

Effects of the Mindful Self-Compassion Program
on Shame and Psychological Wellbeing: A Pilot Study



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DECLARATION

This report contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, this report contains no materials previously published except where due reference is made.

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Literature Review

The Mindful Self-Compassion Program: Rationale, Current Research and Future Directions



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Abstract

This literature review aimed to provide an overview of the Mindful Self-Compassion program, including the rationale for the program, research to date that has examined the effectiveness of the program, and future directions for research on the program. Review of the literature suggests there is a sound rationale for the MSC program. The MSC program appears to be a feasible and acceptable intervention for enhancing self-compassion, mindfulness and other measures of wellbeing. However, the field of literature examining the effectiveness of the MSC program is limited. There are several areas for future research for the MSC program, which are discussed.

Mindfulness-based interventions (MBIs) have been widely investigated, with findings showing their beneficial effects on mental health outcomes (Hofmann, Sawyer, Witt, & Oh, 2010; Khoury, Sharma, Rush, & Fournier, 2015). Emerging evidence suggests that self-compassion plays an important role in the beneficial effects of MBIs (Evans, Wyka, Blaha, & Allen, 2018; Keng, Smoski, Robins, Ekblad, & Brantley, 2012; Kuyken et al., 2010; Sevel, Finn, Smith, Ryden, & McKernan, 2020). Self-compassion is defined as a healthy attitude toward the self and is conceptualised as including three components: self-kindness, mindfulness and common humanity (Neff, 2003). Research shows that self-compassion is positively associated with psychological wellbeing, and negatively associated with symptoms of psychological disorders (MacBeth & Gumley, 2012; Zessin, Dichkäuser, & Garbade, 2015). The documented benefits of self-compassion and the literature that highlights the role of self-compassion in the beneficial effects of MBIs, suggests that specifically focusing on the cultivation of self-compassion may be beneficial to optimize therapeutic change. This rationale led to the development of the Mindful Self-Compassion (MSC) program, a manualised intervention designed specifically to help individuals cultivate self-compassion. The aim of this literature review was to provide an overview of the rationale of the MSC program, the research to date examining the effectiveness of the MSC program, and future directions for research on the MSC program.

Rationale of the Mindful Self-Compassion Program

Mindfulness and Mindfulness Based Programs

Mindfulness is defined as focusing on the present moment without judgement (Kabat-Zinn, 2003). MBIs, including Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990) and Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2013), have been developed to help individuals practise and cultivate mindful awareness. Research has widely investigated these MBIs and their effects on mental health. A meta-

analysis conducted by Hofmann et al. (2010) investigated the effect of mindfulness-based therapy, including MBSR and MBCT, on anxiety and depressive symptoms in a range of clinical conditions. Findings showed that mindfulness-based therapy was effective in improving symptoms of anxiety and mood disorders with large effect sizes (Hofmann et al., 2010). Mindfulness-based therapy was also shown to be moderately effective in improving anxiety and depressive symptoms in other psychiatric and medical conditions (Hofmann et al., 2010). Another meta-analysis investigated the effects of mindfulness-based therapy, specifically MBSR, for nonclinical populations (Khouri et al., 2015). MBSR had a large effect on stress, moderate effects on anxiety, depression, distress and quality of life, and a small effect on burnout (Khouri et al., 2015). Findings showed that participation in MBSR led to significant increases in mindfulness and compassion, and that these changes were correlated with improvement in clinical outcomes (Khouri et al., 2015). These findings highlight the effectiveness of MBIs as an intervention for improving mental health outcomes in clinical and nonclinical populations.

Given the large evidence base supporting the effectiveness of MBIs, researchers have examined the mechanisms by which these programs lead to improvements in mental health. A systematic review using meta-analytic techniques revealed consistent evidence for cognitive and emotional reactivity, mindfulness, rumination, and worry, as mechanisms underlying the effects of MBIs (Gu, Strauss, Bond, & Cavanagh, 2015). Findings also suggested preliminary evidence for self-compassion as a mechanism underlying the effects of MBIs (Gu et al., 2015). It is important to note that most of the reviewed studies were considered to have weaknesses in their methodology, and only a few studies had investigated self-compassion as a mediator of the effects of MBIs on wellbeing (Gu et al., 2015). These studies investigated the role of self-compassion in addition to mindfulness in the effects of MBIs on wellbeing. The reviewed randomized controlled trials showed that both increases in

mindfulness and self-compassion mediated effects of MBIs on mental health outcomes (Keng et al., 2012; Kuyken et al., 2010).

Recent studies have further examined the meditation effect of mindfulness and self-compassion in the relationship between MBIs and mental health. These studies have aimed to address the methodological and statistical limitations of previous studies (Gu et al., 2015; Sevel et al., 2020). Evans et al. (2018) examined the relationship between mindfulness-based therapy, self-compassion, mindfulness and mood. Evans et al. (2018) found a serial mediation effect, whereby participation in mindfulness-based therapy led to increases in mindfulness, which subsequently led to increases in self-compassion, and then improvements in mood. The reverse model of mindfulness-based therapy leading to increases in self-compassion, then mindfulness, and then subsequent improvements in mood, was not significant (Evans et al., 2018). Sevel et al. (2020) also found self-compassion to mediate the relationship between mindfulness-based therapy and psychological distress, both directly and indirectly through mindfulness. Again, the reverse model of mindfulness-based therapy leading to increases in self-compassion, then mindfulness, and then improvements in psychological symptoms, was not significant (Sevel et al., 2020). These findings indicate that mindfulness is important for the development of self-compassion, and that self-compassion may play an important role in the beneficial effects of mindfulness-based programs on mental health. However further research is needed to support these findings.

Self-Compassion and Cultivating Self-Compassion

Self-compassion is defined as a healthy attitude about the self and is conceptualised as including three components: self-kindness, common humanity and mindfulness (Neff, 2003). Self-kindness involves being kind, understanding and accepting of oneself in the midst of suffering, instead of being self-critical; common humanity involves recognising and acknowledging one's experiences are part of being human, instead of feeling isolated;

mindfulness involves being aware of one's thoughts and feelings, holding them in balanced awareness instead of becoming over identified with them (Germer & Neff, 2019; Neff, 2003). Germer and Neff (2019) provide a comprehensive review of self-compassion research, noting that the literature on self-compassion is expanding exponentially. Meta-analyses show self-compassion is positively associated with psychological wellbeing (Zessin et al., 2015), and negatively associated with symptoms of psychological disorders with large effect sizes (MacBeth & Gumley, 2012). In fact, self-compassion has been shown to be associated with wellbeing across multiple domains, including psychopathology, psychological health, emotional intelligence, self-concept, body image, motivation and interpersonal functioning (Neff et al., 2018).

Based on the beneficial associations of self-compassion with wellbeing and psychopathology, and the reviewed literature that highlights the role of self-compassion in the beneficial effects of MBIs, specifically focusing on the cultivation of self-compassion may be beneficial. However there appears to be debate in the literature, specifically in terms of whether self-compassion should be taught implicitly or explicitly (Germer & Neff, 2019). Self-compassion is taught implicitly in MBIs, with research showing participation in MBIs leads to increases self-compassion (Evans et al., 2018; Gu et al., 2015; Proeve, Anton, & Kenny, 2018; Sevel et al., 2020). Leaders in the mindfulness field state, for example, that “nothing ever needed to be said explicitly” about self-compassion (Kabat-Zinn, 2005, p. 285), and “mindfulness and compassion are caught not taught” (Segal et al., 2013, p. 140) (Germer & Neff, 2019). However, given the emerging evidence that self-compassion plays a key role in the beneficial effects of MBIs, the question is raised as to whether self-compassion should be taught explicitly in an intervention. Kazdin (2007) suggests that further understanding the mechanisms of psychological interventions allows clinicians to optimise therapeutic change. Therefore, if self-compassion does play a role in the effectiveness of

mindfulness-based programs, therapeutic change may be optimized by explicitly using and teaching self-compassion practices.

The Mindful Self-Compassion Program

The Mindful Self-Compassion (MSC) program is a manualised and structured group program developed by Christopher Germer and Kristin Neff (Germer & Neff, 2019; Neff & Germer, 2013). The MSC program was designed specifically to enhance self-compassion among members of the general public. However, the authors also acknowledge the important role of mindfulness in self-compassion, describing the MSC program as a hybrid between self-compassion and mindfulness (Germer & Neff, 2019). The rationale for the program follows the extensive field of research documenting the benefits of self-compassion, and the research highlighting the key role self-compassion plays in psychological wellbeing. Germer and Neff (2019) also propose that self-compassion may be relevant in the context of self-criticism and difficult emotions such as shame, as it is difficult to remain mindful when meeting such intense emotions.

The MSC program focuses on experiential learning and inquiry-based teaching, guiding participants through formal and informal practices, such as meditation, experiential exercises and group discussion (Germer & Neff, 2019). The focus is teaching skills and building emotional resources to use in daily life, and therefore the program is not considered psychological therapy. The MSC program is typically structured as an eight-week program, involving one two-hour session per week and one half-day retreat, with participants also being asked to complete homework between sessions (Germer & Neff, 2019). However, the program may also be delivered in an intensive format (Center for Mindful Self-Compassion, 2017). The intensive MSC program includes the same content as the eight-week program, eight two-hour sessions and a half-day retreat, but is delivered over an intensive five-day period. It is not clear when the intensive MSC program was introduced. However, the

intensive MSC program is listed as an offering on the Center for Mindful Self-Compassion website (Center for Mindful Self-Compassion, 2017) and is delivered by the authors of the program, Christopher Germer and Kirsten Neff, as well as other trained MSC facilitators.

Research Investigating the Mindful Self-Compassion Program

The first evaluation of the MSC program was a pilot study and randomized controlled trial conducted by the authors of the program (Neff & Germer, 2013). Participants were recruited from the general public, as the program was designed to be delivered to the general population (Neff & Germer, 2013). Results of the pilot study showed participation in the eight-week program significantly increased self-compassion, mindfulness, life-satisfaction and happiness, and significantly decreased depression anxiety and stress (Neff & Germer, 2013). Findings of the randomized controlled trial showed that compared to a wait-list control, the intervention led to significant increases in self-compassion (large effect size), mindfulness (medium effect size), compassion for others (medium effect size) and life satisfaction (medium effect size) (Neff & Germer, 2013). Findings also showed that the intervention led to significant decreases in depression (large effect size), anxiety (medium effect size), stress (small effect size) and avoidance (medium effect size), compared to the waitlist control (Neff & Germer, 2013). These initial findings highlight the promising beneficial effects of the MSC program, and the need for a further investigation into the effectiveness of the program.

To my knowledge, the MSC program has not yet been evaluated independently in a meta-analysis or systematic review, and only one other randomized-controlled trial has investigated the effects of the manualised eight-week MSC program. This study randomly allocated participants with diabetes to participate in the MSC program or to a waitlist control (Friis, Johnson, Cutfield, & Consedine, 2016). Findings showed participation in the program led to significant increases in self-compassion and significant decreases in depression and

diabetes-specific distress, with changes maintained at three-month follow up (Friis et al., 2016). Metabolic outcomes also improved following participation in the MSC program, suggesting that the MSC program improves both mental and physical health outcomes in people with diabetes (Friis et al., 2016). These findings provide additional support for the promising beneficial effects of the MSC program.

Pilot studies have further investigated the effectiveness of the eight-week MSC program among different populations. Delaney (2018) investigated the MSC program among a sample of nurses from a range of disciplines. Findings showed significant increases in self-compassion, mindfulness, compassion satisfaction and resilience, as well as significant decreases in secondary traumatic stress and burnout following participation in the program (Delaney, 2018). Effect sizes were large for all measures (Delaney, 2018). The MSC program has also been investigated among a Chinese community sample (Finlay-Jones, Xie, Hung, Ma, & Guo, 2018). Findings showed self-compassion and compassion for others significantly increased, and distress, depression, anxiety, stress, rumination, maladaptive perfectionism and fear of self-compassion all significantly decreased following participation in the program (Finlay-Jones et al., 2018). Again, effect sizes were large for all measures (Finlay-Jones et al., 2018). The MSC program has also been investigated in a sample of clinical and health psychology students (Yela, Gómez-Martínez, Crego, & Jiménez, 2020). Yela et al. (2020) used a quasi-experimental design, assigning participants to two groups based on their level of adherence to the MSC program. Participants with high adherence showed greater improvements in self-compassion, mindfulness and psychological wellbeing compared to participants with low adherence (Yela et al., 2020). However, there were no significant differences between groups for measures of depression and anxiety (Yela et al., 2020). Taken together these findings suggest that the MSC program may be beneficial for improving wellbeing among a range of different populations. However, it is important to note that the

findings from these pilot studies are limited due to the nature of the study and lack of control groups.

On review of the literature, it becomes evident that the field of research investigating the manualised MSC program is limited. However, researchers have investigated adaptations to the MSC program which bear on the question of effectiveness of the MSC program.

Adaptions have involved modifications to the manualised MSC program or a selection of self-compassion exercises that are included in the MSC program. The MSC program has been adapted for adolescents in a program called Making Friends with Yourself (MYA; Hobbs & Bluth, 2016). Research has shown the MYA program to improve self-compassion, mindfulness, life-satisfaction, gratitude and curiosity, depression and perceived stress among adolescents (Bluth & Eisenlohr-Moul, 2017; Bluth, Gaylord, Campo, Mullarkey, & Hobbs, 2016). The MYA program has also been delivered online via a video conferencing platform to young adult cancer survivors (Campo et al., 2017; Lathren, Bluth, Campo, Tan, & Futch, 2018). Findings showed that the online MYA program led to improvements in self-compassion, mindfulness, post-traumatic growth, anxiety, depression, social isolation and body image (Campo et al., 2017; Lathren et al., 2018). Other interventions deviate further from the manualised MSC program. For example, researchers have investigated three-week interventions that involve practices that are included in the MSC program. Randomized controlled trials have shown these brief self-compassion interventions to improve self-compassion, mindfulness and other measures of psychological wellbeing, compared to active and waitlist controls (Albertson, Neff, & Dill-Shackleford, 2015; Haukaas, Gjerde, Varting, Hallan, & Solem, 2018; Smeets, Neff, Alberts, & Peters, 2014). Although these studies utilised adaptations that deviate from the manualised MSC program, the findings provide evidence for the effectiveness of self-compassion practices that are included in the MSC program.

In summary, the field of literature examining the manualised MSC program, and the adaptations and practices of the MSC program, is promising. The effect of the MSC program has been investigated using a range of mental health outcomes among a range of different populations. However, it is clear that the research examining the effectiveness of the MSC program on wellbeing is in its infancy. There are a number of limitations and a number of important areas for future research.

Limitations and Future Directions

The Mindful Self-Compassion Program and Shame

On review of the literature it becomes evident that there is an important gap in the field of research on MSC: an investigation of the effect the MSC program has on shame. This gap in the literature is particularly noteworthy, as part of the rationale for the MSC program is that self-compassion is important when meeting difficult emotions like shame (Germer & Neff, 2019). Shame is a self-conscious emotion that involves the negative evaluation of the self as inferior, undesirable or worthless (Tangney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007). Internal shame refers to an individual's perception of themselves, and external shame refers to an individual's perception of how others evaluate them (Gilbert, 1998). Meta-analyses have shown internal and external shame are associated with depressive and anxiety symptoms (Cândeia & Szentágotai-Tătar, 2018a; Kim, Thibodeau, & Jorgensen, 2011). In both meta-analyses, external shame was shown to be more strongly associated with symptoms of depression and anxiety than internal shame (Cândeia & Szentágotai-Tătar, 2018a; Kim et al., 2011). These findings reiterate the importance of an effective intervention to address internal and external shame, and the importance of this gap in the literature.

Self-compassion has been considered as the “ultimate antidote” to shame (Neff & Germer, 2018, p. 123). Theoretically it is. The three components of self-compassion (self-kindness, common humanity, mindfulness) counteract different aspects of shame (Johnson &

O'Brien, 2013). More specifically, self-kindness counters negative self-evaluation, common humanity counters isolation, and mindfulness counters the preoccupation with distressing mental activity and emotion (Germer & Neff, 2019). While this theoretical justification exists, the research base examining the relationship between shame and self-compassion is somewhat limited.

Studies have shown self-compassion is negatively associated with internal shame (Barnard & Curry, 2012; Mosewich, Kowalski, Sabiston, Sedgwick, & Tracy, 2011; Woods & Proeve, 2014; Zhang et al., 2018) and external shame (Ferreira, Pinto-Gouveia, & Duarte, 2013; Proeve, 2020). Researchers have also started to explore the effect self-compassion interventions have on shame. Johnson and O'Brien (2013) investigated the effect of a self-compassion writing exercise on internal shame in a randomized controlled trial. Participation in the self-compassion exercise led to significant decreases in internal shame. Similarly, Căndea and Szentágotai-Tătar (2018b) found a brief self-compassion training intervention significantly reduced internal shame among socially anxious participants in a randomized controlled trial. Gilbert and Proctor (2006) investigated the effects of Compassionate Mind Training, an intervention for clinical populations with high shame and self-criticism. Findings showed the Compassionate Mind Training intervention significantly reduced external shame and increased participants feelings of warmth and their ability to be self-soothing (Gilbert & Proctor, 2006). Taken together, these findings suggest that self-compassion may be important for both internal and external shame. These findings also support the propositions that targeting self-compassion in an intervention may be effective for reducing shame (Germer & Neff, 2019; Woods & Proeve, 2014).

The MSC Program refers to shame as something it addresses. Part of the rationale for the MSC Program is that self-compassion is relevant in the context of meeting intense and difficult emotions such as shame (Germer & Neff, 2019). In addition, the MSC Program

includes the topic of shame and an optional ‘working with shame’ practice. While there is evidence to support the proposition that self-compassion may be important in reducing shame, research has yet to examine whether the MSC program is in fact beneficial for shame. It is therefore important that future research investigates the effect of the MSC program on shame, both internal and external shame.

The Mindful Self-Compassion Program Modalities

Upon review of the literature, it becomes apparent that there is a lack of consensus regarding the term mindful self-compassion. Some studies use the term mindful self-compassion to refer to self-compassion exercises or refer to a series of self-compassion exercises as the MSC Program (e.g., Eriksson, Germundsjö, Åström, & Rönnlund, 2018; Guo, Zhang, Mu, & Ye, 2020). Germer and Neff (2019) state in the MSC program manual, that labelling a program MSC can only occur if the content includes 80% or more of the MSC program. However, this does not seem to be the case. These discrepancies are likely to be explained by the fact that the manual was published only in 2019. However, it is important to consider this limitation.

It is interesting to note research to date has yet to investigate the effectiveness of the intensive modality of the MSC program. The intensive program contains the same content as the eight-week program but is delivered over an intensive five-day period. The intensive MSC program is delivered to members of the general public due to its advantages, for example time commitment. Given the findings showing the beneficial effects of brief self-compassion interventions (Albertson et al., 2015; Haukaas et al., 2018; Smeets et al., 2014), it is likely that the intensive MSC program would be beneficial for psychological wellbeing. However, it is important that further research investigates the effect of delivering the MSC program over an intensive five-day period, and whether the different modality influences the beneficial outcomes of the MSC Program that have been documented to date.

When considering different modalities, it is also important to consider the advantages of delivering the MSC program online or using different technologies. For example, using an online video conferencing platform to deliver the MSC program to facilitate accessibility. Adaptions of the MSC program have been delivered online via video conferencing platforms (Campo et al., 2017; Lathren et al., 2018). Findings have shown that these online adaptions of the MSC program lead to improvements in psychological wellbeing (Campo et al., 2017; Lathren et al., 2018). Based on these findings it would be anticipated that delivering the MSC program online via video conferencing platforms would be beneficial for improving psychological wellbeing. However future research investigating the effects of delivering the manualised MSC program online on measures of psychological wellbeing is warranted.

The Mindful Self-Compassion Program and Mindfulness-Based Programs

Considering the rationale for the MSC program and the research to date investigating the MSC program, question is raised as to whether the MSC program would compare to mindfulness-based programs in terms of the benefits for psychological wellbeing. Compassion-based interventions have the potential to be largely beneficial for mental health (Austin et al., 2020; Ferrari et al., 2019; Kirby, Tellegen, & Steindl, 2017) and it is interesting to consider whether research into compassion-based interventions will follow the same exponential trajectory as research into mindfulness-based programs. As Germer and Neff (2019) state, it is an empirical question as to whether self-compassion should be taught implicitly or explicitly, and to understand the common and unique benefits of compassion-based interventions and mindfulness-based interventions. The two types of interventions may complement one another or be more effective in different contexts; for example, compassion-based interventions may be more relevant for high self-criticism (Germer & Neff, 2019). It would make for a very interesting comparison and would answer the questions and debate

regarding the cultivation of self-compassion. Therefore, future research to compare the effectiveness of the MSC program and MBIs is warranted.

Other Considerations for Future Research into the Mindful Self Compassion Program

As the evidence base for the MSC program grows, it will be interesting to investigate the mechanisms by which the MSC program leads to improvements in psychological wellbeing. While increases in self-compassion are expected to be important, question is raised about the role of mindfulness in the beneficial effects of the MSC program on psychological wellbeing. Previous research has highlighted that mindfulness is important for the development of self-compassion (Evans et al., 2018; Sevel et al., 2020). The authors of the MSC program also note the importance of mindfulness in self-compassion and in the MSC program (Germer & Neff, 2019; Neff & Germer, 2013). Therefore, future research should investigate the mechanisms by which the MSC program leads to improvements in psychological wellbeing.

As the field of research is in its early stages, many studies investigating the MSC program have used observational pilot study designs with small sample sizes. These pilot studies are an important first step to determine the feasibility and acceptability of the program (Kirby et al., 2017). However, large scale controlled studies will be required in future to further examine the effectiveness of the MSC program for psychological wellbeing. These studies include comparing the MSC program to waitlist and active controls, and to established effective interventions.

Conclusion

The MSC program appears to be a feasible and acceptable intervention for enhancing self-compassion, mindfulness and other measures of psychological wellbeing. However, on review of the literature, it becomes evident that the field of research on the MSC program is in its early stages. There are a number of areas for future research. Importantly, research to

date has yet to investigate the effect of the MSC program on shame, despite the fact that self-compassion has been considered to be important in reducing shame and the rationale for the MSC program. Research has also yet to investigate other modalities of the MSC program, including the intensive MSC program, or using different technologies to deliver the MSC program online. It is important that future research addresses these gaps in the literature, before moving to large scale controlled studies to further examine the effectiveness of the MSC program compared to waitlist and active controls, and well established interventions including MBIs. Although further research is warranted, the MSC program appears to be a promising intervention to enhance psychological wellbeing and mental health.

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Journal Article

Effects of the Mindful Self-Compassion Program on Shame and Psychological Wellbeing:

A Pilot Study



The University of Adelaide

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**Effects of the Mindful Self-Compassion Program
on Shame and Psychological Wellbeing: A Pilot Study**

Mindful Self-Compassion and Wellbeing



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Abstract

Objectives

The Mindful Self-Compassion (MSC) program is a manualised group program designed to help individuals cultivate self-compassion. This study aimed to investigate the effectiveness of eight-week and five-day modes of the MSC program on shame and measures of wellbeing.

Methods

Members of the general public completed online measures of self-compassion, mindfulness, internal shame, external shame, depression, anxiety and stress, before and after participation in the eight-week ($N = 8$; M age = 56.38; 75% female) or five-day MSC program ($N = 7$; M age = 47.86; 86% female).

Results

Participants in the eight-week program showed significant increases in self-compassion and mindfulness, and significant decreases in internal shame, depression, anxiety and stress, with medium to large effect sizes. External shame decreased with a large effect, but findings were not statistically significant. Participants in the five-day program showed significant increases in self-compassion and mindfulness. Internal shame, external shame, depression, anxiety and stress decreased but findings were not statistically significant. Effect sizes ranged from small to large. Reliable change indices supported findings for eight-week and five-day programs.

Conclusion

This study supports previous research that the MSC program is beneficial for improving wellbeing. The study also provides preliminary evidence that the MSC program may be effective in reducing shame. Research using controlled study designs and more representative samples is required to further evaluate the effectiveness of the program.

Keywords: Self-compassion; Mindfulness; Intervention; Shame; Psychological wellbeing.

Self-compassion is defined as a healthy attitude about the self and is conceptualised as including three components: self-kindness, common humanity and mindfulness (Neff, 2003). Self-kindness involves being kind, understanding and accepting of oneself in the midst of suffering, instead of being self-critical; common humanity involves recognising and acknowledging one's experiences are part of being human, instead of feeling isolated; and mindfulness involves being aware of one's thoughts and feelings, holding them in balanced awareness instead of becoming over identified with them (Germer & Neff, 2019; Neff, 2003). The field of literature investigating self-compassion is expanding exponentially. Meta-analyses show self-compassion is positively associated with psychological wellbeing (Zessin, Dichkäuser, & Garbade, 2015), and negatively associated with symptoms of psychological disorders with large effect sizes (MacBeth & Gumley, 2012). Based on these findings that highlight the benefits of self-compassion for wellbeing, researchers have started to explore interventions designed to enhance self-compassion. In particular, researchers have focused on Mindfulness-Based Interventions (MBIs), moving towards the development of compassion-based programs, including the Mindful Self-Compassion (MSC) program.

MBIs, including Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990) and Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2013) have been widely investigated, with findings showing their beneficial effects on mental health outcomes (Hofmann, Sawyer, Witt, & Oh, 2010; Khoury, Sharma, Rush, & Fournier, 2015). MBIs implicitly foster self-compassion through the practices and messages that are delivered. Studies have shown participation in MBIs leads to increases in self-compassion (Evans, Wyka, Blaha, & Allen, 2018; Gu, Strauss, Bond, & Cavanagh, 2015; Proeve, Anton, & Kenny, 2018; Sevel, Finn, Smith, Ryden, & McKernan, 2020). There is also emerging evidence that suggests self-compassion plays an important role in the beneficial effects of MBIs on mental health and wellbeing (Evans et al., 2018; Keng, Smoski, Robins, Ekblad, &

Brantley, 2012; Kuyken et al., 2010; Sevel et al., 2020). For example, Evans et al. (2018) found a serial mediation effect when examining the relationship between MBSR, mindfulness, self-compassion and mood. Participation in MBSR led to subsequent increases in mindfulness, self-compassion and then improvements in mood (Evans et al., 2018). The reverse model of MBSR leading to subsequent increases in self-compassion, mindfulness and then improvements in mood, was not significant (Evans et al., 2018). Sevel et al. (2020) replicated these findings when examining the relationship between MBSR and psychological distress. That is, MBSR led to subsequent increases in mindfulness, self-compassion and then improvements in psychological distress (Sevel et al., 2020). Again, the reverse model of MBSR leading to subsequent increases in self-compassion, mindfulness, and then improvements in psychological distress, was not significant (Sevel et al., 2020).

This emerging evidence that suggests self-compassion plays an important role in the beneficial effects of MBIs, raises the question whether self-compassion should be taught explicitly in an intervention. As Kazdin (2007) states, understanding the mechanisms of psychological interventions allows clinicians to optimise therapeutic change. Therefore, if self-compassion is taught implicitly in MBIs, and if self-compassion does play a role in the beneficial effects of MBIs, therapeutic change may be optimized by explicitly teaching self-compassion. In other words, an intervention that focuses specifically on the cultivation of self-compassion may be important to maximise benefits for psychological wellbeing. This argument provides the rationale for compassion-based interventions, including the MSC program (Germer & Neff, 2019; Neff & Germer, 2013).

The MSC program is a manualised and structured group program developed by Christopher Germer and Kirsten Neff (Germer & Neff, 2019; Neff & Germer, 2013). The MSC program was designed specifically to enhance self-compassion among members of the general public (Germer & Neff, 2019; Neff & Germer, 2013). The MSC program focuses on

experiential learning and inquiry-based teaching, guiding participants through formal and informal practices, such as meditation, experiential exercises and group discussion (Germer & Neff, 2019). The focus of the program is on teaching skills and building emotional resources to use in daily life; therefore, the program is not considered psychological therapy. The MSC program is typically structured as an eight-week program (Germer & Neff, 2019). The eight-week program involves one two-hour session per week and one half-day retreat, with participants also being asked to complete homework between sessions. However, the MSC program is also delivered to members of the general public using an intensive structure (Center for Mindful Self-Compassion, 2017). The intensive MSC program includes the same content as the eight-week program, eight two-hour sessions and a half-day retreat, but it is delivered over an intensive five-day period.

The evaluation of a new intervention initially involves pilot feasibility studies, and then progresses to randomized controlled trials to compare the intervention to controls or well-established effective treatments (Kirby, Tellegan, & Steindl, 2017). Neff and Germer (2013) first investigated the MSC program in a pilot study and randomized controlled trial among participants of the general public. Findings showed that participation in the MSC program led to significant increases in self-compassion (large effect size), mindfulness (medium effect size), compassion for others (medium effect size) and life satisfaction (medium effect size), compared to a waitlist control (Neff & Germer, 2013). Participation in the MSC program also led to significant decreases in depression (large effect size), anxiety (medium effect size), stress (small effect size) and avoidance (medium effect size), compared to a waitlist control (Neff & Germer, 2013). These initial findings highlight the promising beneficial effects of the MSC program for psychological wellbeing, and the need for further investigation into the effectiveness of the MSC program.

On review of the literature it becomes clear that the field of research investigating the MSC program is in its early stages (Austin et al., 2020; Germer & Neff, 2019; Kirby et al., 2017; Neff & Germer, 2013). To my knowledge, the MSC program has not been examined independently in a meta-analysis or systematic review. In fact, to my knowledge, only one other randomized-controlled trial has investigated the effectiveness of the MSC program. In this study, participants with diabetes were randomly allocated to participate in the eight-week MSC program or to a waitlist control (Friis, Johnson, Cutfield, & Consedine, 2016). Participation in the program led to significant increases in self-compassion and improvements in metabolic outcomes, and decreases in depression and diabetes-specific distress, compared to a waitlist control (Friis et al., 2016). Effect sizes were large (Friis et al., 2016). Pilot studies have examined the feasibility of the eight-week MSC program among participants from different professions (Delaney, 2018; Yela, Gómez-Martínez, Crego, & Jiménez, 2020) and different cultural backgrounds (Finlay-Jones, Xie, Huang, Ma, & Guo, 2018). In these studies, participants showed significant improvements in measures of wellbeing following participation in the eight-week MSC program, including self-compassion, mindfulness, resilience, burnout, depression, anxiety and stress (Delaney, 2018; Finlay-Jones et al., 2018; Yela et al., 2020). Effect sizes were large for these measures (Delaney, 2018; Finlay-Jones et al., 2018). However, the findings need to be interpreted with caution due to the nature of the studies. Nevertheless, taken together these findings support the promising beneficial effects of the eight-week MSC program for psychological wellbeing,

Research has yet to investigate the effectiveness of the intensive five-day MSC program. Although the intensive five-day MSC program covers the same content as the eight-week MSC program, it is interesting to consider whether the intensive modality would influence the beneficial outcomes of the MSC program that have been documented in the literature to date. Researchers have investigated brief self-compassion interventions that

deviate from the MSC program. For example, researchers have investigated the effect of various three-week self-compassion interventions that include practices of the MSC program (Albertson, Neff, & Dill-Shackleford, 2015; Haukaas, Gjerde, Varting, Hallan, & Solem, 2018; Smeets, Neff, Alberts, & Peters, 2014). Randomized controlled trials show these brief interventions improve self-compassion, mindfulness and other measures of wellbeing, compared to waitlist and active control groups (Albertson et al., 2015; Haukaas et al., 2018; Smeets et al., 2014). Based on these findings, it is likely that the five-day intensive MSC program would be effective in improving measures psychological wellbeing. However, further research is warranted.

While evidence suggests the MSC program is beneficial for improving multiple measures of wellbeing, research has yet to investigate the effect of the MSC program on shame. This gap in the literature is particularly noteworthy, as part of the rationale for the MSC program is that self-compassion is important when meeting intense emotions such as shame (Germer & Neff, 2019). Shame is a self-conscious emotion that involves the negative evaluation of the self as inferior, undesirable or worthless (Tangney & Dearing, 2002; Tangney, Stuewig, & Mashek, 2007). Internal shame refers to an individual's perception of themselves, and external shame refers to an individual's perception of how others evaluate them (Gilbert, 1998). Meta-analyses show internal and external shame are associated with depressive symptoms and anxiety symptoms (Cândeia & Szentágotai-Táatar, 2018a; Kim, Thibodeau, & Jorgensen, 2011). Therefore, an intervention that addresses both internal and external shame is important.

Neff and Germer (2018) state “self-compassion is the ultimate antidote to shame” (p. 123). Theoretically it is. The three components of self-compassion (self-kindness, common humanity, mindfulness) counteract aspects of shame (Johnson & O'Brien, 2015). More specifically, self-kindness counters negative self-evaluation, common humanity counters

isolation, and mindfulness counters the preoccupation with distressing mental activity and emotion (Germer & Neff, 2019). While this theoretical justification exists, the research base examining the relationship between self-compassion and shame is somewhat limited.

Previous research has investigated the relationship between self-compassion and shame. Studies show self-compassion is negatively associated with internal shame and external shame in a diverse set of populations (Barnard & Curry, 2012; Ferreria, Pinto-Gouveia, & Duarte, 2013; Mosewich, Kowalski, Sabiston, Sedgwick, & Tracy, 2011; Woods & Proeve, 2014; Zhang et al., 2018). Researchers have also investigated the effect of self-compassion practices on internal and external shame. For example, Căndea and Szentágotai-Tătar (2018b) found that a brief two-week self-compassion intervention led to significant decreases in internal shame compared to a waitlist control. Johnson and O'Brien (2013) similarly found a brief self-compassion writing exercise led to significantly lower internal shame compared to a waitlist control. Gilbert and Proctor (2006) investigated the effects of Compassionate Mind Training on external shame. Participants showed significant decreases in external shame following the Compassionate Mind Training intervention (Gilbert & Proctor, 2006). Taken together, these findings suggest that self-compassion practices may influence both internal shame and external shame. These findings also support the proposition that targeting self-compassion in an intervention may be effective for reducing shame (Germer & Neff, 2019; Woods & Proeve, 2014). Based on the theory and research to date, it is expected that the MSC program, both eight-week and five-day modes, would be effective in reducing internal shame and external shame. However further research is warranted.

The Present Study: Aims and Hypotheses

The present study had two primary aims. First, the study aimed to investigate the effect of participation in the eight-week and five-day modes of the MSC program on shame.

As shame has been shown to play an important role in psychopathology, these findings may highlight important clinical implications regarding the MSC program as an intervention. The study also aimed to examine the effect of the intensive MSC program on other measures of psychological wellbeing. This intensive modality of the MSC program may have practical advantages for members of the general public, thus increasing accessibility and engagement.

Due to COVID-19, the eight-week MSC program was unable to be delivered in its typical face-to-face group program format. Therefore, the eight-week program was delivered online via a video conferencing platform. As COVID-19 restrictions had lifted prior to the start of the five-day MSC program, the five-day program was delivered using the typical face-to-face group program format. The unforeseen circumstances and discrepancies in the delivery of both eight-week and five-day modes of the MSC program, meant that it was not appropriate to compare the two interventions in this study.

The study used a repeated measures design to investigate the effectiveness of eight-week and five-day modes of the MSC program on measures of internal and external shame, and other measures of psychological wellbeing including self-compassion, mindfulness, depression, anxiety and stress. Participants were asked to complete the quantitative measures before, one-week after and two-months after their participation in the eight-week or five-day MSC program.

For both eight-week and five-day modes of the MSC program, it was hypothesised that internal shame and external shame would decrease from pre-intervention to post-intervention. It was also hypothesised that for both eight-week and five-day modes of the MSC program, participants would show increases in self-compassion and mindfulness, and decreases in depression, anxiety and stress, from pre-intervention to post-intervention.

Methods

Participants

Eight-week MSC program. Eleven members of the general public enrolled in an eight-week MSC program at a South Australian mindfulness clinic completed pre-intervention measures. Participants ranged in age from 32 to 86 years ($M = 54.09$; $SD = 15.51$). Nine participants were female (81.8%) and two participants were male (18.2%). All participants identified as being of Caucasian cultural background (100%). In terms of highest level of formal education, seven participants (63.6%) reported completion of a university degree, three participants (27.3%) reported completion of a TAFE, trade or technical qualification, and one participant (9.1%) reported graduation from high school. All participants reported having previous meditation experience (100%). Eight participants completed post-intervention measures and three participants completed follow-up measures.

Five-day MSC program. Eight members of the general public enrolled in a five-day MSC program at a South Australian mindfulness clinic completed pre-intervention measures. Participants ranged in age from 30 to 61 years ($M = 48.38$; $SD = 9.68$). Seven participants were female (87.5%) and one participant was male (12.5%). All participants identified as Caucasian (100%) and indicated that their highest level of formal education completed was a university degree (100%). All participants reported having previous meditation experience (100%). Seven participants completed post-intervention measures and two participants completed follow-up measures.

Measures

Self-compassion. Self-compassion was measured using the Self-Compassion Scale (SCS; Neff, 2003). The SCS consists of 26-items that assess three dimensions of self-compassion with six subscales; self-kindness versus self-judgement, mindfulness versus overidentification, and common humanity versus isolation (Neff, 2003). Participants are

asked to respond to items using a 5-point Likert scale ranging from 1 (*almost never*) to 5 (*almost always*). Negative items of the self-judgement, isolation, and over-identification subscales are reversed scored before calculating a total self-compassion score. Only total self-compassion scores were used in this study, with higher scores reflecting greater self-compassion. The SCS is a valid measure of self-compassion and shows high internal consistency for the subscales ($\alpha = .75$ to $\alpha = .81$) and for total self-compassion ($\alpha = .92$; Neff, 2003). In the present study, Cronbach's Alpha for the SCS total score was .91.

Mindfulness. Participants completed the 15-item Five Facet Mindfulness Questionnaire (FFMQ-15; Baer, Carmody, & Hunsinger, 2012) as a measure of mindfulness. The 15-item FFMQ was developed as a short form of the original FFMQ (Baer, Smith, Hopkins, Krietemeyer, & Tomey, 2006), and has been shown to be a valid and reliable alternative (Gu et al., 2016). Items assess five facets of mindfulness, including observing, describing, acting with awareness, non-judging, and non-reactivity. Participants are asked to indicate how true responses are of them using a 5-point Likert scale from 1 (*never or very rarely true*) to 5 (*very often or always true*). A total FFMQ-15 score is calculated by summing all items. Only total FFMQ-15 scores were used in this study, with higher scores indicating greater mindfulness. The FFMQ-15 scale shows good internal consistency ($\alpha = .80$ to $\alpha = .85$; Baer et al., 2012). The FFMQ-15 Cronbach's Alpha for the present study was .76.

Internal shame. Internal shame was measured using the Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002). The ESS contains 25-items assessing areas of characterological, behavioural and bodily shame. Participants are asked about their experiences, cognitions and behaviours for each area of shame, using a 4-point Likert scale from 1 (*not at all*) to 4 (*very much*) to indicate their response. A total ESS score is calculated by summing all 25 items. Only total scores were used in the present study, with higher total ESS scores reflecting greater internal shame. The ESS demonstrates construct validity and

high internal consistency ($\alpha = .92$; Andrews et al., 2002). Cronbach's Alpha for the ESS in the present study was .97.

External shame. External shame was measured using the Other as Shamer Scale (OAS; Goss, Gilbert & Allan, 1994). The OAS assesses how the self is evaluated by others by asking participants to respond to a list of statements regarding their feelings and experiences. The OAS contains 18-items using a 5-point Likert scale from 0 (*never*) to 4 (*always*). The total OAS score is calculated by summing all 18 items. Higher OAS scores indicate greater external shame. The OAS demonstrates construct validity and high internal consistency ($\alpha = .92$; Goss et al., 1994; Balsamo et al., 2015). In the present study, Cronbach's Alpha for the OAS was .96.

Depression, anxiety and stress. Participants completed the Depression, Anxiety and Stress Scale 21 (DASS-21) as a short form of the original Depression, Anxiety and Stress Scale (DASS; Lovibond & Lovibond, 1995). For each item participants are asked to indicate how often they have experienced symptoms of anxiety, depression and stress using a 4-point scale from 0 (*did not apply to me at all*) to 3 (*applied to me very much or most of the time*). The depression, anxiety and stress subscale scores are calculating by summing relevant subscale items, and a total score is obtained by summing all items. The DASS-21 score is doubled to conform to original DASS-42 norms. Subscale scores for depression, anxiety and stress were used in the present study, with higher scores indicating greater psychological distress. The DASS-21 demonstrates construct validity and good internal consistency for the depression ($\alpha = .88$), anxiety ($\alpha = .82$) and stress ($\alpha = .90$) subscales, and for the total scale ($\alpha = .93$; Henry & Crawford, 2005). In the present study, Cronbach's Alpha was .90 for the depression subscale, .84 for the anxiety subscale, .85 for the stress subscale, and .94 for total DASS-21.

Demographic items. Participants were asked to answer a series of demographic questions, including their age, gender, cultural background and highest level of formal education completed. Participants were also asked to report on their previous meditation experience with reference to the type of meditation and duration of practice.

Procedure

The study was approved by the School of Psychology Human Research Ethics Subcommittee at the University of Adelaide. Members of the general public enrolled in an eight-week MSC program and a five-day MSC program at a South Australian mindfulness clinic, were invited to participate in the research study. Eligibility criteria was for participants to be over 18 years of age and fluent in English. The facilitator of the MSC program provided participants with an information sheet about the research study and informed consent was obtained prior to participation in the research study. Participants who expressed interest in the research study were sent an email invitation containing a link to an online questionnaire and a unique identifier to enable matching of responses. Participants were asked to complete the online pre-intervention questionnaire before starting the MSC program. The pre-intervention questionnaire contained demographic questions and quantitative measures of self-compassion, mindfulness, internal shame, external shame, depression, anxiety and stress. One-week after completing the MSC program, participants were sent another email invitation containing the link to the online post-intervention questionnaire including the same quantitative measures of self-compassion, mindfulness, internal shame, external shame, depression, anxiety and stress. Two-months after completing the MSC program, participants were sent a final email invitation to complete the online follow-up questionnaire containing the same quantitative measures of self-compassion, mindfulness, internal shame, external shame, depression, anxiety and stress.

Intervention

Eight-week MSC program. The eight-week MSC program followed the manualised MSC program developed by Christopher Germer and Kirsten Neff (Germer & Neff, 2019; Neff & Germer, 2013). The program involved eight weekly two-hour sessions and a half-day retreat. The program was independently facilitated by a certified MSC Teacher Trainer and Mentor, and a trained MSC Teacher. Due to the impact of COVID-19, the eight-week MSC program was delivered via an online video conferencing platform. The program retained the same structure, content, practices and exercises as the manualised eight-week MSC program.

Five-day MSC program. The five-day intensive MSC program followed the same content as the eight-week MSC program, eight two-hour sessions and a half day retreat, delivered over consecutive days. The program was independently facilitated by the same certified MSC Teacher Trainer and Mentor, and trained MSC Teacher. As COVID-19 restrictions had lifted, the five-day intensive MSC program was delivered using the face-to-face group program format.

Results

Data were analysed using the software package IBM SPSS Statistics 26. Preliminary analyses were conducted to test normality, the presence of outliers and missing data. Tests of normality based on the Kolmogorov-Smirnov statistic indicated that scores on all measures were normally distributed for the eight-week program sample. There were two outliers in the data, one for post-intervention mindfulness scores and one for post-intervention depression scores. Inspection of SPSS boxplots revealed that these outliers were not extreme points. The outliers were not considered large enough to substantially influence the results, and therefore the outliers were not excluded from the data. For the five-day program sample, tests of normality based on the Kolmogorov-Smirnov statistic indicated scores on all measures were normally distributed, except pre-intervention depression scores, post-intervention external

shame scores and post-intervention stress scores. There were no outliers in the data. Inspection of histograms, plots, skewness and kurtosis, indicated minor deviations from normality that were not considered enough to make analyses untenable. Therefore, no transformations of data were performed.

For the eight-week program, post-intervention data was provided by eight participants (72.7%) and follow-up data was provided by three participants (27.3%). The loss of data may be explained by one participant withdrawing from the eight-week program, and other participants choosing not to complete the post-intervention and follow-up questionnaires. For the five-day program, post-intervention data was provided by seven participants (87.5%) and follow-up data was provided by two participants (25%). As all participants completed the five-day program, the loss of data may be explained by participants choosing not to complete the post-intervention and follow-up questionnaires. This loss of data limited the sample available for pre-post analyses, and restricted follow-up analyses.

Data for the eight-week and five-day programs were analysed separately due to the different modalities of the programs. As the eight-week program was delivered online and the five-day program was delivered face-to-face, it was not appropriate to combine or compare data for the two programs. The results for the eight-week and five-day program are therefore reported separately.

To answer the research question and test hypotheses, data for the eight-week program and five-day programs were analysed at three levels. Firstly, a series of paired-samples t-tests were conducted to investigate whether there were statistically significant differences between pre-intervention and post-intervention measures. Effect sizes were then examined using Cohen's *d* effect sizes for repeated measures (Dunlap, Cortina, Vaslow, & Burke, 1996). Finally, Reliable Change Indices (RCIs) were calculated to examine change at an individual level (Evans, Margison, & Barkham, 1996). RCIs were calculated for pre-intervention to

post-intervention scores, and for pre-intervention to follow-up scores. Considering these three levels of analysis together to answer the research questions and test hypotheses and was deemed important given the small sample size available for analyses and the nature of the study.

Descriptive Analyses

Prior to examining intervention outcomes for the eight-week and five-day programs, participants who completed post-intervention measures ($n = 15$) were compared with participants who completed pre-intervention measures but dropped out of the research study ($n = 4$). Independent samples t-tests revealed that there was a significant difference between the two groups for self-compassion and mindfulness. Those who dropped out of the study showed higher self-compassion ($M = 86.75$, $SD = 14.84$) than those who completed post-intervention measures ($M = 63.07$, $SD = 13.09$), $t(17) = -3.14$, $p = .006$. Those who dropped out of the study also showed higher mindfulness ($M = 51.50$, $SD = 6.76$) than those who completed post-intervention measures ($M = 41.87$, $SD = 5.94$), $t(17) = -2.81$, $p = .012$. Independent samples t-tests revealed no significant differences between those who completed post-intervention measures and those who dropped out of the study on measures of internal shame, $t(17) = 1.56$, $p = .137$, external shame, $t(17) = 0.71$, $p = .490$, depression, $t(17) = 1.38$, $p = .185$, anxiety, $t(17) = 0.47$, $p = .648$, and stress, $t(17) = 0.92$, $p = .372$.

Prior to examining intervention outcomes for the eight-week and five-day programs, participants enrolled in each program were compared on demographic and baseline measures. Independent samples t-tests revealed no significant differences between participants in the eight-week program and five-day program at baseline for age, $t(17) = 0.92$, $p = .372$, self-compassion, $t(17) = 0.04$, $p = .969$, mindfulness, $t(17) = 0.20$, $p = .844$, internal shame, $t(17) = 0.45$, $p = .656$, external shame, $t(17) = 0.67$, $p = .511$, depression, $t(17) = 1.52$, $p = .148$, anxiety, $t(16) = 0.16$, $p = .877$, and stress, $t(17) = 0.94$, $p = .362$.

Intervention Outcomes

Eight-week MSC program. Paired samples t-tests were conducted to evaluate pre-post changes in measures of self-compassion, mindfulness, internal shame, external shame, and depression, anxiety and stress, for the eight participants who completed post-intervention measures. As displayed in Table 1, results showed statistically significant increases in self-compassion and mindfulness, and statistically significant decreases in internal shame, depression, anxiety and stress. Effect sizes were large for all measures, except for anxiety and stress which had medium effect sizes. External shame decreased with a large effect size, but findings were not statistically significant.

Table 1

Eight-week MSC program pre-intervention and post-intervention means, standard deviations, t-tests, and effect sizes for all measures.

Measure	Pre-intervention	Post-intervention	Intervention change	
	<i>n</i> = 8 <i>M</i> (<i>SD</i>)	<i>n</i> = 8 <i>M</i> (<i>SD</i>)	<i>t</i> ^a	<i>d</i>
Self-compassion	60.50 (15.04)	81.88 (11.98)	-6.37**	0.79
Mindfulness	40.63 (4.53)	49.00 (4.04)	-3.55*	1.30
Internal shame	71.13 (19.45)	58.50 (9.97)	2.93*	0.84
External shame	31.75 (17.76)	24.50 (7.98)	1.75	0.80
Depression	23.00 (7.93)	12.00 (8.49)	2.99*	1.65
Anxiety	12.25 (8.17)	5.25 (4.40)	3.01*	0.69
Stress	19.00 (7.63)	13.25 (6.58)	2.42*	0.78

Note. *M* = mean; *SD* = standard deviation; *t* = t-test; *d* = Cohen's *d* effect size.

^adf = 7.

* $p < .05$, ** $p < .01$ (two-tailed).

Reliable change indices. RCIs were calculated to examine change scores for all measures at an individual level (Evans et al., 1998). The RCI value was calculated using descriptive data from the present study and published reliability coefficients for measures (Andrews et al., 2002; Baer et al., 2012; Balsamo et al., 2015; Goss et al., 1994; Henry & Crawford, 2005; Neff, 2003). RCIs were calculated for pre-intervention to post-intervention scores, and for pre-intervention to follow-up scores. RCIs are presented in Appendix A.

Pre-intervention to post-intervention. Eight participants provided data for pre-post analyses. Results indicated that eight participants showed reliable increases in self-compassion (100%) and that six participants showed reliable increases in mindfulness (75%). Results showed reliable decreases in internal shame for four participants (50%), external shame for two participants (25%), depression for six participants (75%), anxiety for three participants (37.5%) and stress for three participants (37.5%).

Pre-intervention to follow-up. Three participants completed follow-up measures. Of the three participants, one participant showed a reliable increase in self-compassion (33.3%) and two participants showed reliable increases in mindfulness (66.7%). One participant showed a reliable decrease in internal shame (33.3%) and no participants showed reliable decreases in external shame (0%). All participants showed reliable decreases in depression (100%), no participants showed reliable decreases in anxiety (0%) and one participant showed a reliable decrease in stress (33.3%).

Changes in RCI. Comparing the RCI analyses from pre-intervention to post-intervention and from pre-intervention to follow-up, shows that most participants' reliable changes were maintained at two-month follow up. However, some differences were observed in the RCIs at pre-intervention to post-intervention and pre-intervention to follow-up. Two participants who showed reliable changes in self-compassion at post-intervention, did not show reliable changes at follow-up. One participant who did not show a reliable change in

depression at post-intervention, showed a reliable change at follow up. This suggests the participant's score for depression decreased between post-intervention and follow-up.

Another participant who did not show a reliable change in stress at post-intervention, showed a reliable change at follow-up. Again, this finding suggests the participant's stress score decreased between post-intervention and follow-up.

Five-day MSC program. Paired samples t-tests were conducted to evaluate pre-post changes in measures of self-compassion, mindfulness, internal shame, external shame, and depression, anxiety and stress, for the seven participants who completed post-intervention measures. As shown in Table 2, there were statistically significant increases in self-compassion and mindfulness, with large effect sizes. Internal shame, external shame, depression, anxiety and stress decreased but findings were not statistically significant. While these findings were not significant, it is important to note the large effect size for internal shame, and the medium effect sizes for external shame and stress. Effect sizes for depression and anxiety were small.

Table 2

Five-day MSC program pre-intervention and post-intervention means, standard deviations, t-tests, and effect sizes for all measures.

Measure	Pre-intervention	Post-intervention	Intervention change	
	<i>n</i> = 7 <i>M</i> (<i>SD</i>)	<i>n</i> = 7 <i>M</i> (<i>SD</i>)	<i>t</i> ^a	<i>d</i>
Self-compassion	66.00 (10.82)	83.29 (15.74)	-3.23*	2.06
Mindfulness	43.29 (7.34)	53.00 (9.81)	-2.61*	1.58
Internal shame	64.71 (21.85)	54.43 (19.20)	2.12	1.13
External shame	25.57 (20.65)	20.57 (21.69)	1.50	0.52
Depression	12.86 (14.14)	12.29 (15.21)	0.38	0.15
Anxiety	13.66 (13.70)	12.33 (11.96)	1.09	0.09
Stress	15.71 (9.05)	15.43 (13.55)	0.10	0.55

Note. *M* = mean; *SD* = standard deviation; *t* = t-test; *d* = Cohen's *d* effect size.

^adf = 7.

* $p < .05$, ** $p < .01$ (two-tailed).

Reliable change indices. RCIs were again calculated to investigate individual level change for all measures (Evans et al., 1998). The RCI value was calculated using descriptive data from the present study and published reliability coefficients for measures (Andrews et al., 2002; Baer et al., 2012; Balsamo et al., 2015; Goss et al., 1994; Henry & Crawford, 2005; Neff, 2003). RCIs were calculated for pre-intervention to post-intervention scores, and for pre-intervention to follow-up scores. RCIs are presented in Appendix B.

Pre-intervention to post-intervention. Seven participants provided data for pre-post analyses. Results indicated that five participants showed reliable increases in self-compassion (71.4%) and that four participants showed reliable increases in mindfulness (57.1%). Results

showed reliable decreases in internal shame for two participants (28.6%), external shame for one participant (14.3%), and stress for two participants (28.6%). No participants showed reliable decreases in depression (0%) and anxiety (0%).

Pre-intervention to follow-up. Two participants completed follow-up measures. Both participants showed reliable increases in self-compassion (100%) and mindfulness (100%). One participant showed a reliable decrease in internal shame (50%) and external shame (50%). No participants showed reliable decreases in depression (0%) or anxiety (0%), but both participants showed reliable decreases in stress (100%).

Changes in RCI. Comparing the RCI analyses from pre-intervention to post-intervention and from pre-intervention to follow-up, shows that most participants' reliable changes were maintained at two-month follow up. However, some differences were observed. One participant showed a reliable change in self-compassion at follow-up that was not observed in the pre-post analyses, suggesting self-compassion increased between post-intervention and follow-up. One participant also showed a reliable change in mindfulness at follow-up, that was not observed in the pre-post analyses. This also suggests that mindfulness increased between post-intervention and follow-up. Similarly, one participant also showed a reliable change in stress at follow-up that was not observed in the pre-post analyses. Again, this suggests stress decreased from post-intervention to follow-up.

Discussion

Overview of Findings

The present study aimed to investigate the effectiveness of eight-week and five-day modes of the MSC program on internal and external shame, and other measures of wellbeing including self-compassion, mindfulness, depression, anxiety and stress. To answer the research question and to test the hypotheses, three levels of analysis were considered: statistical significance, effect size and reliable change. Considering these three levels of

analysis was important given the small sample size and the nature of the study. For both eight-week and five-day modes of the MSC program, it was hypothesised that participants would show increases in self-compassion and mindfulness, and decreases in internal shame, external shame, depression, anxiety and stress from pre-intervention to post-intervention.

Eight-week MSC program. For the eight-week program, participants showed significant increases in self-compassion and mindfulness with large effect sizes. RCIs supported these findings, with all participants showing reliable increases in self-compassion, and three quarters of participants showing reliable increases in mindfulness following their participation in the program. These findings support the hypothesis. Participants showed significant decreases in internal shame with a large effect size, with RCIs indicating half of the participants showed reliable decreases in internal shame. These findings support the hypothesis. External shame decreased, but findings were not statistically significant. It is important to note that there was a large effect size for external shame, and RCIs indicated that a quarter of participants showed reliable changes in external shame. Therefore, while the hypothesis was not supported, the eight-week program does still seem to have an effect on external shame. Finally, participants showed significant decreases in depression with a large effect size, anxiety with a medium effect size, and stress with a medium effect size. RCIs supported these findings, with three quarters of participants showing reliable decreases in depression, and approximately one third of participants showing reliable decreases in anxiety and stress. Therefore, the hypothesis was supported.

Five-day MSC program. For the five-day program, participants showed significant increases in self-compassion and mindfulness with large effect sizes. RCIs supported these findings, with over half of participants showing reliable increases in self-compassion and mindfulness. These findings support the hypothesis. Internal shame decreased with a large effect size however findings were not statistically significant. RCIs indicated that

approximately one third of participants showed reliable decreases in internal shame. Similarly, external shame decreased with a medium effect size, but findings were not statistically significant. RCIs indicated one participant showed a reliable change in external shame. While these findings do not support the hypothesis, it appears that the five-day program may have some effect on internal shame and external shame to a lesser extent. Participants did not show significant decreases in depression or anxiety. Effect sizes were small and RCIs indicated no participants showed reliable decreases in depression or anxiety. Therefore, the hypothesis was not supported. Finally, participants did not show a significant decrease in stress. There was a medium effect size and RCIs indicated that about one third of participants showed reliable decreases in stress. These findings do not support the hypothesis but suggest that the five-day program may have some effect on stress.

The Mindful Self-Compassion Program and Shame

A primary aim of this study was to investigate the effect of the eight-week and five-day modes of the MSC program on internal shame. For the eight-week program, the findings showing significant improvements in internal shame with a large effect size, suggest that the eight-week MSC program is effective in improving internal shame. For the five-day program, the decreases in internal shame were not statistically significant, however the large effect size suggests that the intensive program may also have an effect on internal shame. To my knowledge, this is the first study to investigate the effect of the manualised MSC program on internal shame. Previous studies have shown self-compassion is associated with internal shame (Barnard & Curry, 2012; Mosewich et al., 2011; Woods & Proeve, 2014; Zhang et al., 2018), and that brief self-compassion interventions reduce internal shame (Cândeia & Szentágotai-Táatar, 2018b; Johnson & O'Brien, 2013). The present study findings that the eight-week MSC program may be effective in improving internal shame are therefore in line with previous research. The present study findings that the five-day intensive MSC program

may not be effective in improving internal shame are surprising, as previous research has shown brief self-compassion interventions are effective in improving internal shame. However, the tests of statistical significance were dependent on small participant numbers. The large effect size suggests that the five-day program may have an effect on external shame. It is interesting that for both eight-week and five-day modes of the MSC program, effect sizes for internal shame were large. This suggests that overall, MSC may be helpful for internal shame. However, further research to support these findings is warranted.

Another primary aim of the study was to examine the effect of the eight-week and five-day modes of the MSC program on external shame. For the eight-week program, the findings showed external shame decreased with a large effect size, but the results were not statistically significant. Similarly, for the five-day program, the findings showed external shame decreased with a medium effect size, but the results were not statistically significant. Again, to my knowledge, this is the first study to investigate the effect of the manualised MSC program on external shame. Self-compassion has been shown to be negatively associated with external shame (Ferreira et al., 2013; Proeve, 2020), and self-compassion interventions have been shown to reduce external shame (Gilbert & Proctor, 2006). Therefore, the findings that suggest the eight-week and five-day MSC programs may not be effective in improving external shame are unexpected. However, again it is important to note that this is based on statistical significance, which was dependent on small participant numbers. Although findings were not statistically significant, the large and medium effect size for the eight-week and five-day program respectively, suggest that the MSC program may have some effect on external shame. However, future research to investigate the effect of the MSC program on external shame is warranted.

Taken together, the present study contributes to the field of literature by providing preliminary evidence that the MSC program may be effective in reducing shame. It appears

that the MSC program has an effect on internal shame, more so, but also external shame to a reasonable extent. Internal shame refers to an individual's perception of themselves as inferior, undesirable or worthless; whereas external shame refers to an individual's perception of how others evaluate them, for example others perceiving them as inferior, undesirable or worthless (Gilbert, 1998; Tangney & Dearing, 2002; Tangney et al., 2007). It is perhaps not surprising that the MSC program may have a greater effect on internal shame, as the focus of the program is on the self. However, this proposition warrants further research. As internal and external shame are associated with psychological wellbeing (Cândeia & Szentágotai-Tătar, 2018b; Kim et al., 2011), an intervention that addresses both internal and external shame is important. Therefore, the effect of the MSC program on shame should be further investigated, using large scale controlled study designs.

The Intensive Mindful Self-Compassion Program and Measures of Wellbeing

The study also aimed to examine the effect of the five-day intensive MSC program on other measures of psychological wellbeing including self-compassion, mindfulness, depression, anxiety and stress. Participants in the five-day intensive MSC program showed significant increases in self-compassion and mindfulness with large effect sizes. These findings suggest that the five-day intensive MSC program may be effective in enhancing self-compassion and mindfulness. Participants in the intensive MSC program did not show significant decreases in depression, anxiety and stress, and effect sizes were small to medium. These findings suggest that the five-day intensive MSC program may not be effective in improving depression, anxiety and stress.

Research has yet to investigate the effectiveness of the five-day intensive MSC program on measures of psychological wellbeing. However, previous studies have shown brief self-compassion interventions to have beneficial effects on measures of psychological wellbeing including self-compassion, mindfulness, depression and anxiety (Albertson et al.,

2015; Haukaas et al., 2018; Smeets et al., 2014). Findings that the intensive MSC program may be effective in improving self-compassion and mindfulness, are in line with this previous research. However, the findings that the intensive MSC program may not be effective in improving depression, anxiety and stress are surprising. It is important to note that the MSC program is considered a skills and resource building program, not psychological therapy. Therefore, the intensive MSC program appears to be doing what it is intended to do.

The findings for the five-day program are interesting given the present study findings and previous research that shows the eight-week MSC program is effective in improving depression, anxiety and stress (Neff & Germer, 2013). There are a number of factors that may explain why the intensive MSC program did not have an impact on measures of depression, anxiety and stress. It may be that the MSC program requires a longer duration to affect depression, anxiety and stress symptoms. For example, the longer duration of the eight-week program, compared to the five-day program, may provide participants with more of an opportunity to integrate and practice exercises. It is important that further research is conducted using large scale controlled studies to further investigate the effectiveness of the five-day MSC program. This future research is important, as the intensive modality of the MSC program is currently being delivered to the general public, and the intensive modality may have practical advantages of increasing engagement and accessibility.

The Online Mindful Self-Compassion Program and Measures of Wellbeing

While not initially intended, the present study also addressed another gap in the field of research on the MSC program; the effect of delivering the manualised MSC program online via a video conferencing platform on measures of psychological wellbeing. The findings of the present study suggest that this online eight-week MSC program was effective in improving self-compassion, mindfulness, depression, anxiety and stress. Researchers have

used online video conferencing platforms to deliver adaptations of the MSC program, with findings showing the beneficial effects of these adaptations on psychological wellbeing (Campo et al., 2017; Lathren, Bluth, Campo, Tan, & Futch, 2018). However, research has not yet investigated the delivery of the manualised eight-week MSC program using these technologies. The present study findings therefore contribute to the field of literature by providing preliminary evidence that the online delivery of the MSC program may be effective for improving wellbeing.

These findings for the online eight-week MSC program are in line with previous research that documents the beneficial effects of the traditional face-to-face eight-week MSC program on measures of psychological wellbeing (Delaney, 2018; Finlay-Jones et al., 2018; Friis et al., 2016; Neff & Germer, 2013; Yela et al., 2020). This suggests that the online delivery of the MSC program may be comparable to the traditional face-to-face delivery of the MSC program. However, future research to compare the two modalities is warranted. While future research is needed, the present study findings provide promise for the online delivery of the manualised MSC program using videoconferencing platforms. This online modality may hold advantages for members of the general public in terms of accessibility and engagement. These considerations are particularly relevant at this current point in time, given the circumstances and restrictions of COVID-19. Therefore, future research to support these findings is important.

Limitations and Future Research

This pilot study had a number of limitations that should be considered. Firstly, the study lacked a control group. Therefore, it cannot be concluded that the findings were due to participation in the MSC program. It may be that other variables influenced the results. It is important to note that the data was collected during COVID-19. In addition, the samples for the eight-week and five-day intensive MSC programs were small. For both programs, several

participants did not complete post-intervention measures, and most participants did not complete follow-up measures. This attrition limited the sample available for pre-post analyses, and restricted follow-up analyses. That is, it was not appropriate to conduct statistical analyses with the small sample size at follow-up, which restricted the conclusions that could be drawn. In addition, the findings of the present study and the size of the effects highlight that the small sample size may have impacted on statistical significance. Furthermore, most participants were females who were highly educated with previous meditation experience. This sample limits the generalisability of the findings to the wider population.

Based on these limitations and the findings of the present study, there are a number of areas for future research. First, future research should further investigate the effectiveness of the MSC program on internal and external shame. These findings may provide important clinical implications regarding the effectiveness of the MSC program as an intervention for both internal and external shame. Future research should also further examine the intensive MSC program, and compare the effectiveness of the five-day MSC program to the eight-week MSC program. While the intensive modality may hold advantages for individuals regarding time commitment, it is important that participants benefit from the intensive duration of the program. It is also important to further investigate the effectiveness of the online delivery of the MSC program. Again, the online MSC program should be compared to the original face-to-face MSC program to ensure the beneficial effects of the MSC program are maintained. Finally, it is important that this future research utilises large scale controlled studies to further investigate the effectiveness of the MSC program. For example, comparing the MSC program with waitlist or active control groups, or to other well-established effective interventions.

Conclusion

Despite the limitations of this pilot study, the findings support previous research that the MSC program is beneficial for improving measures of psychological wellbeing, including self-compassion, mindfulness, depression, anxiety and stress. The present study also provides preliminary evidence that the MSC program may be effective in reducing shame. These findings are important given that shame has been shown to play an important role in psychopathology. The study findings suggest that the intensive program may not be effective in improving some measures of psychological wellbeing, however further research is required. Finally, the present study findings provide preliminary evidence that the online delivery of the MSC program is effective in improving psychological wellbeing. These findings are also important, as online technologies may increase accessibility and engagement with the MSC program. This is particularly relevant today given the current circumstances of COVID-19. It is important that future research utilises controlled study designs and more representative samples to further evaluate the effectiveness of the program. Although further research is required, the MSC program appears to be a promising intervention for enhancing psychological wellbeing and mental health.

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Appendix A

Table 1

Reliable change indices for the eight week MSC program.

ID	Self-compassion		Mindfulness		Internal shame		External shame		Depression		Anxiety		Stress	
	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²
1	+16*	-	+11*	-	-18*	-	-22*	-	-24*	-	-14*	-	-6	-
2	+15*	-	+4	-	-19*	-	-7	-	-8*	-	-18*	-	-16*	-
3	+21*	-	+12*	-	-24*	-	-23*	-	-14*	-	-10*	-	-6	-
4	+19*	-	+5*	-	-3	-	-7	-	-10*	-	-2	-	-14*	-
5	+44*	+42*	+14*	+11*	-24*	-20*	-13	-6	-24*	-23*	-4	-7	+2	-6
6	+15*	-2	-5	+4	12	+1	+5	-1	-14*	-20*	-6	-8	0	-14*
7	+21*	+8	+11*	+12*	-10	-12	+9	-2	+2	-23*	0	-1	+4	-2
8	+20*	-	+15*	-	-15	-	0	-	+4	-	-2	-	-6*	-

Notes. ID = Participant ID; Change¹ = Change in scores from pre-intervention to post-intervention; Change² = Change in scores from pre-intervention to follow-up. Reliable Change Index (RCI) values: Self-compassion = 11.79; Mindfulness = 4.87; Internal shame = 15.25; External shame = 13.92; Depression = 7.61; Anxiety = 9.61, Stress = 6.69.

*Reliable change

Appendix B

Table 2

Reliable change indices for the five-day MSC program.

ID	Self-compassion		Mindfulness		Internal shame		External shame		Depression		Anxiety		Stress	
	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²	Change ¹	Change ²
1	+25*	-	+20*	-	-9	-	-10	-	+2	-	-4	-	-8*	-
2	+7	+35*	+3	+14*	-5	-7	+4	0	+4	-3	0	0	+6	-9*
3	-2	-	-4	-	5	-	+1	-	0	-	-4	-	+2	-
4	+12*	-	+4	-	-8	-	+2	-	+2	-	+2	-	+10	-
5	+27*	-	+9*	-	0	-	-1	-	0	-	+2	-	+2	-
6	+40*	-	+24*	-	-24*	-	-11	-	-6	-	-	-	-4	-
7	+12*	+30*	+12*	+14*	-31*	-34*	-20*	-17*	-6	-6	-4	-6	-10*	-9*

Notes. ID = Participant ID; Change¹ = Change in scores from pre-intervention to post-intervention; Change² = Change in scores from pre-intervention to follow-up. Reliable Change Index (RCI) values: Self-compassion = 11.79; Mindfulness = 4.87; Internal shame = 15.25; External shame = 13.92; Depression = 7.61; Anxiety = 9.61, Stress = 6.69.

*Reliable change.

Tables

Table 1

Eight-week MSC program pre-intervention and post-intervention means, standard deviations, t-tests, and effect sizes for all measures.

Measure	Pre-intervention	Post-intervention	Intervention change	
	<i>n</i> = 8 <i>M</i> (<i>SD</i>)	<i>n</i> = 8 <i>M</i> (<i>SD</i>)	<i>t</i> ^a	<i>d</i>
Self-compassion	60.50 (15.04)	81.88 (11.98)	-6.37**	0.79
Mindfulness	40.63 (4.53)	49.00 (4.04)	-3.55*	1.30
Internal shame	71.13 (19.45)	58.50 (9.97)	2.93*	0.84
External shame	31.75 (17.76)	24.50 (7.98)	1.75	0.80
Depression	23.00 (7.93)	12.00 (8.49)	2.99*	1.65
Anxiety	12.25 (8.17)	5.25 (4.40)	3.01*	0.69
Stress	19.00 (7.63)	13.25 (6.58)	2.42*	0.78

Note. *M* = mean; *SD* = standard deviation; *t* = t-test; *d* = Cohen's *d* effect size.

^a*df* = 7.

* $p < .05$, ** $p < .01$ (two-tailed).

Table 2

Five-day MSC program pre-intervention and post-intervention means, standard deviations, t-tests, and effect sizes for all measures.

Measure	Pre-intervention	Post-intervention	Intervention change	
	<i>n</i> = 7 <i>M</i> (<i>SD</i>)	<i>n</i> = 7 <i>M</i> (<i>SD</i>)	<i>t</i> ^a	<i>d</i>
Self-compassion	66.00 (10.82)	83.29 (15.74)	-3.23*	2.06
Mindfulness	43.29 (7.34)	53.00 (9.81)	-2.61*	1.58
Internal shame	64.71 (21.85)	54.43 (19.20)	2.12	1.13
External shame	25.57 (20.65)	20.57 (21.69)	1.50	0.52
Depression	12.86 (14.14)	12.29 (15.21)	0.38	0.15
Anxiety	13.66 (13.70)	12.33 (11.96)	1.09	0.09
Stress	15.71 (9.05)	15.43 (13.55)	0.10	0.55

Note. *M* = mean; *SD* = standard deviation; *t* = t-test; *d* = Cohen's *d* effect size.

^adf = 7.

* $p < .05$, ** $p < .01$ (two-tailed).

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