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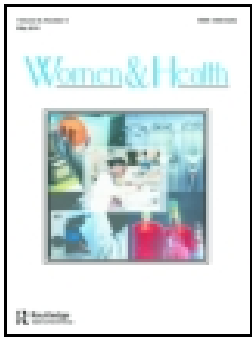


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Understanding the role of mother guilt and self-compassion in health behaviors in mothers with young children

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ABSTRACT

We explored whether the guilt mothers of young children feel about engaging in health behaviors mediates the relationship between self-compassion and self-reported engagement in health-promoting behaviors such as physical activity, eating a healthy diet and getting enough sleep. In this online, cross-sectional study, 143 mothers of young children completed measures of self-compassion, guilt about taking time to engage in health-promoting behaviors, trait guilt, health-promoting behaviors, self-esteem, and demographics. Mediation analysis, using Hayes' PROCESS macro showed that mother guilt mediated the relationship between self-compassion and health-promoting behaviors, $\beta = .05$, Bca CI (.0014, .1133) with a bootstrapped standard error of .03 and a 95% confidence interval. Self-compassion may offer mothers a positive way to deal with guilty feelings about looking after their health.

ARTICLE HISTORY

Received 4 May 2019
Revised 2 December 2019
Accepted 3 January 2020

KEYWORDS

Ethics of care; health behaviors; mediation; mothers; self-compassion

Introduction

Adjustment to motherhood often involves a shift in lifestyle, priorities and personal time, which can be both physically and emotionally demanding (Evenson, Aytur, and Borodulin 2009). The extent to which mothers engage in behaviors which promote their health and well-being (health-promoting behaviors) such as physical activity, eating healthy and getting enough sleep, during the early years of motherhood can have a lasting effect on their future health outcomes (Cramp and Bray 2013). Although more important than ever, taking the time to look after oneself by engaging in health-promoting behaviors becomes much more difficult for mothers to achieve than before motherhood. Mothers are less physically active (Bellows-Riecken and Rhodes 2008), have lower sleep efficiency (Teti et al. 2016) and have higher intakes of sugary drinks, saturated fat and overall calories (Berge et al. 2011) than women without children. Making improvements in health-promoting behaviors are frequent targets for interventions designed for new mothers (Ayers, Fitzgerald and Thompson 2015) as these behaviors tend to be overlooked when a new baby is introduced into a mother's life (Taveras et al. 2011).

Mothers of young children must pursue these health-promoting behaviors in the context of taking on a larger proportion of the family's childcare duties as well as bearing more than their share of household responsibilities (Bianchi et al. 2012). Various explanations for the difficulty mothers have engaging in health-promoting behaviors have been

identified: lack of self-discipline (Adachi-Meija et al. 2010), social support (Bellows-Riecken and Rhodes 2008), time (Berge et al. 2011), lack of information about implementing positive postpartum lifestyle behaviors (Evenson, Aytur, and Borodulin 2009) as well as the number and intensity of maternal stressors (Currie 2018). However, research findings regarding some of these barriers have been mixed highlighting the need for researchers to understand this subpopulation. Within this lack of agreement about which factors serve as barriers to mothers' engagement in health-promoting behaviors, one consistent suggestion has been that the role of mother and motherhood *itself* is the real barrier; this barrier needs further exploration (Elliott, Powell, and Brenton 2013).

Maternal ethics of care

The connection of the motherhood role to a maternal ethics of care may clarify why this role, as "mother", poses a barrier to engagement in health-promoting behaviors for women of young children. Carol Gilligan (1982) described the ethics of care as the voice of caring, in which one considers herself within the context of others. Although value exists in caring within relationships, an ethics of care can have a negative effect when caring for others takes priority over caring for oneself. This can happen to some mothers. Through socialization and exposure to society's traditionally held view of motherhood, some mothers' maternal ethics of care involve taking on the role of primary care giver and this can result in mothers prioritizing the needs of the family members while putting their own needs aside (Martinez et al. 2011). One study, by McGannon and Schinke (2013) that focused on an ethics of care as a barrier to health-promoting behaviors, found that societal expectations put on mothers interfere with their willingness to engage in physical activity. Although not framed within the idea of an ethics of care specifically, mothers who identify with the primary caregiver role are more vulnerable to weight gain, poorer diets, less physical activity and more interrupted sleep patterns than fathers (Berge et al. 2011). The maternal ethics of care placed on mothers can be associated with some mothers' compromised ability to engage in health-promoting behaviors.

Ethics of care and mother guilt

Even if mothers could overcome individually perceived barriers to their own care such as lack of partner support, motivation or childcare, to engage in health-promoting behaviors, they must still contend with resisting the maternal ethics of care and the accompanying societal expectations of the "good mother" role (Liss, Schiffrin, and Rozzo 2013). Mothers often describe experiencing guilt when thinking about living up to the "good mother" ideal (Rotkirch and Janhunen 2009) and when taking time away from their mother-role obligations to look after themselves (Martinez et al. 2011). Guilt is a self-conscious emotion that is considered to be distressful (Tangney, Stuewig, and Mashek 2007) as it is associated with doing something wrong or not having done something one should have (Dunford and Granger 2017). This maternal guilt is related to mothers' sense of responsibility for their children as well as negative perceptions from society toward their choices (Sutherland 2010). Feelings of guilt can be intensified when mothers cannot be constantly available to their child or when they ask for help in matters they feel a mother should be doing (Martinez et al. 2011). Consequently, mothers are impeded by their feelings of guilt

for leaving their children (Rotkirch and Janhunen 2009). Even mothers who resist the idea of the good mother ideal will measure their actions against this cultural norm (Liss, Schiffrin, and Rozzo 2013).

Although mothers live under the influence of a maternal ethics of care in our society (McGannon and Schinke 2013) and may experience guilt for caring for themselves (Liss, Schiffrin, and Rozzo 2013), some mothers feel that taking care of their health needs is the best way to accomplish being a “good mother” (Lloyd, O’Brien, and Riot 2016). Consistent with this perspective, some mothers take the time to engage in health-promoting behaviors and categorize that time as necessary. They may also view other mothers who do not take time to look after themselves as women who must be coping well and do not need the time away from family (Lloyd, O’Brien, and Riot 2016). Such alternative views of motherhood may allow mothers to make space for their own health-promoting behaviors while playing out the “good mother” role. However, such alternative views stand in contrast to the prevailing view of motherhood. One variable that may influence mothers’ willingness to care for themselves in the midst of their motherhood responsibilities is self-compassion.

Self-compassion

Stemming from Buddhist philosophy, self-compassion involves showing kindness and understanding to oneself in difficult times (Neff 2003). Self-compassion is made up of three components: self-kindness (ones’ ability to accept and view personal failures in a nonjudgmental way) as opposed to self-criticism, common humanity (the knowledge that one is not alone in suffering) versus isolation, and mindfulness (viewing ones’ present situation in a balanced way) instead of over-identification. Researchers examining self-compassion have often distinguished self-compassion from self-esteem (Magnus, Kowalski, and McHugh 2010). Like self-compassion, self-esteem is related to positive feelings, but it differs from self-compassion because of its evaluative component (Neff and Vonk 2009). Self-esteem is influenced by people’s judgments about their self-worth and influenced by other’s perceptions. According to Neff and Vonk (2009) self-esteem loses its effect once self-compassion has been taken into account, capturing the ‘good’ that is part of self-compassion but not the bad, that is unique to self-esteem, such as narcissism, anger toward others and self-worth contingent on social approval.

According to Neff (2003), self-compassion is a way of relating to the world around us and showing consideration for oneself as fully human, with all our imperfections and foibles. Thus, self-compassion may relate to the extent to which mothers of young children are able to overcome the guilt they may feel about engaging in health-promoting behaviors. Free of this guilt, they may be more likely to take care of themselves through attending to their own health.

A direct relationship may exist between self-compassion and engagement in health-promoting behaviors. Terry and Leary (2011) have shown that people with high levels of self-compassion are more likely than those lower in this construct to actively engage in health-promoting behaviors (Terry et al. 2013). A cross-sectional study by Dunne, Sheffield, and Chilcot (2016) found that self-compassion was positively related to health-promoting behaviors such as exercise, eating healthy, and getting enough sleep.

Self-compassion’s positive association with health-promoting behaviors may be due to, or mediated by, this construct’s documented mitigating effect on negative emotions. The

guilt that some mothers experience when they take time or consider taking the time to engage in health-promoting behaviors should make it less likely for them to engage in these behaviors. Negative emotions, such as guilt, can interfere with self-regulation (Gross 2013) and have been negatively associated with engagement in health-promoting behaviors (Sirois, Kitner, and Hirsch 2015). According to self-compassion theorists (Terry et al. 2013), self-compassionate people overcome negative emotions because self-compassion makes it less likely that they will over-identify with their emotions or let those emotions deter them from looking after themselves (e.g., engaging in health-promoting behaviors). Hollis-Walker and Colosimo (2011) showed that self-compassion can alleviate negative feelings, such as guilt and self-criticism, which in turn facilitates well-being. As the authors speculate, negative emotions may interfere with participants' engagement in health-promoting behaviors, while positive emotions may assist with the motivation required to pursue health-promoting behavioral goals. Considering these findings, self-compassion may be negatively associated with the experience of guilt, or the ability to deal adaptively with guilt about taking time to engage in health-promoting behaviors among mothers of young children. With guilt mitigated, mothers should be freer than they would otherwise be to engage in health-promoting behaviors.

The purpose of this study was to test this proposed mediated sequence. Specifically, we explored whether feelings of guilt about taking the time or thinking about taking the time to engage in health-promoting behaviors, such as physical activity, healthy eating and getting enough sleep, mediated the relationship between self-compassion and engagement in these health-promoting behaviors of mothers with young children. The following hypothesis guided this research: Mothers' guilt would mediate the relationship between self-compassion and engagement in health-promoting behaviors while controlling for self-esteem and trait guilt.

Methods

Design and participants

A self-administered, web-based questionnaire was used in this cross-sectional, correlational study. An online questionnaire was used as mothers with young children express a desire to participate in studies with a flexible mode of delivery and minimal face-to-face contact (Fjeldsoe, Miller, and Marshall 2010). Online surveys also offer a convenient and easy way for people to participate who might otherwise not have the time to travel or spend in a face-to-face session, such as mothers with young children (Wright 2005). Online questionnaires also offer practical advantages in that they allow researchers to reach a large number of participants in a short amount of time (Wright 2005).

Participants were women who met the inclusion criteria of speaking and reading English, and with at least one child five years of age or younger living in the same home. Participants were excluded if they reported injuries or medical conditions that limited their ability to engage in physical activity, eating a healthy diet or getting enough sleep. We chose to restrict participation to mothers with children under the age of five because these mothers report low levels of engagement in health-promoting behaviors. Indeed, research suggests that while all women with children in their care are less likely than women without to consistently engage in health-promoting behaviors, this

association is even more profound for mothers with children under the age of five (Berge et al. 2011). In this study, we aimed to recruit a minimum of 120 participants to achieve 80% power, with a two-sided 5% significance level (G*Power3: Faul et al. 2007). This power calculation was based on results derived by Sirois, Kitner, and Hirsch's (2015) meta-analysis, which found an effect size of 0.25 between self-compassion and positive health-promoting behaviors.

Upon approval from the ethics review board of the institution which the research was conducted, participants were recruited using posters throughout the community (e.g. university campuses, community centers, Health Action Centers, Healthy Baby program centers); within community distribution lists, and through social media (e.g. Facebook and Twitter and Kijiji). An e-mail address was provided on all recruitment materials for potential participants to express their interest in participating in the study. Upon emailing the researcher, potential participants received a link to the study website where they provided informed consent.

Measures

Demographics

Participants were asked to provide the following demographic and descriptive information: age, education, marital status, number and age of children, employment status, income range and ethnicity.

Health-promoting behaviors

The Wellness Behavior Inventory (WBI) scale, developed by Sirois (2001), assesses how often people perform common health-promoting behaviors. The 10-item WBI asked participants to recall their engagement in the following behaviors over the past three months: physical activity, sleep quality, healthy eating and stress reduction. Participants were asked to indicate, on a 5-point scale with responses ranging from 1 (less than once a week or never) to 5 (every day of the week), how often they currently performed health-promoting behaviors such as "I eat fresh fruits and/or vegetables". The total score was derived by first reverse coding two negative items then calculating the mean of all items. The original scale reported a Cronbach's alpha of 0.75. In this study, Cronbach's alpha coefficient was 0.67 (10-items).

Mother guilt

Mother guilt, which in this study is defined as guilty feelings mother's might have had when taking time away, or thinking about taking time away, from their motherhood responsibilities, was assessed as state guilt and measured by the State Shame and Guilt Scale (SSGS; Marschall, Sanftner, and Tangney 1994). The original 15-item questionnaire measures feelings of shame, guilt, and pride *in the moment*. The five guilt items of the SSGS was used as this study focused specifically on mothers' *guilt* about taking a specific action, such as taking time away from the family to engage in health-promoting behaviors. A sample item assessing guilt is "I feel remorse/regret". Participants considered each of the five guilt items of the SSGS, in the context of how they feel when they engage in, or think about engaging in, health-promoting behaviors, rating them on a 5-point scale, (1 = rarely or never and 5 = feeling that way all the time). An example was "When I think about

taking time, or I do take time, to engage in health-promoting behaviors, I feel like apologizing”. A total score was derived by calculating the mean sum of the 5 items. In the original study, Cronbach’s alpha was 0.82 for guilt. In this study, Cronbach’s alpha coefficient was found to be highly reliable ($\alpha = .91$).

Self-compassion

Self-compassion was measured using the 26-item Self-Compassion Scale (SCS; Neff 2003a). This scale has been used previously in studies considering health-promoting behaviors and self-compassion (Sirois, Kitner, and Hirsch 2015). Participants were asked questions about how often they typically act toward themselves, with scores ranging from 1 (almost never) and 5 (almost always). A grand mean is calculated by first reverse coding the negative items then computing an overall mean. Recent empirical evidence validates the use of a total scale score with a reliable variance of at least 90 per cent (Neff 2016). Internal consistency for the 26 SCS items was found to be very good ($\alpha = 0.92$; Neff 2003b) and in a recent study considering self-compassion and health-promoting behaviors was also found to be high ($\alpha = 0.94$; Dunne, Sheffield, and Chilcot 2016). For this study, Cronbach’s alpha coefficient for the 26-item scale was found to be highly reliable ($\alpha = 0.94$).

Trait guilt

To control for the influence of participants’ characteristic tendency to be guilt-prone – guilty across all situations – the Test of Self-Conscious Affect v. 3 was used to measure trait guilt (Tangney 1990). The questionnaire consists of 11 situations in which participants were asked to rate their reactions to each, from 1 – not a likely reaction to 5 – a very likely reaction. Each score for each situation corresponds with shame self-talk, guilt self-talk or blaming others. For the purpose of this study, the guilt self-talk scores were assessed by calculating the mean of the 11-items in the guilt self-talk subscale. Previous reported alphas for this scale were 0.70. In the current study, Cronbach’s alpha coefficient was 0.61 (11-items). This internal reliability is low but comparable to reports by Tangney and associates ($\alpha = 0.66$ for adult populations and $\alpha = 0.62$ for student populations; Tangney et al. 1996).

Self-esteem

Much of the literature on self-compassion uses self-esteem as a comparison model or in conjunction with self-compassion, as another identity construct associated with self-acceptance (Magnus, Kowalski, and McHugh 2010). Past self-compassion research has considered both self-compassion and self-esteem together as both constructs are correlated (Neff and Vonk 2009). However, Neff and Vonk (2009) argue that self-compassion often captures the ‘good’ that is part of self-esteem without some of the negative aspects such as self-worth that is contingent on social approval. Therefore, self-esteem was chosen as a covariate in this study as is common practice. Self-esteem was measured using the Self-Esteem Scale (Rosenberg 1965), a 10-item scale that measures peoples’ level of general self-esteem. Participants consider each statement and decide whether they Strongly Agree (SA), Agree (A), Disagree (D) or Strongly Disagree (SD) with the statement. Scoring is as follows: SA = 3, A = 2, D = 1, SD = 0. The score was summed for the 10 items and the higher the score, the higher the self-esteem. The Rosenberg Self-Esteem scale

demonstrates an excellent internal consistency with a coefficient of reproducibility of 0.92 and test-retest reliability over a two week period (0.85 and 0.88, respectively). In the current study, Cronbach's alpha coefficient for the 10 items was 0.89. The scale also demonstrates concurrent, predictive and constructive validity using known groups (Rosenberg 1979).

Analysis

The data were checked and examined according to recommendations by Pallant (2010) and Tabachnick and Fidell (2007). Any negative scale item scores were recoded. Composite scores were produced and checked for errors and univariate outliers. Data were then tested for randomness of the missing values, confirmed by the non-significance of the Little's MCAR test (Field 2014) and missing values were replaced using multiple imputations.

To choose the variables to be included in the multivariate regression model to test mediation, we chose those variables that we wanted to test to make up the mediated relationship (i.e., self-compassion, guilt and health-promoting behaviors) as well as covariates that we felt should be included in the model, chosen on theoretical grounds. Self-esteem is conceptually similar yet distinct from self-compassion (Neff 2003) and this construct is often included as a covariate in self-compassion research; we therefore controlled for it. We also controlled for trait guilt to remove participants' tendencies to experience guilt across situations. Finally, we controlled for age given that self-compassion can increase with age (Allen, Goldwasser, and Leary 2011). Prior to running the model, we analyzed correlations to explore the relationships between variables in the study to check for multicollinearity between variables; we found none. We also ensured normal distributions of variables and the assumption of linearity and found no violations with either of these.

To test the effect of the presumed mediating variable (M; mother guilt), the Preacher and Hayes (2008) procedure was employed, which uses bootstrapping. To consider the significance of the indirect effect, a confidence level of 95% and 1000 bootstrap samples were entered into the Hayes macro PROCESS (Hayes 2012). The statistical output included the regression with self-compassion associated with state guilt after controlling for age, self-esteem and trait guilt, guilt associated with health-promoting behaviors, after controlling for trait guilt and whether guilt reduced the relationship between self-compassion and health-promoting behaviors, after controlling for age, self-esteem and trait guilt. Although the mediation analysis produced regression models between the variables, the PROCESS model only yields unstandardized betas, which is standard for reporting mediation but difficult to interpret for regression (Hayes 2013). For each test of the mediating effect, the beta and bootstrapped standard error provide an interval range. If zero does not fall within this range then the mediating effect of guilt is statistically significant (Leech, Barrett, and Morgan 2015).

Results

A total of 215 participants logged on to the study website. Participant's ages ranged from 18 to 46 years of age (*Mean* age = 34 years; *SD* = 5.24). Twenty-five participants (11.63%)

were not eligible, while a further 28 (13.02%) were eligible but did not consent to being part of the study. An additional 16 (7.44%) participants consented to the study but completed only the demographics section. The remaining 143 participants provided responses to two or more of the eleven questionnaires within the core study (67.44%) and were included in the data analysis.

Mediation analysis determined that mother guilt mediated the relationship between self-compassion and health-promoting behaviors and was statistically significant, $\beta = 0.05$, Bca 95% confidence interval (CI) (0.0014, 0.1133) with a bootstrapped standard error of 0.03 (Leech, Barrett, and Morgan 2015). Self-compassion explained 15% of the variance in mothers' guilt in engaging in health-promoting behaviors ($\beta = -0.47$, $t = -3.5$, $p < .001$), after controlling for self-esteem and trait guilt. A combination of self-compassion and mothers' guilt explained 16% of the variance in health-promoting behaviors ($F(4, 141) = 5.2$, $p < .001$).

Discussion

The purpose of this study was to explore whether feelings of guilt about taking the time or thinking about taking the time to engage in health-promoting behaviors, such as physical activity, healthy eating and getting enough sleep, mediated the relationship between self-compassion and engagement in these health-promoting behaviors of mothers with young children. As predicted, self-compassion was associated with engagement in health-promoting behaviors and this effect was mediated by feelings of guilt about taking time to engage in these behaviors. These results make a unique contribution to our understanding of factors that are related to a mother's engagement in health-promoting behaviors, which is important given the high levels of inactivity in this sector of the population (Cramp and Bray 2013). The results also contribute to the self-compassion literature by demonstrating that mothers of young children are another population that may benefit from self-compassion. Further, the current findings contribute to a growing body of research demonstrating the association between self-compassion and health-promoting behaviors (see Biber and Ellis 2017; Dunne, Sheffield, and Chilcot 2016; Homan and Sirois 2017; Sirois, Kitner, and Hirsch 2015).

In this study, guilt that mothers felt about engaging in health-promoting behaviors mediated the relation of self-compassion to engagement in health-promoting behaviors, over and above the relation of age, trait guilt and self-esteem. That is, as a mothers' level of self-compassion increased, the reported guilt about engaging in health-promoting behaviors was decreased. In turn, these diminished levels of guilt were associated with reported increased engagement in health-promoting behaviors. These results are consistent with the theories of self-compassion researchers. They argue that self-compassionate individuals have the capacity to overcome negative emotions, allowing them to look after themselves (Neff 2011; Terry et al. 2013). Further, individuals with higher levels of self-compassion are more intrinsically motivated to make behavior changes that are in the best interest of their well-being than they are to be governed by external pressures (Magnus, Kowalski, and McHugh 2010), including feelings of guilt.

The finding that mothers' guilt mediated the relationship between self-compassion and health-promoting behaviors reinforces past findings (Hollis-Walker and Colosimo 2011) regarding the relation of self-compassion to negative feelings, such as guilt, in

a demographic that is weighed down by societal expectations. For mothers, guilt can emanate from the maternal ethics of care and comparison to the “good mother” ideal (Liss, Schiffrin, and Rozzo 2013). Further, a 2019 study by Sirois, Bogels, and Emerson (2019) found that a self-compassion exercise in which parents wrote about a negative parenting event with self-kindness, common humanity and mindfulness lowered feelings of guilt and shame in parents. Self-compassion appears to buffer mothers against this maternal guilt.

Though we are only able to report a negative *association* between self-compassion and guilt, one way in which mothers may have negotiated these guilty feelings is through determining that engaging in health-promoting behaviors is an extension of society’s definition of a “good mother” (Lloyd, O’Brien, and Riot 2016). Higher levels of self-compassion may encourage mothers to see the value of self-improvement through engagement in health-promoting behaviors which in turn diminishes guilty feelings and allows them to recognize that their actions can contribute to the “good mother” ideal (Magnus, Kowalski, and McHugh 2010). Another way they may navigate their guilty feelings is by endorsing identities (e.g. “runner” or “athlete”) outside of the primary caregiver role (McGannon, McMahon, and Gonslaves 2017). Free from guilt, self-compassionate mothers may feel comfortable taking time for themselves to engage in health-promoting behaviors.

It is important to note that mother guilt scores in this study were below the scale midpoint (*Mean* = 1.8 on a scale of 1–5). These low scores suggest that, relative to taking time for health-promoting behaviors, mothers experience mild levels of guilt. It may be that today’s mothers ascribe less to the maternal ethics of care than mothers once did. However, it is interesting that even though, on average, these mothers reported low guilt, guilt still mediated self-compassion’s relationship with engagement in health-promoting behaviors and it did so beyond the influence of trait guilt. Future research should consider creating a measure specific to mothers’ feelings of guilt, and thus the extent of the maternal ethics of care that may better capture this emotion within this population. The extent to which each subscale of the self-compassion measure plays a role in health-promoting behaviors of mothers would also provide further understanding of self-compassions association with health-promoting behaviors. Further, qualitative methodology may allow us to better understand the nature of the guilt mothers feel, or do not feel, relative to taking time to engage in health-promoting behaviors.

Limitations

The present findings should be considered in light of some limitations. Although online questionnaires offer several advantages, such as convenience and the ability to reach a large number of participants quickly (Wright 2005), this choice to examine our research question using online questionnaires has limitations. Due to the open accessibility of the internet, it was difficult to determine that each participant was a mother and whether each participant considered each question before answering (Evans and Mathur 2005). However, for mothers with young children, online studies offer a convenient and realistic way to participate in studies (Fjeldsoe, Miller, and Marshall 2010). Additionally, the self-selected nature of this sample and the lack of availability of access to computers and the internet, which is related to socioeconomic status (Harris, Straker, and Pollock 2017), further limits the representativeness of the sample and thus the generalizability of results.

Further, the cross-sectional design of this study is not optimal for testing mediation so that prospective designs, in which the proposed predictor, mediators and outcome variables are measured at temporarily distinct times, is recommended to align with the proposed temporal order of the mediated relationship (Frazier, Tix, and Baron 2004). Given the cross-sectional nature of this study, the variables studied may relate to each other in any possible temporal ordering. Notwithstanding this limitation, the mediated-sequence proposed was theoretically-driven (Frazier, Tix, and Baron 2004). Although self-compassion accounted for a small amount of variance in engagement in health-promoting behaviors, it may play an important part of a larger intervention with this population, which in addition to teaching self-regulatory skills, mothers of young children are taught how to approach their behavior change with self-compassion. Further, the present design proved a resource-conservative way to establish proof-of-concept for self-compassion in an area in which it has not received research attention prior to more intensive investment for example, prospective, multi-time point research designs or interventions (Yang, Chang, and Chung 2012). Owing to access to a limited segment of the population, the generalizability of the results is limited.

Practical implications

The motherhood role and the associated maternal ethics of care create a situation in which mothers easily experience guilt, which can be detrimental to a woman's health (Lloyd, O'Brien, and Riot 2016). Although this guilt is present for most mothers, some mothers have found a way around it – through self-compassion. The results of this study suggest that self-compassion may offer mothers a positive way to deal with guilty feelings about looking after their own health. In the future, researchers should consider these relationships over time and consider a self-compassion intervention to understand further the implications of self-compassion on mothers' health-promoting behaviors and to determine if this personal resource can be leveraged to promote their health. Indeed, self-compassion is a malleable variable that can be increased through simple strategies. A systematic review by Biber and Ellis (2017) demonstrated that self-compassion interventions can lead to changes in health behaviors.

The results impart valuable knowledge, both in the importance of raising levels of self-compassion and reducing guilty feelings about looking after oneself, for those that support mothers of young children, including health care providers, midwives and nurses, healthy baby initiatives, programs for mothers with young children as well as partners and families. Ideally, the discourse on what it means to be a mother will change. This study shows that there are women who extend that definition of "mother as primary caregiver" to include looking after themselves. However, more work needs to be done to change the story as those mothers are still the exception and not the norm.

Ethical Statement

This research was conducted after attaining ethics approval from the University of Manitoba Education and Nursing Research Board and in the case of all participants, after attaining informed consent.

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