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Self-Compassion and Relating It to Eating Disorder among University Students

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Abstract

Purpose: *This article aims to screen Eating Disorder Attitude among undergraduate students, as well as examining the differences in self-compassion and Eating Disorder Attitude by gender. The relation between self-compassion and Eating Disorder Attitude has been investigated as well.* ***Methods:*** *(435) students were chosen randomly from of Baghdad University. The Arabic versions of Self compassion scale (SCS), as well as Eating Attitude Test (EAT) are used to achieve the study's objects* ***Results:*** *Results showed that a quarter of the sample had symptoms of eating disorder according to the first criterion. As for the second criterion, the results indicated that just under half of the sample had met this criterion. The same thing with regard to the third criterion, the body mass index, as results showed that about half of the sample had met this criterion. Regarding to the second aim, the correlation coefficients was used between all study variables. The male data founded that one of the subscale of self-compassion (Self-Kindness subscale) was positively correlated to the first and second criteria of eating disorder. However, there were no significant correlations were founded between other variables. In other hand, the female data has different results. Where the results showed that the total score of self-compassion and Isolation subscale of self-compassion have revealed a positive correlation with only the second criterion of eating disorder.*

Keywords*: Self Compassion, Eating Disorder, University Students*

Introduction

Self-compassion in the event of suffering is a way of responding to oneself (K. Neff, 2003). Individuals who are kind to themselves and self-compassionately understand that suffering are a normal human condition and keep in a balanced awareness, painful thoughts, and emotions. Self-compassion is a constructive attitude toward oneself (K. D. Neff, 2003). Yet self-compassion stems from human caregiving capability. This requires showing compassion and affection to one another in the expression of losses and distresses, and unlike self-esteem, it does not allow one's qualities or capabilities to be superior to others (Gilbert, 2005).
Self-compassion appears to provide substantial benefits when investigating how individuals react to personal mistakes, deceptions or setbacks (Crocker & Park, 2004).

Self-compassion thus seems in a less personalized, more independent and growth-promoting way to help weather anxiety and deceit. Self-compassion may show an obvious role in preserving the image of the body and eating habits. (Breines & Chen, 2012).

Wasylkiw and his colleagues (2012) founded that female who reported higher in self-compassion had less concern about their body images, greater body image, and less eating-related guilt. Likewise, Ferreira and his colleagues (2013) found that greater self-compassion was linked to a lower thinness drive in female and adult eating disorders.

Controlling for (BMI), Self-compassion was similarly inversely linked to eating problems and to intuitive eating, which relates to eating according to physiological hunger and satiety gestures(Schoenefeld & Webb, 2013).

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Eating disorder studies for patients showed that those whose self-compassion improved early on fared better (A. C. Kelly, Fau, & Borairi, 2014) and those whose self-compassion pre-treatment capability was weakly enhanced (Allison C. Kelly, Carter, Zuroff, & Borairi, 2013).

Whilst researches up until now advocacy an association between eating behavior and self-compassion, little work is ongoing to find out whether self-compassion will reduce dissatisfactions or perceived shortcomings in the field of eating and the image of body.

A research by Adams and Leary (2007) studied the effect on restrained and guilty eaters of a self-compassion induction. Since eating an unhealthy preload, the experimenters had less subsequent inhibition of feeding, as they thought more compassionately of occasional indulgences.

Longitudinal data, in particular, are necessary to comprehend the persistence and predictors of EDs, to help identify and prevent efforts. Moreover, the mechanisms of self-communion and the association with ED psychopathology are little understood.
Mentally severe conditions like anorexia, bulimia nervous, and binge-eating disorder, with an estimated lifetime prevalence rate of roughly 1% (Udo & Grilo, 2018).

ED in non-clinical populations is also very common, with around fifty percent of female and thirty percent of male having unhealthy weight management behaviors (Haynos et al., 2018). A BMI can be a setback, stressor or failure for many women and men in today's culture. Firstly , the current "tall standard" is remarkably smaller than the average weight of women and is not possible for most female physiologically to achieve (Hawkins, Richards, Granley, & Stein, 2004).

Second, media has presented the images of women as the 'thin ideal' are hard to avoid, and these experiences intensify body discomfort and eating disorders (Buote, Wilson, Strahan, Gazzola, & Papps, 2011; Groesz, Levine, & Murnen, 2002; Hawkins et al., 2004). Third, stigma towards weight, like negative comments, social exclusion, and discrimination, are more commonly found for female with higher BMIs (Vartanian & Shaprow, 2008).

Fourthly, stigma of weight and BMI were also positively linked to ED and body dissatisfaction (Myers & Rosen, 1999; Neumark-Sztainer et al., 2002)

Enhanced understanding of the unique relationship between self- compassion and ED psychopathology and possible mechanisms can broaden our knowledge of the cognitive processes behind ED and inform treatments.

Primary research indicates that self-compassion predicts less ED. Increased self-compassion in both clinical and non-clinical populations is associated with fewer bulimic symptoms such as binge eating (Ferreira et al., 2013; Webb & Forman, 2013).
Data from a number of studies suggest that ED symptoms in college populations are prevalent. The prevalence figures for current EDs of university students ranged between 8% and 17% (Hoerr, Bokram, Lugo, Bivins, & Keast, 2002; Kirk, Singh, & Getz, 2001; Prouty, Protinsky, & Canady, 2002; Reinking & Alexander, 2005).
Twenty percent of respondents in an American study of college students said they had been suspected of an ED at some moment in students' lives (National Eating Disorders Association, 2010).
A study made by the National College of Health Assessment of the United States (ACHA-NCHA) have founded 3% of females and 0.4% of males have ever been diagnosed as having an anorexia in, the previous diagnosis was 2% of females and 0,2% of males of the bulimia, and 4% of females and 1 % of males have stated vomits or laxatives to lose weight in earlier month (American College Health Association, 2009). However, most ED-related studies have studied convenience samples among college students (e.g. in psychological courses or residence halls) or specific groups (e.g. athletes) (Hoerr et al., 2002; Kirk et al., 2001; Reinking & Alexander, 2005).
In addition, the distribution and characteristics of the pathology of eating across whole populations of students are critical for further review. This information can help to develop and implement effective campus strategies for avoidance, detection and intervention. Understanding populations that do not seek professional care is particularly important, since EDs are diagnosed and treated early and are far more likely to recover from them (Becker, Franko, Nussbaum, & Herzog, 2004; Fichter, Quadflieg, & Hedlund, 2006).
In order to recognize the persistence of ED that could help in identifying and preventing efforts longitudinal data are required in particular.

Mentally severe conditions like anorexia, bulimia nervous, and binge-eating disorder, with an estimated lifetime prevalence rate of around 1% (Udo & Grilo, 2018). Eating disorders are also extreme. ED is also highly prevalent in people with an unhealthy weight control behavior in approximately fifty percent of women and thirty percent of men (Haynos et al., 2018).

Study Objects

The study aimed to:

1- Assess the extent of Eating Disorder Attitude among undergraduate students.

2- Examine differences in self-compassion and Eating Disorder Attitude by gender.

3- Investigate the relation between self-compassion and Eating Disorder Attitude.

Methods

Participants

The sample included 435 graduates from Baghdad University were randomly selected from University of Baghdad. All study and recruiting methods were approved by the institutional review board of the University. The participants were asked to answer the questionnaires on paper basis.

Measurement Tools

The Self-Compassion Scale (SCS): The English version of the Self-Compassion Scale of Neff (2003) was translated from English to Arabic. This research used Brislin's model for back-translation (Brislin, 1970).The scale consistent of 26-item self-report questionnaire. The scale has six subscales (Self-Kindness, Self-Judgment, Common Humanity, Isolation, Mindfulness , Over-identified). Replying to Likerte scale ranging from 1 = almost never to 5 = almost always explains how they respond in times of distress. Higher scores reflect higher levels of self-compassion. Internal consistency of the SCS was α = .95. Sub-scale scores are determined by measuring the mean of the answers to subscale answers. To compute the overall self-compassion score, reverse score negative sub-scale items before calculating the subscale mean (i.e. 1 = 5, 2 = 4, 3 = 3. 4 = 2, 5 = 1), then calculate a major mean of all 6 sub-scale means.

Eating Attitudes Test (EAT-26) is settled by David Garner and is widely-used 26-point consistent self-report questionnaire, evaluating symptoms and concerns typical of eating disorders. In high schools, colleges and other special risk groups including sportspersons, EAT has become an especially effective screening method to evaluate the likelihood of eating disorders. Screening for eating disorders is expected to lead to early care, thereby preventing or even death from serious physical or psychological effects. In addition, EAT was highly successful in anorexia nervous screening in many populations (Garner & Garfinkel, 1979).

The EAT-26 is not explicitly intended for the treatment of eating disorders in a non-clinical and a clinical setting. It is managed in groups and in individual environments and is designed for the administration of mental health practitioners, counselors at school, administrators, camp managers, and others interested involved in gathering information on whether a person needs to be referred for treatment by a specialist in eating disorders. It is ideal for schools, sports facilities, wellness centers, clinics for abortion, pediatric services, general procedures, as well as for outpatient clinical units. It is appropriate for teenagers and adults.

The EAT-26 is classified according to the frequency of individual conduct in a six point scale. The answers to these questions are Always, Usually, Often, Sometimes, Rarely, and Never. The completion of EAT-26 produces a 'referencing index' based on three criteria : 1) the average score of the EAT-26 items; 2) answers to behavioral questions(A-E) ; and 3) the individual's height and weight index of body mass (BMI). It is usually best to refer a respondent to one or more parameters when he or she "positively" or fulfills the "cut off" (20 or more) threshold.

BMI (kg/m2). The sample breakdown was based on commonly used BMI categories: 50.2 % underweight (BMI less than 18.5), 47.2 % normal weight (BMI between 18.5 and 24.9), 2,1 percent overweight (BMI between 25and 29,9), and 0.5% obese (BMI between 25 and 29.1), respectively. BMI is based on the recorded height and weight of the participants. The range of BMI was between 11.3 and 34.7.

Result

Screen Criteria

Completion of the EAT-26 offers a 'index of references' based on three criteria: 1) the average EAT-26 score; 2) responses to behavioral questions; and 3) a height and body weight index (BMI) of the individual. In general, if a respondent exceeds the "cut off" (20 or more) in EAT-26 or , if his/her answered YES to any questions A-D, or if his/ her weight is below the number on the weight according to BMI. It is better to adhere to one or more criteria.

A threshold score was used to meet the first EAT criterion since a person who receives 20 or more is more likely to have an eating disorder.

The findings showed 28.3% (n=123) of participants reporting EAT symptoms, according to these criteria. However, no EAT symptoms have been registered by 71.7 percent (n = 311).

The BMI was determined with regard to the second criterion. A 50.2% of BMI participants (18.5 or lower) who are significantly underweights. However, the remaining half of the study is spread over weight and obesity in usual forms.

Finally, the Third Behavior questions criteria (A-D) (Table 1) was added. The table 2 showed that section A (mean = .34), followed by respective C , D and B was established for the highest average score. Furthermore, the percentage of each criteria was presented in (Table 2).

Frequency of EAT (Criteria 2) described by participants (N = 434)

Criteria 2	Yes [n (%)]	No [n (%)]	Mean	SD
A	151(34.8%)	283(65.2%)	.34	.47
B	19(4.4)	415(95.6%)	.04	.20
C	60(13.8%)	374(86.2%)	.13	.34
D	43(9.9%)	391(90.1%)	.09	.29

Table 2 Frequency of the three EAT criteria among university students

Criteria met	n	%
None	**311**	**71.7%**
Criteria (1)	**123**	**28.3%**
Criteria (2)	**225**	**50.2%**
Criteria (3)	**206**	**47.46%**
Criteria (1) + Criteria (2)	**34**	**7.8%**
Criteria (1) + Criteria (3)	**94**	**21.65%**
Criteria (2) + Criteria (3)	**206**	**47.46%**
Criteria (1) + Criteria (2) + Criteria (3)	**131**	**30.18%**

Primary Results

First of all, the data was divided according to the gender variable. For males, the results showed that Self-Kindness subscale of self-compassion was positively correlated to the first and second criteria of eating disorder. However, the results of female displayed that self-compassion as a total score and Isolation subscale has shown a positive correlation with only the second criterion of eating disorder (Table 3).

Differences in Self-Compassion and the three criteria of eating disorder by gender

In order to achieve this aim, t - test was used to examine the significance differences in self-compassion and the three criteria of EAT according to the gender. The results displayed in Table (4) founded that there is a significant difference between male and female in BMI, as Male reported higher level of BMI than Male. However, no significant differences were founded in self-compassion and other criteria of EAT.

Table(4) Differences in self-compassion and the three criteria of eating disorder between Males and Females

	Gender	N	Mean	SD	*df*	*t*	*p*
Self-compassion	Male	257	85.62	11.30	432	0.29	0.77
	Female	177	85.29	11.91			
Eating Disorder Criteria (1)	Male	257	15.46	10.28	432	0.54	0.58
	Female	177	16.02	10.82			
Eating Disorder Criteria (2)	Male	257	.49	.50	432	0.78	0.43
	Female	177	.45	.49			
BMI	Male	257	1.60	.566	432	3.03	0.003**
	Female	177	1.43	.55			

****p<.01**

Table(3) Means, standard deviations (SD) and zero-order correlations between study variables.

			1	2	3	4	5	6	7	8	9	10	Mean	SD
Male	1	Self-compassion	-	.57**	.71**	.39**	.70**	.56**	.30**	.07	.10	.06	85.62	11.30
	2	Self-Kindness	.57**	-	.13*	.46**	.09	.51**	-.25**	-.04	.05	-.03	17.77	3.54
	3	Self-Judgment	.71**	.13*	-	-.08	.62**	.13*	.32**	.12*	.14*	.10	16.00	4.20
	4	Common Humanity	.39**	.46**	-.08	-	-.03	.47**	-.30**	.06	.03	.007	14.49	2.87
	5	Isolation	.70**	.09	.62**	-.03	-	.08	.40**	.01	.09	.09	12.64	3.81
	6	Mindfulness	.56**	.51**	.13	.47**	.08	-	-.16	.05	-.01	-.07	15.02	2.77
	7	Over-identified	.30**	-.25	.32**	-.30**	.40**	-.16	-	.01	-.01	.09	9.67	2.74
	8	Eating Disorder Criteria (1)	.072	-.040	.125*	.06	.01	.05	.01	-	.10	.15	.25	.43
	9	Eating Disorder Criteria (2)	.105	.05	.14	.03	.09	-.01	-.01	.10	-	.17*	.49	.500
	10	BMI	.06	-.03	.10	.007	.09	-.07	.09	.15*	.17*	-	1.60	.56
Female	1	Self-compassion	-	.59**	.66**	.42**	.70**	.62**	.21**	-.01	.19**	.06	85.29	11.91

2	Self-Kindness	.59**	-	.06	.52**	.06	.59**	-.30**	.08	.05	.009	17.70	3.83
3	Self-Judgment	.66**	.06	-	-.10	.70**	.00	.40**	-.04	.09	.03	16.19	3.89
4	Common Humanity	.42**	.52**	-.10	-	-.11	.55**	-.37**	-.01	.13	-.003	14.07	3.14
5	Isolation	.70**	.06	.70**	-.11	-	.16	.32**	-.00	.10	.10	12.70	4.22
6	Mindfulness	.62**	.59**	.00	.55**	.16	-	-.26**	-.03	.20**	.09	14.8	3.38
7	Over-identified	.21**	-.30**	.40**	-.37**	.32**	-.26**	-	-.02	.04	-.03	9.80	2.90
8	Eating Disorder Criteria (1)	-.01	.08	-.04	-.01	-.00	-.03	-.02	-	.12	.23**	.32	.46
9	Eating Disorder Criteria (2)	.19*	.05	.09	.13	.10	.20**	.04	.12	-	.24**	.45	.49
10	BMI	.06	.00	.03	-.00	.10	.09	-.03	.23**	.24	-	1.43	.55

*** p < 0.05**
**** p < 0.01**

Discussion

The first aimed of this study was to screen the EAT. The three criteria were used for eating disorder. Results showed that a quarter of the sample had symptoms of eating disorder according to the first criterion. As for the second criterion, the results indicated that just under half of the sample had met this criterion. The same thing with regard to the third criterion, the body mass index, as results showed that about half of the sample had met this criterion. To find out the percentage of those who applied the three criteria, the results showed that about a third of the total sample had applied to the three criteria.

Regarding to the second aim, the correlation coefficients was used between all study variables. The male data founded that one of the subscale of self-compassion (Self-Kindness subscale) was positively correlated to the first and second criteria of eating disorder. However, there were no significant correlations were founded between other variables. In other hand, the female data has different results. The results showed that the total score of self-compassion and Isolation subscale of self-compassion has revealed a positive correlation with only the second criterion of eating disorder.

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