy, where the YC validates to herself that she is doing okay without her parents monitoring her condition, but it also suggests that some parents might not have time to check up on YCs. In fact, one YC [focus group 6, older female] noted that her parents forget to check up on them because "they have their own problems…they don't always know what you are doing so you get home, and you go upstairs and you work on your own stuff and they think 'oh you always caring about yourself'". This suggested that some parents not only lacked time, but also may assume that their children were fine and had enough time for themselves.

Finally, some narratives revealed an increased conflict with parents regarding self-compassion. This was likely because parents were inconsistent, as sometimes they let their children have time for self-care and other times not, as one younger female participant shared: "Sometimes my mom lets me but sometimes she doesn't. The times that she doesn't, I get really angry easily, and then I start getting mad and I start yelling, and then she starts yelling at me and then I get in trouble" [focus group 2]. Other times, the conflict was brought up because parents and YCs had different ideas about what self-

care entailed. One participant reported: "when they [parents] think of 'caring for yourself', my mom especially thinks of exercising, like 'you should go exercise or something', rather than... I feel like there are other forms of self-care that aren't always exercise" [focus group 4, older female]. For this participant, self-care was more about a distraction or relaxation.

Overall, the variability in parental promotions of self-compassion could simply be a function of individual differences in parents or parenting differences, busyness level, quality of the relationship, and/or the nature of the illness or disability. For instance, the denial for "alone time" could be due to differences in everyday demands, seriousness of the illness, and unavailability of a parent due to work-related pressures. This complemented Stamatopoulos' (2018) findings, in which some YCs reported that their parents "pull out the caring card" (p. 196) when they asked for some alone time, and depending on the circumstances, parents denied their requests, thereby contributing to added familial strain. Given the great deal of variability, these findings should be taken lightly, especially because the present study did not collect data from parents to validate these results. Therefore, future studies should examine how the parental role could facilitate self-compassion in YCs' lives and assess parent' views, in addition to YCs, to gain a more comprehensive idea of how they promote or discourage self-compassion.

In addition to the parent's role in shaping self-compassion, support programs also found ways of promoting it by giving participants opportunities for socializing with other YCs and learning new skills (see Table 4.3 for example quotations). When asked about their experiences with the support programs they were a part of, many participants noted how they used the programs to escape and felt relief from their caregiving role. Using YC

programs as respite or "time out" is a common finding in literature (Richardson et al., 2009; Smyth, Blaxland et al., 2011). Some participants reported that the programs taught them not only how to care for the self, but also how to care for others, as an older male participant [focus group 6] claimed: "…we have programs like this to share or gain more knowledge on how to take care of them…". Most importantly, programs were able to offer peer support, which, in turn, offered YCs the opportunity of engaging with and learning from other YCs. This study found that many of them liked being friends with other YCs. This was also evident in two studies that explored YCs' programs (Richardson et al., 2009; Smyth, Blaxland et al., 2011). Having the opportunity to minimize their isolation through peer support and finding out that others go through similar situations may enhance their understanding of 'common humanity', thereby contributing to higher self-compassion, as previously discussed. However, this study revealed another contradiction. Despite the programs' ability to offer respite and teach skills to the youth, the YCs in the current study showed low self-compassion rates. Thus, it could be beneficial for the organization to evaluate whether their programs help to enhance self-compassion and further examine whether youth in the programs follow a self-care plan.

In summary, the results revealed that showing compassion for others may come with costs to one's own ability to show self-compassion. Despite this, being in a program has helped them establish connections with others and possibly, helped them be more engaged in self-care. This could be their first step towards building self-compassion.

Table 4.3

Example Quotations for Theme C: Supports for Self-Compassion

Themes		Subthemes	Example Quotes
C. Supports for self-compassion	1. Parent's role in relation to self-compassion	1.1 Parents encourage	"My parents think self-compassion is really good for me and they help me a lot" [focus group 2, younger female]
		1.2. Parents disapprove	"Not at all! Whenever I try to have anytime to myself they just immediately get mad at me for no reason" [focus group 4, older male]
		1.3. Parents expect or assume they are fine	"When I get home, its kind of spaced out when it comes to my parents. I have dinner or whatever, but then I go do my own thing. They are not like checking in and being like 'hey, are you okay? We know you have to take care of her, how are you doing?' It's kind of like 'do it'. Its just how it is" [focus group 6, older male]
		1.4. Increased conflicts with parents	"…let's say I spent over an hour on my phone, my mom, she wouldn't get super mad at me about it but…be like 'oh you should be spending time with your brother, like you are wasting all this time on yourself, but you should be spending it with your brother'…its like a mix… other times they are like '[participant name], you have been way too involved in other things, take a day off'. So, I don't know how it works…" [focus group 4, older female]
	2. Program's role in relation to self-compassion	2.1 Escape	"It feels like I have the time off and I don't have to watch them [siblings] because someone else is there to watch them" [focus group 2, younger female]
		2.2 Learn skills	"they teach you ways to care for yourself" [Focus group 1, younger female]

Implications

This study yielded important results that could further contribute to improving support services and helping to guide parents in supporting self-compassion in their children. First, these focus groups revealed that YCs' self-compassion was low. This finding could help service providers to start cultivating self-compassion in youth as young as 12. Past studies found that self-compassion could be a teachable skill (Neff & Germer, 2012), and thus starting to address it with caregiving youth earlier could better equip them to self-care. Second, this study showed that YCs identified the caregiving role as a barrier to self-care and self-compassion. Given they already lack time, teaching self-compassion should not feel like an extra task and instead could be offered during regular program hours with some program modifications. For example, some lessons or intervention plans for YCs' self-compassion could include replacing self-judgement with self-kindness or introducing mindfulness to cope with emotional and physical stressors.

Furthermore, it is imperative to teach parents how to promote self-compassion in their children. This study showed that added tensions arose from having different definitions of self-care or self-compassion, from assuming the children are fine, and from being inconsistent with allowance of free time. Therefore, it would be important for parents to regularly 'check in' with their children, set expectations, monitor everyone's needs, and establish a balance, which could then make YCs feel less guilty about taking a break and furthermore, mitigate some familial conflicts (McDonald et al., 2010).

Strengths and Limitations

The current focus groups were held with YCs from support programs. This presented as a limitation and a strength. It could be argued that YCs' recollections of self-

caring practices were due to their participation in support programs that specifically aimed to reduce their stress. Therefore, it could be that their account of self-caring behaviours was related to what they have been taught in the programs. Given YCs were recruited from support programs, they might have represented more resilient youth (with better coping tools) than other YCs who might have been more isolated and hidden.

Although it presents a limitation, accessing support groups, where YCs knew one another, was beneficial as it yielded rich qualitative content that otherwise would not have been possible to attain given this population is often hidden and private (Bolas et al., 2007; Kennan et al., 2012; Warren, 2008). It also helped to gain some insight into what it meant for identified YCs to be self-carers. Moreover, the youth in these focus groups had low self-compassion, thus suggesting they did not represent a more resilient group.

Finally, this study was also limited to only those YCs who have chosen to share their stories; thus, it did not capture the voices of the ones who remained quiet during the focus groups. Since Kitzinger (2005) urges to pay attention to silenced voices, it is important to note that during the focus groups, some youth, especially younger ones, really struggled with the concept. The conversations (verbatim) were sometimes short and full of breaks. This could be because they were either uncomfortable or not familiar with the concept. This could have also been the case because YCs enjoyed using program time as their escape from caregiving and did not appreciated talking about their experiences there and then (Smyth & Michail, 2010).

Notwithstanding the limitations, this was the first study, to my knowledge, to have examined self-compassion in caregiving youth. The results of this study helped to expand the current knowledgebase on YCs' self-compassion rates. Results revealed that

in addition to being YCs and showing compassion towards their loved ones, they reported to self-care. They spoke about their lack of time to be able to self-care in relation to their caregiving role. There was evidence of low self-compassion; YCs had difficulty coming in terms with or understanding self-compassion. Their accounts were filled with feelings of selfishness, guilt, conflict, and many other aspects that directly minimized self-compassion. Their engagement in the support program has helped them obtain one aspect of self-compassion, common humanity, which protected them against possible isolation. Overall, findings from this study could get integrated into support programs that would help to increase self-compassion in youth who, without a doubt, offer a great deal of compassion to others, despite accumulating some costs to themselves. Future studies could further explore whether YCs' low self-compassion is still maintained when comparing them to non-caregiving youth.

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CHAPTER 5: STUDY 3

Young Carers' Self-Compassion and Subjective Well-Being Relative to Non-Caregiving Youth[4]

In Canada, most recent evidence has shown that young carers (YCs), who provide unpaid care for family members due to specific circumstances in their family (e.g., illness, disability, addiction, language barriers, age-related needs, and parental absence) (Bleakney, 2014; Charles, 2011; Charles et al., 2009; Stamatopoulos, 2015), represent nearly two million of children and youth (27%) between the ages of 15-24 years (Stamatopoulos, 2015). Internationally, especially in the United Kingdom and Australia, YCs are well known and supported by community programs and the government, as well as recognized in society (Becker, 2007; McDonald et al., 2009; Moore & MacArthur, 2007; Richardson et al., 2009; Watson, 1999). However, in Canada, more research is needed to further understand who YCs are, the impact on their lives, and how to best support them.

Provision of care takes time and requires effort. One common finding is that YCs often complete more chores and spend more time on caregiving tasks than other children their age (Banks et al, 2001; Becker, 2007; Nagl-Cupal et al., 2014; Warren, 2007). Their responsibilities may include household tasks, general care, sibling care, medical/nursing care, financial care, and emotional support (Joseph et al., 2009; McDonald et al., 2009; Nagl-Cupal et al., 2014). YCs' experiences (e.g., living with family members with illnesses or disabilities) and circumstances (e.g., having no one else to provide the care) often necessitate 'heavier' caregiving responsibilities (Becker, 2007). This suggests that

[4] A version of this chapter will be submitted for publication

for some YCs, responsibilities may quickly compound and have a tremendous impact on their lives.

Many studies have found that added caregiving can leave some YCs feeling extreme exhaustion, stress, and burn-out (Szafran et al., 2016), and at-risk for several adverse consequences such poorer physical and mental health, as well as lower well-being (Banks et al., 2001; Banks et al., 2002; Chalmers & Lucyk, 2012; Collins & Bayless, 2013; Hamilton & Adamson, 2013; Lakman & Chalmers, 2019; Lloyd, 2013; Polkki et al., 2004; Thomas et al., 2003). Even comparative studies show the same pattern of results, with YCs reporting higher depressive symptoms and lower self-esteem (Banks et al., 2001; Lakman & Chalmers, 2019), lower life satisfaction and more emotional and behavioural problems (Collins & Bayless, 2013), more negative affect and anxiety about their futures (Sahoo & Suar, 2010; Warren, 2007), as well as more physical and mental health problems (Nagl-Cupal et al., 2014). In the case of Canadian-based studies, although Lakman and Chalmers (2019) found that YCs had lower self-esteem and higher depressive symptoms, Remtulla and colleagues (2012) found that YCs did not feel any more overwhelmed than non-YCs. Much remains unknown about YCs' experiences in Canada and what is known so far yielded mixed findings, which reinforces the need for further investigation.

Although the above-mentioned studies have explored mental health generally, only four studies have directly explored well-being in YCs. Bolas, Wersch, and Flynn (2007) reported that all the interviewed YCs felt angry, guilty, and overwhelmed with their caregiving role. Moreover, Järkestig-Berggren and colleagues (2019) found that YCs scored relatively low on psychological well-being, showing levels of emotional

symptoms, hyperactivity, and peer problems, which were above the clinical cut-off for total difficulties. One comparative study directly measured well-being in YCs aged 10-11 years and found that those who looked after somebody at home had poorer well-being and were overall less happy than children who did not look after somebody at home (Lloyd, 2013). Finally, a study from Switzerland found that YCs' SWB was lower than those not identified as a YC (Leu et al., 2019). While this evidence points to relatively low well-being, these studies used different measures (e.g., psychological, emotional, subjective well-being or constructs related to mental health), which precludes any clear conclusions from being derived.

Instead of addressing impact via psychological or emotional well-being measures, it could be more empowering to measure how YCs themselves think and feel about their own lives, eliciting their SWB (Diener, 2000; Seligman & Csikszentmihalyi, 2000). For instance, a few YC studies have already focused on strength-based constructs (e.g., happiness, resilience, coping) or benefit-findings (e.g., maturation, independence, better self-concept, appreciation) (Doutre et al., 2013; Gough & Gulliford, 2020; Heyman & Heyman, 2013; McDonald et al., 2009; Polkki et al., 2004). When asking YCs how they feel, one study explored a phenomenon of the 'duality of caregiving' (Doutre et al., 2013, p. 36), which shows that they can feel happy and appreciative of their caregiving role and at the same time feel miserable (Heyman & Heyman, 2013; McDonald et al., 2009; Stamatopoulos, 2018). Those who persevere, can be viewed as resilient, showing inner growth and coping (Polkki et al., 2004), self-efficacy (Gough & Gulliford, 2020), as well optimism (Lakman & Chalmers, 2019). With only one study that was mentioned earlier measured SWB (Leu et al., 2019), it is imperative to continue this trend, because in

Canada, no studies, to the best of my knowledge, have examined SWB among YCs. Thus, it would be important to examine SWB in YCs in comparison to their peers to not only expand Canadian-based literature, but also to have a better sense of how they think and feel about their lives in comparison to their peers.

Given YCs' tendencies to experience an array of negative emotions (Bolas et al., 2007) and provide caregiving until they report lacking time for other activities (Kavanaugh et al., 2014; Nagl-Cupal et al., 2014; Stamatopoulos, 2018; Szafran et al., 2016; Warren, 2007), it was also important to examine whether YCs leave room for self-compassion. Neff (2003a, 2003b) defines self-compassion as a healthy attitude or an emotional regulatory strategy that is directed towards oneself. Research suggests that self-compassion includes three main components: Self-kindness, mindfulness, and common humanity, countered with self-judgement, identification with emotion, and isolation, respectively (Neff, 2003a, 2003b). Self-compassion is very beneficial, as it was found to be associated with optimism, positive affect, and happiness (Neff, Rude et al., 2007) and enhance psychological functioning, quality of life, and well-being (Neff & Germer, 2012; Neff, Kirkpatrick et al., 2007; Neff & McGehee, 2010; Neff, Rude et al., 2007).

It has been argued, when self-compassion is high, people who provide care to others remain kind to themselves, show mindfulness regarding their emotions, and understand that others share their experiences too (Neff, 2003a). However, when self-compassion is low, people who provide care to others only focus on other people's needs and neglect their own (Neff, 2003a). In YCs', it is common to find them meeting other's needs instead of their own needs (Ali et al., 2012; Nagl-Cupal et al., 2015), yet

surprisingly, the self-compassion construct has been absent in the YC literature. Based on findings from focus groups (Study 2), YCs showed some indication towards having low self-compassion rates**.** However, due to the lack of comparative studies, conclusions cannot yet be derived about where YCs' self-compassion rates are in comparison to their peers. Thus, in addition to measuring their SWB, this study aimed to measure YCs' self-compassion in relation to non-caregiving peers.

Taken together, in comparison with other countries, much remains unknown in Canada with regards to YCs (Waugh et al., 2015). The limited and mixed knowledgebase we have on YCs' well-being in Canada, coupled with the lack of studies that have examined YCs' SWB and self-compassion underpins the need for this study to compare YCs and non-YCs on these two important constructs.

Methods

Participants

The sample comprised of 162 participants, that were split into YCs and non-YCs:

YCs. There were 42 self-identified YCs from support groups and 13 YCs who were screened from the community, comprising a total 55 YCs aged 12-18 years. Of the 55 YCs, 22 were boys (40%) and 33 were girls (60%). Their average age was 14.31 years (SD = 1.69). A total of 92.7% were born in Canada. Yet, the majority identified belonging to another ethnicity/culture (61.8%, n = 34): American (3.6%, n = 2), French (20%, n = 11), Italian (16.4%, n = 9), Chinese (1.8%, n = 1), German (9.1%, n = 5), Ukrainian (3.6%, n = 2), Dutch (7.3%, n = 4), Greek (1.8%, n = 1), African (3.6%, n = 2), British (18.2%, n = 10), Hungarian (7.3%, n = 4), Polish (3.6%, n = 2), and other

(21.82%, n = 12; e.g., Irish, Irish Scottish, Jamaican, Portuguese, South African and others).

Most YCs (41.8%) lived with both parents (n = 23), but some lived with only their biological father (5.5%, n = 3), only their biological mother (20%, n = 11), birth mother and stepfather (14.5%, n = 8), birth father and stepmother (1.8%, n = 1), legal guardians (5.5%, n = 3), grandparents (7.3%, n = 4), or other (e.g., stepmother, 1.8%, n = 1). A total of 23 YCs (41.9%) reported living with 1-2 other people. Fourteen (25.5%) reported to live with 3-4 people, and another 17 (30.9%) reported to live with five or more other people in their home.

Non-YCs. There were 107 non-caregiving youth (ages 12-18 years) who matched YCs' age and sex. Information on how they were matched is described in a later section. Of those, 44 were boys (41.1%) and 63 (58.9%) were girls. Their average age was 14.43 (SD = 1.53). A total of 88.8% were born in Canada and 80.4% (n = 86) belonged to another ethnicity: American (2.8%, n = 3), French (10.3%, n = 11), Italian (14%, n = 15), Russian (2.8%, n = 3), East Indian (2.8%, n = 3), Chinese (5.6%, n = 6), German (9.3%, n = 10), Korean (.9%, n = 1), Ukrainian (3.7%, n = 4), West Indian (.9%, n = 1), Dutch (12.1%, n = 13), Greek (.9%, n = 1), Native Aboriginal (4.7%, n = 5), African (.9%, n = 1), Latin American (2.8%, n = 3), British (15%, n = 16), Hungarian (.9%, n = 1), Polish (3.7%, n = 4), and other (38.3%, n = 41; e.g., Arab Indian, Colombian, Croatian, Irish, Scottish, Middle Eastern, and others).

Most non-YCs (74.8%) lived with both parents (n = 80), but some lived with only their biological father (3.7%, n = 4), only biological mother (14%, n = 15), birth mother and stepfather (7.5%, n = 8), birth father and stepmother (2.8%, n = 3), legal guardians

(.9%, $n = 1$), grandparents (2.8%, $n = 3$), other relatives (.9%, $n = 1$), or other (e.g., brother, .9%, $n = 1$). Reports suggested that 46.7% ($n = 50$) lived with 1-2 other people, 41.1% ($n = 44$) lived with 3-4 people, and 11.2% ($n = 12$) lived with five or more other people in their home.

Measures

Demographics. The participants responded to questions regarding their sex, age, ethnicity, and whether they were born in Canada or not. They were also asked their living arrangements (e.g., with whom they lived and how many other people lived with them). Those identified as YCs proceeded to respond to questions that sought to understand their caregiving role (e.g., how many hours per day they spent on caregiving, duration of caregiving (in years), their onset age for caregiving, how long have they been members of Powerhouse Project, who they cared for, and the reason for caregiving). These caregiving questions have been drawn from other reports that examined the nature of YCs' caregiving role (Aldridge & Becker, 1993; Halpenny & Gilligan, 2004; Morrow, 2005; Nagl-Cupal et al., 2014; Pakenham et al., 2007).

Self-Compassion. The Self-Compassion Scale (SCS; Neff, 2003a) was employed to measure self-compassion with 26 items on a 5-point Likert Scale (1 = *Almost never* to 5 = *Almost always*). Higher scores indicated higher self-compassion. Self-kindness (example item: "I try to be loving towards myself when I am feeling emotional pain"), self-judgment (example item: "When times are very difficult, I tend to be tough on myself"), common humanity (example item: "When things are going badly for me, I see the difficulties as part of life that everyone goes through"), isolation (example item: "When I'm really struggling, I tend to feel like other people must be having an easier

time of it"), mindfulness (example item: "When something upsets me, I try to keep my emotions in balance"), and over-identified (example item: "When something painful happens, I tend to blow the incident out of proportion"). All the negative subscales were reverse coded before a composite was created for an overall self-compassion score. To increase readability, twelve phrases were revised (e.g., Item 1: 'disapproving and judgmental' into 'negative and critical'). The results shall be interpreted with caution. Reliability tests revealed that self-kindness' sample derived Cronbach's alpha was α = .83, self-judgement (α = .84), common humanity (α = .71), isolation (α = .76), mindfulness (α = .70), and over-identified (α = .74). The Cronbach's alpha for overall self-compassion was high (α = .91).

Subjective well-being (SWB). Cognitive and affective measures were employed to measure SWB (Diener, 2000; Seligman & Csikszentmihalyi, 2000). SWB was comprised of three dimensions: positive and negative affect (e.g., good mood and absence of negative emotions), as well as life satisfaction. Cronbach's alpha for SWB was high (α = .94).

Positive and Negative Affect. The Positive and Negative Affect Scale for children (PANAS-C; Laurent et al., 1999) was utilized to assess 30 feeling/emotions that ranged from 1 (*Very slightly or not at all*) to 5 (*Extremely*). In this sample, Cronbach's alphas for positive and negative affect were α = .91 and α = .92, respectively.

Satisfaction with Life. The Satisfaction with Life Scale for Children (SWLS-C; Gadermann et al., 2010) was used to assess participants' life satisfaction with five items on a 5-point Likert scale (1 = *Disagree a lot* to 5 = *Agree a lot*). Higher scores indicated

higher satisfaction with life. The five items were combined to form a total life satisfaction score that ranged from 5-25. This sample's derived reliability was $\alpha = .89$.

Procedure

This study was approved by Brock University's Research Ethics Board (REB #18-294, Appendix A). Following ethics approval, I reached out to a local YC support organization to recruit self-identified YCs via targeted sampling. It included the same procedures and the same questionnaire as Study 1.

Data Screening and Analyses

Due to the comparative nature of this study, a YC and a non-YC samples were required. Recall that the questionnaire included three screening questions that helped to identify young carers in the general population of youth 12-18 years of age: 1. Do you live with an immediate family member(s) who is ill, has a disability, or other special needs? 2. If so, do you help on a daily basis with responsibilities such as cooking, cleaning, dressing, supervising siblings, etc.? 3. Are you a part of Powerhouse Project, a support program for young carers? Anyone who disclosed this information was identified as a YC and was instructed to answer subsequent questions about their caregiving experiences. Anyone who was identified as a YC being a part of a Powerhouse Project was excluded due to the potential of duplication. Once identified as YCs ($n = 13$), they were combined with the self-identified YCs from the local support organization to create the overall 'YC status' group ($n = 55$).

The sample of non-YCs was drawn from a sample of youth aged 12-18 years (N = 159) from a previous data set (Study 1 of this dissertation). Within that sample, non-YCs were matched to YCs' age and sex. They were not matched on other variables (e.g., with

whom they lived and how many people), to refrain from further reducing an already limited sample.

Every YC was matched to two non-YCs to approximate the population. When the match was not possible due to lack of participants of the same sex/age, older or younger participants (by one year only) were chosen instead. For instance, when there were no more 12-year-old girls to match YCs, 13-year-old girls were chosen, until all possible spots were filled. Once there were no more 13-year- old girls, opportunity for further matching stopped. Moreover, in the case where there were no 18-year-old female participants to match one YC, two 17-year-old girls were randomly selected instead.

Using SPSS IBM statistics 22, data were screened to ensure that all statistical assumptions were met. There was evidence for univariate and multivariate normality, as well as for linearity, independence, and homoscedasticity. There were neither univariate or multivariate outliers, nor presence of multicollinearity (Field, 2017; Tabachnick & Fidell, 2001). In this study, I conducted descriptive and correlational analyses to further understand YCs and their caregiving context. I conducted a Missing Value Analyses (MVA) on the YC sample ($N = 55$): Sixteen participants (29.1%) did not report hours and years of caregiving, 15 participants (27.3%) did not report the onset age of caregiving, and 19 (34.5%) did not report on whom they cared for. Some of these missing items were appropriately missing as the earlier version of the survey was only targeting non-YCs and did not have these caregiving variables. However, a later version of the survey included these questions as I noticed a few YCs who identified within the community. Out of the 13 self-identified YCs from the community, five participants had access to these caregiving questions, but of those, only three filled out caregiving hours, duration, and

age of onset. The other two participants who failed to respond to these questions might not have been comfortable doing so. Since these variables were only used for describing who YCs were, the analyses were based on those participants who filled out this section.

Then, multiple analyses of variance (MANOVA) were carried out to assess whether YCs and non-YCs differed on subscales of self-compassion and subscales of SWB. MANOVA analyses were chosen because they represented an omnibus test that measured multiple dependent variables at once and safeguarded against type 1 error (Field, 2017). In addition, I ran these analyses on the subscales only and then on subscales plus the overall score (due to the exploratory nature of this study), and since they produced identical results, the overall score for SWB and self-compassion was left within the model. The MVA for the entire sample on the self-compassion and SWB variables revealed less than 5% of missing data, which was not problematic, thus no actions were implemented (Tabachnick & Fidell, 2001). This was an exploratory study with its main focus for a direct comparison of YCs and non-YCs' levels of self-compassion and SWB. Findings are presented according to two main parts: (i) descriptive statistics on YCs and, (ii) differences of YCs and non-YCs on self-compassion and SWB.

Results

Descriptive Statistics on YCs

YCs had been carers for almost seven years at the time of this study (M = 6.95, SD = 4.14, mdn = 7.50, n = 39), and started caregiving at an average age of years 7.56 years (SD = 3.36, mdn = 8, n = 39). YCs reported to care for about 6.61 hours a day (SD = 7.75, n = 39), with a median of 3.50 hours. Over half of all YCs cared for siblings (58.2%, n = 32) and a quarter for their mother (Please see Table 5.1). While the majority

cared for one person, 23.6% cared for more than one person in the family. For frequencies on caregiving, please see Table 5.1.

Table 5.1

Caregiving Characteristics

Characteristic	Category	YC % (*n*)
Care recipient	Mother	25.5% (14)
	Father	14.5% (8)
	Sister	29.1% (16)
	Brother	29.1% (16)
	Grandfather	9.1% (5)
	Grandmother	7.3% (4)
	Aunt	5.5% (3)
	Uncle	3.6% (2)
	Cousin	12.7% (7)
	Other (e.g., step siblings)	3.6% (2)
Number cared for	One person	41.8% (23)
	Two people	10.9% (6)
	Three people	5.5% (3)
	Four people	1.8% (1)
	Five people	1.8% (1)
	Nine people	3.6% (2)
Caregiving reasons	Spectrum (e.g., Autism, ADHD)	39.8% (22)
	Syndromes (e.g., Down, Fatal Alcohol, Tourette)	10.8% (6)
	Chronic/physical illness (e.g., brain injury, cancer, multiple sclerosis, arthritis)	21.6% (12)
	Mental health/ disorders (e.g., anxiety/depression, substance use, bipolar/ personality disorder)	10.8% (6)

Note. More than one response was possible on any of these variables.

Correlational analyses revealed that caregiving factors, such as the number of hours and years of caregiving, age of onset of caregiving, and the number of people cared for, did not relate to self-compassion and SWB (see Table 5.2). Expectedly, caregiving hours were positively related to the number of people cared for. This indicated that YCs who cared for more people were more likely to spend more hours on caregiving per day. There was also a positive correlation between self-compassion and SWB.

Table 5.2

Zero-Order Correlations between Caregiving Variables, Self-Compassion, and SWB among YCs.

Variable	1	2	3	4	5	6
1.Hours of caregiving	-	.34*	-.32	.60***	-.17	-.08
2.Years of caregiving		-	-.77***	-.27	-.22	-.18
3.Age of onset of caregiving			-	.16	.03	.04
4.Number of people cared for				-	.09	.17
5.Total self-compassion					-	.67***
6. Subjective well-being						-

Note. $*p < .05$, $**p < .01$, $***p < .001$; Total responses on caregiving variables were very low, ranging from $n = 30$ to $n = 50$.

Differences between YCs and Non-YCs on Self-Compassion and SWB

Two separate MANOVA analyses[5] were carried out on self-compassion subscales and subscales of SWB. Results revealed that YCs and non-YCs had similar levels of self-compassion, as there were no significant main effects, (*Wilks* $\lambda = 0.954$, $F(6, 155) = 1.24$, $p = .290$) (please see Table 5.3).

[5] Results stayed consistent when the MANOVAs were conducted on a sample, where every YC was matched to one non-YC of the same age and sex.

Table 5.3

YCs Versus Non-YCs on Measures of Self-Compassion and SWB

Variables	YCs (N = 55)		Non-YCs (N = 107)	
	Mean	Standard deviation (SD)	Mean	Standard deviation (SD)
Self-kindness	2.83	0.94	3.00	0.96
Self-judgement	2.71	1.12	2.60	0.99
Common humanity	3.01	0.90	2.99	0.95
Isolation	2.84	1.14	2.94	0.97
Mindfulness	3.19	0.89	3.22	0.85
Overidentification	2.89	1.01	2.85	0.98
Total self-compassion	2.91	0.70	2.94	0.71
Life satisfaction	16.67	5.29	18.15	4.35
Positive affect	3.25	0.88	3.29	0.80
Negative affect (reversed)	3.54	0.99	3.74	0.82
Total SWB	7.82	2.12	8.39	1.80

Note. There were N = 105 non YCS within the SWB subscales.

Moreover, YCs and non-YCs did not vary on SWB and its subscales, as there was no statistically significant main effect (*Wilks* $\lambda = 0.973$, $F(3, 156) = 1.46$, $p = .229$). Although failing to reach statistical significance, a trend was evident, where YCs reported lower life satisfaction ($p = .061$) and lower overall SWB ($p = .074$) than non-YCs (see Table 5.3). To further test whether there were possible differences between self-identified YCs attending a support program ($n = 42$), YCs from the community who self-identified via the screening ($n = 13$), and non-YCs ($n = 104$), One-way Analyses of Variance (ANOVA) were conducted. None of the models were statistically significant ($p = .188$ - .905). Non-YCs aside, independent sample t-tests comparisons between self-identified YCs attending a support program ($n = 42$) to YCs from the community who self-identified via the screening ($n = 13$) revealed a trend; although YCs from programs (M = 2.87, SD = 1.16) had higher levels of self-judgement than youth identified from the

community ($M = 2.21$, $SD = 0.86$), these differences did not meet even a loose threshold for statistical significance, $t(53) = 1.88$, $p = .065$.

Discussion and Implications

The purpose of this study was to examine whether YCs' self-compassion rates lower than non-caregiving youth. Before a discussion about YCs' self-compassion and SWB rates in comparison to their peers, it is important to take a moment to appreciate what YCs do and what their lives may look like.

At the time of the study, YCs have cared for an average of almost seven years and started caregiving at a very young age. On average, they cared for around seven hours per day, an equivalent of almost 50 hours per week. These results were not surprising, given that other studies found similar trends. For example, McDonald and colleagues (2009) found that some YCs who were 11 to 26 years old (at the time of the study) reported beginning caregiving around the age of 10. Caregiving at a young age could be a necessity in response to the caregivers' circumstances and variability in diagnoses (McDonald et al., 2010; Smyth et al., 2011). Some studies also reported similar hours of care, with anywhere from minimally 7 to upward of 50 hours per week (Banks et al., 2001; Järkestig-Berggren et al., 2019; Marote et al., 2012; Nagl-Cupal et al., 2014; Stamatopoulos, 2018; Warren, 2008).

Of course, there was a range of caregiving hours, from 0 to 24 hours per day, which indicated a continuum of care (Becker, 2007). The one participant who responded to care for zero hours may have a different conceptualization of their tasks, where they did not see their caregiving as a job and may have only seen 'care' as a familial duty (Bolas et al., 2007), which elicited pride (Metzing-Blau & Schnepp, 2008). The five

participants who responded they cared for 24 hours might have experienced the burden of caregiving due to the nature of care required (Järkestig-Berggren et al., 2019).

Among the many reasons of caregiving, spectrum disorders (e.g., Autism, ADHD) were the most common. Coupled with the fact that over half of the YCs in this sample cared for siblings, it could be that their siblings have these diagnoses. In Canada, recent statistics have shown that 1 in every 66 children and youth, aged 5 to 17 years, was diagnosed with Autism Spectrum in 2015 (Public Health Agency of Canada, 2018). Thus, it is important to note how significant this finding is within the Canadian context, where so many other YCs would potentially require helping siblings but would remain hidden. Doctors, nurses, and all frontline workers at support organizations for these spectrum diagnoses should be aware of this subgroup and identify those children within the family unit. By doing so, they could refer them to proper services, which could further support YCs in their caregiving roles.

The existing literature on self-compassion and SWB is limited, at best. This study was designed to determine whether YCs and non-YCs differed on these two important constructs. First, YCs and non-YCs did not show statistically significant differences on self-compassion. This complemented Neff and McGehee's (2010) speculations that youth, in general, may have relatively low self-compassion rates, due to the process of egocentrism, or personal fable where they would think that their experiences are unique and unusual, be more self-critical and lost in their problems. This would suggest that all youth, irrespective of their YC status, might have this, contributing to low self-compassion rates. Thus, more effort should be made to gain a better understanding into the role of self-compassion in young people's lives.

Another potential explanation for non-significant results is that YCs in the current study were not characteristic of “true YCs” described in the literature (as was the case in Remtulla et al.’s (2012) study). Given these youth came from a support program, perhaps they learned how to deal with some negative emotions through therapy, solved their isolation by hanging out with friends, and were able to see that others went through similar experiences. This complemented a previous study that showed that a YC programming aided YCs to decrease isolation, gain meaningful peer support, and have a break (Richardson et al., 2009), thereby pointing to how beneficial these programs can be.

However, smaller, more specific differences might have existed, but did not emerge because of the reliance on the omnibus test and lack of power. YCs’ scores on self-compassion subscales, in relation to non-YCs, might have suggested that YCs have lower self-compassion; specifically, YCs from support services showed more self-judgement than YCs identified from the community, which could be indicative of lower self-compassion, but the results were not statistically significant, perhaps due to the small sample size. Since this research was exploratory, much more investigation is warranted. Future studies should further examine whether YCs and non-YCs in fact report similar levels of self-compassion or whether it was due to limited sample size.

With regards to SWB, results of this study showed that YCs scored similarly to non-YCs. This again could simply illustrate that youth, ages 12 to 18, may have low SWB, which complemented recent findings from Ronen et al. (2016) where older adolescents, in particular, had lower life satisfaction and higher negative affect (rather than positive affect). Given that ‘adolescence’ might represent a stormy and stressed

phase, it might not be surprising to see that some adolescents (but not all) may struggle with well-being (Arnett, 1999; Steinberg & Morris, 2001). For some, 'adolescence' can be an extremely vulnerable phase, where teenagers may already show poorer mental health and may worsen their health further by engaging in risky, health compromising behaviours (e.g., substance use, unsafe sexual behaviours) (Call et al., 2002). YCs are not different; they are adolescents, who on top of everything else provide care to their loved ones. It is also noteworthy that both groups (YCs and non-YCs) ranged between scores of 15 to 19, which signified that they were slightly below average on life satisfaction based on the general scoring system for the satisfaction of life scale (Diener, 2006). This suggests that YCs, like the other youth, might go through certain life events and therefore may be a bit dissatisfied, but to a similar degree.

Having a similar degree of dissatisfaction might suggest that caregiving does not fully impact YCs' SWB. However, a further look into the results showed that descriptively, without reaching statistical significance, YCs showed trending results for lower life satisfaction and overall lower SWB than non-YCs. Of course, these were not significant main effects, but given the exploratory nature of this topic, coupled with the small sample size, these results demand our attention. These trending results complemented a recent article that found that YCs experienced a 'caregiving penalty', whereby they showed lower educational attainment and limited employment opportunities, worsened attachment to their loved ones, and limited or non-existent social life (Stamatopoulos, 2018). Although Stamatopoulos' (2018) study was not comparative, other comparative studies showed similar trends, where YCs showed lower life

satisfaction (Collins & Bayless, 2013) and lower psychological (Järkestig-Berggren et al., 2019) and subjective well-being (Leu et al., 2019).

These mixed results may in part be explained by sample specific characteristics (e.g., sample size) and the nature of the caregiving role (e.g., duration, intensity). First, the above-mentioned comparative studies (except for Järkestig-Berggren et al (2019)) included a larger sample of YCs, which increases the likelihood of finding statistical significance (Field, 2017). Second, it is also possible that the YCs in the current study have been carers for a longer time and have been a part of support program. After all, longer duration of caregiving was shown to be related to fewer self-reported worries, because YCs might have gotten more knowledgeable and felt more in control with some passage of time (Cree, 2003). Thus, further studies could test whether YCs' SWB can be moderated by caregiving duration.

Taken together, this study found YCs and non-YCs had similar levels of self-compassion and SWB. Although no other studies, that I am aware of, have investigated these two constructs among YCs, similar constructs such as resiliency and coping offer comparable evidence. Gough and Gulliford (2020) reported that some YCs had inner strength to persevere, despite their hardships. In that study, resilience was tied to perceived self-efficacy and school connectedness, which were deemed as protective factors and were related to higher levels of mental well-being. This meant that YCs who believed in their ability to be caregivers and were connected to others at school had greater adjustments. Moreover, Lakman and Chalmers (2019) have found that YCs and non-YCs both expected the best out of life, to similar degree, despite YCs' caregiving circumstances. Moreover, Boumans and Dorant (2018) did not find statistical differences

between YCs and non-YCs on level of resilience but found that YCs relied on emotion-focused coping more than non-YCs, which contradicts the present study's lack of differences on self-compassion. However, most evidence showed that YCs and non-YCs have similar levels of resilience, which could be indicative of what they think or how they value their experiences. Finding that both groups showed similar SWB and self-compassion could encourage other studies to examine these two constructs as potential mechanisms that would help promote psychological adjustment of YCs.

Limitations

There are four main limitations to this study. First, this study could have been underpowered due to low number of YCs. The small sample size might have also hindered the ability to find statistically significant differences. However, one strength of this study was that both self-identified YCs from programming and screened YCs from the community were included as participants. Thus, this heterogeneity among YCs could have increased generalizability beyond YCs who were in support programs.

Second, this present study obtained a sample of YCs from a support program, who may be more resilient than other YCs because of all the support they receive. It could be argued that due to their increased engagement with the program, they would have learned self-compassion and improved their well-being. Thus, I recommend that further work be undertaken to investigate self-compassion in YCs who are not in support programs to truly see whether differences exist. Future studies could also explore whether better screening questions can identify more YCs from the population.

Third, this study utilized self-reported measures, and although it showed that they were appropriate (e.g., reliable and valid), they could have still weakened the results.

Fourth, this study used cross-sectional data. Therefore, it could be that although this study did not find any statistically significant results, differences may have emerged over time. Future studies could use experimental designs or longitudinal designs to better understand the constructs of self-compassion and SWB among YCs.

Conclusion

The present study was the first to compare YCs to non-YCs on self-compassion and SWB. This study found that YCs and non-YCs have similar SWB and self-compassion. Although this study did not find any statistically significant differences, further work should be undertaken to investigate self-compassion in youth, especially in vulnerable sectors, to inform programs and services on how to cultivate self-compassion and improve SWB.

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CHAPTER 6: GENERAL DISCUSSION

The main purpose of this dissertation was to generate a better understanding of self-compassion in the lives of youth, and within a sub-sample of YCs, who provide compassion for others on a daily basis. The present dissertation utilized methodology triangulation to build a comprehensive set of studies that explored self-compassion quantitatively and qualitatively. Together, these methods allowed me to understand self-compassion in different but complementary ways, as a state (e.g., healthy attitude, an emotional regulation strategy) and as a coping mechanism (e.g., skill) (Neff, 2003a, 2003b, 2019; Neff et al., 2005). For example, Neff (2019) wrote that self-compassion is the usual way in which people treat themselves when they undergo something negative (e.g., suffering), but they can always change their patterns and learn to be more self-compassionate.

In addition to self-compassion, I wanted to explore SWB in youth. Much of the available literature defines well-being loosely (e.g., as an absence of mental health concerns or psychopathology (MacBeth & Gumley, 2012; Marsh et al., 2018) and quite poorly operationalizes which aspects of well-being are being researched (e.g., physical, psychological, emotional), making it very difficult to compare results across studies and samples. The limited nature of studies that explored SWB in the YC literature (I identified only one study that explored SWB (Leu et al., 2019)), drove the need for further examination of this construct. Additionally, considering that the majority of studies on YCs reported that provision of care can be related to several negative consequences and to worsened mental health outcomes (Banks et al., 2001; Bolas et al., 2007; Collins & Bayless, 2013; Lakman & Chalmers, 2019; Lloyd, 2013; Polkki et al.,

2004; Szafran et al., 2016; Thomas et al., 2003), it was interesting that almost none of the identified studies explored how YCs, themselves, reported their own subjective experiences and how they interpreted their satisfaction and attitude towards their own lives. It was also notable that the few studies which focused on how YCs themselves perceive their caregiving role, found positive outcomes (e.g., Doutre et al., 2013; Polkki et al., 2004).

Both of these constructs (i.e., self-compassion and SWB), are also related to the positive psychology paradigm, which was an influential framework for this dissertation. This was because it delved into the positive aspects of human's lives, capitalizing on individuals' strengths rather than their weaknesses (Neff, 2003a; Seligman & Csikszentmihalyi, 2000). Arguably, showing self-compassion or self-care, in the context of caregiving for others, is a difficult task. In Skovholt and Trotter-Mathison's words (2016): "to see human suffering and need all around oneself and to constantly be on the teeter-totter of other-care vs. self-care – do I give or pull back – demands its own kind of resilience" (p. 5). Looking at self-compassion as a strength allowed me to expand on previous studies, because so many past studies within the YC literature have been focused largely on the negative aspects of life, such as how it impacts well-being (see for example, Bolas et al., 2007) or the negative side of caregiving (see for example, Stamatopoulos, 2018), which are not mutually exclusive from the positive aspects. By focusing on the good side, this dissertation can suggest program modifications that would benefit YCs' lives. Overall, this final discussion chapter ties the findings from the series of studies to establish an integration of results. The first part summarizes the main

purpose and findings of each study and offers program-specific implications. The second part will offer a general summary and report final limitations.

In the first study, I examined the correlates of self-compassion. I found that among youth, 12-18 years of age, self-compassion was related to SWB (e.g., positive and negative affect, as well as life satisfaction) and altruistic personality traits (e.g., honesty/humility, emotionality, and agreeableness), but not to sex and age. Interestingly, youth's level of self-compassion in the current study was consistent with other similar samples of youth from other countries. This suggested that youth's level of self-compassion around this age range is fairly similar, and quite high, considering the scale runs from 1-5, where higher scores represent higher self-compassion (e.g., Study 1 (N = 170, M = 2.90, SD = .68 [*age range*: 12-18 years]); Portugal study (Cunha et al., 2016; N = 3165, M = 3.04, SD = .56 [*age range*: 12-19 years]); USA study (Bluth et al., 2017; N = 765, M = 3.11, SD = .61 [*age range*: 11-19 years]); USA study (Neff & McGehee, 2010; N = 235, M = 2.97, SD = 62 [*age range*: 14-17 years])).

Establishing which variables correlated with self-compassion allowed me to further understand this concept among youth. Programs could use this study to screen for YCs who may show greater negative affect (as opposed to positive affect) and low life satisfaction. Being able to identify them and see these youth as vulnerable may lead to the development of targeted self-compassion enhancing programs. Furthermore, this research showed altruistic personality traits were linked to higher self-compassion. This could indicate that youth with some form of concern for others and/or who show compassion for others, might have higher self-compassion, as was suggested by Neff (2003a, 2003b). However, with respect to YCs specifically, who show compassion towards others every

day, for an average of approximately seven hours per day (as was shown in Study 3), this might represent a different picture. Perhaps those who are more willing to help others, might also have higher emotionality, and since Study 1 showed that high emotionality was correlated with lower self-compassion, YCs' self-compassion could be hindered. Future studies could explore how certain altruistic personality traits foster or hinder YCs' self-compassion. In the current studies, I did not obtain an adequate sample size of YCs to do these further analyses.

Altogether, these results led to the second study, which examined YCs' self-compassion and self-care in the context of providing care to others. This study found that while they showed compassion towards their loved ones, their caregiving role was identified as a barrier to self-compassion. This meant that often they had very minimal to no time for self-care or self-compassion. Beyond this, even though they have reported to engage in some self-caring activities, having this time for self-care was considered as a character flaw, and they identified greater tensions and guilty feelings that were associated with showing self-compassion.

This study also found that YCs' narratives pointed to low self-compassion. Their responses regarding what self-compassion entailed were other-oriented, they were engaging in externalizing and internalizing behaviours and emotions, and they showed more self-criticism rather than self-kindness. Importantly, this study also found two main factors that could support self-compassion: parents and programs. Programs could use this information to create workshops around enhancing self-care and self-compassion in YCs' lives. Further, parents and youth could attend future workshops together in order to create a more family-based intervention, as this is often neglected in interventions

(Areguy et al., 2019). These findings are related to my second theoretical framework, family systems theory, because it clearly demonstrates how caregiving influences everyone within the family, and how self-compassion is implicated in these systems. As families adjust to their changes and organize their new roles around the caregiving role, (Metzing-Blau & Schnepp, 2008), it is paramount that parents and children discuss expectations together and leave some time for self-care and self-compassion to occur. Previous studies have suggested that when family members worked with YCs, the children felt more supported (McDonald et al., 2010; Metzing-Blau & Schnepp, 2008). Moreover, Andrews et al. (2020) found that some formal caregivers (e.g., nurses) needed "permission" to have time for self-care and self-compassion. Having parents attend workshops with their children might make YCs more comfortable as it would indicate to them that their parents are on board. This could also make parents more aware of how much YCs do and give them more time alone, if they need a break (instead of not; Stamatopoulos, 2018), thereby creating a comfortable, flexible, and supporting environment.

Although YCs showed possible benefits on one aspect of self-compassion, namely 'common humanity', due to their program involvement, one finding was still troubling. YCs reported more self-judgemental comments, which pointed to low self-compassion. Further analyses in Study 3 between YCs from programs and YCs who were identified from the community revealed that YCs from programs were more self-judgemental, but the results were only trending and not statistically significant. Given its exploratory nature, despite the limited sample size, this in part confirmed results from Study 2. As previous studies found that YCs reported lower self-esteem (Banks et al.,

2001; Lakman & Chalmers, 2019), this could possibly explain why they may be harsher towards themselves. This is particularly important, given that self-judgement was associated with greater burnout rates and compassion fatigue (Beaumont et al., 2016). This might come into conflict with self-compassion. After all, Donald and colleagues (2018) found that self-esteem was a prerequisite to self-compassion, because only then it would allow people to understand that they were worthy of it. Similarly, Marshall and colleagues (2015) found that self-compassionate training was especially beneficial for adolescents with low self-esteem (Leary et al., 2007). If this is true in YCs, those who were more self-judgemental, could have had lower self-esteem, which would then mean that program staff should identify those youth, as they would greatly benefit from self-compassion enhancing programs. Together, program staff could create programs that foster self-kindness, in the context of self-care, and build interventions around how to change self-judgemental tendencies. Teaching some self-compassion can be very beneficial, as Beaumont and colleagues (2016) showed that in student counsellors and psychotherapists, who may struggle with self-care, higher scores on self-compassion were related to less compassion fatigue and greater well-being.

Another concerning finding in Study 2 was that YCs' responses related to self-compassion were other-oriented. Neff (2003a, 2003b) showed that those who scored higher on self-compassion likely also showed higher compassion towards others, whereas those scoring low on self-compassion likely only cared for others and not for themselves. Particularly problematic were results from Study 2 which revealed that some YCs concealed their well-being and needs from their parents, in order to protect their parents from additional stress. This helps to reinforce their strong other-oriented compassion.

However, this does not protect them. Instead, this concealment from parents can lead to worsened attachment between parents and children (Early et al., 2006) and foster feelings of isolation within the family, sadness, and hopelessness (Chalmers, & Lyuck, 2012) as well as anger, feeling overwhelmed, and frustrated (Bolas et al., 2007). This finding also further validates the need to develop programs for parents and YCs to work together to maintain balance within the family. One good strategy to help with compassion fatigue and burnout is talking about it to others (Skovholt, & Trotter-Mathison, 2016). Talking about troubles, sharing with others, expressing their needs, and asking for help might make them more resilient (Keidel, 2002; Skovholt, & Trotter-Mathison, 2016). Overall, results of Study 2 expanded research on self-compassion in YCs, but it remained unknown whether YCs truly had low self-compassion when compared to youth without the caregiving role

Hence, the third study compared YCs to non-YCs, on measures of self-compassion and SWB and found no differences between the two samples. In other words, all youth, with and without the caregiving role, had similar levels of self-compassion and SWB. The fact that YCs and non-YCs had similar levels of self-compassion, places Study 2 into a clearer context. Even though YCs showed some indication for lower self-compassion in Study 2, it was not enough to be statistically different from non-caregiving peers. This was also consistent with López et al. (2018) who found no relationship between compassion for others and self-compassion in adults and within an undergraduate sample (Neff & Pommier, 2013).

Two explanations might be noteworthy for these findings: First, it might indicate a level of resilience, where YCs, who despite living in more trying circumstances, show

similar self-compassion to non-caregiving youth. This is consistent with research by Leary and colleagues (2007), who found that self-compassion was associated with how well a person handles a difficult situation. Perhaps YCs from the current study, who provided prolonged care (an average of seven years), became better equipped to be caregivers and knew how to handle their unpredictable life circumstances. Muris et al. (2019) also found that self-compassion was linked with optimism and perspective taking. This again shows that the current YCs may have been more optimistic and therefore, might have been more comparable to youth without the caregiving role.

Second, as previously mentioned, current YCs participated in a program that was aimed to support them with their caregiving role. These youth might have gained certain benefits, which could have translated to higher self-compassion levels, thereby again, becoming more comparable to youth without the caregiving role. This placed more importance on Study 2, where accounts from the focus groups showed that YCs appreciated being in the program, which has helped them to gain ‘common humanity’, which could have translated to gained friendships and support, thereby potentially reducing isolation. Clearly, there are many benefits from YCs’ programs (e.g., feeling validated and supported (Thomas et al., 2003)), but unfortunately, in Canada, only three programs exist, two of which are located in the same province (Ontario) (Stamatopoulos, 2016) and as of 2020, they are the only two operational ones. Therefore, this study also helped to draw attention to the need for more programs that support YCs, nationally.

The fact that YCs and non-YCs had similar levels of SWB can also be explained by the following reasons. First, similar to above, it could indicate that some YCs are more resilient, because despite their adversities, they have similar SWB to their peers.

Resilience here is operationalized as a response that is adaptable, in face of adversity (Luthar et al., 2000), where one is able to bounce back from stress (Windle et al., 2011), overcome and resist (Ungar, 2013), as well as persist in face of disturbances (Holling, 1973), thereby steeling/ strengthening their personal capabilities (Rutter, 2012). Such adverse circumstances are particularly important to SWB, because in this dissertation I operationalized SWB as a fluctuating and variable state based on circumstances and as a result of how people react to them (Diener et al., 1999; Lishner, & Stocks, 2017). This helps suggest that these YCs might not see their circumstances as negative and as a result, it might not be affecting their state of SWB. This, in turn, could indicate some level of optimism, complementing findings of Lakman and Chalmers (2019). It also confirmed Study 2, where some YCs accepted their caregiving role and saw it as a normal part of their lives.

Second, it could be that due to the small sample size and usage of omnibus tests, main effects were masked. There is also a great deal of variability that might have played a role. For instance, Within YCs, there was a great variability in caregiving continuum (Becker, 2007) and in the reasons they cared for. Since SWB is highly tied to circumstances, this may suggest different configurations to SWB. Busseri and colleagues (2009) found five profiles of SWB (e.g., high negative affect and low positive affect and life satisfaction; high positive affect and life satisfaction and low negative affect; moderate life satisfaction, and low positive and negative affects; moderate life satisfaction and positive affect, but high negative affect; moderate life satisfaction, low positive affect, and high negative affect), which can change over time in response to adversity (Busseri & Sadava, 2013). Future studies could explore these SWB

configurations in YCs, to see if the same structure holds depending on who they provided care for, for how long, and for what reasons and within a larger sample size. Future research should also collect longitudinal data, because some YCs exit their roles as carers and it would be particularly interesting to investigate how exiting the role impacts their SWB.

Overall, results from Study 3 also showed that YCs have been caregivers for a prolonged time, cared for many hours a day, and for multiple people and reasons. Yet, self-compassion and SWB were not related to these caregiving factors (e.g., number of hours and years of caregiving, age of onset of caregiving, and the number of people cared for). This contradicted results from Study 2, where many YCs have reported that their caregiving was a barrier to self-care or self-compassion. Together, this suggested that statistically, this effect was not validated. This is interesting considering in many studies, having the caregiving role took their time away from being able to engage in other activities and restricted their social lives (Stamatopoulos, 2018; Warren, 2007). Future studies could further explore the link between caregiving factors and self-compassion, and how it might affect SWB.

Finally, this chapter concludes by addressing several limitations within this dissertation. The first limitation was the small size of a YCs' sample. Obtaining an adequate sample of YCs was proven to be very difficult. Unfortunately, there were not many programs to collect data from; in fact, only two programs in the region included self- identified YCs (Stamatopoulos, 2016). For this reason, I decided to add three screening questions to identify YCs from the community and add them to the YC group. Yet, many YCs are known to maintain secrecy and keep their role hidden (Bolas et al.,

2007; Rose & Cohen, 2010), thus I was only able to identify 13 from the larger community. Future studies could further explore how to enhance these screening questions for the purpose of better identifying YCs from the community.

Another limitation was using the 12-18 years age range. The local program that supported YCs had many participants ages 12 and younger. I chose to exclude them based on the fact that the construct of self-compassion might not be relevant for younger age groups because the scale was only suitable for those ages 14 and older. I identified only one MA [unpublished] thesis that validated a shorter version of the self-compassion scale with children in grades 4-7 (Sutton, 2014). For these reasons, I chose age 12 as my starting point. However, I could have expanded the age range to include those under the age of 25 years, as it aligns better with how YCs are defined within the Canadian context (Stamatopoulos, 2015). This could have increased my sample size as well. However, based on the fact that Neff and McGehee (2010) found no age differences between undergraduate and adolescent samples, I would have expected results to remain the same, even with greater number of YCs. But, given that undergraduate YC students might have more stressors, and caregiving has been found to restrict YCs' future aspirations and impact their education (Cluver et al., 2012; Moore, 2005; Moore et al., 2009), it would have been interesting to see if their self-compassion and SWB levels would remain similar, despite these different life stressors. Future studies could explore this with YCs between the ages of 18 and 25 years and compare them to those 12 to 18 years of age.

Nevertheless, this dissertation has significantly contributed to the progression of the field. As it currently stands, this was the first study to investigate self-compassion and SWB among caregiving youth. These three studies showed that certain variables (e.g.,

personality, SWB measures) were associated with youth's self-compassion rates, but sex and age, were not. In YCs, as they show significant levels of compassion for others, their self-compassion might be limited, at best. However, regardless of their circumstances, they showed similar self-compassion and SWB to their non-caregiving peers, providing further evidence for potential underlying mechanisms of resilience and optimism and perhaps a developmental aspect to self-compassion.

However, due to the lack, limited, and mixed research on these constructs among YCs, prior to this study, there was no conclusive evidence to suggest that YCs are comparable to non-YCs on levels of self-compassion and SWB. The fact that conversations with YCs complemented descriptive statistics, showing some tendencies towards lower self-compassion and SWB, underpins the need for further research in this field to explore these seemingly inconsistent findings. Future studies could explore these areas with YCs, but select YCs outside of programs, who may be younger or older, and who may provide care for more complicated reasons.

Finally, having completed all the three studies, one may wonder if anything should be done about YCs' self-compassion and SWB? The answer is yes. Throughout the dissertation, I have included many program implications and ways to support YCs' lives. Programs may also choose to apply pre-existing youth-based intervention for self-compassion, called 'Making Friends with Yourself' (MFY), that was proven to effectively increase one's mental health and emotional well-being (Bluth et al., 2016). Overall, based on the results from these three studies, this program could be implemented for youth, in general. Those with negative affect and higher emotionality (results from Study 1) may be particularly responsive to this program, as it was shown to increase life

satisfaction and reduce depression and anxiety (Bluth et al., 2016). YCs may also benefit from it, if program staff utilizes the same design and offer it during program hours, especially if their self-compassion and SWB is still in question and warrants future research to determine exactly where they stand.

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Appendix A

Ethics Clearance (Study 1 and 3)

Brock University
Office of Research Ethics
Tel: 905-688-5550 ext. 3035
Email: reb@brocku.ca

Social Science Research Ethics Board

Certificate of Ethics Clearance for Human Participant Research

DATE:	5/8/2019		
PRINCIPAL INVESTIGATOR:	CHALMERS, Heather - Child and Youth Studies		
FILE:	18-294 - CHALMERS		
TYPE:	Ph. D.	STUDENT: SUPERVISOR:	Yana Lakman Heather Chalmers

TITLE: A Comparative Study of Self-Compassion in Young People's Lives

ETHICS CLEARANCE GRANTED

Type of Clearance: NEW Expiry Date: 5/1/2020

The Brock University Social Science Research Ethics Board has reviewed the above named research proposal and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement. Clearance granted from 5/8/2019 to 5/1/2020.

The Tri-Council Policy Statement requires that ongoing research be monitored by, at a minimum, an annual report. Should your project extend beyond the expiry date, you are required to submit a Renewal form before 5/1/2020. Continued clearance is contingent on timely submission of reports.

To comply with the Tri-Council Policy Statement, you must also submit a final report upon completion of your project. All report forms can be found on the Office of Research Ethics web page at http://www.brocku.ca/research/policies-and-forms/research-forms.

In addition, throughout your research, you must report promptly to the REB:

a) Changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) All adverse and/or unanticipated experiences or events that may have real or potential unfavourable implications for participants;
c) New information that may adversely affect the safety of the participants or the conduct of the study;
d) Any changes in your source of funding or new funding to a previously unfunded project.

We wish you success with your research.

Approved:

Lynn Dempsey, Chair
Social Science Research Ethics Board

Robert Steinbauer, Chair
Social Science Research Ethics Board

Note: Brock University is accountable for the research carried out in its own jurisdiction or under its auspices and may refuse certain research even though the REB has found it ethically acceptable.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and clearance of those facilities or institutions are obtained and filed with the REB prior to the initiation of research at that site.

Appendix B

Questionnaire (Study 1 and 3)

PART A ***Let's begin with some information about you.***

1. How old are you? _______
2. What gender are you? ________
3. Were you born in Canada?

○ Yes ○ No ➔ If No, how long have you been living in Canada? ______________________

4. Other than Canadian, is there another culture or ethnic background that your family belongs to?

○ Yes ○ No

If yes, which one? ***(Fill in all that apply)***

○ American	○ French	○ Italian	○ Russian	○ East Indian
○ Chinese	○ German	○ Korean	○ Ukrainian	○ West Indian
○ Dutch	○ Greek	○ Native/Aboriginal	○ African	○ Latin American
○ British	○ Hungarian	○ Polish	○	Other: _________________

5. With whom do you live with right now? ***(Fill in all that apply)***

○ Both birth parents	○ Birth father only	○ Birth mother only
○ Birth mother and stepfather	○ Birth father and stepmother	○ Neither birth parent
○ Adoptive parents	○ Foster parents	○ Legal guardian
○ Grandparent(s)	○ Other relatives	○ On your own
○ With roommates	○ Group home	○ Other: ______________

6. How many OTHER people live in your home?

○ 1 ○ 2 ○ 3-4 ○ 5-6 ○ 7 or more

7. Do you live with an immediate family member(s) who is ill, has a disability, or other special needs?

Yes No IF NO, PLEASE **SKIP to PART B**

If yes, do you help on a daily basis with responsibilities such as cooking, cleaning, dressing, supervising siblings?

Ye No IF NO, PLEASE **SKIP to PART B**

8. Are you a part of Powerhouse Project, a support program for young carers?

Yes No IF NO, PLEASE **SKIP to PART B**

******IF YOU ANSWERED **YES** TO **QUESTIONS 7 OR 8**, PLEASE ANSWER ADDITIONAL **QUESTIONS 9-15**.

9. How many hours per day do you spend on caregiving tasks? ____

10. How many years have you been a caregiver for? _____

11. At what age did you start to provide care for your family member(s)? ____

12. How long have you been in the program (Powerhouse Project)? _____

13. Would you consider yourself a new program member? ○ Yes ○ No

14. Who do you care for? ***(Fill in all that apply)***
    ○ Mother ○ Father ○ Sister ○ Brother
    ○ Aunt ○ Uncle ○ Cousin ○ Grandfather
    ○Grandmother ○ Other- who? _____

15. Why does your family member need care? E.g., Alzheimer's, MS, depression, Down's, autism, language, addiction/ substance use, and more

____

PART B	***Think about your personality traits. Please read the following traits that may or may not apply to you and shade the option that best applies to you.***

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE, NOR DISAGREE	AGREE	STRONGLY AGREE
1. I rarely hold a grudge, even against people who have badly wronged me.	○	○	○	○	○
2. I would feel afraid if I had to travel in bad weather conditions.	○	○	○	○	○
3. I wouldn't use flattery to get a raise or promotion at work, even if I thought it would succeed.	○	○	○	○	○
4. People sometimes tell me that I am too critical of others.	○	○	○	○	○
5. I sometimes can't help worrying about little things.	○	○	○	○	○
6. If I knew that I could never get caught, I would be willing to steal a million dollars.	○	○	○	○	○
7. People sometimes tell me that I'm too stubborn	○	○	○	○	○
8. When I suffer from a painful experience, I need someone to make me feel comfortable	○	○	○	○	○
9. Having a lot of money is not especially important to me.	○	○	○	○	○
10. People think of me as someone who has a quick temper.	○	○	○	○	○
11. I feel like crying when I see other people crying.	○	○	○	○	○
12. I think that I am entitled to more respect than the average person is	○	○	○	○	○
13. When it comes to physical danger, I am very fearful	○	○	○	○	○
14. My attitude toward people who have treated me badly is "forgive and forget".	○	○	○	○	○
15. If I want something from someone, I will laugh at that person's worst jokes	○	○	○	○	○
16. I tend to be lenient in judging other people.	○	○	○	○	○
17. I worry a lot less than most people do.	○	○	○	○	○
18. I would never accept a bribe, even if it were very large	○	○	○	○	○
19. I am usually quite flexible in my opinions when people disagree with me	○	○	○	○	○
20. I can handle difficult situations without needing emotional support from anyone else.	○	○	○	○	○
21. I would get a lot of pleasure from owning expensive luxury goods	○	○	○	○	○
22. Most people tend to get angry more quickly than I do.	○	○	○	○	○
23. I feel strong emotions when someone close to me is going away for a long time.	○	○	○	○	○

24.	I want people to know that I am an important person of high status.	○	○	○	○	○
25.	Even when people make a lot of mistakes, I rarely say anything negative.	○	○	○	○	○
26.	Even in an emergency I wouldn't feel like panicking	○	○	○	○	○
27.	I wouldn't pretend to like someone just to get that person to do favors for me.	○	○	○	○	○
28.	When people tell me that I'm wrong, my first reaction is to argue with them.	○	○	○	○	○
29.	I remain unemotional even in situations where most people get very sentimental	○	○	○	○	○
30.	I'd be tempted to use counterfeit money, if I were sure I could get away with it.	○	○	○	○	○

PART C	***Think about how you typically act towards yourself when you find yourself in difficult times. Please read the statements and shade in the best option as you think about your situation.***

		ALMOST NEVER	RARELY	SOMETIMES	OFTEN	ALMOST ALWAYS
1.	I'm negative and critical about my own flaws	○	○	○	○	○
2.	When I'm feeling down I tend to focus on everything that's wrong	○	○	○	○	○
3.	When things are going badly for me, I see the difficulties as part of life that everyone goes through	○	○	○	○	○
4.	When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.	○	○	○	○	○
5.	I try to be loving towards myself when I'm feeling emotional pain	○	○	○	○	○
6.	When I fail at something that's important to me, I feel alone	○	○	○	○	○
7.	When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am	○	○	○	○	○
8.	When times are really difficult, I tend to be tough on myself	○	○	○	○	○
9.	When something upsets me I try to stay calm	○	○	○	○	○
10.	When I feel like I am not good enough, I try to remind myself that most people sometimes feel the same way	○	○	○	○	○
11.	I'm usually annoyed with the parts of my personality that I don't like	○	○	○	○	○
12.	When I'm going through a very hard time, I am usually thoughtful and caring toward myself	○	○	○	○	○
13.	When I'm feeling down, I usually think that others are probably happier than I am	○	○	○	○	○
14.	When something painful happens I try to look at both positive and negative parts of the situation	○	○	○	○	○
15.	I try to see my failings as something that everyone experiences, not just me	○	○	○	○	○
16.	When I see aspects of myself that I don't like, I get down on myself	○	○	○	○	○
17.	When I fail at something important to me I try to keep things in perspective	○	○	○	○	○
18.	When I'm really struggling, I tend to feel like other people must be having an easier time of it	○	○	○	○	○
19.	I'm kind to myself when I'm experiencing suffering.	○	○	○	○	○
20.	When something upsets me I get carried away with my feelings	○	○	○	○	○
21.	I can be a bit cold-hearted towards myself when I'm experiencing suffering.	○	○	○	○	○
22.	When I'm feeling down I try to approach my feelings with curiosity and openness	○	○	○	○	○
23.	I'm tolerant of my own flaws and inadequacies	○	○	○	○	○
24.	When something painful happens I tend to blow the incident out of proportion	○	○	○	○	○
25.	When I fail at something important to me, I keep thinking that I am not good enough	○	○	○	○	○
26.	I try to accept the parts of myself that I don't like	○	○	○	○	○

PART D	*Please read the following statements and shade in the best option that describes you the best*

		DISAGREE A LOT	DISAGREE	NEITHER AGREE/ NOR DISAGREE	AGREE	AGREE A LOT
1.	In most ways my life is close to the way I would want it to be	○	○	○	○	○
2.	The things in my life are excellent	○	○	○	○	○
3.	I am happy with my life	○	○	○	○	○
4.	So far I have gotten the important things I want in life	○	○	○	○	○
5.	If I could live my life over, I would have it the same way	○	○	○	○	○

PART E	*Please read the following list of feelings and emotions. Please shade in the best option that applies to whether you felt this way in the past few weeks.*

		VERY SLIGHTLY OR NOT AT ALL	A LITTLE	MODERATELY	QUITE A BIT	EXTREMELY
1.	Interested	○	○	○	○	○
2.	Sad	○	○	○	○	○
3.	Frightened	○	○	○	○	○
4.	Alert	○	○	○	○	○
5.	Excited	○	○	○	○	○
6.	Ashamed	○	○	○	○	○
7.	Upset	○	○	○	○	○
8.	Happy	○	○	○	○	○
9.	Strong	○	○	○	○	○
10.	Nervous	○	○	○	○	○
11.	Guilty	○	○	○	○	○
12.	Energetic	○	○	○	○	○
13.	Scared	○	○	○	○	○
14.	Calm	○	○	○	○	○
15.	Miserable	○	○	○	○	○
16.	Jittery	○	○	○	○	○
17.	Cheerful	○	○	○	○	○
18.	Active	○	○	○	○	○
19.	Proud	○	○	○	○	○
20.	Afraid	○	○	○	○	○
21.	Joyful	○	○	○	○	○
22.	Lonely	○	○	○	○	○
23.	Mad	○	○	○	○	○
24.	Fearless	○	○	○	○	○
25.	Disgusted	○	○	○	○	○
26.	Delighted	○	○	○	○	○
27.	Blue	○	○	○	○	○
28.	Daring	○	○	○	○	○
29.	Gloomy	○	○	○	○	○
30.	Lively	○	○	○	○	○

Appendix C

Age and Sex Split Across Six Focus Groups (Study 2)

Focus group #	Location	Sex	Age range	Younger/Older
1	St. Catharines	1 male; 5 female	12-13	Younger
2	Haldimand	0 male; 5 female	12-14	Younger
3	Toronto	1 male; 5 female	12-14	Younger
4	St. Catharines	2 male; 4 female	15-18	Older
5	Haldimand	3 male; 4 female	15-18	Older
6	Toronto	1 male; 3 female	15-18	Older

Appendix D

Ethics Clearance (Study 2)

Brock University
Office of Research Ethics
Tel: 905-688-5550 ext. 3035
Email: reb@brocku.ca

Social Science Research Ethics Board

Certificate of Ethics Clearance for Human Participant Research

DATE:	5/3/2019		
PRINCIPAL INVESTIGATOR:	CHALMERS, Heather - Child and Youth Studies		
FILE:	18-295 - CHALMERS		
TYPE:	Ph. D.	STUDENT: SUPERVISOR:	Yana Lakman Heather Chalmers

TITLE: Exploring Self-Compassion and what it means in Young Carers' Lives

ETHICS CLEARANCE GRANTED

Type of Clearance: NEW   Expiry Date: 5/1/2020

The Brock University Social Science Research Ethics Board has reviewed the above named research proposal and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement. Clearance granted from 5/3/2019 to 5/1/2020.

The Tri-Council Policy Statement requires that ongoing research be monitored by, at a minimum, an annual report. Should your project extend beyond the expiry date, you are required to submit a Renewal form before 5/1/2020. Continued clearance is contingent on timely submission of reports.

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In addition, throughout your research, you must report promptly to the REB:

a) Changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) All adverse and/or unanticipated experiences or events that may have real or potential unfavourable implications for participants;
c) New information that may adversely affect the safety of the participants or the conduct of the study;
d) Any changes in your source of funding or new funding to a previously unfunded project.

We wish you success with your research.

Approved:

Lynn Dempsey, Chair
Social Science Research Ethics Board

Robert Steinbauer, Chair
Social Science Research Ethics Board

Note: Brock University is accountable for the research carried out in its own jurisdiction or under its auspices and may refuse certain research even though the REB has found it ethically acceptable.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and clearance of those facilities or institutions are obtained and filed with the REB prior to the initiation of research at that site.

Appendix E

Focus Group Questions (Study 2)

1. What does the term ‘young carer’ mean to you?
    a. What do you like or dislike about this term?
    b. What other terms, if any, do you prefer instead to showcase your ‘carer’ role?
2. How do you define ‘compassion’?
    a. How do you show compassion towards others?
    b. How does showing compassion towards others make you feel?
3. What does the term ‘self-compassion’ mean to you?
    a. How do you care for yourself? Or What things do you do for self-care?
    b. Do you have time to provide care to the self?
    c. If you don’t have time, how do you feel about forgoing self-care?
4. What factors in your life minimize self-care?
5. How would you increase self-care?
6. Is there anything that you would add or change about your role as a carer?
7. Is there anything that you would add or change about your role as a self-carer?
8. How would you describe your relationship with your parents?
    a. How might they promote self-compassion?
    b. How important is it for them that you show self-compassion?
9. How would you define ‘well being’?
    a. How would you describe your well-being?
    b. How does your caregiving role may impact self-care or self-compassion?
10. How does being a part of the program may help you increase self-compassion?

Is there anything else that you want to add? Are there any more ideas, or thoughts you’d like to discuss?