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Exploring and Evaluating the Cross-Cultural Applicability of Compassion-Based Approaches

by

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Abstract

The concept and benefits of practicing compassion have been recognised and discussed in the contemplative traditions for thousands of years. However, it is within the last two to three decades, that research and psychotherapy have shown an increased interest in integrating compassion for addressing mental health difficulties and increased well-being. Although heavily influenced by Buddhist philosophy and Eastern traditions, compassion related studies and interventions are mostly developed and applied in the Western communities. In fact, compassion-based studies are particularly scarce in the Asian context. Therefore, whilst briefly outlining the theories and existing compassion-based interventions, this thesis explored the cross-cultural applicability of compassion-based interventions in the Asian communities. A rigorous qualitative investigation discussed that compassion is a culturally embraced concept in Sri Lanka, a Buddhist influenced, collectivistic Asian community, and discussed the challenges Sri Lankan participants (n = 10) experience when practicing compassion. Participants discussed that showing compassion to others was easier than showing compassion to themselves, whilst religion, society, and upbringing influenced these experiences. To understand whether these compassionate experiences are similar across cultures, a cross-sectional quantitative study was conducted among Sri Lankan (n = 149) and UK (n = 300) participants. This study indicated that some similarities (e.g., compassion to and from others, depression, anxiety) and some differences (e.g., self-compassion and self-reassurance, fears of compassion and external shame were higher in the Sri Lankan group, and social safeness was higher in the UK group) existed in the levels of compassion, and facilitators and inhibitors of compassion across the two samples. Therefore, it was important to note that the impact of compassion-based interventions might have cross-cultural differences. To test this, a longitudinal Compassionate Mind Training was implemented among Sri Lankan (n = 21) and UK participants (n = 73), which produced promising results towards increasing compassion for the self and others, along with significant reductions in distress and improvements in well-being in participants across both countries. Thus, this thesis suggests that although research is limited in

exploring the cross-cultural applicability of compassion, compassion-based interventions can be used effectively in the Asian communities.

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Research Thesis: Declaration of Authorship

I, Lasara Kariyawasam declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

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I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
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Definitions and Abbreviations

SCS: Self-Compassion Scale

SMT: Social Mentality Theory

CEAS: Compassionate Engagement and Action Scales

MSC: Mindful Self-Compassion

CFT: Compassion Focused Therapy

CMT: Compassionate Mind Training

CCT: Compassion Cultivation Training

CBCT: The Cognitively Based Compassion Training

CM: Compassion Meditations

LKM: Loving-Kindness Meditations

CEB: Cultivating Emotional Balance

RCT: Randomised Controlled Trial

IPA: Interpretative Phenomenological Analysis

C-MT: Compassion Mindfulness Therapy

Individualistic culture: A social context in which people have an independent concept of self, pursue their goals independently from their ingroups, their social behaviors are driven by personal attitude, values, and belief, and individuals make their own choice of social relationships based on individual rationalisation (Bhawuk, 2017).

Collectivistic culture: A social context in which people's concept of self is and goals are interdependent and compatible with ingroups, and their social behaviours are norm driven and guided by their social exchange with other people (Bhawuk, 2017).

Chapter 1 An Introduction to Compassion and its Cross-Cultural Applicability, and the Rationale, Aims of the Thesis, and Chapter Summaries

1.1 Definitions and History of Compassion

Compassion has been defined in a range of different ways and the Oxford English dictionary recognises the word compassion as stemming from the Latin word *compati*, which means "to suffer with" (Simpson & Weiner, 1989. p. 1340). Literature identifies with this notion as most definitions view compassion as an antidote to suffering (e.g., Lampert, 2005; Richard, 2015). For instance, Lazarus (1991, p.289) defined compassion as "being moved by another's suffering and wanting to help", while Goetz and colleagues (2010, p.351) viewed it as "a feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help". The Dalai Lama (1995) viewed compassion as an openness to the suffering of others with a commitment to relieve it. In addition, two of the most popular scholars of compassion research, Kristin Neff (2003a) and Paul Gilbert (2009a) provided their own definitions for self-compassion and compassion. Neff (2003a, p.87) viewed self-compassion as compassion turned inward and defined it as "being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness". Gilbert and Choden (2013, p.94) defined compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it". Thus, definitions of compassion are varied (Strauss et al., 2016), with some researchers suggesting it as an emotion (Goetz et al., 2010), a motivation (Gilbert, 2014), or a multidimensional construct (Jazaieri et al., 2013). Drawing together on these various definitions from Buddhist philosophy and Western psychological perspectives, Strauss et al. (2016, p.25) identified five components of compassion, "recognition of suffering; understanding its universality; feeling sympathy, empathy, or concern for those who are suffering...; tolerating the distress associated with the witnessing of suffering; and motivation to act or acting to alleviate the suffering".

As with the various definitions, various possible underpinnings of compassion have also been identified over the years. Some of the most agreed upon underpinnings of compassion are evolutionary theory (Gilbert, 2000), attachment systems (Bowlby, 1969, 1982), biological approaches (Goetz et al., 2010), and Buddhist philosophy (Dalai Lama, 1995).

Roots of compassion from an evolutionary perspective can be traced back to Darwin (1871), who mentioned that only the societies with highest number of sympathetic members would flourish best and produce most offspring. Evolutionary theory emphasises that kindness and compassion emerged for human survival, and empathy is built from within (de Waal, 2009). This theory also discusses that natural selection favours altruistic acts as they help one group outweigh another even at a cost to an individual (Wilson, 2015; Wilson et al., 2009). Therefore, the evolutionary approach to compassion recognises that the ability to feel compassion originated from the evolutionary advantages of caring for others particularly offspring, kin (family and relations), and in-group associates (Gilbert, 2015).

The attachment approaches (Bowlby, 1969, 1982) applied to compassion signify that compassion is likely to have originated from early relationships with primary caregivers (Gilbert, 2009a; Gilbert & Procter, 2006, Neff, 2011; Neff & McGeehee, 2010). According to this approach, care giving motivations develop from parent-child relationships and extends to non-kin meaning beyond one's family and relations (Gilbert, 2015; Neff, 2011). The attachment theory identifies three main attachment styles: *secure*, *avoidant*, and *anxious* attachment style (Bowlby, 1969, 1982). A secure attachment style is formed through validation of the child's emotions, which later plays a role in adult affect regulation (Siegel, 2012). Individuals with a secure attachment style are more likely to be motivated to care giving rather than individuals who are avoidant or anxious. These individuals are also more likely to develop compassionate and empathic concerns towards others and are receptive to compassion given from others (Bowlby, 1969; Mikulincer & Shaver, 2001). Absence of a secure attachment often makes children vulnerable to developing psychopathology as adults, due to the inability of regulating their emotions (Gross & Munoz, 1995; Mikulincer & Shaver, 2012).

In contrast, insecure attachment with primary caregivers leads to avoidant or anxious attachment styles in children (Mikulincer et al., 2003). This is when parents neglect, or do not respond to the emotional needs of the children (Bowlby, 1969). Anxious attachment is displayed in hyper-activating strategies, and avoidant attachment is displayed in deactivating strategies of emotion. In other words, children with an anxious attachment style act out by being overly emotional in an attempt to receive parental attention, whilst children with an avoidant attachment style dissociate from the feelings of abandonment when their needs are not met by the caregiver (Mikulincer et al., 2003). This leads to those with an avoidant attachment style to be less empathetic, less compassionate, and less willing to help those in need, and those with an anxious attachment style to feel personally distressed when having to help others in distress (Erez et al., 2008; Mikulincer et al., 2005).

The biological approaches to compassion suggest that the human nervous system enables the recognition of distress and the ability to empathise (Preston, 2013; Preston & de Waal, 2002). Several cross-sectional (e.g., Lutz et al., 2008; Kim et al., 2009) and longitudinal (Klimecki et al., 2012) studies suggested that compassion activates certain brain regions such as the insula, ventral striatum, and medial orbitofrontal cortex, which are typically activated in the reception of reward, love, and affiliation. In support, a compassion-training study found increased brain activations in the medial orbitofrontal cortex, pregenual anterior cingulate cortex, and ventral striatum, all of which have previously been identified to correlate with affiliation and positive affect (Kringelbach & Berridge, 2009; Strathearn et al., 2009). Several compassion cultivating studies have also observed various physiological functions associated with compassion. For instance, when presented with compassion eliciting images, a greater amygdala activation has been found in people who practice compassion (Desbordes et al., 2012). Furthermore, compassion training has shown to increase the engagement of the dorsolateral prefrontal cortex regions that down-regulate distress (Weng et al., 2013). Additionally, practicing compassion has shown to strengthen the activity of certain brain functions such as the brain pathways between the Nigra and Orbital Frontal cortex, a specific network in the brain recognised for triggering compassion (Singer & Lamm, 2009), suggesting that compassion has a direct physiological basis.

Compassion is a concept embraced across all the world's most practiced religions (e.g., Christianity, Judaism, Islamism) as a core component of their faith and is predominantly discussed as a fundamental tenet of Buddhist philosophy (Germer & Siegel, 2012). Buddhism defines compassion as a caring response to the suffering of the self and others with a deep commitment to alleviate that suffering (Dalai Lama, 1995; Kuan, 2008). It is believed that the concept of self-compassion originated from Buddhism (Neff, 2003a; Zeng et al., 2016). Buddhist teachings inform compassion by the wisdom to understand the inner causes of suffering (Germer & Siegel, 2012) and emphasise that practicing compassion has the capacity to awaken all the positive states of mind to relieve such suffering (Makransky, 2012). Buddhist influenced compassion practices such as mindfulness meditation and loving kindness meditation have helped people with depression and anxiety (Herman, 2014). Studies have also suggested that people who follow Buddhism are more self-compassionate than people who do not practice Buddhism (Kariyawasam et al., 2021; Neff, 2003a).

Although the concept, benefits and endorsements of practicing compassion have been discussed in the contemplative traditions for centuries, it is within the last two to three decades or so that Western psychology and psychotherapy have identified compassion for its influencing effects for reducing psychopathology and promoting prosocial behaviour and well-being (Gilbert, 2020). Therefore, several theorists have attempted to explore compassion and provide a theoretical framework of how compassion may be a fundamental factor in dealing with human suffering and in facilitating well-being (Irons, 2014).

1.2 Theoretical Models of Compassion

Kristin Neff and Paul Gilbert are pioneers in the field of compassion research and have introduced the two most widely discussed theories of compassion. Neff's work is centred on self-compassion (2003a) whilst Gilbert's (2014a) model focuses on compassion for the self and others.

1.2.1 Neff's Theory of Compassion

Neff (2003a, b) was one of the first researchers to define and measure self-compassion, forming the basis of extensive research in this area by several researchers over the years (Germer

& Neff, 2013). Being self-compassionate according to Neff's approach (2003a), involves taking the stance of a *compassionate other* towards oneself. Drawing on various Buddhist teachings, Neff put forward a theory specifically focusing on self-compassion and conceptualised it as consisting of three components with opposing negative counterparts: mindfulness/over-identification, common humanity/isolation, and self-kindness/self-judgement. *Mindfulness* is described as the non-judgemental, systematic observation of thoughts and feelings as they arise without denying or suppressing them. *Over-identification*, on the other hand, is proposed as being caught up and swept away by the negative reactivity caused by distressing thoughts and feelings. Neff emphasised the importance of acknowledging that pain is a shared-human experience, known as *common humanity*, whereas *isolation* is the perception that one is alone in their suffering. *Self-kindness* is treating oneself gently and warmly, and *self-judgement* is treating oneself from a cold and critical perspective when faced with failure and suffering. The interplay between mindfulness, common humanity, and self-kindness facilitates one to create a self-compassionate frame of mind (Germer & Neff, 2013). Considering these positive and negative components of self-compassion theory, Neff (2003b) developed the Self-Compassion Scale (SCS). The SCS measures all six positive and negative components of self-compassion, which are totalled to produce an overall score for self-compassion. Whilst Neff's approach is centred around self-compassion, she emphasised that self-compassion enhances compassion and concern for the self and others.

1.2.1.1 Criticisms of Neff's Model

Although this approach has informed research across the world (e.g., Anuwatgasem et al., 2020, Finlay-Jones et al., 2018; Mak et al., 2018), several criticisms have been made on Neff's (2003a, b) conceptualisation of self-compassion. One of the criticisms, is that although Neff's conceptualisation of self-compassion originated from Buddhism, several studies concluded that her model is theoretically different from the Buddhist concept of self-compassion (Peng & Shen, 2012; Zeng et al., 2016). For instance, Peng and Shen (2012) argued that the concept of common humanity discussed in Neff's (2003a) theory, contradicts with the idea of common humanity in the Buddhist philosophy. They emphasised that while Neff viewed common humanity as acknowledging failure as a common weakness of humanity, Neff's theory encourages one to

compare themselves against others. This contradicts from the Buddhist's view of common humanity, which emphasises the "oneness" of self and others by viewing oneself as being part of the rest of humankind (Peng & Shen, 2012). Furthermore, they emphasised that the self-kindness component of Neff's (2003a) self-compassion theory, only focuses on serving the happiness of oneself, which also contradicts with Buddhist compassion, that emphasises on developing compassion and loving-kindness for all beings.

Many of the other criticisms also focus on Neff's (2003b) SCS scale. Although SCS is the most used measure of compassion (Kurebayashi, 2021), Lopez et al. (2015) suggested that from a theoretical standpoint, it is more appropriate to separate the positive and negative items of the SCS, as it seems to measure two different processes: *self-compassion* and *self-criticism*, rather than one construct of self-compassion. This is in line with Gilbert et al.'s (2011) proposal that self-compassion is distinct from self-criticism and they should not be measured together. Thus, Neff's (2003a, b) conceptualisation of self-compassion as a bipolar construct ranging from high self-compassion (as indicated by the positive items of the scale) to high self-criticism (as indicated by the negative items), has been questioned and critiqued by studies that evidenced self-compassion and self-criticism as two independent processes (Gilbert et al. 2011; Lopez et al., 2015; Williams et al., 2014).

1.2.2 Gilbert's Model of Compassion

Gilbert's (2014, 2019) theory is rooted in an evolutionary informed, biopsychosocial approach, which recognises compassion as an "evolved strategy" to support basic survival needs. According to this view, compassion is a multi-faceted process originally evolved to be shared within one's family and relations or to be reciprocated in relationships. Gilbert emphasised that for an individual to develop compassion, they need to show a degree of motivation, willingness, courage, and distress tolerance. This would include the identification of suffering (also referred to as *engagement* with suffering), and also taking ownership to acquire the skills and ability needed to relieve and prevent such suffering (referred to as *action* towards compassion). Thus, this theory posits that compassion involves not just a wish to be helpful, but also a reasoning process and judgment of what is best to do in a moment of distress (Gilbert, 2019). To enable this to happen,

it is proposed that one should display six essential competencies related to "motivation" to care for well-being, "sensitivity" to suffering, "sympathy", "distress tolerance", "empathy", and being accepting and "non-judgmental" (Gilbert et al., 2017). In reality, however, Gilbert emphasised that people can be good at some competencies of compassion, and not so good at others. Therefore, he stressed that practicing compassion helps one to develop a compassionate identity, known as a *compassionate self*, which in turn would train the mind to develop all six compassion competencies, and expand one's compassion beyond their family and existing relationships. The compassionate self can be further developed through several practices such as meditations, thought monitoring, and behaviour modification (Gilbert, 2019). Gilbert's (2020) approach to compassion is multidimensional and consists of several elements such as the Social Mentality Theory (SMT), the tripartite model of affective regulation, the three flows of compassion, and facilitators and inhibitors of compassion. These will be discussed in detail in the below sections.

1.2.2.1 Social Mentality Theory (SMT)

To understand how to develop a compassionate self, Gilbert (1989, 2000) developed the Social Mentality Theory (SMT) and defined social mentalities as "internal systems that generate patterns of cognition, affect and behaviour … that allow for the enactment of social roles" (Gilbert, 2000, p.120). In other words, this theory suggests that social mentalities are internal systems developed to create cognitions, affects and behaviours that are necessary for acts of survival such as care-seeking and reproduction. According to SMT, people relate to themselves through systems that were initially developed for relating to others, and as a result, social mentalities activate in relationships with others as well as relationships within the self (Gilbert, 2000, 2005a).

1.2.2.2 The Tripartite Model of Affective Regulation

In addition to the SMT perspective, Gilbert (2015) suggested that there are three interacting affective regulatory systems called the *threat, drive*, and *soothing* system, which are triggered by different social mentalities to induce the basic human survival responses (Depue & Moronne-Strupinsky, 2005). Perceived threats (e.g., perception of a predator) activate the threat system, which triggers motivating feelings (e.g., anxiety, fear) that in turn creates defensive

strategies to protective behaviours (e.g., fight, flight, freeze). The drive system, on the other hand, alerts individuals to potential opportunities and drives them towards accomplishment, such as the evolutionary motivating force that guides animals to find food and humans to pursuit for social rank. Whilst these systems are evolved to protect and motivate within an evolutionary context, the model proposed that they could negatively affect a person's well-being in this modern world (Gilbert, 2009a). This is because the persistent activation of the threat and drive systems (e.g., fear of failure, high anxiety, work stress), can be exhausting and feed more adverse thoughts and feelings (e.g., fear, rumination), leading to psychopathology (e.g., depression and/or anxiety). The soothing system's role then, is to calm the threat state, creating safety, and downregulate the impact of the over aroused threat system. The soothing system can also generate compassionate motivations by activating the care-seeking and caregiving social mentalities (Gilbert, 2005; Hermanto & Zuroff, 2016). Gilbert proposed that the activation of the soothing system can be impaired due to a variety of factors such as early attachment issues, adverse childhood experiences, and an enduring activation of the threat system. This explains the biological, evolutionary, and attachment basis of Gilbert's (2000, 2009a) theory, which posits that practicing compassion during distressing (threat activating) events allows for the activation of the soothing system, which would in turn reduce the likelihood of psychological distress and illness (Allen & Leary, 2010).

1.2.2.3 The Three Flows of Compassion

According to Gilbert (2000, 2019), compassion is experienced across three directional flows, through the activation of a combination of care-seeking and caregiving social mentalities. These three flows of compassion include, *self-compassion, compassion towards others,* and *compassion from others* (Gilbert et al., 2017). Self-compassion refers to the compassion people give to themselves, compassion to others refers to the compassion people give to others, and compassion from others refers to one's experiences of compassion from people around them (whether one perceives others to be supportive towards them). Gilbert's (2019) notion puts forward that compassion can be understood as a reciprocal process between the provider of compassion and the recipient of it. Whilst one would need practice to acclimatise themselves to

be open to receiving compassion from themselves or from others, the provider of compassion will also focus on the impact of their caring on others (Gilbert, 2019). Thus, Gilbert and colleagues (2017) discussed that compassion is not only felt towards the self, but also for others in the form of offering compassion to others and receiving others' compassion. To measure the aforementioned three flows, and to avoid the issues discussed in the measurement of opposing constructs within one measure as in Neff's SCS (2003b), they developed a self-report measure, named the Compassionate Engagement and Action Scales (CEAS). The CEAS measure one's "engagement" with suffering and "action" towards compassion across self-compassion, compassion to others, and compassion from others (Gilbert et al., 2017).

1.2.2.4 Facilitators and Inhibitors of Compassion

Gilbert and Mascaro (2017) argued that the motivation to be compassionate, like any other behaviour that requires motivation, has facilitators and inhibitors. They proposed that one of the biggest facilitators of compassion is *self-reassurance*, which is the ability to show oneself kindness, care, and support during times of distress and failure (Gilbert et al., 2004). Whilst predicting increased well-being (Barnard & Curry, 2011), self-reassurance has negatively correlated with the manifestation of psychopathology including depression and anxiety (Hermanto & Zuroff, 2015). Self-reassurance is underlined by the care-seeking and care giving social mentality (Gilbert, 2000, 2005), meaning self-reassurance is largely determined on a person's social relationships and attachments with others. Therefore, *social safeness and pleasure*, which is the perception that the social world is safe and warm, has also shown strong correlations with increased compassion (Alavi et al., 2017; Gilbert, 2005, 2015). The perception that one's immediate surrounding is safe calms the threat and drive systems and keeps the soothing system activated (Gilbert, 2005, 2015). Given that self-reassurance and social safeness predict increased well-being and higher self-compassion, Giblet et al. (2009) identified these factors as facilitators of compassion.

In contrast, Gilbert and Mascaro (2017) suggested that inhibitors of compassion are related to *fears, blocks, and resistances* (Gilbert et al., 2011, 2014), meaning that one's experiences of compassion can be inhibited by these factors. They posited that such fears relate

to negative and self-doubting thoughts of compassion, such as compassion is a weakness, or that one would be judged as self-indulgent or manipulative. These also relate to the assumption that one's compassionate efforts would be rejected, shamed or unhelpful. It is noted that some people could also be fearful that offering compassion would be too upsetting or cause them to overwhelm (Gilbert & Mascaro, 2017; Vitaliano et al., 2013). Compassion could be blocked due to lack of understanding or not knowing how to be compassionate. Other environmental contingencies such as staff shortage or hectic health settings could also inhibit (or block) health professionals from being as compassionate as they would like to be (Brown et al., 2014; Gilbert & Mascaro, 2017). Resistances are related to simply not wanting to be compassionate, which can also inhibit compassion (Gilbert, 2019). Sometimes, people resist showing compassion to others, either when they are fearful of others, or hold grudges from previous experiences, which negatively impact on their desire to be compassionate (Dalenberg & Paulson, 2009; Furnham et al., 2013). Self-advantage such as not wanting to share their resources with others can also be considered as a resistant factor for individuals to show compassion (Keltner, 2016).

Self-criticism and shame are known as two of the most pervasive features of psychopathology (Gilbert & Irons, 2005; Gilbert et al., 2012). *Self-criticism*, which involves constant negative self-labelling and harsh judgment of the self (Kannan & Levitt, 2013; Shahar, 2015), has been strongly associated with increased depression (Zuroff et al., 2005). Additionally, Gilbert et al. (2014) emphasised that social comparison and the sense of inferiority one feels in relation to a desired social context, is linked to self-inadequacy and criticism. This leads to *external shame* (Matos et al., 2015) and *internal shame* (Gilbert, 2007), which are a self-perception of scrutiny and negative judgement of self by significant others, and one's own negative judgements of oneself, respectively. Both external shame and internal shame have shown strong correlations with a range of psychopathological traits including anxiety (Tangney et al., 1992; Matos et al., 2015) and depression (Alexander et al., 1999; Gilbert & Irons, 2004; Matos & Pinto-Gouveia, 2010). In addition to fears, blocks, and resistances, these factors such as self-criticism, psychopathology, and shame, often overlap and interplay with one-another, inhibiting one's experiences of compassion (Gilbert et al., 2011).

1.2.2.5 Criticisms of Gilbert's Model

Although Gilbert's (2009, 2014) model provides a solid framework for understanding the emergence of mental health problems and well-being (Gilbert & Proctor, 2006; Kelly et al., 2012), several criticisms exist. For example, it has been suggested that the model's heavy reliance on early attachments with primary caregivers in the development of the soothing system, ignores the valuable influence of affiliative experiences with significant others beyond the primary caregivers (Allen & Land, 1999; Duarte & Pinto-Gouveia, 2017; Farr, 2019). In support, studies have found that, in addition to the primary caregivers, strong relationships with other figures such as peers, teachers, and even strangers can have an impact on increased well-being, self-compassion, and a sense of belonging (Allen & Land, 1999; Cunha et al., 2017; Ferreira et al., 2020; Matos & Pinto-Gouveia, 2014). These results also corroborate the research that has showed that adolescence is an influential phase of the development of the soothing system and compassion (Farr, 2021; Matos & Pinto-Gouveia, 2014). Additionally, Noh and Cho (2020) identified that Gilbert's approach does not fully account for the habitual aspect of self-criticism, which they argue is an unconscious response triggered by self-critical schemas (Cho et al., 2019), that can lead to psychopathology (Verplanken et al., 2007). Although Gilbert (2014) discussed the impact of self-criticism on compassion and vice versa, the argument is that the formation of self-criticism is not sufficiently detailed in the model (Noh & Cho, 2020).

1.2.3 Compassion-Based Interventions

Based on the various definitions (e.g., Lazarus, 1991; Strauss et al. 2016) and theoretical approaches (e.g., Gilbert, 2010a; Neff, 2003a) to compassion, a multitude of clinical psychotherapeutic and general population interventions have been developed to promote compassion for the self and to/from others (Kirby, 2016). Many of these have indicated various benefits of compassion for mental well-being, physiological health, and genetic expressions (Fredrickson et al., 2013). Some of these include improved clinical outcomes (Epstein et al., 2005; Sanghavi, 2006), higher life satisfaction (Yamagata et al., 2011), quality of life (Van Dam et al., 2011), social, family, and maternal support (Neff & McGehee, 2010), mindfulness (Fredrickson et al., 2008), and improved mental and personal well-being (Feldman & Kuyken, 2011; Neff et al.,

2007: Neely et al., 2009). Practicing self-compassion has shown to reduce interpersonal problems and psychological distress (Mak et al., 2018; Schanche et al., 2011), personal pathology and psychiatric symptoms including stress (e.g., Lutz et al., 2008), depression (Leary et al., 2007; Shapira & Mongrain, 2010), and anxiety (e.g., Van Dam et al., 2011). Several longitudinal studies and laboratory experiments have also discussed the impact of compassion on direct physiological health improvements, such as reduced sympathetic nervous system activation, increased heart rate variability, and reduced inflammatory responses following exposure to a lab stressor (Arch et al., 2014; Breines et al., 2014, 2015; Crocker & Canevello, 2012; Rockliff et al., 2008), and indirect health benefits caused from healthy behaviour such as healthy eating (Adams & Leary, 2007; Schoenefeld & Webb, 2013), exercise (Magnus et al., 2010), medical adherence (Brion et al., 2014), dietary adherence (Dowd & Jung, 2017), and terminating smoking (Kelly et al., 2010).

Considering the promising findings from compassion-based intervention research on a range of presentations, an increased interest in compassion-based interventions that specifically focus on compassion cultivation (e.g., Gilbert, 2014; Neff & Germer, 2013) has developed over the past decade. For example, Kirby (2016) conducted a review on the effectiveness of compassion-based interventions with a primary focus on compassion-cultivation and found that there were at least six empirically supported interventions. These are Mindful Self-Compassion (MSC: Neff & Germer, 2013), Compassion Focused Therapy (CFT: Gilbert, 2014), Cognitively Based Compassion Training (CBCT: Pace et al., 2009), Compassion and Loving Kindness Meditations (LKM: Hofmann et al., 2011) and Compassion Meditations (CM: Wallmark et al., 2013), Cultivating Emotional Balance (Kemeny et al., 2012), and Compassion Cultivation Training (Jazaieri et al., 2013), which will be discussed in detail in the following sections. A meta-analysis of these interventions found evidence for the trans-diagnostic applicability of these interventions, with significant improvements in compassion for the self (*d* = .70) and others (*d* =.55), well-being (*d* = .51), and significant reductions in mental health problems such as depression (*d* = .64) and anxiety (*d* = .49) (Kirby et al., 2017).

1.2.3.1 Mindful Self-Compassion (MSC)

Neff and Germer (2013) developed the MSC programme to cultivate self-compassion. It has been effective among both clinical (Neff & Germer, 2012) and non-clinical (Neff & Germer, 2012; Yela et al., 2019) populations. This programme incorporates several practices such as psychoeducation, mindfulness, loving-kindness, and self-compassion practices. Significant improvements in self-compassion, mindfulness, and life satisfaction and significant reductions in depression, anxiety, and stress have been found among people who were enrolled in the MSC programme (Neff & Germer, 2013). Gilbert (2020) recognised the MSC as one of the most well-developed, evidence-based approaches to address self-criticism. However, Kirby (2016) emphasised that the programme lacks evidence-base underpinnings and evaluations in clinical samples. Furthermore, the efficacy of the MSC is often assessed using the SCS (Neff, 2003b), which has been criticised for its conceptualisation and structure as previously discussed.

1.2.3.2 Compassion Focused Therapy (CFT)

Gilbert (2014) developed CFT based on the previously discussed Social Mentality Theory (Gilbert, 1989, 2000). CFT was intended to help people to be motivated to engage with suffering, and to act on alleviating and preventing that suffering. CFT provides psychoeducation specifically related to the three emotion-regulation systems by emphasising how the soothing motivational system helps cultivate compassion to reduce the impact of self-criticism and shame caused by the activation of threat and drive systems (Gilbert, 2014; Kirby, 2016). Clinicians and researchers have used the CFT approach to help people with a range of mental health complications, such as anger issues (Kolts, 2012), anxiety disorders (Tirch, 2012), and eating disorders (Goss & Allan, 2014). Some researchers have also integrated CFT with other well-known approaches such as Acceptance and Commitment Therapy (ACT: Hayes & Lillis, 2014), and Cognitive Behavioural Therapy (CBT: Beck, 1970) and created new psychotherapeutic approaches such as the Compassion Focused ACT (CFACT: Tirch et al., 2014) and Group CBT with Compassion Training (Asano et al., 2017) respectively. A Japanese study designed a new group programme named the Enhancing Self-Compassion Programme (ESP: Arimitsu, 2016) using CFT, which significantly increased self-compassion in the participants. To date, CFT remains the most evaluated

intervention with a systematic review (Leaviss & Uttley, 2015) and meta-analysis (Kirby et al., 2017) discussing the effects of CFT as a successful intervention for increased well-being and reduced distress.

1.2.3.2.1 Compassionate Mind Training (CMT)

Compassionate Mind Training (Gilbert, 2000, 2009, 2010; Gilbert & Procter, 2006) is another compassion-based approach, which is an integral part of CFT. CMT was originally developed as a group-based therapy, to help people with high levels of shame and self-criticism. This training incorporates several practices designed to develop physical and mental competencies to promote self-grounding, a sense of compassionate self and sensitivity to the suffering of others, and to help people regulate different emotions to face distress and life difficulties (Crocker & Canevello, 2012; Gilbert, 2009b; Matos et al., 2017a). Some of these practices include mindfulness training, soothing rhythm breathing, and compassion-based imagery etc. (Beamont et al., 2021; Gilbert, 2009b, 2010). A substantial portion of CMT, when compared to CFT, prioritises on psychoeducation and is known to be more suitable than CFT for group-based treatment than specific individual cases (Matos et al., 2017a). It is also a hybrid of several therapies, with an evolutionary basis similar to CFT. Interestingly, an initial CMT study found that participants were reluctant to engage in a compassion-based intervention due to beliefs that compassion is a weakness or a self-indulgent concept, and these thoughts were challenged and completely changed upon receiving the CMT (Gilbet & Procter, 2006). This implies that the perception that compassion is not something one should cultivate, may reduce people from participating in compassion-based interventions, although the actual participation might change these attitudes and bring positive outcomes.

Engaging in a two-week CMT increased participants' self-compassion as well as compassion for others. In addition, the two-week CMT intervention increased facilitators of compassion such as safeness and contentment, and reduced inhibitors of compassion such as all three forms of fears of compassion (fear of self-compassion, and fear of compassion to and from others), self-criticism, and external shame (Matos et al., 2017a). CMT has also shown to

significantly reduce depression, anxiety, feelings of inferiority, and submissive behaviour (Gilbert & Procter, 2006).

1.2.3.3 Compassion Cultivation Training (CCT)

Underpinned on Tibetan Buddhist contemplative practices and Western psychology (Jazaieri et al., 2013), CCT aims to promote feelings of open-heartedness and connection with others (Kirby, 2016). CCT is conducted in group settings in the form of group discussions, and includes practices such as guided meditation, mindfulness practices and other interactive exercises to induce self-compassion and compassion towards others (Kirby, 2016). Although CCT has reported to increase compassion and mindfulness (Jazaieri et al., 2013, 2014), and reduce attention to unpleasant topics (Jazaieri et al., 2016), CCT is still at an early developmental stage with limited number of studies conducted (Kirby, 2016).

1.2.3.4 Cognitively Based Compassion Training (CBCT)

This programme was originated to help university students develop emotional resilience (Ozawa-de Silva & Negi, 2013). Underpinned on Tibetan Buddhist traditions, mindfulness, and cognitive-restructuring strategies, CBCT consists of eight stages, which include homework exercises and meditation practices (Kirby, 2016). CBCT has been evaluated in multiple randomised controlled trials and tested with adolescents in addition to adults in the general public. Some benefits of using CBCT have been reported, although no independent evaluations of the efficacy of CBCT have been published (Kirby, 2016).

1.2.3.5 Compassion Meditations (CM) and Loving-Kindness Meditations (LKM)

CM and LKM are combined in many Buddhist practices (Hoffmann et al., 2011). CM is a Buddhist practice where the meditator wishes for others to be free from suffering. LKM involves developing caring feelings starting with oneself, and expanding towards loved ones, acquaintances, strangers and as far as towards those one may have had experienced difficulties with, and towards all living beings with no distinction (Galante et al., 2014). Kirby (2016) emphasised that CM and LKM are used in all compassion-based interventions as means to help calm the mind, enhance compassion for the self and others, and to improve mental health.

1.2.3.6 Cultivating Emotional Balance (CEB)

This is another compassion-based intervention which is underpinned by Western psychology, traditional Eastern attention focus, and contemplative practices (Ekman & Ekman, 2013). Through a variety of practices such as mindfulness and LKM, the CEB training encourages individuals to recognise the suffering in the self and others and to tolerate distress through compassion cultivation. Practicing CEB has significantly reduced depression, anxiety, rumination, and negative affect, and increased positive affect and mindfulness (Kemeny et al., 2012). However, Kirby (2016) emphasised that the studies exploring the efficacy of CEB have been limited to female schoolteachers, implying the need to be further explored in different populations and settings.

1.2.3.7 Similarities and Differences of Compassion-Based Interventions

Several similarities and differences have been observed between various compassion-based interventions, indicating the multidimensional nature of compassion (Kirby, 2016). In consideration of the similarities, all the interventions have been influenced by the Tibetan Buddhism and incorporated some form of mindfulness practice. CFT and MSC programmes focused less on mindfulness whilst the CCT, CBCT, and CEB programmes spent most of the interventions focusing on mindfulness-based training. Importantly, all interventions included a portion of psychoeducation, providing a rationale for engaging in the compassion-based training. All interventions also entailed activities and tasks that participants actively practiced using specific compassion strategies. These practices were similar in most interventions and contained techniques such as breathing exercises, facial and body expressions, building compassionate inner voices, compassionate letter writing, and imagery tasks aimed at producing calm and soothing sensations by activating the parasympathetic system (soothing system). A homework component was also incorporated in all interventions. Interestingly, these interventions also demonstrated the ability to be delivered in group settings (Kirby, 2016).

In consideration of the differences, CFT was notably different from other compassion-based interventions, as it is a form of psychotherapy, whereas the other interventions are simply programmes developed to increase compassion. CFT can be tailored to meet the needs of the

individual, whilst the other interventions are delivered by following the prescribed session content for each session (Kirby, 2016). All interventions, except MSC, focus on compassion as a broader experience that spreads across the self and towards others, whilst MSC only focuses on self-compassion as measured by the SCS (Neff & Germer, 2013). The MSC should be used with caution as incorporating SCS (Neff, 2003b) to measure self-compassion, and Neff's (2003a) conceptualisation of self-compassion have been criticised (Kirby, 2016) as discussed earlier in the introduction section.

Due to the scarcity of rigorous methodologies and research in clinical populations, Kirby (2016) acknowledged that CFT is the most appropriate form of intervention especially for clinical populations. Furthermore, CFT is the only model to address fears, blocks, and resistances to compassion as well as affiliative feelings and behaviours that would promote compassion (Gilbert, 2014; Kirby, 2016). The consideration of inhibitors (fears, blocks, and resistances) and facilitators (affiliative feelings and behaviours) of compassion in CFT further strengthens the use of this intervention, over and above the other methods.

However, it is important to note that there are only a limited number of RCT studies (e.g., Arimitsu, 2016; Tung, 2020) conducted so far, to support the use of these compassion-based interventions (Kirby, 2016; Matos et al., 2017a, 2022a, b). Furthermore, literature exploring compassion-based interventions also seem to be at an infancy stage (Kirby, 2016), with the need for more rigorous trials to explore the efficacy of compassion-based interventions across clinical and non-clinical samples from a range of diverse backgrounds.

1.2.4 Cross-Cultural Applicability of Compassion

Many religions have discussed the perceived benefits of compassion in one way or another (Vivinio et al., 2009). In fact, it is one of the key virtues in the Buddhist philosophy (Keown, 2005). Self-compassion is believed to have originated in the Buddhist philosophy (Neff, 2003a), and compassion is also deeply embedded in the culture of Asian communities, especially where Buddhism is the predominant religion (Shih et al., 2013). Due to these reasons, it has been proposed that people in Asian communities maybe more self-compassionate than people in Western communities (Markus & Kitayama, 1991). In fact, Neff (2003a) compared Buddhist

participants with a group of university students and found that the Buddhist participants were more self-compassionate. Whilst this appears to be the only study conducted explicitly exploring the interplay of Buddhism using the SCS, it has been criticised for the small sample size (n = 172 Buddhists) and for not examining the psychometric properties of the scale (Zeng et al., 2016). In contrast, some studies (e.g., Kitayama & Markus, 2000; Kitayama et al., 1997; Neff et al., 2008) have found that people from Asian Buddhist communities are more self-critical and less self-compassionate when compared to people from Western backgrounds. This disparity signifies the importance of exploring cross-cultural differences of compassion.

1.2.4.1 Cultural Differences of Compassion

Some cultures, such as the Japanese and other Confucian cultures (e.g., Chinese culture) appreciate compassion for others, whilst condemning self-compassion (Arimitsu, 2016). These cultures encourage self-criticism and believe that self-critical thoughts lead to self-improving efforts by allowing one to achieve hierarchy and role mastery through developing interconnectedness and interdependence belongingness (Heine et al., 2001). Furthermore, collectivistic environments are known to be rich in emotional interdependence and communal relationships, causing individuals from these backgrounds to become self-critical and feel more pressure from their relationships with others during shortcomings and failures (Kitayama & Uchida, 2003). This potentially explains the aforementioned low self-compassion found in participants from Asian Buddhist communities, which could perhaps be due to their increased self-criticism. This was also evident in a cross-cultural study by Neff et al. (2008), which indicated that levels of self-compassion were lowest in Taiwan (an Asian collectivistic Confucian culture) and highest in Thailand (an Asian collectivistic Buddhist culture), with the United States falling in between (a Western individualistic culture). This implies that whilst Buddhism may be an indicator of increased self-compassion, the Confucian and other cultural dynamics might inhibit this. A study between Japan and the USA also found that self-compassion was strongly related to increased positive affect in the USA compared to Japan, indicating that self-compassion promotes more positive affect in Western individualistic cultures than in Asian collectivistic cultures (Arimitsu, 2016). These findings suggest that self-compassion and compassion for others may be

moderated by cultural differences such as Confucian self-critical attitudes and other culture-specific factors as well as religion (Arimitsu, 2016; Neff et al., 2008).

1.2.4.1.1 Sri Lanka

Sri Lanka is a collectivistic Asian country, where Buddhism is the predominant religion, and is practised by 69% of the population (De Zoysa 2013; Marecek 1998). Despite this, Buddhist practices (e.g., mindfulness and compassion) in Sri Lanka are mostly restricted to monastic settings, with not many studies incorporating Buddhist philosophy into psychological research (De Zoysa 2011, 2013). Mental health professionals are also reluctant to accept Buddhist influenced psychotherapy in Sri Lanka, perhaps due to the lack of knowledge and social acceptance that Buddhist practices, such as meditation, should be practiced in religious settings rather than in the psychotherapeutic context (De Zoysa, 2013).

Sri Lanka has been faced with several catastrophes over the years, including a 30-year long civil war that ended in 2009, which caused over 100,000 causalities and one million refugees (Neumann & Fahmy, 2012), and the 2004 tsunami, which resulted in 35,000 deaths (Brun & Lund, 2008). Presently, in addition to the impact of the global COVID-19 pandemic (World Bank, 2021), Sri Lanka is going through its worst economic and political crisis in history (Al-Jazeera, 2022). It has also been shown that Sri Lankans experience higher rates of grief, domestic violence, learned helplessness, alcohol abuse, self-harming, and attempted suicides (WHO, 2012), in addition to increased levels of shame, self-criticism, depression, anxiety, and post-traumatic stress disorder particularly in the war affected areas (Gunaratnam et al., 2003). A cross-cultural study between UK and Sri Lankan university students who were not living in the war affected areas, also found that Sri Lankan participants' self-harming behaviour was significantly higher than that of the UK participants (Kariyawasam et al., 2019). Therefore, it seems fair to suggest that a Buddhist influenced country, such as Sri Lanka, may benefit from a compassion-based intervention, given that all compassion-based interventions are influenced by the Buddhist philosophy (Kirby, 2016), whilst approaches such as CFT and CMT focus on reducing shame, self-criticism, and psychopathology (Gilbert, 2014) that are highly prevalent in Sri Lanka.

1.3 Rationale for the Thesis

In comparison to cross-cultural studies on self-compassion, few studies have explored cultural differences on compassion towards and from others (Arimitsu, 2016). People in collectivistic cultures (e.g., Japan, Sri Lanka), where people's lifestyle is influenced by high levels of social interdependence (Neff et al., 2008) are presumed to be more compassionate towards others. People in such cultures tend to enjoy social relationships when there are compassionate exchanges, given that social support and connections are considered as the ultimate goal of life for people in these cultures (Arimitsu, 2016; Hitokoto & Uchida, 2015). This was evident in a study that found Japanese participants' compassion towards others was associated with interdependent happiness when compared to American participants (Arimitsu, 2018). This is further clarified in Gilbert's (1989) SMT, as the theory discusses how compassion is developed through social roles such as care seeking and care giving. In addition, SMT predicts that social rank mentality, which creates a competitive, individualistic, and materialistic atmosphere with others in society, therefore, will decrease compassion for others. This begs the question, whether people in Western individualistic cultures who strive for personal success are more self-compassionate, in contrast to Eastern collectivistic cultures where social acceptance is acquired for sharing compassion towards others.

1.3.1 Thesis Aims

As this is an area of interest that is yet to be explored, the overarching aim of this thesis was to explore the cross-cultural applicability of compassion-based approaches in an Asian community, namely Sri Lanka. This was explored across seven chapters including four independent research papers as outlined below.

1) Chapter 1: This chapter was written to introduce the concept of compassion and to summarise the existing compassion-based theories and interventions. Objectives included:
    a. To provide an overview of compassion in relation to history and definitions of compassion.
    b. To discuss the theoretical models and interventions based on compassion.

c. To discuss the experience of compassion in relation to cross-cultural differences.

d. To emphasise on the scarcity of cross-cultural studies on compassion and to lay the groundwork for testing compassion-based studies in Sri Lanka and other Asian communities.

2) Chapter 2: This chapter aimed to summarise the different methodological approaches used in this thesis. Objectives included:

a. To discuss the reasons for the data collection and analyses methods used in the four independent papers.

b. To discuss the importance of conducting mixed-methods studies.

c. To discuss the use of online studies and questionnaire designs.

3). Chapter 3 (Paper 1): The first paper aimed to explore compassion-based interventions that have been tested in Asian communities. Objectives included:

a. To explore whether compassion-based interventions have been previously tested among Asian communities.

b. To test whether if any, the existing compassion-based interventions have been effective to be used in Asian communities.

4. Chapter 4 (Paper 2): The second paper aimed to understand the experience of compassion in Sri Lankan university students. Objectives included:

a. To gain an in-depth idea of the views and lived experiences of compassion in Sri Lankan students.

b. To understand the perceived facilitators and inhibitors of compassion in Sri Lankan students.

5. Chapter 5 (Paper 3): The third thesis paper aimed to explore compassion and facilitators and inhibitors of compassion in a cross-cultural group of Sri Lankan and UK people. Objectives included:

a. To compare the levels of compassion between Sri Lankan and UK people.

b. To investigate the predictors of compassion in relation to the facilitators of compassion and inhibitors of compassion for Sri Lankan and UK people separately.

c. To discuss (if) any cross-cultural differences in the levels of compassion and facilitators and inhibitors of compassion, and the predictors of compassion in Sri Lankan and UK people.

6. Chapter 6 (Paper 4): The fourth and final paper aimed to implement a Compassionate Mind Training intervention to Sri Lankan and UK people. Objectives included:

a. To explore whether CMT will increase the three flows of compassion in the intervention group when compared to the wait-list control group, regardless of the cultural background.

b. To explore whether CMT will improve the facilitators and inhibitors of compassion, and to explore whether these changes will be similar or different between Sri Lankan and UK people.

c. To explore whether the improvements of CMT (if any) will be maintained at a two-week follow-up.

7. Chapter 7: This chapter provides a summary of the findings of this programme of research. In addition, strengths and limitations of each paper, and overall theoretical, research, and clinical implications are discussed in more detail. The objectives of this chapter included:

a. To discuss findings that were not sufficiently explored in the individual papers.

b. To discuss the overall theoretical implications

c. To discuss the overall research and clinical implications

1.4 Summary of Chapters

The introduction to this thesis (Chapter 1) provided relevant background on compassion from its history and definitions to theoretical underpinnings and models, and the existing compassion-based interventions. The introduction chapter also discussed the cross-cultural applicability of compassion and emphasised on the scarcity of compassion especially in the Asian communities.

Chapter 2 discusses the methodological approaches used in the four independent research papers of this thesis. This includes the rationale behind choosing the research methods

that were utilised to address the paper objectives. This chapter also outlines different elements of qualitative research, in relation to paper 2. In addition to the methods used in this thesis, and discussing the rationale for each paper, this chapter considers context in relation to internet and questionnaire use.

Chapter 3 (Paper 1) is a systematic review and meta-analysis of existing compassion-based interventions conducted among Asian communities. The aim was to understand the prevalence and efficacy of such interventions regarding whether compassion-based interventions lead to increased levels of compassion in people living in Asian communities. As most compassion-based interventions are formed and tested in Western cultures, this paper also investigated the cross-cultural applicability of these interventions in the Asian context. To test these aims, a meta-analysis was conducted with randomised controlled trials (RCTs). The rigorous methodology resulted in only eight compassion-based interventions conducted in a few Asian countries. Results indicated that although limited in number, there is promise for implementing compassion-based interventions to increase compassion and well-being in Asian communities. This study has been submitted for publication and is under review on the peer reviewed journal: "Psychology and Psychotherapy: Theory, Research and Practice".

Chapter 4 (Paper 2) is a qualitative study conducted in Sri Lanka. As there were no compassion-based studies that had been conducted (prior to this thesis) in Sri Lanka, a qualitative study among ten Sri Lankan undergraduate students was conducted. The aim was to gain an in-depth understanding of whether participants were familiar with the concept of compassion and if so, to explore their views and experiences of practicing or engaging in compassion. This study also sought to gain an understanding of whether Sri Lankan people would be open to receiving a compassion-based intervention. Study findings showed that Sri Lankan participants were well aware of the concept of compassion and its impact on increasing their well-being and reducing distress. However, most participants struggled to experience compassion due to several inhibitors such as social shame, self-criticism, and depression whilst they discussed that religion and certain cultural values facilitated them to experience compassion towards and with others. This study has been published in "PLOS ONE", a peer reviewed journal:

Kariyawasam, L., Ononaiye, M., Irons, C., Stopa, L., & Kirby, S.E. (2021). Views and experiences of compassion in Sri Lankan students: An exploratory qualitative study. *PLoS ONE*, *16*(11): e0260475. https://doi.org/10.1371/journal.pone.0260475

Chapter 5 (Paper 3) is a quantitative cross-sectional study that compared all three flows of compassion (self-compassion, compassion to and from others) and explored facilitators and inhibitors of compassion affecting these three flows. This study aimed to explore whether there were any cross-cultural differences in the three flows of compassion and compared a sample of 300 participants from the UK, an individualistic, Western country (Gardner et al., 1999), with a sample of 149 participants from Sri Lanka, a collectivistic, Asian country (Freeman, 1997). Results indicated that there were differences in the levels of self-compassion, which was significantly higher in the Sri Lankan group, although no significant differences were found in compassion to or from others between the two countries. In addition, there were some similarities (anxiety did not significantly differ) and some differences (self-reassurance, fears of compassion and external shame were significantly higher in the Sri Lankan group, social safeness was significantly higher in the UK group) across the two countries, when exploring the facilitators and inhibitors of compassion. This study also explored predictors of each flow of compassion (in relation to the facilitators and inhibitors of compassion, and psychopathology) and found that there were some cross-cultural similarities and differences in these predictors (for instance, self-reassurance predicted self-compassion in both countries whilst the lack of fear of self-compassion and following Buddhism also predicted self-compassion only in the Sri Lankan group). Findings of this study suggested that society and culture seem to significantly influence one's experiences of the three flows of compassion, highlighting that these specific factors should be carefully considered when implementing Western compassion-based approaches in non-Western contexts such as Sri Lanka. This study has been published in "Global Mental Health", a peer reviewed journal:

Kariyawasam, L., Ononaiye, M., Irons, C. & Kirby, S.E. (2022). A cross-cultural exploration of compassion, and facilitators and inhibitors of compassion in UK and Sri Lankan people. *Global Mental Health*, 1–12. https://doi.org/10.1017/gmh.2022.10

Chapter 6 (Paper 4) implemented a two-week, online, Compassionate Mind Training (CMT) to explore whether engaging in the CMT will result in any improvements across the three flows of compassion, and if there will be any changes in the inhibitors and facilitators of compassion post CMT, between a cross-cultural group of Sri Lankan and UK people. This longitudinal study also investigated if CMT would result in any lasting effects, at a two-week follow-up test. In total, 21 Sri Lankan and 73 UK participants, who were randomly allocated to the CMT group, completed the training. The results suggested that CMT was effective in increasing all three flows of compassion (self-compassion, compassion to others, and compassion from others) in both Sri Lankan and UK participants, highlighting the efficacy and cross-cultural applicability of the CMT. In addition, several improvements were observed in the facilitators and inhibitors of compassion with significant increases of positive affect and significant decreases of negative affect in the two countries. There were some cross-cultural similarities (e.g., fear of compassion from others, fear of self-compassion) and some differences (fear of compassion to others, reassured-self, social safeness and pleasure, anxiety, depression, and well-being) in the improvements observed across participants from the two countries, upon practicing the CMT. All improvements were sustained at a two-week follow up with further improvements in some variables (anxiety, and depression reduced in the Sri Lankan group, and social safeness increased in the UK group). Thus, results of this study indicated that a two-week CMT showed promise in consideration of cross-cultural efficacy (Sri Lanka) in not only increasing compassion, but also increasing well-being and reducing distress. This paper has been submitted to the “Mindfulness” journal and is presently being peer reviewed.

Finally, a general discussion is presented in Chapter 7, which begins with a summary of findings of the four papers. Drawing from the findings, this discussion provides recommendations for prospective studies and compassion-based intervention development and discusses the clinical implications from conducting compassion-based interventions in cross-cultural settings. This chapter also discusses the findings in relation to theoretical perspectives, the strengths and weaknesses of the present thesis, and highlights areas for future research.

Chapter 2 Methodological Approaches used in the Thesis

The methods for all four papers discussed in this thesis, were carefully selected within an overarching mixed methods approach. The following sections will discuss the rationale for the data collection methods and the analyses chosen for each of the four papers of this thesis.

2.1 Using a Mixed Methods Approach

This thesis used a mixed methods approach by conducting both qualitative and quantitative studies. Altogether, this thesis included a systematic review and meta-analysis, a qualitative study, a quantitative study following a cross-sectional survey design, and a longitudinal intervention study following a Randomised Controlled Trial (RCT) design. Well-designed mixed-method studies have the ability to combine qualitative and quantitative methods to mitigate the limitations that arise in qualitative and quantitative studies individually (Young, 2016). Mixed methods studies serve three purposes: *triangulation*, *facilitation*, and *complementarity* (Young, 2016). Triangulation refers to the combination of quantitative and qualitative methods to corroborate the findings of each other. This means results obtained from one approach is validated if data obtained from another method produces convergent results. Triangulation was expected to be observed in this thesis as the qualitative analysis in Paper 2 and the cross-sectional quantitative design in Paper 3 aimed to discover a shared set of variables, which are common inhibitors and facilitators of compassion (Gilbert, 2014). Facilitation refers to the use of one research approach to make another research approach more effective. For instance, qualitative information gained through interviews (Paper 2) may facilitate the formation of a hypothesis that will be tested in a quantitative study (as tested in Paper 3 and Paper 4). Complementarity is when two different research approaches (qualitative and quantitative) are selected to understand different aspects of an investigation to gain a clear picture of a broader issue. This is reflected across the studies as the understanding gained from Paper 2 especially related to Sri Lankan society being an inhibitor of compassionate experiences, helped the understanding of the cross-

cultural differences observed in Paper 3 and Paper 4. In addition, Sri Lankan participants' lived experiences and the societal challenges of compassion (Paper 2) broadened the understanding of the cross-cultural differences between Sri Lankan and UK people.

It is important to note that this programme of research was conducted in English across both Sri Lanka and UK people. This includes the interviews, questionnaires used, and the final intervention study. The majority of the Sri Lankan participants were university students who were studying in English. However, not all Sri Lankans are fluent in English and therefore, additional research should be conducted in the participants' native languages before generalising these findings. Such research should however confirm congruency between the terms and their true meaning in the language to which studies are translated (Kalfoss, 2019). For instance, when translating the term "compassion", researchers should thoroughly study whether the translated term conveys the true meaning of the construct to fully understand participants' experiences from their perspectives.

2.1.1 Paper 1: Meta-Analysis

For the first paper of this thesis, a systematic review and meta-analysis was conducted to explore existing compassion-based interventions in Asian communities and to understand whether compassion-based interventions lead to increased levels of compassion in people living in Asian communities. A meta-analysis is a scientific and objective method of combining and examining different results (Ahn & Kang, 2018). The use of high-quality RCTs is recommended in systematic reviews and meta-analyses to obtain more reliable results and are considered as the pinnacle of evidence-based research (Akhter et al., 2019; Uetani et al., 2009). Therefore, this meta-analysis limited the search to RCTs. Previous meta-analyses and systematic reviews of compassion interventions have been limited to papers published in English (Austin et al., 2020; Ferrari et al., 2019; Kirby et al., 2017), conducted in adult populations (Kirby et al., 2017) or people with long term physical conditions (Austin et al., 2020), and/or only focused on self-compassion of the three flows of compassion (Austin et al., 2020; Ferrari et al., 2019). The present

meta-analysis was not restricted by the publication date, the language the papers were published in, or the age of the participants and focused on compassion-based interventions in Asian communities aimed at increasing one or all three flows of compassion (self-compassion, compassion to others, compassion from others).

A meta-analytic approach was deemed suitable, as there is no restriction on the similarity of studies based on the interventions, participants or exposures when conducting meta-analyses (Borenstein, 2009; Borenstein et al., 2009). Borenstein (2009) emphasised that a certain amount of diversity among studies is inevitable and in fact desirable in a meta-analysis. In addition, generalisability and usefulness of meta-analyses are increased noticeably when there is heterogeneity in populations, settings, and other variables across studies (Gotzsche, 2000). Borenstein further highlighted that a good meta-analysis should anticipate this diversity and interpret findings with caution. This is because, for a meta-analysis to be meaningful, researchers should pay careful attention to the diversity of studies filtered and create specific eligibility criteria to obtain comprehensive and methodologically rigorous studies (Akhter & Khan, 2019; Borenstein et al., 2009). The present meta-analysis adhered to these guidelines and narrowed the search to RCTs conducted in at least one Asian country, aiming to generate compassion (to and/or from others) or self-compassion, and included at least one self-report measure of compassion.

As the meta-analysis within this thesis aimed to explore existing compassion-based interventions and to investigate their effectiveness among Asian communities, a meta-analytic approach over just a systematic review seemed more suitable. This is because meta-analyses employ statistical methods to synthesise results across multiple studies to uncover the true effects buried within data by examining and comparing findings of multiple studies (Akhter & Khan, 2019; Wright et al., 2007). This is a notable benefit of meta-analyses as pooling studies increases statistical power, which would otherwise be unattainable in individual studies (Akhter et al., 2019). Adhering to various guidelines for presenting meta-analyses, the present meta-analysis followed criteria outlined by the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA), a research quality improvement body (Page et al., 2020).

2.1.1.1 Analysis

The pooling and analysis of data in this meta-analysis was conducted using the version 5.4 of RevMan statistical software package (The Cochrane Collaboration, 2020). The effect sizes were interpreted using the Cohen's (1992) guidelines of small (*d* = .2), medium (*d* = .5), and large (*d* = .8) effects. Each trial of the meta-analysis was assigned a weighting based on its size and the precision of study findings (effect size) using a random effects model (Rodseth & Marais, 2016). A random effects model appeared suitable for this meta-analysis as it assumes that the observed estimates of treatment effect can vary across studies due to differences in the treatment effects and due to variations in the samples (chance). Therefore, heterogeneity in treatment effects is expected in meta-analyses as differences in study variables such as different populations, different types of interventions, and the length of interventions can all contribute to these variabilities (Riley et al., 2011). Considering the expected heterogeneity in studies (due to the scarcity of research in Asian context), a random effects model was selected.

2.1.2 Paper 2: Qualitative Study

This paper used an Interpretative Phenomenological Analysis (IPA) to understand Sri Lankan students' lived experiences of offering and receiving compassion. This involved exploring their thoughts, attitudes, and perceptions of compassion, and lived experiences with a specific focus on the influence of culture, religion, and societal upbringing. Participants' perceived inhibitors and facilitators of compassion were also explored in line with the Gilbert's (2014) model. Conducting qualitative studies is highly important to fully comprehend the challenges that mental health problems pose to experiencing compassion and to discover the potential inhibitors that wider cultural discourses produce (Campion & Glover, 2017). Therefore, to capture a detailed personal account from each participant, a qualitative interview approach was adhered.

A *contextual constructionist* perspective (Madill et al., 2000), which stands in between the *epistemological* (knowledge) and *realist* (the idea that world exists independently to our perception of it) perspectives was used to comprehend the information gathered. A contextual constructionist perspective holds the idea that research findings are context bound and therefore,

dependent and variable on the framework in which the data is collected and analysed (Jaeger & Rosnow, 1998; Madill et al., 2000). This approach allows the researcher to actively contribute to the research process with knowledge discovery and construction (Jaeger & Rosnow, 1998). Additionally, Pidgeon and Henwood (1997) declared that a contextual constructionist standpoint can be affected by the researcher's interpretation, participants' personal understanding as well as the cultural setting where both understandings are immersed.

2.1.2.1 Reflexivity

A contextual constructionist position seemed particularly useful when reflecting on the reflexivity of this research. Reflexivity is an integral part of qualitative research which describes the researcher's role in the research (Palaganas et al., 2017). Reflexivity facilitates transparency by allowing the researchers to openly consider their position, background, and motivations within the research (Dowling, 2006). As researchers closely engage with the analysis process of qualitative research, it is impossible to completely avoid personal bias. Therefore, by discussing reflexivity, researchers are encouraged to introduce themselves to the readers, and clarify their experiences, training, and personal characteristics (gender, occupation etc). This will improve the credibility of findings by allowing the readers to determine how discussions of papers might have been influenced by the researcher's interpretations (Tong et al., 2007). The following section will be written in first person to reflect on the reflexivity of this research.

As the primary researcher of this programme, I have a close relationship with the research conducted. I am a Sri Lankan female, with experience in cross-cultural research settings, particularly with Sri Lankan and UK people. In addition, I am also a Buddhist follower, with lived experience on how Buddhism influences the Sri Lankan society. My passion for cross-cultural research and understanding how Western methods and treatment delivery can be successfully applied to non-Western settings adhering with cultural sensitivity, guided the interests of this research. The reflexive position of me as the primary researcher may have also influenced the interview flow and participants' responses, as the participants were aware of my position as a Sri Lankan researcher. This may have allowed participants (particularly female participants) to share information more freely and in detail. My perspectives will also be integrated through the analysis

and interpretation of the study findings of Paper 2. This is, however, not a limitation of this study, but a reflection of the interpretative nature of qualitative research as the "objectivity" strived for in quantitative research is not the goal of qualitative research (Yardley, 2000). In fact, understanding the socio-cultural context in which qualitative research is conducted (e.g., me being a Sri Lankan and understanding its culture) and the researcher's ability to draw on their personal interpretations is considered to enrich the research process and its outcomes (Palaganas et al., 2017; Yardley, 2000). Therefore, participants' lived experiences discussed in this paper were comprehended using a subjective standpoint within a relativist position (Willig, 2013).

2.1.2.2 Interpretative Phenomenological Analysis

An *Interpretative Phenomenological Analysis* (IPA: Smith et al., 2009) was used as a methodological approach to analyse the interview data. This method was chosen due to its specific focus on perception and experience, that allows the researcher to discover participants' understanding and experiences of compassion in a rich, detailed manner. This allowed the researchers to make logical interpretations of the discussed phenomenon (Smith et al., 2009; Tindall, 2009). IPA is a reflexive, transparent approach which provides a thorough understanding of individuals' lived experiences with meaningful interpretations in reflection with their relationships to the world and others (Bhaskar, 2008: Smith et al., 2009).

Three key areas; *phenomenology*, *hermeneutics*, and *ideography* comprise the basis of IPA (Smith, 2011). Langdridge (2007, p. 11) described phenomenology as focusing on "people's perceptions of the world or the perception of the things in their appearing". Husserl, the founder of the phenomenological view explained that *intentionality*, a critical feature of consciousness, allows us to direct our minds towards how people perceive matters as they present themselves to consciousness (Langdridge, 2007; Larkin et al., 2011). Hermeneutics, the theory of interpretation, enables the underpinning for interpretations across wider contexts (Langdridge, 2007; Smith et al., 2009). This is where the link between phenomenology and hermeneutics is created as people's engagement with the world and their making sense of matters are often retrieved through the interpretation in which our past experiences, assumptions and preconceptions are drawn upon (Heidegger, 1988). Unlike other popular qualitative approaches where human

behaviour is generalised in their overarching claims, IPA is ideographic in nature (Smith, 2004). This allows a specific focus on personal experiences and perspectives of individual cases rather than grouping participants' answers to make common claims (Smith, 2004; Smith et al., 2009).

IPA has been comprehensively used in psychological research, especially within the clinical and social context (Smith, 2004). Additionally, Reid and colleagues (2005) emphasised the valuable applicability of using IPA in research areas that significantly lack previous investigations. Given that there was no compassion-related psychological research that has been conducted in a Sri Lankan population, IPA was used as the most appropriate methodology to analyse the data gathered from Paper 2. Additionally, the inductive nature of the analysis also meant that this particular study did not necessarily need previous literature to build upon as the inductive approach facilitated the possibility of unexpected and novice experiences to emerge (Eatough & Smith, 2008).

As with any analysis approach, several strengths and limitations of IPA have been recognised. The exploration of individuals' subjective experiences is particularly beneficial for studies that aim to understand people's unique personal experiences and how they make sense of it, within a given cultural context (Shaw, 2001). In addition, the inductive nature of the questioning, may facilitate unexpected discoveries leading the IPA research in new directions. This would allow the researchers to uncover areas that they were not previously aware of as beneficial for their research (Eatough & Smith, 2008; Noon, 2018).

On the other hand, one of the most agreed upon limitations of IPA is the language barrier. This emphasises that the interpretation of the analysis relies on the representational validity of language (Willig, 2013). This can be especially problematic, when people with language difficulties, or those of whom English is not their first language are interviewed (Noon, 2018). Although Paper 2 was conducted among Sri Lankan students, whose first language was not English, they were all fluent in English and were undertaking psychology undergraduate degrees in English.

Another criticism is that search for common themes could reduce the idiographic focus of the analysis (Arroll, 2015). In response to this criticism, whilst acknowledging the challenge of

maintaining an idiographic focus, Noon (2017) stressed that emphasising each participant's unique idiosyncrasies within shared concepts was indeed a possibility. Whilst a smaller sample is recommended to maintain the idiographic focus (Smith et al., 2009), using a smaller sample inhibits the generalisability of findings to a larger population (Charlick et al., 2016). IPA researchers, however, do not consider this as a great limitation, as they highlight that the objective of IPA is not to uncover a phenomenon in *every* setting, but rather the perception of a selected group within *their* setting (Noon, 2017). In fact, IPA is considered in relation to theory (meaning researchers should identify connections between the IPA findings and literature) rather than an empirical generalisability (Smith & Osborn, 2003).

2.1.2.3 Semi-Structured Interviewing

Following the IPA guidelines, to enable participants to engage with an in-depth interview freely, and reflectively (Smith et al., 2009), a series of semi-structured questions were incorporated to an interview guide. This ensured that topics discussed during the interviews were consistent with the research questions that were informed by Gilbert's (2014) theoretical approach. Participants were interviewed individually in person using a semi-structured interview that enables the interviewer and participant to engage in a conversation while making modifications to the interview guide to better understand the participant's experiences (Smith & Osborn, 2007). This also allowed the researcher to probe significant areas that arose through the conversation (Smith & Osborn, 2007; Smith et al., 2009). Semi-structured interviewing is known as the best method of collecting data for an IPA report (Smith & Osborn, 2007). It has been proposed that IPA research would ideally incorporate a semi-structured interview with a maximum of 25 and a minimum of two participants (Smith & Osborn, 2007). Furthermore, Smith et al. (2009) emphasised that a smaller sample of four to ten participants is advised for doctoral studies, to maintain the idiographic commitment of the analysis. Therefore, ten participants were purposively recruited for individual face-to-face interviews (Alase, 2017).

The semi-structured interviews in Paper 2 followed a carefully preconstructed interview guide. The face-to-face interviews were audio recorded with participants' consent and later transcribed verbatim into written transcripts. Each transcript was read multiple times to allow the

researcher to immerse themselves in the original data. Whilst reading and re-reading the transcripts, the primary researcher took notes in the margin of each transcript. These notes helped the researcher to re-read chunks of transcript and analyse the notes, to develop initial emergent themes. This process was repeated for each transcript. Emergent themes within transcripts were studied to search for connections across themes, with the aim of integrating any related themes. However, where there were no clear connections, the researcher kept an open mind and did not force themes to be integrated, maintaining the individuality of each case. Transcripts were further studied to explore any patterns across participants and to identify emerging themes and noting idiosyncratic occurrences. Once these themes were identified, the researcher conducted a rigorous analysis by utilising metaphors and importing other theories to make sense of the participants' interpretations (Charlick et al., 2016; Smith et al., 2009).

2.1.2.4 Quality in Qualitative Research

Yardley (2000) suggested four essential criteria for assessing validity and quality in qualitative research. These are namely, *sensitivity to context*, *commitment and rigour*, *transparency and coherence*, and *impact and importance*. Paper 2 considered and applied these criteria where appropriate. Sensitivity to context refers to the theoretical and empirical data within research and the context in which researchers' and participants' perspectives and experiences are considered. This also emphasises the importance of awareness of socio-cultural contexts in which the study is conducted. In consideration of this, previous literature was explored, and the interview guide was developed with an awareness of the socio-cultural background of the participants, and questions and probes were asked with cultural sensitivity. The ability to ask interview questions with cultural sensitivity was further facilitated by the primary researcher's personal experiences and perspectives as a Sri Lankan. Commitment and rigour refer to the in-depth immersion of the topic and development of skills and competencies to conduct methodologically rigorous research. In line with this, the primary researcher studied the existing literature on the topic as well as IPA manuals and learned interview skills prior to conducting the study. Careful consideration was also given to the depth and breadth of the analysis. Transparency and coherence refer to the clarity in the rationale, methods and

presentation of the study and the reflexivity of the researcher. Whilst clearly stating the study objectives and detailing the methodological steps of this study, the researcher also maintained a diary for each interview to reflect on the researcher's experiences, challenges faced, and suggestions for conducting prospective interviews. The diary also allowed the researcher to reflect on their own emotions from the topics discussed in the interviews and to expect and manage these emotions appropriately in future interviews. Finally, impact and importance refer to the theoretical, socio-cultural, and practical impact of the study. This relates to the relevance of the study to theoretical models, and the general usefulness of the research for the participant population, the public, and other researchers. In line with this, the socio-cultural impact of compassion was reflected throughout the interview discussions and elaborated in the clinical and research implications section of Paper 2.

2.1.3 Paper 3: Quantitative Study

An online, questionnaire-based cross-sectional quantitative survey was used in this study among Sri Lankan and UK people, to compare their levels of the three flows of compassion, and a series of facilitators and inhibitors of compassion as identified by Gilbert (2010b, 2014). Questionnaires are the most common form of conducting surveys (Young, 2016), and the most widely used tools in the social sciences research (Fife-Schaw, 2006). Questionnaires are easy to access, can be transformed into online versions, can be used to obtain large datasets with a relative ease, and the data gathered through questionnaires can be analysed and generalised to a larger population relatively easily (Demetriou et al., 2017; Young, 2016). The increased use of well-designed questionnaire studies has been seen to obtain data relating to demographic and background information, attitudes, opinions of participants, and for determining prospective interventions (Young, 2016), all of which were aims of Paper 3. Therefore, a series of validated questionnaires were delivered online.

2.1.3.1 Analysis

The primary aim of this study was to explore the cross-cultural similarities and differences in the three flows of compassion (self-compassion, compassion to others, and compassion from

others), facilitators of compassion (self-reassurance, and social safeness), inhibitors of compassion (fears of compassion, self-criticism, external shame), and psychopathology (depression, and anxiety) between Sri Lankan and UK participants. To test this, analyses of covariance (ANCOVA) tests were conducted whilst controlling for age and gender. This approach of using ANCOVA allowed the researchers to compare the Sri Lankan and UK groups whilst controlling for the effect of the demographic characteristics. The second aim was to identify the predictors of the three flows of compassion (in relation to facilitators and inhibitors of compassion, and psychopathology) and to test whether there will be any cross-cultural differences in the predictors of the three flows of compassion between the Sri Lankan and UK participants. The second aim was tested using six hierarchical multiple linear regressions (one for each flow of compassion in each country). Religion, age, and gender were controlled in the first block, depression and anxiety scores were controlled in the second block, and then the final block contained all the controlled variables and all the scales measured in the study. This method of hierarchical regressions was useful to test the true impact of each predicting variable without the influence of other variables (such as age, gender, religion, depression, and anxiety) as they were controlled in the first blocks. All the statistical analyses were performed using the SPSS version 28 and only complete datasets were downloaded and analysed. Chi square tests were performed to explore differences between age, gender, and religion in the two countries. Exploratory analyses to identify relevant mediators were carried out using PROCESS (Gray & Kinnear, 2012).

2.1.4 Paper 4: Experimental Study

This paper examined a brief online CMT intervention with pre-post and a two-week follow-up design, among a cross-cultural group of Sri Lankan and UK participants. This study used an RCT design where participants were randomly allocated to either the intervention group (CMT group) or the Wait-List Control group (WLC group) on a 1:1 ratio. Participants in the control group were also given access to the two-week CMT, after the waiting period. Randomisation of groups was conducted by an independent researcher using a computer randomisation programme (Qualtrics, 2022), so the main researcher was blinded to the condition allocated.

2.1.4.1 Randomised Controlled Trials (RCT)

RCTs are considered as the gold standard of evidence-based research due to their ability to minimise bias (Bondemark & Ruf, 2015). Randomisation in RCTs also provides a rigorous tool to examine causal relationships between an intervention and its corresponding outcome. Researchers are advised to carefully select the target group, and the interventions using which outcomes would be compared (Hariton et al., 2018). This is because randomisation allows both known and unknown determinants to be evenly distributed into different groups (WLC and CMT) minimising the assessment bias of differences in effects between the two groups (Bondemark & Ruf, 2015). To further reduce bias, a process known as *concealment* (also known as blinding) is suggested. This is where both the researcher and the participant are unaware of the group that participants would be allocated to (Hariton et al., 2018). In line with this, participants from universities and the general public were recruited from Sri Lanka and the UK, and a two-week CMT design was compared with a wait-list group (participants in the control group had no tasks to complete). In addition, the primary researcher as well as participants were unaware of which group participants would be allocated to, at the time of the initial baseline data collection. The participants were then randomised into their group and given the participatory nature of the intervention could not be further blinded. However, the primary research continued to remain blinded for the post and follow up assessments.

2.1.4.2 Analysis

Statistical analyses were conducted using SPSS version 28. Only complete datasets were analysed. Variables that did not meet normality were either bootstrapped, or re-coded based on the severity of the skewness. Differences in the variables across the two countries (Sri Lanka and UK) and the two conditions (CMT and WLC) at the baseline were tested using chi square and independent samples *t*-tests. The pre-test post-test efficacy of the CMT was investigated using a 2 × 2 mixed ANOVA design with the two conditions (CMT vs WLC) as the between-group factor, and time (T1: pre-test and T2: post-test) as the within-group factor. Analyses were repeated for Sri Lankan and UK samples separately. To investigate whether the intervention efficacy was maintained at a two-week follow-up, a repeated measures ANOVA was carried out on the CMT

group in relation to the three time points (T1: before CMT, T2: immediately post CMT, and T3: two-weeks post CMT). The Greenhouse-Geisser correction was used for *F*-test comparisons when sphericity was not met. Analyses were repeated for Sri Lankan and UK samples separately.

Both Intention to Treat (ITT) and Per-Protocol (PP) analyses were conducted to observe the intervention efficacy. The ITT takes all the participants originally randomised into account, including those that dropped out halfway through the intervention. The ITT recommends the last value of missing observations to be carried forward (Shah, 2011). Per-protocol analyses on the other hand, only include data of the participants who adhered to the study protocol and completed the intervention, in the primary analyses (Ranganathan et al., 2016). ITT analyses are usually conducted as the exclusion of missing cases violates the principle of randomisation, results in a decrease of sample size, and fails to estimate the number of participants who would benefit from the prospective intervention. Therefore, the inclusion of both ITT and PP analyses are recommended to facilitate a realistic interpretation of the effect of an intervention in RCTs (Ranganathan et al., 2016; Schulz et al., 2010). ITT was used for the pre- and post-intervention (T1-T2) analyses only (no further analyses were conducted at T3, as this would have over-inflated the study outcomes), with PP analyses being conducted using data from all three time points (pre-post and follow-up: T1-T3).

2.1.5 Considering Context

2.1.5.1 Questionnaire Use

All the interventions chosen for the meta-analysis in Paper 1, and the measures used for Paper 3 and Paper 4 relied on self-report measures. A common limitation of self-report measures is *response bias* (Ivtzan et al., 2017). A response bias is a phenomenon that takes place when individuals complete self-report measures and provide biased estimates of self-assessed behaviours (Rosenman, 2011). On such occasions, some participants might respond in a certain pattern regardless of the question presented (for example only selecting “yes” responses or “no” responses), which could affect the reliability and validity of questionnaires (Demetrious et al., 2017). One of the most common reasons for response bias is *social desirability bias*, where

individuals complete self-report measures to appear to be displaying socially accepted behaviour, or to "look good", even when the surveys are completely anonymous. This is a serious problem in interventions when a *recalibration of bias* is caused after completing an intervention (Howard, 1980). This is, when there is a *response-shift bias*, meaning that respondents' answers may vary across measurement time points although this might not be an actual representation of the intervention efficacy, but of a respondents' change in perception or internal calibration of the construct being measured (Roesenman, 2011). As this thesis focused on Asian populations, with a specific interest in Sri Lankan people in comparison to UK people in the experimental chapters, this could be particularly problematic. This is because social desirability bias might be higher in Asian people including Sri Lankan people due to the stigma of mental illness restricting Asian people from reporting affective complaints (Wong & Mak, 2016). Another limitation of questionnaire use is that the lack of clarity in questions may lead participants to interpret questions differently (Demetrious et al., 2017; Young, 2016), which could potentially occur among the participants in this thesis for whom English is not a first language.

To minimise the biases of questionnaire use, researchers have recommended the use of multimethod studies (more than one method of assessment) to corroborate the findings of one another. In addition, the use of carefully thought-through and clarified, well-structured questionnaires are recommended (Demetrious et al., 2017). Internet-based studies have also found lower rates of social desirability responding, suggesting that the confidentiality and anonymity in online studies might reduce the pressure of participants to respond in socially desirable ways (Nayak & Narayan, 2019). Therefore, considering these suggestions, to minimise such biases, this thesis adopted a mixed methods approach using qualitative and quantitative studies, used a series of validated measures, and converted the questionnaires to be delivered online.

2.1.5.2 Internet Use

The meta-analysis conducted in Paper 1 discussed that both online and face-to-face interventions were equally effective. Paper 3 and Paper 4 of this programme of research used online survey designs. The online approach was especially useful as data collection for these

studies took place during the COVID-19 pandemic where face to face studies were not possible/advised (Pfefferbaum & North, 2020), as well as during a period of political and economic unrest in Sri Lanka (Al-Jazeera, 2022). Additionally, online interventions are cost effective, self-administered, feasible, and accessible to a larger sample (Chi, 2013; Mak et al., 2018). The use of online survey designs also enable data collection from participants who might otherwise have hesitated to meet face-to-face (Wright, 2005). For instance, the questionnaires used in Paper 3 and Paper 4 included depression, anxiety scales, and questions related to social shame, fears of compassion, and self-criticism, which are related to sensitive information that people would be reluctant to share openly (Halamova et al., 2020; WHO, 2001). Furthermore, considering that disclosing mental illness is stigmatised in countries such as Sri Lanka (Kariyawasam et al., 2021, Lauber & Rossler, 2007), the use of internet approaches seemed particularly useful for the present thesis. Whilst internet-based studies facilitate the recruitment of diverse samples across age, gender, geographic setting, and socioeconomic status, findings from internet-based studies are found to be consistent with findings from traditional face-to-face methods (Gosling et al., 2004). In addition, studies have discussed that people prefer mobile phone-based interventions as opposed to other internet-based interventions (Berry et al., 2016). Considering this, questionnaires in Paper 3, and the intervention and questionnaires in Paper 4 were made available via both mobile phones and other online formats (e.g., laptop, iPad).

Chapter 3 Compassion-Based Interventions in Asian Communities: A Meta-Analysis of Randomised Controlled Trials

Abstract

Compassion is known as a sensitivity to suffering and being motivated to relieve such suffering in the self and others. Research has shown that practicing compassion increases well-being and reduces depression, anxiety, and psychological distress among clinical and non-clinical populations. Despite a rapid increase of compassion-based interventions within the past two decades, the reviews are limited to predominantly Western cultures. Therefore, this systematic review and meta-analysis aimed to evaluate the literature attempting to promote and increase compassion in Asian communities. The effectiveness of eight Randomised Controlled Trials conducted across 1012 participants from Thailand, Japan, China, and Hong Kong was explored using a random effects model. Significant between-group differences in change scores were reported on self-compassion with large effect sizes in interventions with wait-list control groups (d = .86) and small effect sizes in interventions with active control groups (d = .19). The findings suggest that although the existing compassion-based interventions are heterogeneous in nature and limited in scope, there is promising evidence of improving self-compassion in Asian communities, also supporting for their cross-cultural applicability. However, research within the Asian context is limited and at an infancy stage, signifying the importance of conducting further compassion-based interventions in clinical and non-clinical groups living in the Asian communities.

Keywords: compassion, self-compassion, RCT, efficacy, Asian, cross-cultural

3.1 Background

The concept of compassion has been widely discussed in Buddhist philosophy and other practiced religions (Germer & Siegel, 2012; Strauss et al., 2016). Compassion is commonly understood as an openness to consciously turn towards suffering, rather than away from it (Gilbert, 2014a). Whilst compassion-based meditations have formed a central part of some spiritual traditions (e.g., Buddhism: Lama & Thupten, 1995), they have also been incorporated into treatment approaches in psychotherapy (Gilbert, 2013; Neff, 2003a). Practicing compassion has shown increased improvements in psychological and physiological well-being in clinical and non-clinical populations (Germer, 2009; Gilbert, 2013; MacBeth & Gumley, 2012; Neff, 2003a). Therefore, the existing literature provides evidence to support the notion that compassion cultivation and practice may have a positive impact on a range of emotional, physical, and life experiences whilst reducing psychopathology (Kirby, 2016).

3.1.1 Models and Measures of Compassion

Neff (2003a) introduced one of the earliest and most widely used approaches to self-compassion (Germer & Neff, 2013), and viewed self-compassion as being moved by one's own suffering and turning towards the suffering to alleviate it with kindness and non-judgment. Drawn from Buddhist philosophy, this model outlines three key components of self-compassion: *mindfulness*, the acknowledgement and the non-judgmental acceptance of suffering, *common humanity*, the recognition that suffering is common to all humankind, and *self-kindness,* showing kindness to oneself during times of distress (Neff & Dahm, 2015). Neff emphasised that these three key components of self-compassion are conceptually distinct, yet overlap with one another, and is best understood when combined with their negative counterparts: *overidentification*, being absorbed by one's own negative thoughts and feelings, *isolation*, perception that one is isolated from the rest of humanity, and *self-judgment*, negative and harsh judgments of oneself during their shortcomings.

To measure self-compassion using its key components and the negative counterparts, Neff (2003b) developed the Self-Compassion Scale (SCS). However, several studies have questioned the use of this scale as combining the positive and negative components of self-compassion inaccurately represents the concept of self-compassion. For instance, Lopez et al. (2015) suggested that the positive and negative components seem to measure two different processes: *self-compassion* and *self-criticism*, rather than self-compassion as one construct. Furthermore, Gilbert et al. (2011) proposed that self-compassion is distinct from self-criticism and should not be measured together. More recently, Neff and colleagues (2021) developed two new state measures of self-compassion, named the State Self-Compassion Scale-Long Form (SSCS-L) to measure the six components of self-compassion, and the State Self-Compassion Scale-Short Form (SSCS-S) to measure the global state of self-compassion. Although they did not address the criticisms of the SCS, these new scales were developed to complete the void of a state measure to assess causal inferences of self-compassion (Neff et al., 2021).

Gilbert, another pioneer in the compassion field developed the Social Mentality Theory (SMT: 1989, 2014, 2017) and suggested that compassion emerges from the evolution of the mammalian care-giving motivational system designed to regulate negative affect. These motivational systems are referred to as *social mentalities*, which evolved to overcome challenges essential for survival, such as care-seeking and caregiving (Gilbert, 2005, 2014). Gilbert (2014) emphasised that one could feel compassion for the self and others, and therefore, compassion can be experienced across three directional flows, namely *self-compassion*, *compassion to others*, and *compassion from others* (Gilbert, 2009b).

To measure all three flows of compassion, as well as addressing the issues of the SCS, Gilbert and colleagues (2017) developed a self-report measure called the Compassionate Engagement and Action Scales (CEAS). The CEAS has been found to be a psychometrically robust measure to measure the three flows of compassion in clinical and non-clinical populations (Davalos-Batallas et al., 2020; Lindsey, 2017) cross-culturally (Asano et al., 2020).

3.1.2 Compassion-Based Interventions

To date, only two meta-analyses have investigated the efficacy of existing compassion-based interventions for the use of public, with randomised controlled trials (Ferrari et al., 2019; Kirby et al., 2017). Of these, only one review has provided a rigorous overview of the aims, design, and evidence underpinning the existing compassion-based interventions (Kirby, 2016). Kirby (2016) identified at least six empirically supported interventions designed with a specific focus on developing a more compassionate stance. These are Compassion Focused Therapy (CFT: Gilbert, 2010b), Mindful Self-Compassion (MSC: Neff & Germer, 2013), Cognitively Based Compassion Training (CBCT: Pace et al., 2009), Compassion and Loving Kindness Meditations (LKM: Hofmann et al., 2011) and Compassion Meditations (CM: Wallmark et al., 2013), Cultivating Emotional Balance (CEM: Kemeny et al., 2012), and Compassion Cultivation Training (CCT: Jazaieri et al., 2013). Providing evidence for the trans-diagnostic applicability, Kirby et al.'s meta-analysis (2017) found that compassion-based interventions improved self-reported compassion (*d* =.55), self-compassion (*d* = .70), and well-being (*d* = .51), and decreased mental health indicators such as depression (*d* = .64) and anxiety (*d* = .49). They also concluded that although there are multiple similarities in these interventions, CFT, which was developed by Gilbert (1989, 2005) is notably different due to its theoretical basis of evolutionary psychology, attachment theory, and SMT. In addition, Ferrari et al. (2019) found that when compared to the control groups, self-compassion interventions indicated significant improvements in self-compassion (*g* = 0.75) and several other psychological outcomes including eating behaviour (*g* = 1.76), rumination (*g* = 1.37), stress (*g* = 0.67), depression (*g* = 0.66), mindfulness (*g* = 0.62), self-criticism (*g* = 0.56), and anxiety (*g* = 0.57). Despite these promising results, the majority of the studies included in these reviews were based in Western countries, and neither review (Ferrari et al., 2019; Kirby et al., 2017) assessed the potential influence of culture on the efficacy of these compassion-based interventions.

3.1.3 Rationale for the Meta-Analysis

Although there is an increased interest in developing compassion-based interventions and promising evidence for their use for a range of clinical presentations (Kirby et al., 2017), most interventions have been limited to Western cultures (Fredrickson et al., 2008; Jazaieri et al., 2013; Neff & Germer, 2013). However, cross-cultural investigations are important, as cultural differences have been found in the experiences of compassion and their relationship with well-being and psychopathology (Arimitsu et al., 2019).

It is often assumed that people in Asian collectivistic cultures (where one's lifestyle and decision making may be influenced by their society) would experience more compassion towards and from others, as these cultures are rich in interpersonal connectedness, social conformity and caring for one another (Arimitsu et al., 2019; Gardner et al., 1999; Markus & Kitayama, 1991; Steindl et al., 2020). However, several cross-cultural studies have found that when compared to Western cultures, people from Asian collectivistic cultures such as Singapore (Steindl et al., 2020) and Sri Lanka (Kariyawasam et al., 2022) were less likely to experience compassion towards and from others possibly due to their heightened fears of the society, and perceived external shame. Kariyawasam et al. (2021, 2022) discussed that compassion and help-seeking behaviour is considered as weak and shameful in such collectivistic societies. Increased fears and self-criticism also seemed to inhibit self-compassion in Japanese people in a related cross-cultural study (Kitayama & Markus, 2000). These findings signify the importance of conducting further studies in Asian communities to understand the cross-cultural differences of compassion and imply that efficacy of compassion-based interventions may vary due to these cultural differences.

Due to the cross-cultural differences and that, several compassion-based approaches (Gilbert, 2010b) propose a cross-cultural applicability, the present study aimed to explore the efficacy of the existing compassion-based interventions conducted in Asian communities.

Therefore, this meta-analysis aimed to answer the question: do compassion-based interventions lead to increased levels of compassion for people living in Asian communities?

3.2 Method

3.2.1 Protocol and Registration

This meta-analysis adhered to the general principles of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA: Page et al., 2021). The protocol was prospectively registered in PROSPERO, the international prospective register of systematic reviews, under the registration number CRD42020201832.

3.2.2 Eligibility Criteria

The primary researcher and two voluntary research assistants carried out searches independently. Studies that met the following criteria were included: (a) a Randomised Controlled Trial (RCT) in which the primary focus was to purposively generate compassion or self-compassion; (b) conducted in at least one Asian country; and (c) included at least one self-report measure related to compassion or self-compassion. Both clinical and non-clinical populations of all ages were included. No publication date, language, or study design restrictions were applied. Eligibility criteria was based on the population, intervention, comparator, outcomes, and the study type (Table 3.1). Studies conducted across countries in the Middle East and North Africa (MENA) region were excluded as although some Middle Eastern countries are situated in the Asian continent, they are considered as countries in the MENA region (separately from other Asian countries) and share certain cultural and religious norms that are different from other Asian cultures (Alkaiyat & Weiss, 2013; Kabasakal et al., 2012).

Table 3.1. Inclusion and Exclusion Criteria for the Review.

	Inclusion Criteria	Exclusion Criteria
Population	Asian communities	Participants in non-Asian settings/ non-Asian
Intervention	RCTs aimed to increase compassion	Non-RCTs/ aim is not compassion (e.g., mindfulness)
Comparator	Waitlist control, active control group	No comparator/control
Outcome	Measures compassion/self-compassion	Does not measure compassion/ self-compassion
Studies	Published/unpublished studies, all languages	Literature reviews, opinion papers, abstracts, policy reports

3.2.3 Search Strategy

The systematic literature search was conducted using Scopus, Medline, Web of Science, AMED, APA PsycINFO, Ovid (EMBASE) and CINAHL databases. Cochrane Library, ProQuest for Dissertations and Theses, and Open-Dissertations databases were systematically searched to detect any relevant grey literature. The final search took place on the 10th of March 2022. The following search terms were developed with a research librarian: TI (compassion*) AND AB (random* control*) AND AB (trial OR interven* OR stud* OR program* OR therap* OR training) AND TX (Asia* OR East* OR "Eastern culture*" OR Japan* OR Chin* OR Vietnam* OR Malaysia* OR Singapore* OR "Hong Kong" OR Korea* OR India* OR Pakistan* OR Bangladesh* OR "Sri Lanka*"). Although various other interventions have integrated compassion (e.g., Mindfulness-Based Compassion Training: Lo, 2011) or produced increased compassion (e.g., Mindfulness-Based Cognitive Therapy: Segal et al., 2002a, b), their primary focus is not compassion cultivation. Therefore, such interventions were excluded from the search results and only the interventions with a specific focus of compassion/self-compassion cultivation were included.

3.2.4 Data Extraction

The following data on study characteristics were extracted: Name of authors and year of publication, country, intervention name, design, and underpinning theory/model, aim of the study, target population, measures used, duration of the intervention, intervention tasks, and the main findings of the study. For the meta-analyses, the means, standard deviations, and sample sizes for each group at pre- and post-interventions were extracted.

3.2.5 Analysis Strategy

Version 5.4 of the RevMan software (The Cochrane Collaboration, 2020) was used for the analyses. Cohen's (1992) guidelines of small (0.2), medium (0.5), and large (0.8) effects were used when interpreting effect sizes, represented by *d*. Computations were based on a weighted-average of the effect sizes using a random-effects model, as the random effects model assumes that study variations can be systematic and not only due to random error. A random-effects model is also appropriate as true effects of interventions are likely to vary depending on the sample characteristics and implementation of the intervention (Borenstein et al., 2009).

The efficacy of the interventions was compared in relation to the control groups of either waitlist control (WLC) or active control (AC) with the effectiveness of the compassion interventions analysed separately. WLC groups received no intervention, and the AC groups received a different form of intervention than the intervention groups (Kirby et al., 2017). It was assumed that studies with an AC would report smaller effect sizes than studies with a WLC group, as the different interventions received by the AC groups would also influence the outcome variables (Cuijpers et al., 2016, Kirby et al., 2017).

3.2.6 Risk of Bias within Studies

As the PRISMA statement suggests the inclusion of a risk of bias assessment (Page et al., 2021), risk of bias within studies was assessed using the Cochrane risk of bias tool of the Revman

software (Higgins et al., 2011). Critical assessments were made separately for each study for the following domains: sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessment, incomplete outcome data, selective outcome reporting, and for other biases. Studies that adequately described these domains were given a judgment of 'low risk', studies that stated the domains were not addressed were given a 'high risk', and studies that did not describe the process of these domains were given a judgment of an 'unclear' risk of bias (results for each study are reported in Appendix A).

3.3 Results

3.3.1 Systematic Search Results

The initial database search resulted in 266 records, which were transferred to EndNote, a reference management software. Sixty-three duplicates were detected by EndNote, and 19 duplicates were detected manually. All 82 duplicates were removed. Titles and abstracts of the remaining 184 papers were screened and 159 papers were excluded, as they were not related to the search. After a full text screen of 25 papers, 16 were excluded based on the eligibility criteria. Of the final 9 results, three papers reported on one study (Mak et al., 2018, Mak et al., 2019, Yip et al., 2018) and therefore, only one of them was retained (Mak et al., 2018). Four conference/meeting abstracts were obtained although they were excluded as the full papers of these could not be acquired (after contacting and receiving no response from the authors of the abstracts). Reference lists of the chosen studies and other resources were searched for any potential studies and one suitable study was found from 'ResearchGate', a social networking website for researchers and scientists. This resulted in eight studies with quantitative data that were included in this meta-analysis. All studies were allocated a number from 1 to 8 (see Table

3.2) and are referred to by their assigned number (e.g., [2, 4]) going forward. Figure 1 details the search strategy.

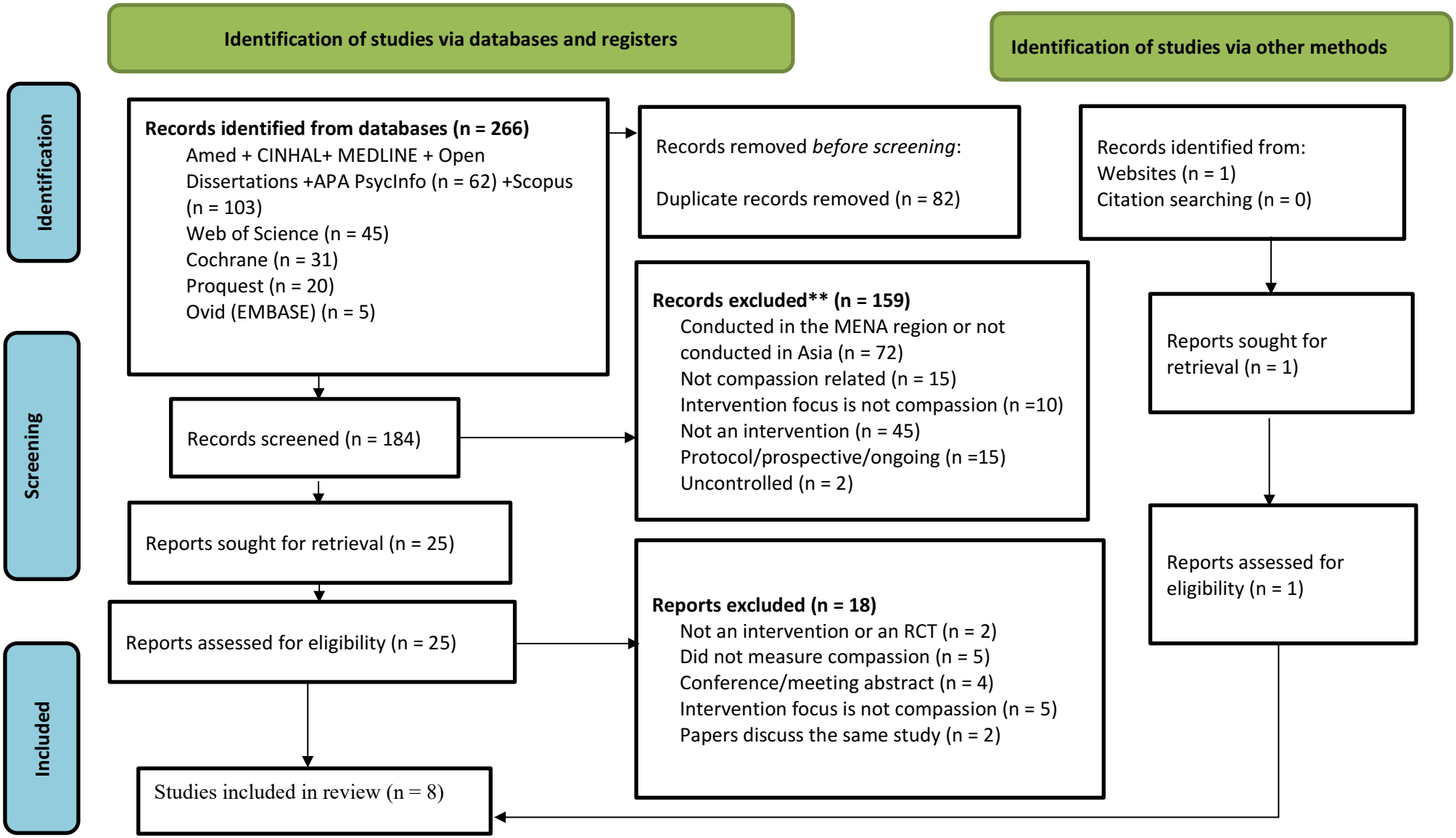

Figure 1. PRISMA Flow Diagram of Study Selection

3.3.2 Quantitative Results

3.3.2.1 Intervention and Participant Characteristics

A total of six of the eight studies included at least one of the six compassion-based interventions that Kirby (2016) outlined. Four studies were based on MSC (Neff & Germer, 2013) [1, 4, 6, 7], one was based on CFT (Gilbert, 2010b) [2], and another study incorporated both MSC and CMT approaches [5]. Although not outlined in Kirby's review, the remaining two studies in the present review were based on approaches by Neff (2009) and colleagues (2021) with one study conducting a self-compassion writing exercise (Neff, 2009) [8] and the other looking at a new approach named the Self-Compassionate Mind-state Induction (SCMI: Neff, 2021)[3]. Four studies were delivered in person, [1, 2, 5, 7] and four were delivered online [3, 4, 6, 8], and used a group[1, 2, 3, 5, 7] or a self-delivered approach [4, 6, 8]. All studies, except for one [3], used the SCS (Neff, 2003b) to measure self-compassion. Some studies used the complete scale (with 26 items) of the SCS [1, 2, 4, 5, 7], and other studies only used the 13 positive items of the scale [6, 8]. One study used the State Self-compassion Scale-Long Form [3] (SSCS-L: Neff et al., 2021).

Intervention duration varied from one to eight weeks. One study did not specify the duration of the intervention [3]. The authors were contacted to ascertain the information regarding the intervention duration, but no response was received. Four studies included a waitlist-control group (WLC) [2, 4, 5, 7], and four studies included an active control group (AC) [1, 3, 6, 8]. The AC groups received a form of intervention different to the compassion-based interventions given to intervention groups, whilst the WLC groups received no treatment/intervention. The type of intervention received by the AC groups varied between a standard psychotherapy [1], neutral writing condition [3], cognitive behavioural therapy [6], and a control writing condition [8] . The majority of the studies also reported follow-up data, [2, 4, 5, 6, 7, 8] with follow-up periods ranging from one to twelve months post-intervention (Table 2 gives a summary of the study characteristics). All studies were conducted within a five-year period (2016-2021) in various Asian countries including

Thailand [1], Japan [2], China [3, 4, 5], and Hong Kong [6, 7, 8]. The studies included university students [2, 3, 5, 7, 8], adults from the public [1, 6], and pregnant women [4]. Some studies specifically recruited adults with low self-compassion [2], and symptoms of anxiety and/or depression [1, 4] at the baseline level. One paper did not discuss the gender of the participants [2], one paper consisted of only female participants [4], one paper had more male participants than female participants [3], and the other five out of eight papers had more female participants than male participants [1, 5, 6, 7, 8]. All the papers that considered gender differences in the analyses discussed that no significant impact of gender was reported in the findings [3, 5, 6].

Table 3.2. Intervention Characteristics.

No	Author, Year and Country	Intervention, Design, Underpinning Model and Duration	Aim and Target Population	Measures	Comparator	Tasks	Findings
1	Anuwatgasem et al. (2020) Thailand	Mindfulness and Self-Compassion-based therapy (MSC), RCT, group, in person study design, based on MSC, 7 weeks	To compare the effect of MSC on group psychotherapy on people with a DSM-V diagnosis of Major Depressive Disorder (n=23 intervention group, n=11 control group)	MADRS, SCS - Thai, PSQI, HADS, Thai-PSS-10, RSES, WHOQOL	Pre-test and post-test against a standard intervention (AC group)	Activities to promote self-kindness, common humanity, mindfulness via meditation and compassionate body scan etc.	Significant decreases in depression, anxiety and stress, self-esteem, and quality of life
2	Arimitsu (2016) Japan	Enhancing Self-Compassion Programme (ESP), RCT, in person study design, based on CFT, CMT, 7 weeks	To develop an ESP and test the efficacy of the programme in enhancing self-compassion in low compassionate Japanese psychology university students (n=20 intervention, n =20 control group)	Acceptability questionnaire, SCS - Japanese, RSES, BDI-2, STAI, DACS, MMS, SCES	Pre-test post-test and 3month follow up against a WLC group	Loving-kindness meditation, mindfulness training, compassionate mind training using imagery, compassionate letter writing, three-chair work, homework	increases in each subscale of self-compassion except for mindfulness, reduced negative thoughts and emotions

No	Author, Year and Country	Intervention, Design, Underpinning Model and Duration	Aim and Target Population	Measures	Comparator	Tasks	Findings
3	Guan et al. 2021 China	Self-Compassionate Mindstate Induction (SCMI) RCT, online group, based on SCMI by Neff (2020), duration not specified	To investigate online self-compassion exercises' effectiveness in alleviating negative affect in university students during the COVID-19 pandemic (n=50 intervention, n=45 control)	Demographic information, SSCS-L, PANAS-negative affect, STAI-S	Pre-test post-test against a neutral control group (AC group)	Writing task containing a series of writing prompts that aimed to induce mindfulness, common humanity, and self-kindness	Increases in self-compassion and decreases in negative affect when compared to the control condition
4	Guo, Zhang, Mu & Ye (2020) China	Mindful Self-Compassion Programme (MBSP), RCT, online study design, based on MSC, 6 weeks	To explore MBSP's effects in preventing the development of PPD in women in 2nd or 3rd trimester of pregnancy with antenatal depressive or anxiety symptoms (n=144 intervention, n = 140 control group)	MAAS, EPDS, STAI 1 and 2, BDI 2, SCS-Chinese, WBI of WHO-5, Chinese PSI, The Scales of warmth and negativity of the CPBQ, IBQ-Short Form	Pre-test (2nd/3rd trimester), post-test (3 month post-partum), one-year post-partum and control group	Six sequential steps involving different types of exercises with guided instructions were performed in a stepwise way (steps/tasks not specified)	Reduced anxiety, improved mindfulness, self-compassion, and well-being in the MBSP group
5	Huang et al. (2021) China	Self-Compassion Intervention, RCT, in person, group study design, based on MBCT, CMT, and MSC, 4 weeks	To test the effects of the self-compassion intervention on future-oriented coping and psychological distress in Chinese college students	SCS, The 16-item Future-Oriented Coping Inventory, DASS	Pre-test post-test and 1 month follow up against a WLC group	Psychoeducation, observing body sensations under stress, affectionate breathing meditation,	Improvements in self-compassion, future-oriented coping, depression, stress

No	Author, Year and Country	Intervention, Design, Underpinning Model and Duration	Aim and Target Population	Measures	Comparator	Tasks	Findings
			(n=32 intervention group, n=34 control group)			loving-kindness meditation	
6	Mak et al. (2018) Hong Kong	Self-Compassion Programme (SCP) 3-arm randomised, parallel, positive-controlled, noninferiority trial, online study, based MSC, 4 weeks	To examine the efficacy of a mobile app-based self-compassion programme in improving mental well-being and reducing distress among adults in general population (n=180 intervention group, n=160 cognitive behavioural group)	WHO's 50item WBI, The 6-item K6, MAAS, SCS (13 items only), Depressed Mood and Anxiety Subscales of the ACS, 9-item Discomfort with Ambiguity sub scale from the NCS, CSQ	Pre-test post-test, 3 month follow up against a cognitive behavioural programme: CBP (AC group)	Compassionate body scan, affectionate breathing, loving-kindness meditation, compassionate walking, self-compassion break, self-compassion journaling	Improved mental well-being and reduced psychological distress. Enhanced mindfulness awareness at post programme
7	Tung (2020) Hong Kong	Mindful Self-Compassion Programme, RCT, in person, group study design, based on MSC, 8 weeks	To increase self-compassion and reduce stress in nursing students in Hong Kong (n=33 intervention group, n=44 control group)	Chinese versions of PSS, SCS, ProQOL-5, FFMQ	Pre-test post-test, 1 month follow up against a waitlist group	Meditations (affectionate breathing, compassionate body scan, loving-kindness), informal	Reduced stress, improved self-compassion

No	Author, Year and Country	Intervention, Design, Underpinning Model and Duration	Aim and Target Population	Measures	Comparator	Tasks	Findings
						practices (soothing touch, compassionate walking, letter writing, listening), homework	
8	Wong & Mak (2016) Hong Kong	Self-Compassion Writing, Mixed research design with a RCT, online study, based on Neff (2009), Leary et al. (2007), 1 week	To examine the efficacy of self-compassion writing on post-writing mood, physical and psychological health in Hong Kong Chinese university students (n=33 intervention group, n=32 control group)	SCS (13 items only), PANAS, The 10-item CESD, The 33-item CHIPS, The 30-item TMMS	Baseline, 1 month and 3 month follow up against a control writing group (AC group)	Writing on an adverse recent event and experiences about this event using mindfulness, common humanity and self-kindness	Increased post-writing negative affect, reduced physical symptoms in intervention group.

Note. SCS – Self-Compassion Scale, HADS – Hospital Anxiety Depression Scales; FFMQ – Five Facet Mindfulness Questionnaire; CS – Compassion for others Scale; MADRS – Montgomery-Åsberg Depression Rating Scale; PSQI – Pittsburgh Sleep Quality Index; PSS – Perceived Stress Scale; RSES – Rosenberg Self-Esteem Scale; WHOQOL – World Health Organization Quality of Life; BDI – Beck's Depression Inventory; RRS – Ruminative Responses Scale; STAI - State-Trait Anxiety Inventory; MAAS – Mindfulness Attention Awareness Scale; WBI – Well-Being Inventory; CHIPS – Cohen-Hoberman Inventory of Physical Symptoms; TMMS – Trait Meta-Mood Scale; CESD – Center for Epidemiological Studies Depression Scale; FOCS – Fear of Compassion Scale; SMS – State Mindfulness Scale; DACS – Depression Anxiety Cognition Scale; MMS – Multiple Mood Scale; SCES – Self-Conscious Emotions Scale; DASS – Depression Anxiety Stress Scale; APS – R – Almost Perfect Scale – Revised; EPDS – Edinburgh Postnatal Depression Scale; WHO – World Health Organisation; PSI – Parenting Stress Index; CPBQ – Comprehensive Parenting Behaviour Questionnaire; IBQ – Infant Behaviour Questionnaire; K6 – Kessler Psychological

Distress Scale; FSCRC – Fear of Self-Criticising/Attacking and Self-Reassuring Scale; ACS – Affective Control Scale, NCS – Need for Closure Scale; NAS – Non-Attachment Scale; CSQ – The client satisfaction questionnaire; LCS – Loving-Kindness Compassion Scale; ISS – Internalised Shame Scale; SWLS – Satisfaction with Life Scale; ProQOL-5 – Professional Quality of Life Scale; PANAS – Positive And Negative Affect Scale; SHS - Subjective Happiness Scale; CAMS-R - Cognitive and Affective Mindfulness Scale; SSCS – L - State Self-compassion Scale-Long Form.

3.3.3 Compassion Outcomes

Separate analyses were conducted for studies with WLC groups and studies with AC groups respectively. Prior to that, effect sizes and heterogeneity statistics for self-compassion (SC) were tested for the two categories (Table 3.3). A random effects model was conducted for all analyses.

Table 3.3. Post intervention effects on self-compassion.

Category	Outcome	*k*	*N*	*d*	*z*	*p* for *d*	*Q*	*p* for *Q*	I^2
Studies with a WLC	SC	4	478	0.86	4.27	<0.0001	8.95	0.03	66%
Studies with an AC	SC	4	534	0.19	2.06	0.04	3.15	0.25	5%

Note. SC = self-compassion; *k* = number of samples; *N* = number of participants contributing to the outcome; *d* = standardised mean difference effect size; *z* = *z*-score; *Q* = test statistic for heterogeneity; *p* = test for significance evaluated against .05; I^2 = measure of degree of heterogeneity.

3.3.3.1 Compassion-Based Interventions Compared to Waitlist Control Groups

A significant large effect size was found for self-compassion, *d* =.86, *k* = 4, 95% CI [0.46-1.25], *p* < .0001 when comparing the intervention group with a WLC group (Figure 2). There was a significant amount of heterogeneity in effect sizes for self-compassion, $Q(3) = 8.95$, $p = .03$, $I^2 = 66\%$. The high degree of statistical heterogeneity suggests that results should be interpreted with caution (Kirby et al., 2017).

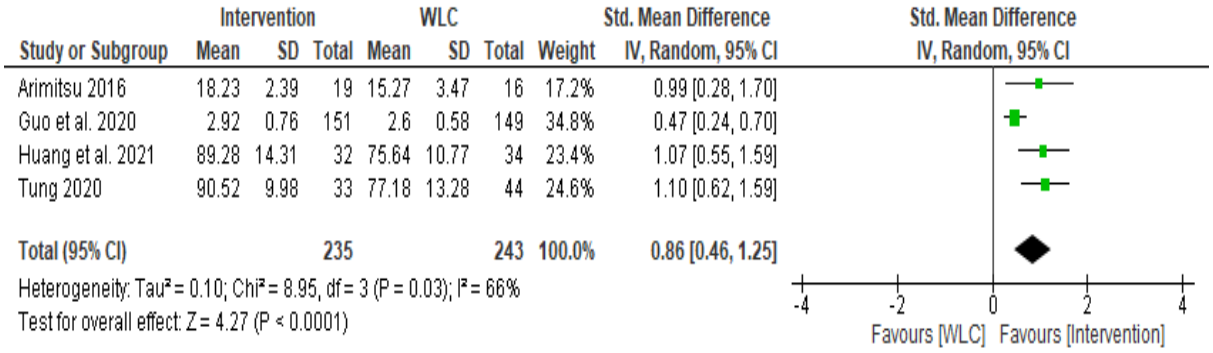

Figure 2. The effect of compassion-based interventions with wait-list control groups on self-compassion.

3.3.3.2 Compassion-Based Interventions Compared to Active Control Groups

When looking at compassion intervention groups compared with AC groups, the results indicated a significant small effect size for self-compassion, *d* =.19, *k* = 4, 95% CI [-.57-.40], *p* = .04. Heterogeneity of variance in the effect sizes for self-compassion was not significant, $Q(3) = 3.15$, $p = .37$, $I^2 = 5\%$. This means, that despite the differences in the intervention design, population and other variables, the overall variability in studies with an AC group was relatively negligible (Weiss et al., 2016). See Figure 3 for a visual representation of the effects.

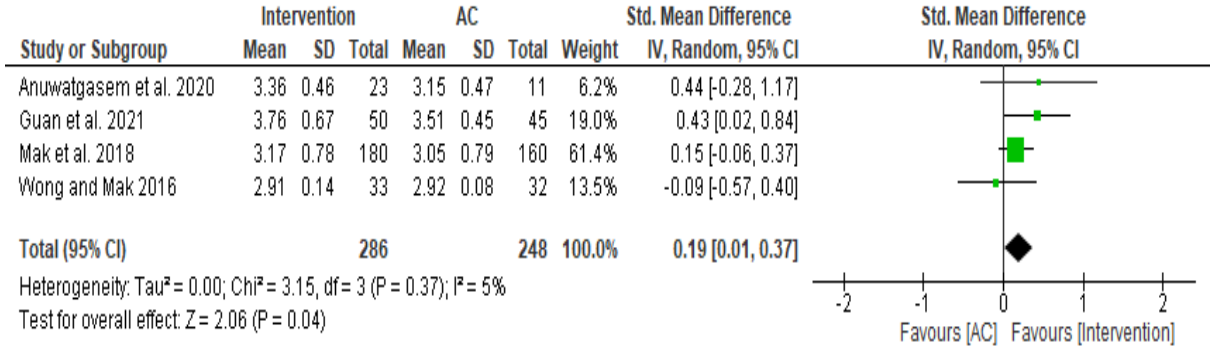

Figure 3. The effect of compassion-based interventions with active control groups on self-compassion.

3.3.4 Risk of Bias within Studies

The risk of bias evaluation is displayed in Figure 4. Overall, the summary figure of risk of bias indicated a low risk of bias across studies (as indicated in the grey area). However, several studies failed to report the method of randomisation [2, 3, 5, 8], performance bias [5, 7], and detection

bias [1, 2, 4, 6, 7]. Whilst all studies discussed the attrition rates and possible reasons for participant dropouts, they indicated a low risk of bias for reporting bias, selection bias, and other sources of bias.

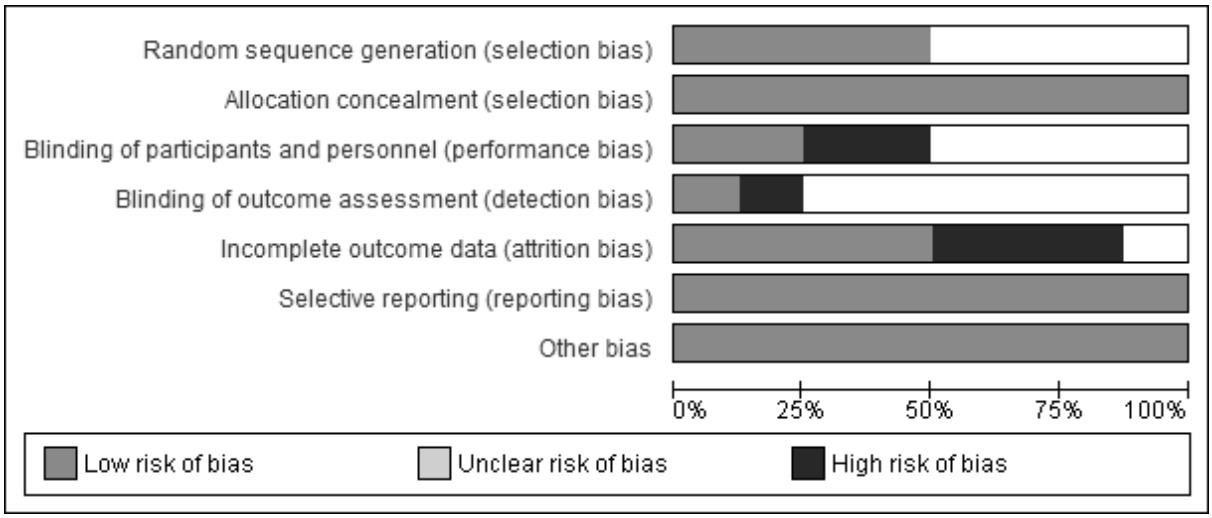

Figure 4. Risk of bias graph across studies.

3.3.5 Risk of Bias across Studies

Due to the limited number of studies included in the present meta-analysis, this study was not sufficiently powered to assess publication bias across studies (Borenstein et al., 2021).

3.4 Discussion

This is the first meta-analysis to explore the efficacy and cross-cultural applicability of compassion-based interventions in Asian populations. Incorporating eight RCT studies which gathered data from 1012 participants from Thailand, Japan, China, and Hong Kong, this study aimed to answer the question 'can compassion-based interventions increase compassion in people living in Asian communities?'.

In consideration of this, significant effect sizes were reported for increased levels of self-compassion in the intervention groups when compared to both WLC groups and AC groups. As predicted, effect sizes of studies including an AC group were lower, when compared to studies with WLC groups (Cujipers et al., 2016; Kirby et al., 2017). This implies that the AC interventions may have also increased self-compassion among participants in the AC groups to some extent

(Kirby et al., 2017). This raises the question whether the AC interventions also incorporated compassion-enhancing tasks, or whether engaging in any intervention (possibly with a well-being indicator) increases self-compassion in general. It is important to note, that although an overall significant large effect size was observed for self-compassion in studies containing WLC groups, they also indicated a significantly large variability for self-compassion, reducing the confidence in the interventions used. This implies that despite the encouraging results from the compassion-based interventions (with WLC groups), the variability across studies were considerably high (Weiss et al., 2016). In consideration of the research question, this meta-analysis evidenced promising findings that compassion-based interventions can increase self-compassion in participants from Asian communities.

Kirby et al. (2017) concluded in their review, that there is an evident lack of clarity in relation to the most appropriate measure of self-compassion. This suggestion is still apparent in this review as almost all the studies discussed in this review used the SCS to measure self-compassion, whilst some of them acknowledged the criticisms of the scale (e.g., Arimitsu, 2016; Huang et al., 2021). As the CEAS (Gilbert et al., 2017) was developed to measure all three flows of compassion (self, to/from others) whilst also addressing issues surrounding the SCS, it seems fair to propose that the CEAS may be a more appropriate measure of compassion. Indeed, recent research has used this measure in Asian countries such as Japan (Asano et al., 2020) and Sri Lanka (Kariyawasam et al., 2021; Kariyawasam et al., 2022), and emphasised on the advantages of using this measure (Asano et al., 2020). Thus, it would be useful to investigate the effectiveness of compassion-based interventions using the CEAS in Asian communities to further understand the interplay between these flows of compassion and well-being.

3.4.1 Strengths and Limitations

A strength of this meta-analysis is that it only included papers with a specific focus on compassion cultivation and excluded interventions that prioritised other elements such as

mindfulness (e.g., Mindfulness Based Stress Reduction, Mindfulness Based Cognitive Therapy). One intervention (Huang et al., 2021) however, was informed by both MSC (Neff & Gerrmer, 2013) and CMT (Gilbert, 2009b) approaches. This means that is difficult to differentiate which approach produced which outcome (e.g., whether self-compassion increased due to the mindfulness element, or the compassion element or both) when assessing the efficacy of compassion interventions based on integrated approaches (Kirby et al., 2017).

Overall, this review highlights the lack of research exploring the effectiveness of compassion-based interventions in Asian communities, as there were only four Asian countries to have conducted RCTs of compassion-based interventions so far. This was surprising given that many Asian countries such as Japan (Arimitsu, 2016) and Sri Lanka (Kariyawasam et al., 2021) are familiar with the concept of compassion due to the significant Buddhist influence in these cultures.

Whilst the rigorous inclusion criteria helped to choose studies with higher methodological quality, this was also a limitation of this meta-analysis as that lead to the exclusion of several studies that did not meet the eligibility criteria (e.g., Finlay-Jones et al., 2018, Noh & Cho, 2020; Yeung et al., 2022). Although there were a few existing compassion-based interventions in Asian communities which were able to promote compassion and self-compassion, these were not RCTs (e.g., Finlay-Jones et al., 2018), or did not include measures to assess compassion (e.g., Lo et al., 2015), and therefore, had to be excluded from this review and the analysis.

Another limitation this meta-analysis discovered was that all the studies discussed in this meta-analysis only assessed self-compassion, disregarding the other two flows, namely compassion to others, and compassion from others (Gilbert et al., 2017). Ferrari et al. (2019) also narrowed the search to self-compassion-based interventions only, when conducting their meta-analysis of compassion-based interventions. Gilbert et al. (2017) argued that compassion is not only felt for the self, but also towards and from others, whilst studies have discussed how these flows interact with one another (Rashid et al., 2021), and are linked with increased well-being (Asano et al., 2020; Gilbert et al., 2017).

In addition, findings of the studies included in this review were largely limited to non-clinical populations (e.g., Arimitsu, 2016; Guan et al., 2021; Huang et al., 2021), indicating the need for further research to be conducted among both clinical and non-clinical populations in Asian communities. Despite the common use of small underpowered sample sizes in majority of evidence-based interventions (Kirby et al., 2017), this review noted that the papers generally included a small sample size, which limits the generalisability of the findings (Huang et al., 2021). The limited number of RCTs also meant that a funnel-plot was not suitable to assess the risk of publication bias (Higgins et al., 2011) leaving the risk of publication bias undetermined.

Similar to Kirby et al. (2017), this meta-analysis did not include studies that assessed compassion using heart rate variability and other bodily measures. Incorporation of these measures would have increased the researchers' understanding of the effectiveness of the interventions (Luo et al., 2018; Tian et al., 2020) at a physiological level. Furthermore, the RCTs discussed in this meta-analysis included a range of self-reported measures of depression, anxiety, psychological distress, and well-being questionnaires, which may be particularly problematic due to the stigma of mental illness in Asian cultures as people might respond with a social desirability bias (Wong & Mak, 2016). Therefore, it seems fair to propose that future research should focus on using physiological measures (Finlay-Jones et al., 2018) in addition to self-report measures to help build a comprehensive understanding of the efficacy of compassion-based approaches.

Another limitation was that the secondary gain relating to well-being or distress was not tested in this analysis, as the primary aim was to focus on understanding the impact of compassion-based interventions on increasing compassion in Asian communities. However, in addition to increased self-compassion, there is clear evidence to suggest that the compassion-based interventions also increase well-being and reduce distress in Asian communities. In fact, studies included in this meta-analysis reported significant increases in mindfulness (Mak et al., 2018), coping (Huang et al., 2021), and quality of life (Anuwatgasem et al., 2020), and significant decreases in depression, anxiety, and stress (Anuwatgasem et al., 2020; Guan et al., 2021; Guo et al., 2020; Huang et al., 2021). Now that this review has found promising evidence for the increase

in self-compassion using these interventions, future research would benefit from exploring the implications for well-being and reduced distress and psychopathology.

Additionally, this meta-analysis comprised studies that varied in multiple components such as the intervention duration, content, and targeted population. Thus, prospective interventions should investigate the contents and structure of compassion-based interventions, to determine the most suitable intervention for their targeted populations.

3.4.2 Clinical Implications

This review found potentially positive effects on self-compassion when using compassion-based interventions in Asian communities. Both online (e.g., Mak et al., 2018; Wong & Mak, 2016) and in-person approaches (e.g., Huang et al., 2021; Tung, 2020) were found to be effective in increasing self-compassion. Given that many people from Asian backgrounds do not seek help for their mental well-being due to high shame and criticism, stigma, and other help-seeking barriers in their societies (Mak et al., 2019), it seems fair to propose that online interventions (e.g., Self-Compassion App: Beaumont & Irons, 2021) maybe more appropriate for people in Asian communities. This would also reduce the need and cost of training clinicians to deliver compassion-based approaches in cultures where there is high levels of poverty and limited funding for mental health clinics. Online approaches are found to be more interactive, cost-effective, quick, scalable, and convenient (Chi, 2013; Mak et al., 2018). In addition, with the rapid increase of mental health complications due to the recent COVID-19 pandemic (Pfefferbaum & North, 2020), and with the new working from home environment, online interventions for facilitating well-being would be particularly convenient, timely and effective. Thus, the applicability and efficacy of online compassion-based compassion approaches are avenues of future research.

3.4.3 Conclusion

This meta-analysis explored the efficacy of compassion-based interventions in Asian populations to increase levels of compassion. The results suggested that compassion interventions increased self-compassion in clinical and non-clinical samples, providing evidence for the trans-diagnostic (Anuwatgasem et al., 2020) and cross-cultural application of these approaches (Tung, 2020). Self-compassion increased with significant effect sizes, in studies with WLC groups when compared to studies with AC groups, indicating that active-control conditions may have also increased self-compassion. Prospective studies are encouraged to develop interventions followed by a series of carefully selected measures and assess physiological changes to expect outcomes that are more informed. Although there were several limitations including the limited number of studies, limited sample sizes, and the exclusion of abstracts and protocols, this meta-analysis encourages the use of compassion-based interventions, in favour of online interventions to promote compassion and well-being in Asian communities.

Chapter 4 Views and Experiences of Compassion in Sri Lankan Students: An Exploratory Qualitative Study

Abstract

Practicing compassion has shown to reduce distress and increase emotional well-being in clinical and non-clinical populations. The existing research is primarily focused on Western populations although the concepts of compassion are heavily influenced by Asian Buddhist views. There is a dearth of compassion research conducted particularly in the Asian context. Therefore, this study explored the views and lived experiences of compassion in Sri Lankan students, from a collectivistic Asian community. The purpose of this study was to understand whether compassion is a socially embraced construct in Sri Lanka. Participants' views and lived experiences of compassion towards themselves and to/from others were investigated, with a specific focus on their perceived inhibitors and facilitators of compassion. Aims were set to identify whether this study could inform the cross-cultural applicability of Western compassion-based practices to Asian societies such as Sri Lanka. An Interpretative Phenomenological Analysis approach was used to obtain and analyse qualitative data from a convenience sample of ten Sri Lankan undergraduate students. The phenomenological analysis of the semi-structured face-to-face interviews elicited three predominant themes: *What compassion means to me, what I make of it,* and *compassion through facilitators and inhibitors.* The findings suggest that participants shared a similar understanding of the concept of compassion as reflected in the Western definitions. Experiences and views of compassion were shaped by several factors including religion, culture, society, and upbringing. In general, this study revealed that participants were well aware of the concept of compassion and its impact on their psychological well-being. Despite this, inhibitors existed in experiencing compassion. The religious and collectivistic-cultural influences need to be further explored and considered when implementing Western compassion-based practices to non-Western contexts such as Sri Lanka.

Keywords: compassion, Sri Lankan, qualitative, IPA, facilitators, inhibitors

4.1 Background

Compassion is defined as "a sensitivity to suffering in the self and others, with a commitment to try to alleviate and prevent it" (Gilbert & Choden, 2013, p.94). The term compassion has been discussed for its healing properties for centuries (Gilbert, 2018), with ancient Latin literature, Buddhist philosophy, and Western psychology, all identifying it as a concept related to alleviating suffering (Jazaieri et al., 2012). It is also advocated in other religions such as Islam, Hinduism, Christianity, Judaism, and Jainism (Vivino et al., 2009). However, compassion is considered as a key component of Buddhist philosophy and has been actively discussed and practiced in Eastern traditions for many centuries (Welwood, 1999). From a Buddhist perspective, compassion is viewed as an openness to the suffering of others, with a commitment to relieve it (Dalai Lama, 1995).

For over two thousand years, Buddhist philosophy has emphasised the impact of compassion on dealing with suffering, and facilitating happiness and well-being (Watts, 2012). Western psychology has also been influenced by Buddhist philosophy and implications for psychotherapy for many decades (Kelly, 2008). Indeed, Buddhist practices have been successfully incorporated into positive psychology (Cassaniti, 2014) and the third wave of cognitive behavioural approaches (De Zoysa, 2013), such as Mindfulness-Based Cognitive Therapy (MBCT: Segal et al., 2002a), Dialectical Behavioural Therapy (DBT; Dimeff & Linehan, 2001), and Acceptance and Commitment Therapy (ACT; Hayes et al., 2003). Dalai Lama (Lama & Vreeland, 2008) emphasised that happiness is the purpose of life for Buddhists and non-Buddhists, and encouraged contemplative practices of positive psychology, such as mindfulness and compassion for increased happiness and well-being. More recently, within the last two or three decades, Western Psychology has shown a significant interest in the concept of compassion and developed compassion-based practices such as Compassion Focused Therapy (CFT: Gilbert, 2009a, 2010b), into psychotherapy.

While compassion is generally understood as a positive emotion (Bstan-Tdzin-rgya-mtsho & Jinpa, 1995), evidence suggests that the experience of compassion can sometimes feel

unpleasant (Kelly, 2008; Watts, 2012). This nuance is explained by the fact that the conceptualisation of compassion is found to arouse a pleasant feeling (Cassaniti, 2014), whilst the experience of compassion, following exposure to another's suffering could feel unpleasant (Kelly, 2008). Therefore, people's subjective views and experiences of compassion are largely taken into account by Western psychologists to understand the different emotional reactions caused from compassion (Kelly, 2008).

4.1.1 Theory and practice of compassion

Gilbert, a pioneer of Western compassion research, developed CFT as an integrative, multidisciplinary, and process-based approach, underpinned by Buddhist views and several schools of psychotherapy (Gilbert, 2010b, 2018; Gilbert & Procter, 2006). CFT was developed to help people with high levels of shame and self-criticism, who were struggling to derive benefits from standard therapeutic interventions. People with pathogenic levels of shame and self-criticism typically come from insecure, negligent, or traumatic backgrounds, and often fear seeking compassion and affiliation. This "fear of compassion" is found to be one of the biggest inhibitors to practising compassion towards the self and others (Gilbert, 2018). CFT attempts to suppress these inhibitors, and develop compassion across three directional flows, namely, compassion *to others*, compassion *from others*, and compassion *to the self* (*self-compassion*).

Western studies integrating CFT, and other compassion-based practices have reported psychological benefits, with evident decreases in depression, anxiety, self-harm, and several other psychological presentations (Barnard & Curry, 2011; Bluth & Blanton, 2014; Brown et al., 2014). These practices have also shown a cross-cultural effect in improving well-being in Eastern Buddhist societies such as Japan (Asano et al., 2020), Western non-Buddhist communities (Neff et al., 2008a), as well as in Middle Eastern and Muslim societies (Ghorbani et al., 2012).

4.1.2 Cultural influence

One's cultural background plays a vital role in shaping compassion, and these cultural

dimensions influence their tendency to show compassion for the self and others (Gilbert, 2014). Research has explored how self-compassion manifests across different cultures. For example, an individual's functioning, including the extent to which they can develop self-compassion, is congruent with the cultural and societal values they share with their community (Montero-Marin et al., 2018). Furthermore, Birkett (2013) attributed differences between the levels of compassion, to the beliefs and religious practices affiliated to each country, rather than a simple East-West cultural contrast. To date, most compassion studies have been limited to Western countries (Monter-Martin et al., 2018; Sinclair et al., 2016 a,b) and even where studies exploring compassion have made cultural comparisons, this has been limited to a few countries (Neff et al., 2008). This signifies the need for more diverse cross-cultural research.

As most compassion practices stem from Buddhist philosophy (Brown, 1999), and Buddhism is mainly practised in Asian traditions, one would expect Asian Buddhist followers to exhibit higher levels of compassion. Furthermore, it appears fair to expect people in Asian collectivistic countries where people's decisions are very much influenced by others in their society, to be more compassionate due to high levels of social interconnectedness, caring, and social conformity shared between one another (Neff et al., 2008). However, studies have found the opposite result, with people in Asian interdependent societies such as Japan (where Buddhism is practised as a main religion), having higher levels of self-criticism than people in the Western world (Kitayama & Markus, 2000). In consideration of these findings, Kitayama and Uchida (2005) suggested that self-criticism is often prevalent in emotionally interdependent and densely knit Asian societies. Therefore, levels of self-compassion could be expected to be lower among those in Asian cultures, as self-criticism is a key inhibitor of self-compassion (Neff et al., 2008). Social pressure to conform with social norms and values might then hinder one's self-compassion. Thus, it is important to take cultural and religious backgrounds, as well as one's upbringing, into account when understanding the interplay of factors that may impact upon compassion (Neff et al., 2008).

Sri Lanka is a South Asian multi-ethnic country, where Buddhist philosophy is practised by 69% of the population (de Zoysa, 2011, 2013). Although the Sri Lankan community is heavily

influenced by the teaching of Buddha, the incorporation of Buddhist philosophy into psychotherapy and education remains unexploited (de Zoysa, 2011, 2013) and are yet to be incorporated into the academic curricular of psychological teachings in Sri Lanka (Vithanapathirana, 2013). Applying Buddhist practices such as mindfulness and compassion into psychotherapy is also problematic in Sri Lanka, as the lack of knowledge in integrating Buddhist influenced psychotherapy has restricted mental health professionals from accepting such therapeutic methods. This is mainly due to the social view of meditation and Buddhist practices as spiritual practice rather than a psychotherapeutic approach (de Zoysa, 2013).

4.1.3 Rationale for the present study

With Sri Lanka being a largely Buddhist influenced, collectivistic and interdependent society where social dominance, comparison, and criticism influences one's identity and behaviour (Pathirana, 2016), it seems fair to propose that implementing compassion-based practices may enhance the well-being of Sri Lankan people. However, while compassion interventions conducted in Asia appear to be minimum, to date, there has been no published research exploring compassion in Sri Lanka from a psychological view, let alone implementing compassion-based practices.

This study, therefore, aimed to explore the views and lived experiences of compassion in Sri Lankan students using the three flows of compassion: self-compassion, compassion to others, and compassion from others, with a particular emphasis on their perceived inhibitors and facilitators.

4.2 Method

4.2.1 Design and participants

The scientific account of compassion greatly depends on the understanding of individuals' subjective experiences (Condon & Feldman Barrett, 2013). Thus, a qualitative approach was determined suitable to understand participants' subjective experiences of compassion in the

present study. Although it is critical to conduct qualitative studies to fully understand the challenges that mental health problems pose to experiencing compassion and to uncover potential inhibitors that wider cultural discourses create, qualitative research exploring compassion among community populations remain at an infancy stage (Campion & Glover, 2017). Therefore, this study used a qualitative design to gain a realistic and detailed personal account into how Sri Lankan students view and make sense of their experiences with compassion. As IPA provides rich and insightful data, Tindall (2009) recommended that four to ten participants are sufficient for a professional study. They also emphasised on the importance of adapting an in-depth semi-structured interview approach as the most suitable method to elicit meaningful qualitative data.

Therefore, ten Sri Lankan participants (3 males, 7 females), aged between 19 – 46 years (M = 26.1, SD = 8.0) were recruited on a first come first serve basis. Participants' religious faith varied from Buddhism (n =3), Catholicism (n = 1), Christianity (n = 2), Hinduism (n = 1), Islam (n = 2), and Atheism (n = 1). They were recruited from an undergraduate psychology course in Sri Lanka and participants declared that they had not learnt about compassion in their course.

4.2.2 Interview structure

A semi-structured interview guide was created aiming to understand participants' views of the concepts of compassion and their experiences of self-compassion, compassion to and from others. Questions also sought to understand participants' interpretations of the motives behind a person offering and receiving compassion, and the facilitators and inhibitors that participants encountered in doing so. In addition to the structured interview questions, probing questions were asked when necessary. See Table 4.1 for a list of questions asked.

Table 4.1. Interview Questions.

1. Can you tell me what the term compassion means to you?
2. Can you talk about your understanding of self-compassion?
3. I would like you to think about one or two occasions when a loved one was going through a tough time or difficult situation. (this could be a family member or a close friend) Can you tell me if you showed compassion towards them? Could you tell me why (or why not)? Can you tell me the things that you did or said to them? What were your feelings and thoughts towards them? And then afterwards…. How did your words and actions affect them? How about you? Was there an impact on you? How did it make you feel? Were there any consequences for you and your life? If the same thing happened again, would you do and say the same things? If so, why/if not, why not? Are there any factors that facilitate or help you to be compassionate towards others? Are there any barriers that make it difficult to be compassionate towards others? *Repeat for compassion from others and self-compassion accordingly*.

4.2.3 Procedure

This study was approved by the Ethics committee of the University of Southampton. Participants' informed consent to partake and the interviews to be audio recorded was obtained prior to starting the study. All names reported in the results section are pseudonyms used to protect participants' identity. Pilot interviews were conducted with two participants from the sample, in order to check the feasibility of the interview guide and to observe whether the

questions sampled the areas of interest. As the pilot did not show the need to change the questions, interview guide was not refined, and the pilot data were added to the final analysis. Interviews lasted around 20-30 minutes on average.

4.2.4 Data analysis

All audio-recorded interviews were manually transcribed verbatim, and subjected to Interpretative Phenomenological Analysis (IPA: Smith, 1996; Tindall, 2009). IPA is a reflexive, transparent approach, which provides a thorough understanding of individual accounts with meaningful interpretations of their relationships to the world and others. The inductive nature of IPA, which is not based on predetermined hypotheses, facilitated the emergence of unpredicted themes (Smith, 1996). Reid and colleagues (2005) emphasised the importance of using IPA in areas that significantly lack previous literature. As the authors were not aware of any psychological research conducted on compassion in Sri Lanka, IPA was considered an appropriate method.

Analysis involved reading the transcripts multiple times to allow the primary researcher to familiarise with the interview content and fully immerse in the narrative. Each transcript contained two wide margins, with the significant meanings written on the left-hand margin and emerging themes on the right-hand margin. Next, the descriptive, linguistic, and conceptual comments for quotes were made throughout the transcripts to elicit the themes. Preliminary themes were then developed, amended, and refined. Each theme was summarised and allocated a participant number with an identifiable verbatim quote. In order to confirm the validity of the interpretations, themes were analysed with recurrent reference to the original text and where appropriate, these themes were clustered together based on relevance to originate the superordinate and subordinate themes. This process was repeated until all the superordinate themes and subordinate themes were developed.

4.3 Results

The IPA elicited three superordinate themes (*What compassion means to me, what I make of it,* and *compassion through facilitators and inhibitors)* and nine subordinate themes. The first superordinate theme discusses how participants viewed compassion and self-compassion (*sympathetic consideration towards suffering)* and differentiated the experience of compassion with others versus the self *(self and others: it is not the same)*. The second superordinate theme discusses participants' overall experience of compassion across the three flows, with their perception of the motives behind the compassion received and offered. Subthemes varied based on positive experiences (*positive vibes and genuine motivation)*, negative experiences (*obligations and exhaustion)*, and reluctance to disclose the need for compassion *(disclosure: nobody should feel bad about my life)*. The final superordinate theme captures the facilitators *('god is good': religion in shaping compassion, being there for one another)* and inhibitors *(compassion is conditional, society as an inhibitor)* that shaped participants' experiences of compassion. Themes and subthemes will be discussed in turn and can be found in Table 4.2.

Table 4.2. Superordinate Themes and Subordinate Themes.

Superordinate Theme	**Subordinate Theme**
What compassion means to me	*Sympathetic consideration towards suffering* *Self and others: It is not the same*
What I make of it	*Positive vibes and genuine motivation* *Obligations and exhaustion* *Disclosure: Nobody should feel bad about my life*
Compassion through facilitators and inhibitors	*'God is good': Religion in shaping compassion* *Being there for one another* *Compassion is conditional* *Society as an inhibitor*

4.3.1 Superordinate theme: what compassion means to me

Participants discussed their understanding about compassion and what it meant to them. Compassion was needed the most in tough times and participants viewed it as an innate ability to express a sympathetic consideration towards one's suffering. However, many participants found it easier to show compassion to others than towards themselves. Some participants also found accepting compassion from others challenging. This superordinate theme elicited two subordinate themes: *sympathetic consideration towards suffering,* and *self and others: it is not the same.*

4.3.1.1 Subordinate theme: sympathetic consideration towards suffering

This theme discusses how participants viewed and defined compassion and self-compassion. Most participants conceptualised giving compassion to others, when describing what compassion is. However, they recognised that the term self-compassion refers to the compassion that is given to the self. All participants had a similar view of what compassion is and explained

that compassion meant being actively engaged in one's life by showing a level of understanding, kindness and love, particularly in tough times.

"It's being kind to people, being understanding, kind of understanding what they are going through and feeling sympathetic about their situation". (Angelo, aged thirty-two years).

Mathew believed that having a sympathetic consideration was not enough and that one should make an effort to go out of their way to relieve the suffering of another.

"My family and I, we always tell it to put ourselves in other people's shoes and even if we have to go out of our way to help them, that's what compassion is to me". (Mathew, aged twenty-six years).

Many participants discussed self-compassion as the love for oneself and taking care of the self with kindness and the understanding that problems are a shared human experience. Hafsa described the process of generating self-compassion as firstly, identifying who you are, and what you want with life, and then acting on that self-reflection to create a stronger version of herself, amidst suffering.

"Me being compassionate to myself is me being understanding in my own self, when I'm in a really bad situation, trying to bring myself up through worse, it's like talking to a mirror. I want to keep myself strong, keep myself happy, I know what I want". (Hafsa, aged twenty-one years).

Self-compassion was also seen as a process, which takes time and effort to attain.

"My understanding is it is a process. It is basically a goal that needs to be reached through a process where you are able to show love and care towards yourself. But it doesn't happen overnight. And you need to work towards it and be aware of what your needs are who you are to be compassionate towards yourself". (Radhi, aged twenty-four years).

4.3.1.2 Subordinate Theme: self and others: It is not the same

Although all participants acknowledged the benefits of self-compassion, most of them struggled to experience it. Even though they showed compassion to others, they seemed judgemental and particularly harsh towards themselves when they were going through a difficult time themselves. When questioned about this disparity between offering compassion to others and oneself, participants explained that the experience of self-compassion was not the same as showing compassion to someone else, or even receiving compassion from another person.

> *"Helping another person comes easier to me than helping myself because you feel a lot of sympathy when you see something bad happening to someone else. That same level of sympathy is very difficult to have towards yourself when you are in a difficult situation. You tend to be more critical and feel a lot of guilt. Your personal judgements about the way you acted in that situation and the guilt you have and the part that you have landed yourself in prevents you from sympathising towards yourself. That makes it difficult for you to help yourself because you are not putting yourself in the victim shoes. So, you are seeing yourself responsible, you don't really feel like you deserve the help. It is difficult to feel bad about yourself and try to help yourself".* (Angelo, aged thirty-two years).

Radhi added that people set themselves high expectations and when these are not achieved, they beat themselves with a sense of harsh self-criticism and judgement.

> *"I think we always put ourselves in a box where we are so protected and guarded but then we want each and every one of our efforts to be impressed or acknowledged or recognised. We do not give that space to ourselves as much as we do for others. I think we are harsh on ourselves and judge ourselves harder than we judge others".* (Radhi, aged twenty-four years).

4.3.2 Superordinate Theme: What I make of it

This superordinate theme discusses participants' overall experience of engaging in the three flows of compassion. To many, this was a healing and positive experience, which motivated them to continue seeking and offering compassion, whereas for others, the experience was rather

negative. Experience was mostly positive when participants viewed the compassion received and given as genuine, whereas the compassion perceived as fake or obligatory was experienced negatively, causing exhaustion.

4.3.2.1 Subordinate theme: positive vibes and genuine motivation

All participants recollected memories where they showed compassion to someone they cared about and memories where they received compassion from a loved one. While participants found it easier to engage compassionately with people they knew well, the overall experience was positive when they offered compassion because they genuinely wanted to alleviate the suffering of the other, as well as when they received compassion from someone who genuinely wanted to help.

> *"At the end of the day, I knew that if I did not have them in my life, I would not have thought of this solution and my situation would have been much worse".* (Angelo, aged thirty-two years).

> *"Their actions, words helped me a lot. My sadness and tension reduced. I could be the happy girl they wanted me to be. It didn't take so many days for me to recover".* (Ashini, aged twenty years).

While most participants felt positively about receiving compassion from others, they believed that the feeling was mutual to those who showed them compassion.

> *"I'm sure they felt good about themselves too. They've been through similar issues. More than helping me, they were honestly doing themselves a favour".* (Sonali, aged twenty-five years).

In addition to feeling good about receiving compassion from others, many participants found the experience of offering compassion to others rewarding and self-satisfying.

"I feel whenever I become compassionate to someone, I feel like this vibe going out of me. I feel good when I show love to someone, it's a self-satisfying thing for me". (Ashini, aged twenty years).

4.3.2.2 Subordinate theme: Obligations and exhaustion

It was striking that although most participants believed that they genuinely expressed compassion to others, they questioned how genuine others were, when offering compassion. While some of them viewed compassion they received as genuine, others perceived it as an obligation or an artificial expression of care. When compassion offered/received was perceived as fake or obligatory, the overall experience of the compassionate engagement was felt exhaustive and negative.

"That's a fake thing. I feel that. They say oh just ignore that, you're a good person, don't be too emotional, when we're in a situation you're the one who help us, they say so. But I think it's because I help them, not because they want me to be happy". (Heshan, aged twenty-seven years).

Nelu explained that offering compassion is not always an easy or pleasant experience, and that when it had to be done out of obligatory reasons, she felt exhausted and tried to distance herself from others in order to avoid giving compassion to others.

"Sometimes it's actually being a little distancing as well because they keep coming back to me and with my work, I feel distracting. To tell the truth, I have been irritated". (Nelu, aged forty-six years).

Sonali too had a very different, yet an excruciatingly painful experience from having shown compassion to others. This was because she was too emotionally involved in the other person's suffering to a point that it became detrimental to her own well-being.

"I was very emotionally down. It's a memory that I will never be able to erase from my mind because it's not me who went through it, it's that particular person, but I felt really depressed, down and I didn't have an appetite for a couple of days. I felt really helpless and I honestly felt that there was no purpose of living". (Sonali, aged twenty-five years).

4.3.2.3 Subordinate theme: disclosure: nobody should feel bad about my life

Whether the overall experience of receiving compassion was negative or positive, all participants found comfort in knowing that they received compassion from others and that they were not alone in their suffering. However, some of them were reluctant to seek compassion and disclose their problems to others, which eventually inhibited them from receiving compassion from others.

> *"I don't show that I am down. I've always been down in a way, but I don't want others to feel down because of me. I never want to add to anyone's problems".* (Fatima, aged nineteen years).

To Mathew, because of his previous negative experiences of seeking compassion from others, suffering alone was easier than disclosing his struggles or putting his parents through pain.

> *"Depression and overweight don't help. I'm not the one to show it. For me to even tell my mom that I was going through depression was huge. I don't tell anyone".* (Mathew, aged twenty-six years).

4.3.3 Superordinate theme: compassion through facilitators and inhibitors

Participants also discussed what factors they believed facilitated their experiences of compassion and the factors that inhibited it. Most participants signified the importance of their religion and culture in shaping compassion. Some of them however, elucidated how one's religion and culture could restrict their compassion only to those who belong to the same religion and culture, and could act as an inhibitor towards showing compassion to others who belong to out-groups. On the other hand, all participants indicated society and the stigma surrounding certain social constructs and norms as their biggest inhibitor to compassion.

4.3.3.1 Subordinate theme: 'god is good': religion in shaping compassion

Participants of this study were from various religious backgrounds. Despite this variety, most of them discussed the role their religion played in shaping their compassion.

"So, in my religion which is Christianity, we are always taught that we should show compassion to others, and it is something that you grow with. It is not something you should do, but something you should get from within you". (Ashini, aged twenty years).

Fatima recalled how God protected and prevented her from pleading help from others.

"Whenever I ask my God for something, he has created me not to go and beg or cry for someone. He is there with me, so why do I need other people in my life?" (Fatima, aged nineteen years).

Nelu, a Buddhist follower explained how she incorporated mindful meditation into practicing compassion.

"I learned about compassion through meditation. I've been doing this Buddhist meditation for the past 10 years. It gives you a deep understanding of the things in mind and matter. So, you're able to analyse and understand things that, it's happening because of this and what needs to be changed, and if it cannot be changed, you have to just accept it. Most of the time it's all about accepting, accepting the present moment and living in the present moment, going step by step and going with the flow". (Nelu, aged forty-six years).

4.3.3.2 Subordinate theme: being there for one another

Participants also discussed how the collectivistic social dynamic in Sri Lanka, reminds them that they are not alone in their suffering. Angelo viewed the Sri Lankan culture as a close-knit entity, which postulates that for the society to move forward as one, people need to show love and kindness to one another.

"Culture says that for our society to survive, to come to a better place, we need to be there for each other. Our culture is a communal one where people tend to look into other peoples' worries and difficulties, and stick to like family. And even the extended families and friends and relations and everyone are closely tight together". (Angelo, aged thirty-two years).

Nelu emphasised how being brought up in a cultural and religious background shaped her to become the compassionate person that she is.

"I have values. When I'm compassionate towards others, I use them properly and also being in a very religious, we are from a family very helpful, religious and cultural background, so I think those things also mattered in who I am". (Nelu, aged forty-six years).

4.3.3.3 Subordinate theme: compassion is conditional

This theme stands out from the rest as it describes a completely different aspect of how culture and religion could affect compassion. Some participants pointed out how the elements that others described as facilitators of compassion, could at the same time act as inhibitors towards the emergence of compassion when seen from a bigger picture.

"If I talk about the culture that I am living in, people are compassionate, but if you start comparing this culture and another culture, it's definitely different. They are only compassionate towards people who share their same beliefs and who are in their same belief system. But when that changes a little bit, you are either from a different religion, or different racial background or different educational or socio-economical background, that compassion changes. So obviously this compassion is very conditional towards the person's background. That's how I see culture has influenced this society. Therefore, having been religious before, has actually taught me how I can be compassionate even without religion or the teachings of a religion". (Radhi, aged twenty-four years).

Mathew, who spent his childhood in Australia, further supported Radhi's allegation. Mathew described how upon return to Sri Lanka, the way he was treated made him feel like an outsider, and how this experience affected him negatively.

"Coming from a country (Australia) where decency and manners are the most important and coming to a country like this (Sri Lanka) where people don't even realise it's missing, I felt helpless. I said I felt like a foreigner in the country I was born. I feel like that now.

Nobody understands unless you have been through the same thing". (Mathew, aged twenty-six years).

4.3.3.4 Subordinate theme: society as an inhibitor

Participants' experiences of being judged or criticised by the society for offering compassion to others, led them to fearing or being discouraged to genuinely show others compassion. Heshan attributed social judgements to the "tradition", as he emphasised that people become narrow minded by being stuck within this outdated framework. Heshan's statement tallies with what Radhi and Mathew described earlier as compassion being conditional from one entity such as tradition to another.

"In Sri Lanka, when I try to help a girl, people see it as a different thing. My parents too. There are so many friends who come to me when they need help, mostly girls. My parents sometimes misunderstand that I have many girlfriends. But that's not true. I want to help them. And if we consider about other people, I mean the society, they see it as a real different thing. Because they are in a frame called tradition". (Heshan, aged twenty-seven years).

Showing compassion to others resulted in Fatima losing her own support system. She was even condemned by other people when she was treating her own self with compassion.

"People call me overconfident when I'm self-compassionate. That affected me. When I helped my friend, they were like you're not the godmother to go and explain people and make them understand, why do you have to worry about them? Many people blame me for supporting her. Many people ignored me, my best friend totally ignored me, she's not even talking to me and that affected me a lot and still it does". (Fatima, aged nineteen years).

Fatima was not alone in feeling discouraged to give herself compassion due to social judgements. In addition to being discouraged to show compassion to others, Radhi too found it difficult to be self-compassionate when people judged her. She stressed how she internalised other people's negative attributes.

"When others are mean or judgemental to you it's difficult for you to be compassionate towards yourself. You take other peoples' views into account of how you should treat yourself. When somebody is mean to you when you're sad, you start thinking ok maybe it's my fault, maybe what I did was so wrong that I cannot forgive myself". (Radhi, aged twenty-four years).

The discussions implied that participants believed lack of awareness fuelled narrower views and social judgements. For instance, participants emphasised that people were more judgemental when their knowledge of mental illness was limited. Mathew described how disclosing his struggles with depression to his mother further disappointed him. However, it was intriguing that instead of feeling frustrated, Mathew expressed a great sense of compassion towards his mother.

"I fell into this depression where I felt like a rain cloud was following me everywhere. I told my mom I'm feeling like this. But they are old school, born in the 50's in an era when people told to just get over it. So, I told her this is what I was going through and she said why don't you just get over it. I know your normal reaction is angry. I understood, I understand if I grew up in that era. Life is easier for us these days, they had to go through a lot and they just got over it, they had to". (Mathew, aged twenty-six years).

Similar to this experience, Sonali explained that her father was not being understanding of her struggles with mental health. Again, however, she too expressed a sense of understanding towards her father's reaction, as she felt that the Sri Lankan society in general lacked understanding of mental health problems and people just do not know how to help.

"I was feeling very down to a point that I felt no purpose of living anymore. If my father was understanding, I would have overcome way easier. I don't blame him. He's not a compassionate person. But because of the way this society is, people of his generation don't understand these struggles. In Sri Lanka, people don't really know much about mental health. They just think people with depression are weak and don't know how to help.

Instead, they just hide mental illnesses to just avoid judgements". (Sonali, aged twenty-five years).

Insecure relationships and lack of reassurance from parents also inhibited participants' experiences of compassion.

"My father is not a compassionate person I would say. So, when I talk about my father that brings up you know my whole history from the time I remember up to now". (Sonali, aged twenty-five years).

"I barely appreciate myself. Because even if I do something great, my parents don't appreciate me. So now, I don't appreciate anything. I have difficult parents who worry about what others think, so they got me engaged to a guy who I don't know". (Fatima, aged nineteen years).

These comments greatly imply that society and significant others have a major impact on participants' compassionate engagement. These will be further discussed in relation to existing literature in the discussion section.

4.4 Discussion

This study aimed to explore and understand Sri Lankan undergraduate students' views and lived experiences of the concept of compassion within the three flows: self-compassion, compassion to others, and compassion from others. The objective was also to understand perceived facilitators and inhibitors that Sri Lankan students encounter when expressing and experiencing compassion, to inform prospective compassion-based intervention development. Findings will be discussed in relation to their corresponding themes.

4.4.1 What compassion means to me

Compassion is known as a sensitivity to suffering in oneself and others, with a motivation to alleviate and prevent it (Gilbert, 2014). Gilbert (2005, 2010b) outlined some key competencies involved in compassion, including the motivation to care, tolerance of negative emotions, sympathetic concerns, and non-judgemental and empathetic understanding. Although

participants had not previously learnt about compassion in their psychology course, all participants shared a similar view to Western definitions whilst actively recalling memories of previous compassionate engagements. Their recalled experiences with compassion implied that they were well aware of its impact on increasing well-being and reducing suffering. Participants described compassion as not just being sensitive towards suffering, but also having the motivation to relieve that suffering. When asked to describe their understanding of compassion as a construct, they shared a similar understanding to Western explanations, and expressed genuine sympathetic considerations towards people's problems, motivation to alleviate suffering, and kind and loving feelings as attributes of compassion (Gilbert, 2014). Compassion is viewed as stepping out of one's typical frame of position and perceiving the world from a standpoint of another (Goetz et al., 2010). In support, many participants identified the act of showing compassion as a process that requires not only sympathetic considerations towards suffering, but also a conscious effort to achieve.

Participants then described self-compassion as compassion given towards the self. Their views of self-compassion were in line with that of Neff (2003a), who defined self-compassion as being kind and non-judgmental towards oneself and their own suffering or failure, while intending to alleviate that suffering rather than being harsh towards the self or avoidant of that suffering. Overall, it appeared that despite the absolute lack of compassion research conducted in Sri Lanka, interviews of the present study indicated that Sri Lankan students would possibly benefit from compassion-based practices as they shared a good knowledge of compassion as a construct and of its benefits in increasing their psychological well-being.

4.4.2 What I make of it?

Despite being fully aware of the concept and its benefits, most participants however reported feeling as if they struggled to develop self-compassion although they found it easier to give compassion to others. To many, "guilt" obstructed self-compassion and incited self-blame and criticism instead. Although many psychological models emphasise that humans are primarily

guided on self-interest (Miller, 1999), studies signify that people are more likely to use harsh language towards themselves rather than to a loved one, or even a stranger in that regard (Neff, 2003a; Robinson et al., 2016). Participants' statements such as "*I'm wasting my life"* (Mathew), and *"I was ugly and fat"* (Fatima) further confirmed this. Furthermore, studies emphasise that some people who are extremely compassionate to others have a tendency to be harsh towards themselves even when things are out of their control (Neff, 2003a). People generally have a different way of viewing others when compared to how they view themselves (Brown et al., 2014) and become self-critical when they fail to achieve what they want, self-inflicting pain (Neff, 2012). On the other hand, studies have found that females have slightly lower self-compassion and higher compassion to others than men (Yarnell et al., 2018), due to females' natural propensity towards nurturing and compassionate care than men (Neff & Pommier, 2013). This gender difference may have also affected the present study, as seven out of ten participants were females. Further quantitative and mixed method studies could be conducted to explore the possible differences of gender, age, and other demographic factors on the varying levels of compassion.

Participants also enjoyed giving compassion to others and receiving compassion from others when they believed it was offered genuinely. In the interviews, they expressed that they could sense when someone was being real, and recognised when the compassion felt superficial. In such cases, it appeared to participants that the compassion that was offered, was done so with a sense of obligation, and was perceived as forced. Heshan explained *"I think it's because I help them, not because they want me to be happy"*, igniting a powerful understanding of the true motive behind others' compassion. From an evolutionary perspective, compassion is not always seen as unconditional due to its propensity towards cost-benefit outcomes, meaning every relationship is an exchange of some form (Leiberg et al., 2011). *The reciprocity norm* (Schwartz & Sendor, 1999) suggests that people generally feel obliged to reciprocate help when they have received favours from others. This transactional behaviour raises a question for future research to consider, with regards to how genuine this type of compassionate giving is, or if people who feel

obliged to offer compassion to others really want to relieve the suffering of others. Catarino and colleagues (Catarino et al., 2014) attributed this perceived difference to *genuine compassion*, which is the genuine concern for others' needs and the motivation to help them (Gilbert, 2018), and *submissive compassion*, the caring that develops for self-advancing or defensive needs in order to be liked by others or to avoid rejection. In this study, most participants felt genuine compassion for others, while they implied that the compassion they received from some people might have been submissive.

However, when the motivation was genuine, participants believed that it benefited both the recipient and the giver of compassion. They stressed that people who had experienced similar life events could find comfort in offering compassion towards others. This is consistent with previous research. For example, Catarino et al. (2014) established that giving compassion to others positively influences one's own well-being. Studies have also found positive relationships between compassion to others and life-satisfaction (Reid et al., 2005), prosocial behaviour (Goetz et al., 2010), self-esteem, self-awareness, and negative relationships between giving compassion to others and depression (Catarino et al., 2014). In addition, the phenomena of giving compassion to others have led to increased feelings of connectedness, social support, and trust (Buchanan & Bardi, 2010).

Whilst many participants found the experience of receiving and offering compassion to be pleasant, this was not the outcome for some others. Nelu felt exhausted from showing compassion to others, although she felt compelled to do this. Fears, blocks, and resistances of compassion (Gilbert & Mascaro, 2017) can often inhibit compassion. Being overwhelmed by distress can generate a sense of fear, while lack of understanding of compassion or environmental and external difficulties can lead to blocks. People also resist compassion when they do not want to be compassionate due to exhaustion, previous negative experiences and for other reasons (e.g., personal likes and dislikes towards the person in distress). This implies that compassion

offered with obligation (submissive compassion) may not feel as satisfactory as genuine compassion, which would then be reflected in the experience of the recipient.

Despite the perceived benefits, compassion can lead to avoidance or fear reactions in some individuals, especially among those with high self-criticism (Gilbert, 2010b). Gilbert (2010b) found that for some people, the experience associated with compassion from others can generate grief feelings of wanting but not getting the love and care from loved ones, which can increase the awareness of an inner loneliness. In such situations therefore, if the experience of receiving compassion from others is unfamiliar, people would dissociate or avoid the compassion received from others. Compassion from others is an under-researched area and, it would be interesting for future research to explore whether the discrepancy between believing participants' own compassion to be genuine and compassion offered from others to be submissive, is due to participants' own fear reactions, and if this was their reason for avoiding others' compassion.

In support, Fatima and Mathew discussed how maintaining a negative self-image pushed them away from seeking compassion from others. Most participants exhibited problems with overthinking, anxiety, and rumination, implying a link between these traits and low self-compassion. Overthinking, anxiety, and rumination lead to low self-esteem, which in turn guides people to be their own worst self-critics (Yadav, 2016). This is supported by previous cross-cultural research, which emphasised that people in Asian collectivistic backgrounds indicated higher self-criticism and rumination than those in the West (Chang et al., 2010; Maxwell et al., 2005). Self-criticism in collectivistic cultures is considered as a facilitator of self-improvement that helps to perpetuate social harmony (Aruta et al., 2020; Markus & Kitayama, 1991). Thus, participants' experiences with low self-compassion and reluctance to seek compassion from others might have had a cultural impact.

4.4.3 Compassion through facilitators and inhibitors

Although experiences and recollections of memories varied, all participants shared a common set of factors that enabled their compassion and others that hindered it. Despite

participants following different religions, almost everyone believed that religion taught them to be compassionate. Studies have found that religion plays a major role in the majority of the Sri Lankan society especially when determining self-identity (Dissanayake & McConatha, 2011). This is consistent with other studies that religious identification is the strongest constituent of one's self-identity (Gutmann, 2003). Although compassion is central to the Buddhist teaching, studies have found that compassion is taught and practiced in many other religions, including Christianity (Bernhardt, 2010) and Islam (Ghorbani et al., 2012). Deliberating on the links between compassion in Buddhism and Islam, Shah-Kazemi (2010) demonstrated that compassion is inseparable from love in both religions and that the level of loving compassion defines the core of one's humanity. Successful application of compassionate practices among non-Buddhist, Western communalities (Neff et al., 2008), and Middle Eastern Muslim countries (Ghorbani et al., 2012), imply the cross-cultural applicability of compassion practice.

All participants discussed the idea of a collectivistic culture that encourages its members to be there for one another during tough times. These cultures and their values often shape human behaviours and thought processes (LeFebvre & Franke, 2013). *Values* are socially accepted concepts that are set to help achieve motivational goals such as well-being and social interaction among groups (Schwartz, 2012). *Tradition* is one of these values that requires obligation, respect and acceptance of the norms that one's culture or religion postulates. Gilbert et al. (2011) predicted that cultural elements such as social norms might influence self-compassion, while Neff et al. (2008) suggested that self-compassion might be at least partially culturally determined. Particularly, people in Asian, Buddhist influenced societies may practice compassion more naturally, given that self-compassion and compassion towards others is central in the Buddhist worldview (Neff et al., 2008). In fact, in Buddhist societies such as Thailand, failure is seen as an opportunity for self-improvement, while Buddhist compassion has influenced ethics of daily living such as child rearing (Tulananda & Roopnarine, 2001).

People are more likely to show compassion towards those who share similar values, beliefs, preferences, actions, and physical characteristics with them (Eisenberg & Miller, 1987). According to evolutionary theories, compassion is subjective to evolutionary demands, leading people to be more compassionate towards kin (family and relations) and possible reciprocators of compassion than to those with whom they are unacquainted and non-kin (Burnstein et al., 1994). Although culture helps people identify and unite within their social group, they can encourage people to negatively evaluate those who do not comply with these values (Schwartz, 2012). Radhi, a participant of the present study identified this disparity and explained how society, culture and religion could inhibit compassion as opposed to being a facilitator. She further emphasised how these entities manipulate the level of compassion one should show to others, based on the in-group outgroup diversion. By forming groups and societies, social dominance leads people to identify their groups as superior to other groups, and as a result, act in non-compassionate ways to outgroups (Pratto et al., 1994). Furthermore, obedience to authority, having to abide by group norms and the pressure of fitting in have diminished people's ability to show compassion to others (Kelman & Hamilton, 1989).

Contrary to the aforementioned Asian Buddhist influence on compassion, some studies have found that people in such collectivistic societies exhibit a narrower trust radius, meaning a narrower width of the circle of people they trust, when compared to people in individualistic societies. This is due to collectivistic societies being more discriminatory and limiting of trust towards those in an out-group when compared to those in an in-group (van Hoorn, 2014). The lack of trust may also explain why participants viewed society as an inhibitor towards experiencing compassion towards and from others. As previously detailed, the very definition of tradition itself highlights the need for "obligation" and, Heshan in his interview emphasised how Sri Lankans are limited in their understanding and acceptance of people due to the "*so called frame of tradition*". Participants' understanding of this disparity raises the question whether culture and religion actually influence people to be more compassionate, or whether they hinder one's compassion, signifying the void for further exploratory research.

Another inhibitor participants identified was the stigma and lack of awareness in the Sri Lankan society surrounding the topic of mental illness. Mathew emphasised how his mother wanted him to *"just get over*" his depression, when he disclosed his struggles with depression to his mother. Many Sri Lankan families try to hide mental illness of family members from the society to avoid stigma and discrimination, as mental illness is seen to restrict peoples' chances at employment and marriage (Lauber & Rössler, 2007). Fear of stigma was seen as the biggest obstacle to seeking professional help, and even when help was sought, studies indicated that there is minimum reintegration into families following psychiatric treatment in Sri Lanka (Minas et al., 2017). Negative stigmatising views from others could create self-stigmatising thoughts in people, which consequently result in social withdrawal (LeFebvre & Franke, 2013), as reflected in the experience of Radhi in the present study, who internalised the negative social views and claimed to have treated herself poorly. Such individuals become increasingly sensitive to threat and less adherent to self-soothing actions (Brown, 1999). In the present study, Sonali described how society views depression as "being weak" leading people to conceal mental illnesses. Studies also showed that Sri Lankan children are raised to fear shame and are ridiculed by society if social norms such as norms of sexual modesty and approved behaviour are subverted (Obeyesekera, 1984). Fear of being ridiculed by the society was evident in this study as participants discussed being called overconfident and criticised for showing compassion for the self and others.

Consequences were a lot more severe when participants were misunderstood or judged by their own family, especially parents. Gilbert (2005) emphasised that the attachment system from significant others acts as a foundation for developing capacities for compassion. Thus, the lack of care in early relationships may lead people to feel underserving of love and fear compassion (Gilbert et al., 2011). Fear of compassion manifests in negative self-evaluations resulting in detachment from society (Neff, 2003a). In the present study, participants with negative self-perceptions and weak attachments with significant others were reluctant to seek help, or, according to them, "be a burden" on others. In a non-compassionate self-perception,

people view themselves as underserving and others as deserving of compassion, creating a fabricated sense of separation from the rest of humankind. Self-critics often feel inadequate and believe that they are the only ones facing failure. This irrational belief that everyone else is perfect, makes them isolate themselves from others (Neff, 2012). This is one of the main challenges for psychotherapy, as people fearful of compassion tend to be avoidant or not disclose personal struggles hoping to escape receiving compassion form others (Gilbert, 2010b). Thus, it is apparent that participants' self-criticism may have stemmed from unappreciative, insincere significant others, in this case, parents and family.

Taken together, findings indicate that Sri Lankan students' views and lived experiences of compassion reflect those discussed in the Western psychological models. These findings are not entirely surprising due to compassion-based practices such as the CFT (Gilbert, 2010b), being at least partly influenced by Eastern and Buddhist practices. Findings, therefore, suggest that the Western therapeutic models and practices of cultivating compassion and self-compassion, along with the recognition of fears, blocks and resistances may also be of use to the Sri Lankan population.

4.4.4 Strengths and limitations

This study was the first psychological entrance to investigate compassion in a Sri Lankan sample. The study sample also represented a variety of religions that are presently practiced in Sri Lanka. Use of IPA provided a deeper understanding of participants' lived experiences of compassion as well as their perceived inhibitors and facilitators of compassionate engagement. In addition, the present study indicated that psychology students, even though they had not previously learnt about compassion, were familiar with the compassion construct and were appreciative of its impact on their well-being. This suggests that Buddhist practices such as compassion practice could be incorporated into the academic curricular of psychology courses. However, it is also important to remember that all participants were psychology undergraduates, who may have had an above average understanding of the concept of compassion, and that social desirability bias (Demetrious et al., 2017) may have played a part in all of them disclosing having

shown compassion towards others. Thus, future research could seek to replicate this study in a non-psychology student population.

Although the small sample size meant that generalisation of the findings is limited, sufficient information about participants' experiences was obtained. In fact, IPA supports the use of small samples to extract in-depth rich data and emphasises that small samples can generate considerable accounts of individuals' perceptions (Checa et al., 2020; Smith, 1996). However, the use of undergraduate students may not be generalised to other participant groups although qualitative research is not designed to represent entire populations, but rather to deliver in-depth intuitions into chosen matters (Elliot et al., 2018). Notwithstanding the limitations, this study provided an important insight into the role that cultural factors such as religion and society play in shaping one's experiences of compassion towards the self, to/from others. These insights can be used in future research to explore the representativeness and generalisability in quantitative studies with larger sample sizes.

4.4.5 Implications for future research

An overarching aim of this study was to provide a knowledge base that could contribute to the development of prospective compassion interventions. Findings indicated that Sri Lankan students' views of compassion and its impact are in line with Western studies. However, there is an apparent need for a deep investigation into cultural elements such as social norms and how these interplay with fear reactions to inhibit compassion as well as protective factors such as religion and significant others towards facilitating compassion. Such investigations would contribute to the successful application of Western compassion practices, to collectivistic societies such as Sri Lanka. Furthermore, prospective studies may incorporate psychoeducation to increase awareness of mental health problems and to promote acceptance and help-seeking behaviour in the Sri Lankan community.

4.4.6 Conclusion

This study investigated Sri Lankan undergraduate students' views and lived experiences of the concept of compassion, with a specific focus on their perceived inhibitors and facilitators. Findings suggest that Sri Lankan students are well aware of the concept and meaning of compassion and have experienced compassion in all three forms: *self-compassion, compassion to others* and *compassion from others* to different extents. Whilst all participants acknowledged the benefits of receiving and offering compassion, some of them found the experience of offering compassion to be exhausting or unpleasant. They also questioned the genuineness of the motives of others, although they still found comfort from receiving compassion from others, regardless of the perceived motives. Despite acknowledging the powerful impacts of receiving compassion, those with insecure attachments with others especially parents, were hesitant to seek compassion from others. Most participants believed that religion and cultural upbringing shaped their compassion, while society in the forms of judgements, discrimination, and stigma inhibited their compassionate experiences. This study, therefore, suggests that clinicians should consider these culture-specific factors when implementing compassion-based practices in Sri Lankan people. There is, however, also the issue of stigma surrounding mental illness in this community that may act as an inhibitor to seeking treatment, which will need to be carefully considered in the planning of interventions aimed at developing a more compassionate approach.

Chapter 5 A Cross-Cultural Exploration of Compassion, and Facilitators and Inhibitors of Compassion in Sri Lankan and UK People

Abstract

Compassion is a sensitivity to suffering with a commitment to relieve it. Compassion can be experienced across three flows: self-compassion, compassion to others, and compassion from others. A dearth of cross-cultural research on compassion is evident especially in the Asian context. Therefore, this study conducted a cross-sectional, questionnaire based exploratory quantitative research between 149 Sri Lankan and 300 UK people, to determine their levels of compassion, and facilitators and inhibitors of compassion. Individual predictors were also explored for the three flows of compassion in each country. Results indicated that Sri Lankans were more self-reassured and self-compassionate with Buddhism predicting higher self-compassion. However, external shame and fears of compassion were also higher in the Sri Lankan people compared to the UK people. UK participants were more likely to experience compassion to and from others, with social safeness being a prominent predictor. Overall, this study provides evidence for the pivotal role cultural background and society play in shaping one's experiences of compassion. Therefore, in addition to the East-West cultural disparity, specific cultural and social factors should also be considered when implementing Western compassionate approaches in non-Western populations.

Keywords: compassion, facilitators, inhibitors, cross-cultural, religion, Sri Lankan, UK

5.1 Background

5.1.1 Theoretical Perspective of Compassion

The Social Mentality Theory (SMT) was developed by Gilbert (2014, 2016), who emphasised that compassion is an evolved care-based motivational system, known as a social mentality, which originally evolved to regulate distress in parent-infant relationships. The SMT is underpinned by evolutionary psychology, neurophysiology (Porges, 2007), attachment theory (Bowlby, 1982), and Buddhist philosophy (Wong, 2006). It emphasises that compassion activates the motivation to pay attention to suffering to make sense of it, and the ability to relieve and prevent that suffering (Gilbert, 2000). The social mentality of compassion comprises six essential competencies that are related to sensitivity, sympathy, distress tolerance, empathy, non-judgment, and care for well-being (Gilbert, 2009b). These competencies flow across three directional paths, known as the three flows of compassion, which are *compassion to others, compassion from others*, and *self-compassion* (Gilbert, 2014). Based on the aforementioned theory, Gilbert (2009a) introduced Compassion Focused Therapy (CFT), to treat people experiencing psychological issues that involve high levels of shame and criticism, by cultivating compassion across the three flows.

Gilbert (2005b) used a tripartite model known as the "Tripartite Model of Affective Regulation" to conceptualise psychopathology. According to this model of affect regulation, three systems known as the "threat, drive, and soothing" interact to regulate signals of threat, resources/incentives, and affiliation/soothing, which trigger the negative affect, high arousal positive affect, and social safeness, respectively. This model explains how various psychosocial vulnerabilities can be understood using the interplay between these three regulatory systems (Gilbert, 2005a, 2015). Whilst an overactive threat system is found to inhibit compassion cultivation, the soothing system holds the capacity to suppress the threat and drive systems and facilitate the manifestation of compassion (Gilbert et al., 2008).

5.1.2 Inhibitors and Facilitators of Compassion

According to Gilbert (2007, 2010b, 2014), attachment insecurities, neglect, abuse, or emotional conflicts with significant others generate *fear reactions*, such as avoidances and resistances that inhibit compassion. Such experiences pose a vulnerability to *self-criticism*, which hinders compassion cultivation (Rector et al., 2000), and acts as a pervasive element of shame and psychopathology (Gilbert & Irons, 2005). Studies have found that the conceptualisation of *shame* may differ between cultures (Mesquita, 2001), with shame being an "internal", self-directed construct in individualistic cultures, and an "external" construct, which relates to how a person exists in the minds of others and their judgments (Gilbert, 1998), in collectivistic cultures such as the Asian communities. Self-criticism, fears of compassion, and experiencing shame are found to positively correlate with depression (Gilbert et al*.,* 2011; 2014) and anxiety (Gilbert et al., 2014; Hermanto et al*.,* 2016) also inhibiting compassion. Thus, psychopathology, including depression and anxiety is believed to stem from an over-activation of the threat system and an under-activation of the soothing system making it difficult for one to experience compassion.

On the other hand, the soothing system seeks signals of care, warmth, and affiliation, and arouses calmness and reassurance (Gilbert et al., 2008). Therefore, in the presence of *social safeness*, the warm, calming experience of feeling cared about, reassured by, and connected to others in the society, people are more likely to generate warm affiliative feelings such as compassion (Gilbert et al., 2009). *Self-reassurance* is another factor that activates the soothing system and facilitates compassion. In fact, the ability to self-reassure and recognise one's strengths during suffering has reduced depression in clinical and non-clinical groups (Castilho et al., 2015). Studies have found that whilst self-criticism inhibits compassion and correlates with depressive symptomatology, higher ability to self-reassure could weaken this relationship between self-criticism and depression (Petrocchi et al., 2019). This indicates that although it has been discovered that

external shame and attachment insecurities can suppress one's compassion (Gilbert & Irons, 2005), a soothing-affiliation system with others can increase compassion across all three flows (Gilbert, 2005a).

5.1.3 Compassion across Cultures

Despite the increased interest in compassion research and the evidence supporting the benefits of compassion practice, most studies are limited to Western countries (Neff et al*.,* 2008; Sinclair et al., 2016a, b). Application of Western models to non-Western societies is challenging, as compassion is a context-dependent construct influenced by group norms, cultural practices, and values (Gilbert et al., 2011; Kariyawasam et al., 2021). While compassion is seen as universal, cross-cultural differences have been identified in various facets of compassion (Birkett, 2013), such as compassion competencies, and inhibitors and facilitators of compassion (Steindl et al., 2020). Asian collectivistic societies such as Sri Lanka (Pathirana, 2016) are appreciative of devotion and concerns for others (Triandis, 1993), and may show more compassion to others than the Western societies (Steindl et al., 2020). Thus, it seems fair to propose that people's underlying motivations and views of compassion may vary cross-culturally (Cheon et al., 2011).

Neff (2011) viewed self-compassion as an Asian construct due to compassion being broadly discussed in Buddhism, a religion that is primarily followed by Asian people (Prebish & Baumann, 2002). From a Buddhist standpoint, compassion is the desire to free all people from suffering (Davidson & Harrington, 2002), and Buddhist practices such as loving-kindness and mindful meditation (Leighton, 2012) promote compassion cultivation (Lama & Vreeland, 2008). Thus, one would expect Buddhist followers to be affluent in compassion. In support, a study conducted in the USA where the majority of the participant self-identified as Caucasian found that participants practicing Buddhist meditation were more self-compassionate than college undergraduates and older adults recruited from the wider community. The majority of the participants practicing Buddhist meditation also self-identified as Buddhist (Neff & Pommier, 2013).

In contrast, studies that explored practicing Buddhists in Asian collectivistic countries (e.g., Japan), where people's lifestyle is influenced by high levels of social interconnectedness (Neff et al., 2008), discovered lower self-compassion and higher self-criticism than people in Western societies (Kitayama & Markus, 2000). The social pressure to abide by cultural norms in Asian people may explain their low self-compassion (Neff et al., 2008). Thus, despite the strong Buddhist influence of compassion, cultural differences may explain why Asian Buddhist people living in Western countries indicated higher self-compassion (Neff & Pommier, 2013), and Asian Buddhist people living in Asian countries indicated lower self-compassion and higher self-criticism instead (Kitayama & Markus, 2000). In fact, Wong (2006) emphasised that the lives of many Asian people living in Asian countries are controlled by external forces, pain and tragedy that are beyond their control, which may explain their general lack of self-compassion. Furthermore, Asian Confucian cultures, such as Taiwan, where self-improvement is determined by shame, judgment, and threatened isolation indicated higher self-criticism rather than self-compassion. In the same study however, Thai participants (a Buddhist influenced culture) were more self-compassionate than the American and Taiwanese participants. The collectivistic social dynamic in cultures such as Sri Lanka, are found to inhibit people from receiving compassion from themselves and others (Kariyawasam et al., 2021; Montero-Marin et al., 2018; Steindl et al., 2020). This is due to eastern cultural norms discouraging help-seeking behaviour, as seeking help is considered as a failure that brings shame to one and those around oneself (Kee, 2004). Thus, the existing literature indicates that whilst the Buddhist religion encourages compassion, the collectivistic cultural dynamic seems to inhibit people's compassionate experiences. However, only a few studies have looked at self-compassion in a cross-cultural Asian context (Neff et al., 2008; Birkett, 2013), implying the need for further research.

So far, studies exploring the three flows of compassion in the Asian context remain to be very limited (Asano et al., 2020). It is also noteworthy that many Asian people feel that Western theories are only applicable to people living in the West, as they believe that compared to

Westerners, they have been through, and continue to face, more tragedy and pain in their daily living (Wong, 2006). For example, Sri Lanka is a multi-ethnic, multi-cultural collectivistic South Asian Island, where almost 70% of the population practice Buddhism (De Zoysa, 2013). Sri Lankans have however, experienced several catastrophes such as a civil war and tsunami over the past few decades, and report high rates of grief, domestic violence, learned helplessness, alcohol abuse, self-harming, and attempted suicides (World Health Organisation, 2018), depression, anxiety, and post-traumatic stress disorder (Gunaratnam et al., 2003). In view of this, it is presumed that Sri Lankan people may benefit from compassion cultivation.

5.1.4 Rationale for the Present Study

In consideration of the aforementioned, including the proposal that compassion is at least partially determined by culture, cross-cultural explorations remain at an infancy stage (Montero-Marin et al., 2018). Furthermore, as one's level of compassion is determined by specific cultural practices that are more nuanced than a simple East-West contrast (Neff et al., 2008), there is an apparent research gap on cross-cultural compassion.

This study aimed to compare the three flows of compassion (self-compassion, compassion to and from others) in a Sri Lankan sample in comparison to a UK sample, to understand any cross-cultural similarities and differences in the compassion constructs. Additionally, this study investigated which factors (if any) including the inhibitors of compassion (e.g., fears of compassion, self-criticism, external shame), facilitators of compassion (e.g., self-reassurance, and social safeness), and psychopathology (e.g., depression, and anxiety) predict each of the three flows of compassion. The results were also compared between the two countries, in an attempt to understand any cultural differences of these inhibitors and facilitators. Due to the scarcity of cross-cultural studies and ambiguity of the theoretical associations of the concepts discussed above (Gilbert, 2005a; Neff et al., 2008; Lopez et al., 2018), no firm directional hypotheses were constructed.

5.2 Method

5.2.1 Design and Participants

This study used a cross-sectional, between-participants, questionnaire based exploratory quantitative research design.

Participants were either UK or Sri Lankan nationals, and at least 18 years old. Participants were required to self-identify their nationality, and all participants had to be fluent in English language. The final sample comprised 300 UK and 149 Sri Lankans.

5.2.2 Measures

Demographic information on age, gender, religion, and nationality was obtained. In addition, the following measures were administered in English.

Compassionate Engagement and Action Scales (CEAS: Gilbert et al., 2017) measured participants' compassionate engagement and action in the three flows; self-compassion (engagement α = .77, action α = .90), compassion to others (engagement α = .90, action α = .94), and compassion from others (engagement α = .89, action α = .91), with 13 items measuring each flow. Answers ranged on a Likert-scale from 1 (*never*) to 10 (*always*).

Fears of Compassion Scales (FOCS: Gilbert et al., 2011), measured the fears of self-compassion (15 items), compassion from others (13 items), and compassion to others (10 items) on a 5-point Likert scale from 0 (*don't agree at all*) to 4 (*completely agree*). This scale indicated a good reliability for all three items (α= .85 for fear of self-compassion, α= .87 for fear of compassion from others, and α= .78 for fear of compassion to others).

The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS: Gilbert et al., 2004) assessed self-criticism and self-reassurance on three dimensions: inadequate self, hated self, and reassured self. It is a 22-item Likert scale ranging from 0 (*not at all like me*) to 4 (*extremely like me*)

and is designed to measure people's thoughts and feelings about themselves in times of distress. A good reliability has been reported for all three dimensions (e.g., α= .90 for inadequate self, α= .86 for hated self, and α= .86 for reassured self).

The Others as Shamer Scale (OAS: Allan et al., 1994) tested participants' perception of how others see them, referred to as external shame. This is an 18 item, 5-point Likert scale from 0 (*never*) to 4 (*almost always*), with a high internal consistency of α=.96.

The Social Safeness and Pleasure Scale (SSPS: Gilbert et al., 2009), measured the extent to which people perceive their social world as safe and warm. This 12-item scale ranging from 0 (*almost never*) to 4 (*almost all the time*) has acquired a high alpha of α= .92.

Finally, anxiety and depression were assessed using the Generalised Anxiety Disorder-7 scale (GAD-7: Spitzer et al., 2006), and Patient Health Questionnaire (PHQ-9: Kroenke et al., 2001) respectively. Both scales are scored on a likert scale from 0 (*not at all*) to 3 (*nearly every day*) and have obtained an excellent internal reliability of α=.89 (Lowe et al*.,* 2008).

5.2.3 Procedure

This study was approved by the Ethics Committee of the University of Southampton (ID: 52533.A1). Participants were conveniently recruited from multiple online platforms (e.g., Facebook, Linkedin). A series of questionnaires including a demographic questionnaire, CEAS, FOCS, FSCRS, OAS, SSPS, GAD-7, and PHQ-9 were presented respectively, after obtaining participants' informed consent. A debriefing sheet was provided to all participants after completing the questionnaires.

5.2.4 Data Analysis Plan

Analyses of covariance (ANCOVA) tested the first aim to determine whether there were differences between the Sri Lankan and UK groups in their three flows of compassion, and inhibitors and facilitators (using scores of FOCS, FSCRS, OAS, SSPS, PHQ-9, and GAD-7), controlling for age and gender. Six hierarchical multiple linear regressions (one for each flow of compassion in each country) were then conducted between the two groups, to test the second aim, exploring similarities and

differences in the predictors of compassion (scores of FOCS, FSCRS, OAS, SSPS, PHQ-9, and GAD-7 as predictors). In the first block, religion, age, and gender were entered so that the demographics could be controlled for. Depression and anxiety scores were controlled in the second block. The final block contained all the controlled variables and the remaining scales (FOCS, FSCRS, OAS, and SSPS).

5.3 Results

5.3.1 Participants

There were more females (*n* = 97, 65% Sri Lankan, *n* = 272, 91% UK) than males (*n* = 52, 35% Sri Lankan, *n* = 27, 9% UK) in both samples (X^2 = [1, *N* =448] = 45.819, *p* <.001). Sri Lankans were significantly older than the UK participants (*t* [447] = 6.784, *p* < .05), with the ages ranging from 18-50 years in Sri Lankans (*M* = 24.82, *SD* = 4.70) and 18-62 years in the UK participants (*M* = 20.95, *SD* = 6.11). Chi-square for religion was significant, X^2 = (7, *N* =449) = 333.320, *p* <.001. The majority of the Sri Lankans were Buddhists (74%) and the majority of the UK sample identified themselves as atheists (62%). As the significant differences in the demographic factors (religion, age, gender) could potentially affect the overall results, these factors were controlled when testing the study aims.

5.3.2 Aim 1: Testing compassion, and inhibitors and facilitators of compassion between Sri Lankan and UK participants

ANCOVA tests were conducted to determine if there would be a difference between the Sri Lankan and UK groups on their levels of compassion and associated inhibitors and facilitators, controlling for the demographics (see Table 5.1). The Sri Lankan group reported higher self-compassion and self-reassurance than the UK group, although of inhibitors, they also reported higher fears across all three flows of compassion and perceived external shame. In contrast, the UK group indicated greater levels of social safeness. No significant differences were found for compassion to and from others, and depression and anxiety between the two groups.

Table 5.1. Means, Standard Deviations and ANCOVA Results.

Measure (Scale range)	**SL (*N*= 149)**	**UK (*N* =300)**	**Age covariate**			**Gender covariate**			**Nationality**		
	M (SD)	***M (SD)***	***F***	***p***	***sr²***	***F***	***p***	***sr²***	***F***	***p***	***sr²***
Self-Compassion (10-100)	66.64 (12.87)	61.22 (13.15)	0.65	.422	.001	2.07	.151	.005	12.91	**<.001**	.028
Compassion from Others (10-100)	60.76 (16.72)	64.11 (15.09)	21.44	**<.001**	.046	3.99	**.046**	.009	0.01	.939	.001
Compassion to others (10-100)	75.97 (12.66)	79.44 (10.02)	0.28	.599	.001	12.12	**<.001**	.027	3.10	.079	.007
Fear of Compassion to Others (0-40)	23.03 (6.99)	18.10 (7.22)	0.63	.427	.001	0.01	.971	.001	37.01	**<.001**	.077
Fear of Compassion from Others (0-52)	24.12 (10.23)	16.21 (10.00)	5.69	**.017**	.013	0.29	.590	.001	44.20	**<.001**	.091
Fear of Self-Compassion (0-60)	22.10 (17.52)	17.52 (13.52)	4.48	**.035**	.010	0.58	.446	.001	4.89	**.028**	.011
Reassured self (0-32)	20.44 (18.28)	18.28 (6.44)	0.85	.357	.002	4.29	**.039**	.010	7.10	**.008**	.016
Inadequate self (0-36)	21.88 (8.11)	22.24 (7.68)	0.60	.437	.001	3.19	.075	.007	0.01	.924	.001
Hated self (0-20)	6.31 (5.27)	5.74 (5.23)	2.06	.152	.005	0.01	.908	.001	0.35	.554	.001
Others as shamer (0-72)	35.50 (18.53)	26.68 (14.91)	1.08	.299	.002	3.51	.062	.008	27.55	**<.001**	.058
Social safeness (11-55)	36.30 (9.72)	39.61 (9.10)	7.79	**.005**	.017	0.15	.699	.001	5.29	**.022**	.012

Measure (Scale range)	**SL (*N*= 149)**	**UK (*N* =300)**	**Age covariate**			**Gender covariate**			**Nationality**		
	M (SD)	***M (SD)***	***F***	***p***	***sr²***	***F***	***p***	***sr²***	***F***	***p***	***sr²***
Anxiety (0-21)	10.69 (5.15)	9.60 (5.30)	8.02	**.005**	.018	4.81	**.029**	.011	3.11	.078	.007
Depression (0-27)	11.36 (6.95)	9.77 (6.38)	9.49	**.002**	.021	0.53	.465	.001	2.43	.120	.005

5.3.3 Aim 2: Predictors of the three flows of compassion in the UK and Sri Lankan participants

5.3.3.1 Predictors of Self-Compassion in Sri Lankan and UK participants

A hierarchical multiple linear regression was carried out to predict self-compassion based on the subscales of FOC, FSCRS, OAS, and SSPS scales whilst controlling for religion, age, gender, anxiety, and depression. In the Sri Lankan participants, a significant regression equation (F [14, 134] = 8.88, p <.001) was resulted with an R^2 of .48. Following Buddhism, being older in age, high self-reassurance, and lack of fear of self-compassion predicted greater self-compassion. Results implied that Sri Lankan participants who were less fearful of showing self-compassion were more self-reassured and therefore, more self-compassionate (Table 5.2).

Table 5.2. Regression Results for Predictors of Self-Compassion in Sri Lankan Participants.

Block 3	B	SEB	beta	t	Sig	r zero order	sr^2	95% CI
Buddhism	**6.20**	**2.07**	**.21**	**3.00**	**.003**	**.32**	**.035**	**[2.11, 10.31]**
Atheism	-3.22	2.26	-.10	-1.43	.155	-.20	.008	[-7.69, 1.23]
Gender	-1.55	1.86	-.06	-.84	.405	-.11	.003	[-5.23, 2.12]
Age	**.41**	**.19**	**.15**	**2.24**	**.027**	**.15**	**.020**	**[.05, .79]**
Anxiety	-.32	.23	-.13	-1.40	.163	-.30	.008	[-.78, .13]
Depression	-.16	.22	-.09	-.75	.458	-.38	.002	[-.59, .27]
FCTO	.02	.15	.01	.13	.895	.02	.001	[-.27, .31]
FCFO	.18	.16	.15	1.18	.241	-.27	.005	[-.13, .50]
FSC	**-.24**	**.12**	**-.26**	**-2.10**	**.038**	**-.37**	**.017**	**[-.48, -.01]**
Inadequate self	.19	.18	.12	1.05	.295	-.39	.004	[-.17, .55]
Reassured self	**.88**	**.21**	**.48**	**4.23**	**<.001**	**.63**	**.069**	**[.47, 1.30]**
Hated self	.19	.36	.08	.55	.586	-.47	.001	[-.51, .90]
Others as shamer	.05	.09	.08	.61	.540	-.42	.001	[-.12, .23]
Social safeness	.15	.13	.12	1.21	.227	.47	.006	[-.10, .41]

note. sr^2 small effect size = 0.02, medium effect size = 0.15, large effect size = 0.35, FCTO = Fear of Compassion to Others, FCFO = Fear of Compassion from Others, FSC = Fear of Self-Compassion.

In the UK participants, a significant regression equation (F [14, 284] = 14.73, p < .001) resulted with an R^2 of .42, for self-compassion (Table 5.3). Higher self-reassurance and external shame predicted self-compassion in UK participants with small-medium, and small effect sizes respectively.

Table 5.3. Regression Results for Predictors of Self-Compassion in UK Participants

Block 3	B	SEB	beta	t	Sig	r zero order	sr^2	95% CI
Buddhism	.65	5.38	.01	.12	.904	.05	.001	[-9.93, 11.23]
Atheism	-.67	.63	-.05	-1.06	.290	-.08	.002	[-1.91, .57]
Gender	-.80	2.14	-.02	-.37	.709	-.03	.001	[-5.00, 3.41]
Age	-.05	.10	-.02	-.47	.640	-.10	.001	[-.25, .16]
Anxiety	.02	.19	.01	.12	.909	-.38	.001	[-.36, .40]
Depression	-.12	.18	-.06	-.65	.515	-.44	.001	[-.47, .24]
FCTO	.09	.11	.05	.82	.414	-.06	.001	[-.12, .30]
FCFO	-.06	.12	-.05	-.52	.605	-.38	.001	[-.29, .17]
FSC	-.12	.08	-.12	-1.40	.162	-.45	.004	[-.28, .05]
Inadequate self	-.20	.15	-.12	-1.33	.186	-.52	.004	[-.49, .10]
Reassured self	**.98**	**.16**	**.48**	**6.24**	**<.001**	**.63**	**.080**	**[.668, 1.29]**
Hated self	-.01	.21	-.00	-.03	.977	-.48	.001	[-.43, .42]
Others as shamer	**.15**	**.07**	**.17**	**2.10**	**.036**	**-.39**	**.009**	**[.01, .28]**
Social safeness	.10	.10	.07	.90	.367	.47	.002	[-.11, .31]

note. sr^2 small effect size = 0.02, medium effect size = 0.15, large effect size = 0.35, FCTO = Fear of Compassion to Others, FCFO = Fear of Compassion from Others, FSC = Fear of Self-Compassion.

The significant but positive multivariate relationship between self-compassion and higher external shame in UK participants is striking as a positive relationship is inconsistent with the

existing literature (Allan et al*.,* 1994; Ferreira et al., 2013), which strongly reports external shame as an inhibitor of self-compassion. This is also a change in direction from the zero-order correlation between self-compassion and external shame, which was significantly negative, with a medium-large effect size (r = -.39), consistent with the previous literature. Thus, any possible explanations for this significant directional change were further explored. A simple mediation analyses using PROCESS, indicated that self-reassurance significantly mediated the relationship between shame and self-compassion. In Step 1 of the mediation model, the regression of perceived external shame on self-compassion, ignoring the mediator, was significantly negative, b = -.35, $t(298) = -7.38$, $p < .001$. This meant that self-compassion was lower if the perceived shame was high. Step 2 showed that the regression of external shame on the mediator, self-reassurance, was also significantly negative, suggesting that when participants' perceived shame was high, their levels of self-reassurance was low, b = -.27, $t(298) = -13.81$, $p < .001$. Step 3 of the mediation process however, showed that the mediator (self-reassurance), controlling for external shame, was significantly positive, indicating that participants were more self-compassionate, when they were more self-reassured, b = 1.23, $t(297) = 10.80$, $p < .001$. As a result, step 4 of the analyses revealed that, controlling for the mediator (self-reassurance), external shame was not a significant predictor of self-compassion, b = -.00, $t(297) = -.0354$, p =.9718 in the UK participants. Thus, results explained that although higher external shame inhibits self-compassion, the significantly higher levels of self-reassurance in the UK group meant, that their self-compassion was high even in the presence of higher external shame.

5.3.3.2 Predictors of Compassion to Others in Sri Lankan and UK participants

A hierarchical multiple linear regression indicated a significant regression F (14, 134) = 3.76, $p < .001$, with an R^2 of .28, for predictors of offering compassion to others in Sri Lankans (Table 5.4). Participants with greater fears of self-compassion were less likely to show compassion to others, with higher self-inadequacy predicting higher compassion towards others.

Table 5.4. Regression Results for Predictors of Compassion to Others in Sri Lankan Participants.

Block 3	B	SEB	beta	t	Sig	r zero order	sr^2	95% CI
Buddhism	4.44	2.40	.15	1.85	.067	.18	.018	[-.31, 9.19]
Atheism	-4.46	2.61	-.14	-1.71	.090	-.17	.016	[-9.63, .71]
Gender	-.47	2.15	-.02	-.22	.826	.14	.001	[-4.73, 3.79]
Age	-.43	.22	-.16	-1.97	.051	-.22	.021	[-.85, .00]
Anxiety	.34	.27	.14	1.27	.205	.22	.009	[-.19, .87]
Depression	.12	.25	.07	.49	.624	.09	.001	[-.37, .62]
FCTO	-.10	.17	-.06	-.61	.544	-.04	.002	[-.44, .24]
FCFO	-.06	.18	-.05	-.35	.728	-.10	.001	[-.42, .30]
FSC	**-.32**	**.14**	**-.34**	**-2.32**	**.022**	**-.14**	**.029**	**[-.59, -.05]**
Inadequate self	**.67**	**.21**	**.43**	**3.20**	**.002**	**.19**	**.055**	**[.26, 1.09]**
Reassured self	-.00	.24	-.00	-.01	.995	.05	.001	[-.48, .48]
Hated self	-.40	.41	-.16	-.96	.338	-.02	.005	[-1.21, .42]
Others as shamer	.08	.10	.12	.78	.439	.08	.003	[-.12, .28]
Social safeness	.21	.15	.16	1.38	.170	.09	.010	[-.09, .50]

note. sr^2 small effect size = 0.02, medium effect size = 0.15, large effect size = 0.35. FCTO = Fear of Compassion to Others, FCFO = Fear of Compassion from Others, FSC = Fear of Self-Compassion.

In the UK participants, a significant regression (F [14, 284] = 2.80, p < .001) with an R^2 of .12 was reported for offering compassion to others. UK Participants were more likely to be compassionate towards others, if they were female, less fearful of offering giving compassion to others, and more anxious (Table 5.5).

Table 5.5. Regression Results for Predictors of Compassion to Others in UK Participants.

Block 3	B	SEB	beta	t	Sig	r zero order	sr^2	95% CI
Buddhism	-3.55	5.01	-.04	-.71	.479	-.02	.002	[-13.42, 6.32]
Atheism	-.83	.59	-.08	-1.40	.162	-.07	.006	[-1.99, .33]
Gender	**6.59**	**1.99**	**.19**	**3.31**	**.001**	**.20**	**.034**	**[2.66, 10.51]**
Age	.12	.10	.08	1.26	.210	.04	.005	[-.07, .31]
Anxiety	**.37**	**.18**	**.20**	**2.05**	**.042**	**.10**	**.013**	**[.01, .72]**
Depression	-.12	.17	-.08	-.71	.478	.01	.002	[-.45, .21]
FCTO	**-.28**	**.10**	**-.20**	**-2.78**	**.006**	**-.23**	**.024**	**[-.48, -.08]**
FCFO	-.10	.12	-.10	-.97	.335	-.11	.003	[-.32, .11]
FSC	.03	.08	.03	.33	.743	-.04	.001	[-.13, .18]
Inadequate self	.04	.14	.03	.29	.775	.03	.001	[-.23, .31]
Reassured self	.10	.15	.06	.66	.511	.00	.001	[-.19, .38]
Hated self	-.04	.20	-.02	-.20	.840	.02	.001	[-.43, .35]
Others as shamer	.034	.07	.05	.53	.599	.01	.001	[-.09, .16]
Social safeness	.00	.10	.00	.00	.999	.04	.001	[-.20 .20]

note. sr^2 small effect size = 0.02, medium effect size = 0.15, large effect size = 0.35, FCTO = Fear of Compassion to Others, FCFO = Fear of Compassion from Others, FSC = Fear of Self-Compassion.

5.3.3.3 Predictors of Compassion from Others in Sri Lankan and UK participants

A similar linear regression indicated (Table 5.6) a significant regression (F (14, 134) = 2.73, p < .001) with an R^2 of .22 in Sri Lankan participants. Females were more likely to receive compassion from others, whilst higher social safeness also predicted compassion from others in Sri Lankan participants.

Table 5.6. Regression Results for Predictors of Compassion from Others in Sri Lankan Participants.

Block 3	B	SEB	beta	t	Sig	r zero order	sr^2	95% CI
Buddhism	2.53	3.30	.07	.77	.444	.10	.003	[-3.99, 9.06]
Atheism	3.18	3.59	.08	.89	.377	-.05	.004	[-3.92, 10.27]
Gender	**7.61**	**2.96**	**.22**	**2.57**	**.011**	**.16**	**.038**	**[1.76, 13.45]**
Age	.04	.30	.01	.12	.904	-.06	.001	[-.55, .62]
Anxiety	-.52	.37	-.16	-1.42	.157	-.13	.012	[-1.24, .20]
Depression	.47	.34	.19	1.36	.177	-.12	.011	[-.21, 1.14]
FCTO	.05	.24	.02	.21	.832	.06	.001	[-.42, .52]
FCFO	-.06	.25	-.04	-.25	.804	-.11	.001	[-.56, .43]
FSC	.16	.19	.13	.84	.403	-.08	.004	[-.21, .53]
Inadequate self	.06	.29	.03	.21	.831	-.15	.001	[-.51, .63]
Reassured self	.01	.33	.01	.04	.971	.24	.001	[-.64, .67]
Hated self	-.01	.57	-.00	-.02	.988	-.18	.001	[-1.13, 1.11]
Others as shamer	-.04	.14	-.04	-.26	.794	-.18	.001	[-.31, .24]
Social safeness	**.82**	**.20**	**.48**	**3.98**	**<.001**	**.39**	**.092**	**[.41, 1.23]**

note. sr^2 small effect size = 0.02, medium effect size = 0.15, large effect size = 0.35, FCTO = Fear of Compassion to Others, FCFO = Fear of Compassion from Others, FSC = Fear of Self-Compassion.

A significant regression equation (F (14, 284) = 15.54, p < .001) with an R^2 of .43 was found for compassion from others (Table 5.7) in UK participants. Being younger, lack of fear of receiving others' compassion, low external shame, lower depression, higher social safeness, and higher anxiety all predicted compassion from others, in the UK participants.

Table 5.7. Regression Results for Predictors of Compassion from Others in UK Participants.

Block 3	B	SEB	beta	t	Sig	r zero order	sr^2	95% CI
Buddhism	-4.56	6.08	-.04	-.75	.454	-.06	.001	[-16.53, 7.40]
Atheism	-.05	.71	-.00	-.06	.950	-.02	.001	[-1.45, 1.36]
Gender	1.55	2.42	.03	.64	.521	.08	.001	[-3.21, 6.31]
Age	**-.41**	**.12**	**-.17**	**-3.49**	**<.001**	**-.30**	**.024**	**[-.64, -.18]**
Anxiety	**.69**	**.22**	**.24**	**3.19**	**.002**	**-.25**	**.020**	**[.27, 1.12]**
Depression	**-.55**	**.20**	**-.23**	**-2.70**	**.007**	**-.43**	**.015**	**[-.94, -.15]**
FCTO	-.04	.12	-.02	-.32	.750	-.24	.001	[-.28, .20]
FCFO	**-.37**	**.13**	**-.25**	**-2.84**	**.005**	**-.51**	**.016**	**[-.63, -.11]**
FSC	.14	.09	.12	1.48	.139	-.37	.004	[-.05, .32]
Inadequate self	-.03	.17	-.02	-.18	.854	-.36	.001	[-.36, .30]
Reassured self	.09	.18	.04	.49	.624	.38	.001	[-.26, .44]
Hated self	.33	.24	.11	1.35	.179	-.35	.004	[-.15, .80]
Others as shamer	**-.16**	**.08**	**-.16**	**-2.02**	**.044**	**-.46**	**.008**	**[-.32, -.00]**
Social safeness	**.59**	**.12**	**.36**	**4.95**	**<.001**	**.57**	**.049**	**[.36, .83]**

note. sr^2 small effect size = 0.02, medium effect size = 0.15, large effect size = 0.35, FCTO = Fear of Compassion to Others, FCFO = Fear of Compassion from Others, FSC = Fear of Self-Compassion.

5.4 Discussion

This study investigated the differences and similarities between the three flows of compassion (self-compassion, compassion to others, and compassion from others), and inhibitors (fear of self-compassion, fear of compassion to others, fear of compassion from others, self-criticism, external shame), facilitators of compassion (self-reassurance, social safeness), and psychopathology (depression, anxiety) between a cross-cultural sample of Sri Lankan and UK participants. In comparison to the UK participants, Sri Lankan participants indicated higher levels

of self-compassion, self-reassurance, external shame, and fears of compassion (when controlling for age and gender). In contrast, the UK participants reported higher social safeness.

This study also explored individual predictors of the three flows of compassion for each country, as this may be helpful in adapting interventions with cultural sensitivity. When controlling for religion, age, gender, anxiety, and depression, some similar and some different predictors were identified for each flow of compassion, as discussed below.

5.4.1 Self-Compassion

The significantly higher levels of self-compassion in Sri Lankans may be explained by the fact that 74% of them were Buddhists, compared to the 1% in the UK group, in which 62% of the UK participants self-identified as atheists. When testing the second hypothesis, the multiple regressions also indicated that following Buddhism strongly predicted self-compassion in Sri Lankans. Buddhist compassion teaches that one should fully cultivate self-compassion, prior to practicing it on others (Salzberg, 2012; Bhikkhu, 2018). Thus, the strong Buddhist influence on self-compassion might at least partially explain the cross-cultural difference in the two groups. It is, however, important to understand that a previous qualitative study discussed that many Sri Lankan participants struggled to show themselves self-compassion, whilst they found showing compassion to others, easier (Kariyawasam et al., 2021). This was also evident in the present study as both Sri Lankan and UK participants reported highest scores in compassion to others than self-compassion or compassion from others. Therefore, it is important to note that whilst Sri Lankan group were more self-compassionate than the UK group, both cultures had relatively low self-compassion compared to compassion from others. In addition to following Buddhism, older age, and lack of fear of self-compassion predicted self-compassion in Sri Lankan participants. Studies have found that middle-aged adults, as compared to young adults, practiced self-compassion as a more vital construct towards leading a prosperous and psychologically healthy life (Hwang et al., 2016).

A similar cross-cultural study between Singaporean and Australian participants also found higher self-compassion in the Asian Singaporean sample (Steindl et al., 2020). Although one would

presume people from individualistic backgrounds to be more self-compassionate (Steindl et al., 2020), Montero-Marin et al. (2018) emphasised that the individualistic social dynamic could suppress self-compassion due to the high levels of competition-based motives, social comparisons, and possibly higher self-criticism. Gilbert et al. (2017) also found that self-compassion and self-reassurance were significantly higher in a collectivistic Portuguese student sample in comparison to UK and USA student samples. In addition, in consideration of individualistic samples, a study conducted among UK students found that some participants perceived self-compassion as a self-indulgent construct (Gilbert et al., 2011). Thus, prospective research should explore whether the relatively lower self-compassion in the UK group was due to a belief that self-compassion should not be in one's best interest (Robinson et al., 2016).

Despite the group differences in self-compassion and self-reassurance, self-reassurance predicted self-compassion among participants in both countries. Whilst compassion is a sensitivity to suffering with the motivation to relieve that suffering, self-reassurance possesses the ability to soothe or reassure oneself during times of distress (Gilbert et al., 2004). Thus, self-compassion and self-reassurance have indicated strong correlations (Hermanto & Zuroff, 2016), which is unsurprising as self-reassurance buffers depression and self-criticism, both of which have shown negative correlations with self-compassion (Petrocchi et al., 2019). In support, Gilbert et al. (2017) found that self-compassion and self-reassurance were significantly higher in a Portuguese sample, which also indicated the lowest depression and anxiety scores in comparison to UK and USA samples.

In the UK group however, higher perceived shame predicted higher self-compassion. This positive relationship is theoretically contradicting as literature suggests that one's experiences of themselves as living negatively in the minds of others (external shame) is strongly correlated with low self-compassion and increased psychopathology (Ferreira et al., 2013). Therefore, given that when the society shames one, people internalise that shame and become more self-critical as opposed to being self-compassionate (Matos et al*.,* 2015), it was surprising that the UK

participants' self-compassion was predicted by higher perceived external shame. Thus, further exploratory mediational analyses were conducted, which suggested that the higher self-reassurance in fact, explains how the negative direction between shame and self-compassion can turn into a positive relationship. This is further evidence, to emphasise on the vital role of self-reassurance, even in the presence of external shame, as a mechanism to increase self-compassion. The SMT theory (Gilbert, 2010a) also emphasises that self-reassurance activates a self-to-self caregiving mentality during times of distress, which in turn encourages people to direct compassion inwardly towards themselves.

5.4.2 Compassion to Others

Asian cultures are rich in interpersonal connectedness, social conformity and caring for others, compared to Western societies, such as the UK, that encourage individuality and autonomy (Gardner et al., 1999; Markus & Kitayama, 1991). Thus, one would expect Sri Lankans to be more compassionate towards others, given that they were also more self-compassionate. However, there were no significant difference in the levels of compassion to others between the two groups. In a similar study, Steindl et al. (2020) also found that Australians were more compassionate towards others than the Singaporeans, who come from an Asian tight-knit collectivistic society. Although they expected that the collectivistic social dynamic would encourage compassion towards others, the results led them to believe that the compassion offered in such cultures maybe "submissive" than "genuine". In other words, when the compassion is referred to as submissive, it implies that the motive of the compassion given is based of obligation or submission, and possibly due to a fear of not being liked or valued if the compassion is not offered (Catarino et al., 2014). This may also be explained by the significantly higher fear of compassion to others found in the Sri Lankan sample.

Contradictory however, Gilbert et al. (2017) found that Portuguese participants from a collectivistic background indicated significantly higher levels of compassion across all three flows of compassion, which was also reflected in their significantly low levels of depression and anxiety,

compared to participants from UK and USA samples. Although the three flows of compassion were related in Gilbert et al.'s study, other studies indicated that self-compassion and compassion to others may not be correlated (Lopez et al., 2018; Neff & Pommier, 2013) and that self-compassion is independent from developing compassion towards others (Abele and Wojciszke, 2007).

In the present study, Sri Lankans' likelihood of compassion towards others was predicted by greater fear of self-compassion and self-inadequacy. It is possible that people who feel inadequately about themselves have greater sympathy for the suffering of others and therefore, develop more compassion, in the same way having high anxiety is linked to developing sympathetic considerations towards others (Gambin & Sharp, 2016). This may also explain why Sri Lankans expressed compassion to others, even when they were fearful of showing themselves compassion. In fact, levels of compassion for others in both Sri Lankan and UK groups were higher than their levels of self-compassion, which could also be due to the perception of self-compassion as a self-indulgent construct (Gilbert et al., 2011). Cross cultural studies have identified compassion to others as a submissive function in Asian people (Catarino et al., 2014), and implied that people submissively show compassion to others, in order to avoid being rejected, although this may not increase their life satisfaction (Asano et al., 2020). Thus, a plausible explanation of fear of self-compassion predicting higher compassion towards others in the Sri Lankan group maybe that, despite the fear of treating themselves with compassion, they may have felt compelled to offer it to others, to avoid social rejection. Previous studies identified that some Sri Lankans offer compassion to others, out of obligatory and submissive reasons (Kariyawasam et al., 2020).

In the UK participants, higher anxiety, being female and lack of fear of compassion to others predicted compassion towards others. In consideration of the gender difference, Western studies (Sprecher & Fehr, 2005) found that the nurturing and caring tendencies in females increased their compassion to others. Fear of compassion is known to inhibit compassion and

stem from insecure attachments with others (Gilbert et al., 2011). Thus, it is unsurprising that lack of fear predicted compassion to others in UK participants, especially given that they reported higher social safeness. Higher generalised anxiety is correlated with empathy (Knight et al., 2019). This is because compassion is closely associated with empathy and concern for others can cause increased emotional vigilance and sensitivity towards others, which in turn can increase anxiety, particularly when other people are in a state of suffering and pain (Knight et al., 2019). Therefore, anxiety as a predictor of compassion towards others in the UK sample, is expected (Gambin & Sharp, 2016).

5.4.3 Compassion from Others

As with offering compassion, Sri Lankan participants were expected to experience higher compassion from others (Markus & Kitayama, 1991; Pathirana, 2016). However, there was no significant difference in compassion from others between the two countries. In fact, participants from both cultures had low levels of compassion from others, compared to their compassion levels towards others. Steindl et al. (2020) found higher compassion from others in an Australian sample than in a Singaporean sample, concluding that the collectivistic nature and the perception of help seeking behaviour as being weak or shameful in the Asian communities may have resisted the Singaporean participants from seeking help or being open to receiving compassion from others. However, Gilbert et al. (2017) found highest compassion from others in a Portuguese sample when compared to UK and USA populations. Although Portugal is considered to have a collectivistic culture (Hofstede, 2011), the higher density of the “shame” component in Asian countries should be explored further, to determine this cultural distinction.

Social safeness predicted compassion from others in both groups. Previous studies also emphasised that social safeness mediates the capacity to receiving compassion (Kelly & Dupasquier, 2016) and that lack of social safeness increases trust issues and the perception that others are judgmental and rejecting (Gilbert, 2014). Thus, results suggest that participants were more accepting of others’ compassion when they felt safe within their social relationships, as

social safeness increases affiliative interactions with others (Kelly & Dupasquier, 2016), which in turn activates the soothing system (Gilbert, 2014).

Furthermore, being younger in age predicted compassion from others in the UK participants, together with high levels of anxiety, low levels of depression, lack of external shame, and lack of fear of receiving compassion from others. It feels fair to address whether younger participants may have experienced stronger parental attachments and connections with society, which may explain the higher perception of compassion from others. In fact, warm parental relationships enhance the soothing system, and increase social safeness (Cacioppo et al., 2000). Future studies on student populations should, therefore, investigate participants' relationship with their parents, for a better understanding of this phenomenon. The present study also noted that participants who were less depressed were more likely to perceive higher compassion from others. Self-critical and depressed people tend to show a lack of ability to receive affection and compassion from others (Bowlby, 1982) and resist compassion, even when it is offered (Gilbert & Procter, 2006). This also implies that people who are depressed and self-critical may perceive others as not compassionate as a way of resisting compassion from others (Kariyawasam et al., 2021). Anxiety is positively associated with affective empathy and sympathy (Gambin & Sharp, 2016), indicating that people with anxiety may also have increased considerations towards the suffering of others.

Another cultural difference was that being female in the Sri Lankan group, compared to males, was a predictor of compassion from others, which is supported by females' natural propensity towards engaging compassionately with others (Stellar et al., 2012; Neff & Pommier, 2013). It is noteworthy that there was no gender difference in the UK group, which raises the question whether the autonomous social background may have prevented UK females from seeking compassion, leading them to believe that others are not compassionate towards them. In fact, distance is identified as a positive cultural value in the UK, which links with respect for

individual autonomy (Paxman, 2007). The impact of autonomy on seeking compassion, therefore, needs further exploration.

5.4.4 Strengths and Limitations

This was the first cross-cultural study to investigate the three flows of compassion in a Sri Lankan sample in comparison to a UK sample. This was also the first study exploring Gilbert's (2010a) SMT theory in a Sri Lankan population using a questionnaire-based approach. The use of a series of validated measures and the detailed explanation of the nuances of the three flows of compassion further strengthened the overall study quality. This study also contributed to the understanding of the seemingly strong influence of Buddhism on self-compassion, signifying the importance of further explorations to integrate these vital elements when conducting compassion-based interventions. Additionally, future research may incorporate measures to investigate the associations between religion, culture, well-being, and the different components of compassion to further understand these factors as potential facilitators/inhibitors of compassion.

In consideration of the weaknesses, as this study was cross-sectional, drawing conclusions on the causality of compassion, inhibitors and facilitators was problematic (Matos et al., 2017a). Importantly, as data collection continued during the COVID-19 pandemic (Jia et al., 2020), it is possible that compassion levels varied from the usual levels in all participants, especially in the UK group due to the high pandemic impact at the time of data collection. This may also explain the non-significance in depression and anxiety between the two countries. Although studies have found people in collectivistic countries to be more distressed than people in the West (Birkett, 2013), the alarming situation of the pandemic in the UK might suggest that the UK participants' depression and anxiety levels may have been higher than usual, as reflected in the results. In support, a UK study found that during the pandemic, depression and anxiety exceeded the population norms especially among young people (Jia et al., 2020), who comprised most of the UK sample of this study.

Although religion was accounted as a possible cause of cross-cultural differences observed in the results, this study did not assess differences in cultural or group norms, and other cultural practices which may have had an impact on the overall study results.

Furthermore, the study was mostly advertised among university students, limiting the sample to young people in both countries. In addition, as majority of the participants in both countries were female, results of this study cannot be generalised to the general populations of UK and Sri Lanka. This study was also conducted in English language, allowing only English-speaking Sri Lankans to participate.

5.4.5 Clinical Implications and Recommendations for Future Research

This study aimed to facilitate an enhanced cross-cultural understanding of compassion across its three flows, which is predominantly a Western approach, in cultures such as Sri Lanka. Considering the impact of compassion-based approaches (e.g., CFT and CMT) on reduced anxiety and depression in Western communities (Gilbert et al., 2011), the application of these approaches cross-culturally may result in increased well-being in people around the world. The findings tentatively suggest that compassion-based interventions may be helpful, but also identified that cultural differences should be considered when tailoring individual treatments. It appears that religion, Buddhism in particular in this study, and other demographic factors should be taken into account. This is vital in therapeutic contexts as these maybe useful protective factors in enhancing a person's well-being. When implementing interventions such as CFT, clinicians should also address inhibitors such as fears of offering and receiving compassion, and negative shame-based emotional experiences (such as self-criticism and external shame) stimulating such fears, in order to assist self-generating compassion and reception towards compassion in clients (Matos et al., 2017b). Replications may also integrate a qualitative approach to inform the quantitative findings of the study.

5.4.6 Conclusion

This study identified that cultural differences and similarities were present between UK and Sri Lankan participants in their levels of self-compassion, compassion to and from others. Sri Lankans were significantly more self-reassured and self-compassionate, although they also reported higher external shame and fears of compassion. UK participants found more safeness in others, despite their individualistic social dynamic (Gardner et al., 1999). Regardless of the cultural differences, those who felt highly self-reassured were more self-compassionate. Buddhism predicted greater self-compassion in Sri Lankans although external shame and insecure attachments inhibited their compassionate experiences with others. Overall, this study signified the importance of paying close attention to cultural and religious influences when exploring compassion across cultures. Irrespective of the individualistic-independent and collectivistic-interdependent cultural context, this study highlighted the potential role that significant others and society play in one's level of compassion and well-being. As compassion cultivation across all three flows has resulted in increased well-being and reduced psychological distress (Gilbert, 2005a), it is vital that differences between countries are considered when introducing Western psychotherapeutic approaches into non-Western settings such as Sri Lanka.

Chapter 6 Exploring the Cross-Cultural Applicability of a Brief Compassionate Mind Training in Sri Lankan and UK People

Abstract

Compassionate Mind Training (CMT) is a therapeutic approach recognised to be effective for reducing distress and increasing well-being in clinical and non-clinical populations. This study aimed to explore the efficacy of a short-term, online version of the CMT on compassion, distress, and well-being in a cross-cultural, non-clinical sample of Sri Lankan and UK people. A randomised controlled trial with pre-, post-measurements, and a two-week follow-up was conducted using CMT and wait-list control groups. The intervention effects were investigated using a series of repeated measures ANOVAs using intention-to-treat and per-protocol analyses. Results indicated that the two-week CMT was effective in increasing self-compassion, compassion to others, and compassion from others in both Sri Lankan (n = 21) and UK (n = 73) people. In addition, some cross-cultural similarities (decreases in fear of compassion from others and fear of self-compassion, inadequate self) and differences (decreases in fear of compassion to others, external shame, and increases in reassure-self, social safeness) were present in the improvements following CMT between the two countries, which were maintained at a two-week follow-up. Additional improvements in some variables (depression, anxiety, and social safeness) were also observed at the follow-up. This study provides promising evidence for the efficacy and cross-cultural applicability of CMT for reducing distress and increasing compassion and well-being.

Keywords: compassion, CMT, efficacy, Sri Lankan, UK, cross-cultural

6.1 Background

Compassion has received an increased interest in research and psychotherapy over the last two decades (Fredrickson et al., 2008; Kirby, 2016; Matos et al., 2017a). Practicing compassion has been found to produce various physiological (e.g., Fredrickson et al., 2013), psychological (e.g., Keltner et al., 2014), and social benefits (e.g., Crocker & Canvello, 2012). In fact, studies have found that compassion is linked to several factors such as coping with distress and failures (Leary et al., 2007), decreased anger, anxiety, shame (Barnard & Curry, 2012), and self-criticism (Neff, 2003a), and increased positive affect, optimism, and happiness (Neff et al., 2007). Therefore, several compassion-based interventions have been introduced, with the aim of reducing distress and increasing well-being in clinical and non-clinical populations (e.g., Gilbert, 2010b; Neff & Germer, 2013).

One such intervention is Compassion Focused Therapy (CFT: Gilbert, 2000, 2009a, 2010b), which was originally developed as a psychotherapy for patients with high shame and self-criticism. CFT attempts to cultivate care-based motives, intents, and soothing affiliations, and alleviate persistent patterns of distress, to help people combat shame based and traumatic experiences (Gilbert, 2020; Irons & Heriot-Maitland, 2021; Kirby, 2016). Compassionate Mind Training (CMT) is integrated in CFT and entails several practices to facilitate compassion and the psychoeducation that compassion is a sensitivity to suffering of oneself and others with a commitment to try to relieve and prevent suffering (Gilbert, 2017a).

Gilbert (2014), one of the leading theorists in this area, emphasised that emotions are evolved to serve certain functions that are clustered in a system known as the *affective regulatory system*, which contains three interactive systems: *threat*, *drive*, and *soothing*. He posits that cultivating the soothing system through practicing compassion for oneself and others, maybe helpful in regulating distress. Gilbert emphasised that compassion can be experienced across three directional flows: *self-compassion*, *compassion towards others*, and *compassion from others*, and

these compassionate experiences are often challenged by fears, blocks, and resistances (Irons & Heriot-Maitland, 2021).

In order to cultivate compassion and well-being by reducing the impact of fears, blocks, and resistances, CMT provides psychoeducation that much of the suffering that humans experience is beyond their control and therefore, is not their fault (Gilbert, 2009b, 2014). To help cultivate the soothing system, CMT comprises a series of practices designed to enhance sociality, friendliness, and well-being, particularly among people with high shame and self-criticism (Irons & Heriot-Maitland, 2021; Kirby, 2016; Matos et al., 2017a). These practices include physiological processes such as breathing (e.g., soothing rhythm breathing), imagery (e.g., safe space imagery), body posture, and voice tone training designed to facilitate self-awareness, self-grounding, and a sense of a compassionate self (Matos et al., 2017a). In support, studies have found that the embodiment of a compassionate self has increased optimism (Meevissen et al., 2011), coping behaviours (Peters et al., 2010), and mood (Osimo et al., 2015). Activation of the soothing system via practicing CMT has shown to activate the parasympathetic nervous system and increase heart rate variability (HRV), whilst also increasing well-being and prosocial motivations for self and others (Kirby et al., 2017). Interestingly, the predominance of the research has focused on self-compassion (e.g., Arimitsu, 2016; Campbell et al., 2017; Wong & Mak, 2016), with only a few studies exploring compassion across the three flows (e.g., Irons & Heriot-Maitland, 2021), highlighting the need for future research to explore the complex interplay of the three flows of compassion and well-being.

In addition, CMT has been found to increase other factors such as self-reassurance and social safeness and pleasure (Irons & Heriot-Maitland, 2021; Maratos et al., 2019, 2022). These are known as facilitators of compassion associated with increased compassion (Gilbert, 2017b). On the other hand, in addition to reducing psychopathology such as anxiety and depression (e.g., Matos et al., 2022a, b), CMT has been found to reduce fears of experiencing compassion, self-criticism, and external shame, such as the perception that others in the society judge and criticise oneself (e.g.,

Irons & Heriot-Maitland, 2021: Gilbert & Procter, 2006). These factors (fears, self-criticism, and external shame) are frequently considered as inhibitors of compassion, due to their negative correlation with compassion (Gilbert, 2017b). In line with this, a cross-cultural study between Sri Lankan and UK people found that although Sri Lankan participants reported higher self-compassion and self-reassurance, they indicated higher external shame, and greater fears of compassion for the self and others, and receiving compassion from others (Kariyawasam et al., 2022). In comparison, UK participants reported significantly higher levels of social safeness and pleasure and were not fearful of engaging compassionately with others. CMT appears to increase facilitators of compassion and reduce inhibitors of compassion, in both clinical (Beaumont & Martin, 2013; Gilbert & Procter, 2006) and non-clinical populations (Matos et al., 2017b), which might be useful for cross-cultural studies to explore.

Despite the trans-diagnostic and multifaceted nature of CMT (Matos et al., 2017a) and other compassion-based interventions such as Mindful Self-Compassion Programme (Neff & Germer, 2013), and Compassion-Cultivating Training (Jazaieri et al., 2013), most of the research has been conducted in Western countries (Campbell et al., 2017; Halamova et al., 2020; Johnson & O'Brien, 2013; Kelly et al., 2017). This is surprising given that almost all compassion-based interventions including CFT and CMT are influenced by Buddhism and Eastern philosophies that are embraced across a range of predominantly Asian cultures (Kirby, 2016). Despite this, until recently, there has been a lack of research attempting to enhance compassion in Buddhist influenced Asian cultures such as Japan (Arimitsu, 2016) and Sri Lanka (Kariyawasam et al., 2021, 2022a). In fact, a recent meta-analysis concluded that whilst the existing compassion-based interventions in Asian countries are significantly limited, these interventions have been conducted only within the last five years (Kariyawasam et al., 2022b). Despite the scarcity of research, existing literature indicates that compassion-based interventions can increase well-being and reduce shame and criticism in Asian cultures (e.g., Arimitsu, 2016), highlighting the need for more research in this area.

Introducing online interventions is important as they are easily accessible for a wider population, cost effective, can be self-administered, and more importantly encourage people with mental health problems to access, who would otherwise hesitate to seek professional help (Gosling et al., 2004; Halamova et al., 2020; Lauber & Rossler, 2007; WHO, 2001; Wright, 2005). In fact, it is known that approximately two-thirds of people with mental health presentations resist from seeking professional health (WHO, 2001). Online interventions might be even more useful in collectivistic, developing societies such as Sri Lanka, where stigma and lack of awareness of mental health are highly prominent and restrict people with mental illnesses and their families from seeking help (Kariyawasam et al., 2021, Lauber & Rossler, 2007).

This study therefore aimed to investigate the efficacy of a two-week online CMT in a cross-cultural group of Sri Lankan and UK people. To the authors' knowledge, this was the first cross-cultural study to explore the efficacy of CMT in an Asian sample. Online CMT studies are distinctly scarce (Halamova et al., 2020) and there is also a dearth of cross-cultural CMT studies (Maratos et al., 2019, 2020; Matos et al., 2021, 2022a, b). Additionally, the use of an online CMT was particularly appropriate due to the current climate of the COVID-19 pandemic for both Sri Lankan and UK participants (Halder, 2020; Wang et al., 2020). Therefore, the aim of this study was to explore the impact of CMT on the three flows of compassion and the inhibitors and facilitators of compassion (Gilbert, 2014).

The research questions were:

1. Will CMT increase the three flows of compassion in the CMT group when compared to the wait-list control group, regardless of the cultural background?
2. Will CMT improve the facilitators (self-reassurance, social safeness and pleasure, and well-being) and decrease the inhibitors of compassion (fears of compassion, self-criticism, external shame, anxiety, and depression), and will these changes be similar or different between Sri Lankan and UK people?

3. If there are changes, will they be maintained at follow-up?

In line with the research questions, it was hypothesised that:

1. CMT will increase the three flows of compassion in the CMT group, when compared to the waitlist control group, regardless of the cultural background.
2. CMT will increase the facilitators and decrease the inhibitors of compassion in both Sri Lankan and UK people, and cross-cultural differences will be explored.
3. All post-CMT changes will be maintained at follow-up.

6.2 Method

6.2.1 Design and Participants

This study used an online, randomised controlled trial (RCT) with a pre-post and two-week follow-up design in a cross-cultural group of Sri Lankan and UK participants. All participants self-identified as Sri Lankan or UK nationals, aged at least 18 years or older, and were able to understand spoken and written English. The study design was one month in duration, including the two-week CMT. Using a computer randomisation programme, participants were randomly allocated to either the Compassionate Mind Training group (CMT group) or the Wait-List Control group (WLC group) on a 1:1 ratio.

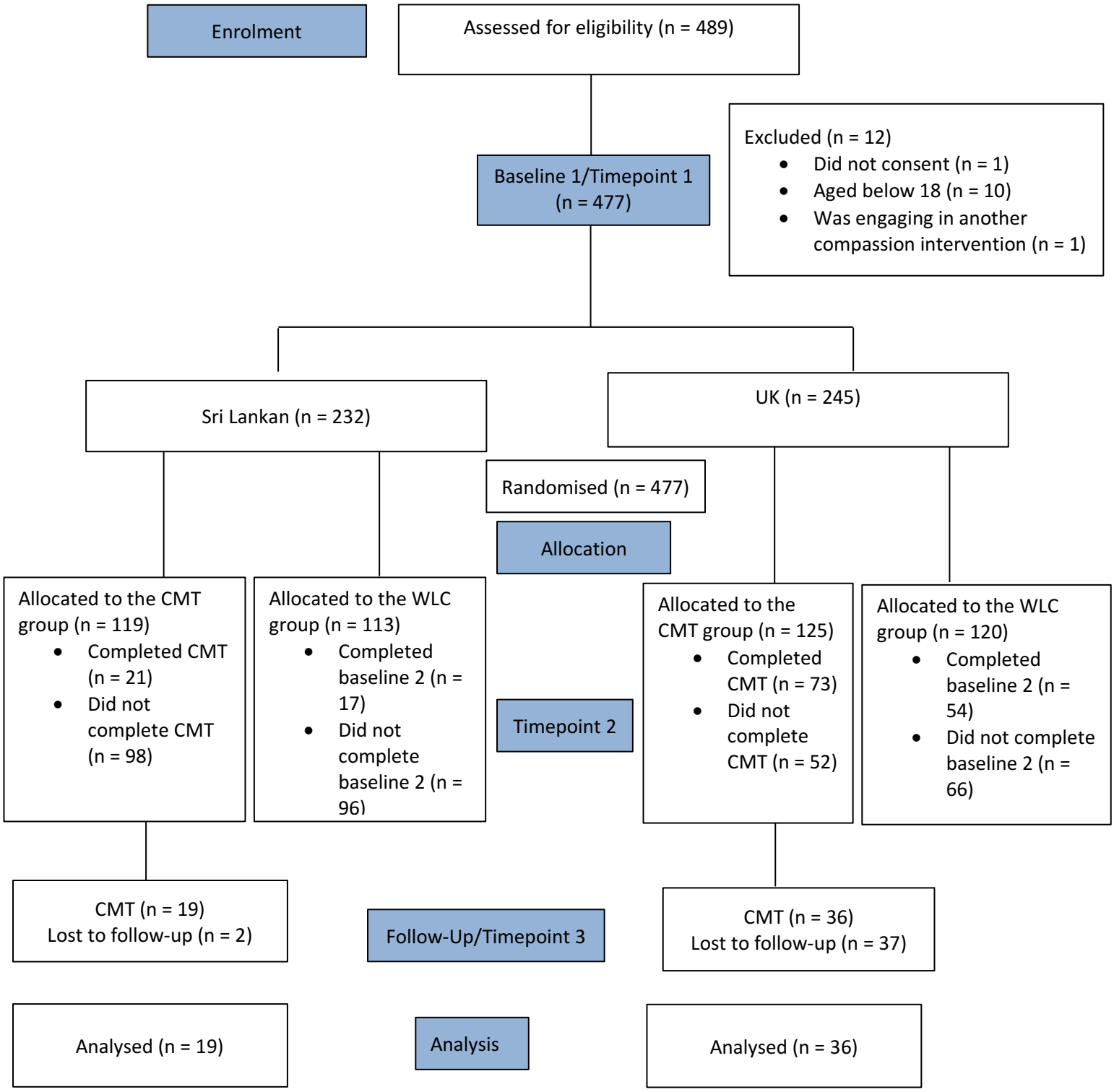

Figure 5. Participant flow chart for baseline, post-intervention, and the two-week follow-up

6.2.2 Measures

6.2.2.1 Demographic Questions

Participants completed a demographic form, in which they were required to identify their nationality (Sri Lankan vs. UK), religion (if any), age (categories), and gender.

6.2.2.2 Compassionate Engagement and Actions Scales (CEAS)

The CEAS (Gilbert et al., 2017) assesses compassion across two domains: *engagement* with suffering, and *action* towards trying to alleviate and prevent suffering (Gilbert & Choden, 2013), across the three flows of compassion: self-compassion (*engagement* α = .77, *action* α = .90), compassion towards others (*engagement* α = .90, *action* α= .94), and compassion from others (*engagement* α= .89, *action* α = .91). Each flow was measured using 13 items with answers ranging on a likert-scale from 1 (*never*) to 10 (*always*).

6.2.2.3 Fears of Compassion Scales (FOCS)

Next, the FOCS (Gilbert et al., 2011) were used to measure participants' fears across the three flows of compassion. This scale consists of 15 items measuring fear of self-compassion, 10 items measuring fear of compassion towards others, and 13 items measuring fear of compassion from others on a five-point likert scale ranging from 0 (*don't agree at all*) to 4 (*completely agree*). The FOCS have indicated a good reliability for all three flows, with Cronbach's alpha values of α = .92 for fear of self-compassion, α = .85 for fear of compassion from others, and α = .84 for fear of compassion towards others in a student sample (Matos et al., 2017a).

6.2.2.4 Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS)

The FSCRS scale (Gilbert et al., 2004) was used to assess participants' self-critical and self-reassuring responses to adverse experiences, measured on three dimensions: *inadequate-self*, *reassured-self*, and *hated-self*, using a 22 item likert scale ranging from 1 (*not at all like me*) to 4 (*extremely like me*). The inadequate-self and hated-self scores are merged to report self-criticism, and the reassured-self scores represent self-reassurance (Halamova et al., 2017). A good reliability

with Cronbach's alpha values of α = .90, α = .86, and α = .86 for inadequate-self, hated-self, and reassured-self dimensions respectively have been reported for this scale (Gilbert et al., 2004).

6.2.2.5 Others as Shamer Scale (OAS)

The OAS (Allan et al., 1994) scale was used to understand participants' perception of how others view them, also known as *external shame*, rather than *internal shame*, which is how people view themselves. OAS scale has 18 items on a 5-point likert scale that range from 0 (*never*) to 4 (*almost always*). A high Cronbach's alpha of α = .92 has been reported for this scale (Goss et al., 1994).

6.2.2.6 Social Safeness and Pleasure Scale (SSPS)

The SSPS (Gilbert et al., 2009) was then used to assess how safe and warm people perceive their society to be. This scale consists of 12 items measured on a likert scale ranging from 0 (*never*) to 4 (*almost all the time*). The SSPS has also acquired a good Cronbach's alpha of α = .92.

6.2.2.7 Generalised Anxiety Disorder-7 Scale (GAD-7)

The GAD-7 (Spitzer et al., 2006) was used to measure participants' anxiety levels. Containing 7 items ranging on a likert scale from 0 (*not at all*) to 3 (*nearly every day*), the GAD-7 has indicated a good internal reliability with a Cronbach's alpha of α = .89 (Lowe et al., 2008).

6.2.2.8 Patient Health Questionnaire (PHQ-9)

The PHQ-9 (Kroenke et al., 2001) was used to assess levels of depression among the participants. This scale consisted of 9 items, that ranged on a likert scale from 0 (*not at all*) to 3 (*nearly every day*). The PHQ-9 has acquired a Cronbach's alpha of α = .89 (Lowe et al., 2008).

6.2.2.9 The Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

The WEMWBS (Tennant et al., 2007) is a 14-item scale that assesses cognitive processes, feelings, and the quality of interpersonal relationships to measure well-being. This scale is measured on a five-point likert scale ranging from 1 (*none of the time*) to 5 (*all of the time*) and has indicated a good internal consistency with a Cronbach's alpha of α = .89 to .91 (Tennant et al., 2007).

6.2.2.10 CMT Engagement Feedback Questions

At the end of each day during the two-week CMT, participants were requested to answer a feedback question on how well they were able to engage with the CMT practices. The answers varied on a 5-point likert scale from 1 (*not very well*) to 5 (*very well*).

In addition, after completing the two-week CMT, participants completed a feedback questionnaire regarding the intervention accessibility and feasibility in addition to the post-intervention measures, which contained 11 statements with answers ranging from 1 *(strongly disagree)* to 7 (*strongly agree*). Participants in the CMT group were sent an additional set of questionnaires at follow-up, with four further statements regarding their experience of the CMT practices, with answers ranging from 1 (*strongly disagree*) to 7 *(strongly agree)*.

6.2.3 CMT: Design and Tasks

This study used an English version of the CMT scripts developed for a two-week CMT intervention by Matos et al. (2017a) and translated to English and converted into audio recordings for UK use by Atuk (2020). In addition, this study incorporated a psychoeducation video by Timings (2022), converted from Matos and colleagues' (2017a) psychoeducation booklet. The CMT scripts included the following practices:

1. Postures and Facial Expressions and Vocal Tones (PFEVT)
2. Mindfulness (M)
3. Soothing Rhythm Breathing (SRB)
4. Building and Cultivating Your Compassionate Self (BCYCS)
5. Compassion for a Close Person (CCP)
6. Compassion for the Self (CFTS)

Over the course of two-weeks, participants watched or listened to one video or audio material every day lasting no longer than 30 minutes (Table 6.1). Qualtrics online survey platform

(Qualtrics, 2022) was used to deliver the CMT practices online. This software also generated a daily reminder for participants to practice the CMT tasks.

Table 6.1. Two-Week CMT as Informed by Matos et al.'s (2017a) Study Manual.

Day 1 – Psychoeducation	Day 8 – CFTS
Day 2 – PFEVT and SRB	Day 9 – BCYCS
Day 3 – M and PFEVT	Day 10 – CCP
Day 4 – SRB and M	Day 11 – CFTS
Day 5 – Psychoeducation	Day 12 – BCYCS
Day 6 – BCYCS	Day 13 – CCP
Day 7 – CCP	Day 14 – CTFS

Note. PFEVT = Postures and Facial Expressions and Vocal Tones; SRB = Soothing Rhythm Breathing; M = Mindfulness; BCYCS = Building and Cultivating Your Compassionate Self; CCP = Compassion for a Close Person; CFTS = Compassion for the Self.

The practices comprised a psychoeducation session, which introduced participants to the concept of compassion. Other materials incorporated CMT practices that were aimed to facilitate a soothing rhythm breathing (Lin et al., 2014; Matos et al., 2017a), friendly facial expressions and voice tones that would establish a compassionate atmosphere (Matos et al., 2017a; Porges, 2007). Additionally, there were practices aimed at increasing mindfulness and attention to one's presence and mental state, and practices aimed at cultivating self-compassion and compassion to others via encouragement of wisdom, strength, and commitment (Matos et al., 2017a). CMT practices also aimed to increase participants' reception towards compassion from others, by incorporating an imagery exercise, where participants were encouraged to develop a compassionate image of a caring other. Practices included exercises to help participants utilise compassion as a tool for dealing with distress and reducing self-criticism (Gilbert & Choden, 2013: Matos et al., 2017a).

6.2.4 Procedure

The study was advertised via social media. In addition, it was advertised in Sri Lankan universities to recruit students where the first 40 participants to complete the entire study received a £5 Amazon voucher each, and UK university students were recruited via research participation scheme for course credit. After signing up, participants who read the information sheet and consented to take part were emailed the link to participate in the study.

Participants were then emailed an online link to complete a series of questionnaires, which were hosted on the Qualtrics online survey platform (Qualtrics, 2022). The questionnaires included a demographic form, CEAS, FOCS, FSCRS, OAS, SSPS, GAD-7, WEMWBS, and the practice feedback questions respectively. Participants were then randomised to either the CMT or WLC group. The CMT group completed the measures, in the same order, immediately after engaging in the two-week CMT (T2), and again at a two-week follow-up (T3). WLC group completed the measures, in the same order, after a two-week waiting period (T2) and immediately after completing the two-week CMT (T3) as seen in Table 6.2.

Table 6.2. Timeline across the Two Groups.

Time 1 (T1)	**Group**		**Time 2 (T2)**		**Time 3 (T3)**
Baseline 1: Before CMT	CMT	*Two-week CMT*	Post-intervention: Immediately after CMT	-	Follow-up: Two-weeks after CMT
Baseline 1: Before CMT	WLC	-	Baseline 2: Two-weeks after Baseline 1	*Two-week CMT*	Post-intervention: Immediately after CMT

An independent researcher generated automated emails to be sent to participants, reminding them to complete the measures and the CMT, based on their allocated group. This study was approved by the Ethics Committee of the University of Southampton.

6.2.5 Statistical Analysis

Data analyses were conducted using SPSS version 28. Prior to the analyses, data were checked for normality and any outliers. No extreme outliers were found although the fears of compassion variable slightly deviated from normality due to a moderate positive skew and hated-self variable largely deviated from normality showing a multi-modal distribution. Therefore, data relating to fears of compassion variables were bootstrapped, and data relating to the hated-self outcome were re-coded into three categories. Chi square and independent samples *t*-tests were performed to check for any differences between the two countries (Sri Lanka and UK) and the two conditions (CMT and WLC) at baseline-1 (T1).

To test the efficacy of the CMT on the two groups across time, a 2 × 2 mixed ANOVA design was employed with the two conditions (CMT vs WLC) as the between-group factor, and time (T1 and T2) as the within-group factor. Analyses were repeated for Sri Lankan and UK samples separately. Where significant time × group interactions were found, pairwise comparisons were further explored to identify which group may have significantly improved post CMT. The analyses were conducted using both Intention to treat (ITT) and per-protocol (PP) analyses (for both countries separately) to look for effects based on randomisation (ITT) as well as by adherence (PP). To conduct ITT analyses, T1 scores were brought forward to participants lost to T2. For PP analyses, only participants who completed T2 measures were included.

Next, analyses were conducted to investigate whether the efficacy of CMT was maintained at follow-up two weeks after completing the CMT (at T3). As only participants in the CMT group were required to complete this stage, a repeated measures ANOVA was carried out on the CMT group in relation to the three time points (T1: before CMT, T2: immediately post CMT, and T3; two-weeks post CMT). The Greenhouse-Geisser correction was used for *F*-test comparisons when sphericity was not met. Only per-protocol analyses were conducted, to see if there were any

changes at follow-up in the intervention group. Analyses were repeated for Sri Lankan and UK samples separately.

6.3 Results

6.3.1 Participants

Overall, 477 participants (232 SL and 245 UK) signed up for the study and completed the baseline-1 (T1) measures. In the Sri Lankan sample, 119 participants were in the CMT group, and 113 participants were in the WLC group. In the UK sample, 125 participants were in the CMT group, and 120 participants were in the WLC group. However, only 21 (17.6%) in the Sri Lankan CMT group and only 73 (58%) in UK CMT group completed the post-CMT measures at T2. In the WLC groups, only 17 In the Sri Lankan group and only 54 in the UK group completed T2. Indicating a further attrition rate, only 19 (15.9%) in the Sri Lankan CMT group and 36 (28.8%) in the UK CMT group completed the follow-up measures at T3.

6.3.2 Differences Between Countries and Groups at Baseline (T1)

The majority of the participants were female in both countries (59.5% in the SL sample and 81.2% in the UK sample). There was a significant difference between age $X^2(4) = 219.95$, $p < .001$, gender $X^2(2) = 32.70$, $p < .001$, and religion $X^2(7) = .270.23$, $p < .001$, with majority of the Sri Lankans being aged 25-34 years (55.6%), and self-identifying as Buddhist (51.7%), and majority of the UK participants being aged 18-24 years (80.4%), and self-identifying as Atheist (30.2%). See Table 6.3 for the demographic information.

Table 6.3. Demographic Information of Sri Lankan and UK Participants.

	Sri Lankan Sample			**UK Sample**		
	CMT Group n = 119 (51.3%)	WLC Group n = 113 (48.7%)	Total (n = 232)	CMT Group (n = 125) (51.0%)	WLC Group (n =120) (49.0%)	Total (n = 245)
Gender						
Male	45 (37.8%)	49 (43.4%)	94 (40.5%)	22 (17.6%)	21 (17.5%)	43 (17.6%)

	Sri Lankan Sample			UK Sample		
	CMT Group n = 119 (51.3%)	WLC Group n = 113 (48.7%)	Total (n = 232)	CMT Group (n = 125) (51.0%)	WLC Group (n =120) (49.0%)	Total (n = 245)
Female	74 (62.2%)	64 (56.6%)	138 (59.5%)	100 (80%)	99 (82.5%)	199 (81.2%)
Other	-	-		3 (2.4%)		3 (1.2%)
Age (years)						
18-24	23 (19.3%)	13 (11.5%)	36 (15.5%)	99 (79.2%)	98 (81.7%)	197 (80.4%)
25-34	65 (54.6%)	64 (56.6%)	129 (55.6%)	20 (16.0%)	14 (11.7%)	34 (13.9%)
35-44	30 (25.2%)	35 (31.0%)	65 (28%)	2 (1.6%)	4 (3.3%)	6 (2.4%)
45-54	1 (0.8%)		1 (0.4%)	4 (3.2%)	3 (2.5%)	7 (2.9%)
55-64	-	1 (0.9%)	1 (0.4%)	-	1 (0.8%)	1 (0.4%)
Religion						
Agnostic	-	-	-	21 (16.8%)	17 (14.2%)	38 (15.5%)
Atheist	-	-	-	34 (27.2%)	40 (33.3%)	74 (30.2%)
Buddhist	65 (54.6%)	55 (48.7%)	120 (51.7%)	2 (1.6%)	-	2 (0.8%)
Catholic	12 (10.1%)	12 (10.6%)	24 (10.3%)	18 (14.4%)	21 (17.5%)	39 (15.9%)
Christian	15 (12.6%)	16 (14.2%)	31 (13.4%)	20 (16.0%)	25 (20.8%)	45 (18.4%)
Hindu	14 (11.8%)	24 (21.2%)	38 (16.4%)	7 (5.6%)	5 (4.2%)	12 (4.9%)
Muslim	13 (10.9%)	6 (5.3%)	19 (8.2%)	5 (4%)	7 (5.8%)	12 (4.9%)
Other	-	-	-	18 (14.4%)	5 (4.2%)	23 (9.4%)

In addition to changes in the demographic characteristics between the two countries, *t*-tests at T1 showed significant differences in compassion to and from others, inadequate-self, and anxiety, which were all higher in UK participants. Fear of compassion to self/others and from others, reassured-self, hated-self, and external shame, were all significantly higher in Sri Lankan participants. In the Sri Lankan sample, significant differences were indicated in fear of compassion from others, and fear of self-compassion between the CMT and WLC groups, with the CMT group indicating greater scores. No significant differences were indicated at T1 between the CMT and WLC groups in the UK sample (Table 6.4).

Table 6.4. Sample Characteristics at Baseline-1.

	Differences between countries			**Differences between conditions**					
	SL	UK		Sri Lankan Sample			UK Sample		
	N = 232	N = 245	**Difference Tests**	**CMT**	**WLC**	**Difference Tests**	**CMT**	**WLC**	**Difference Tests**
	M (SD)	*M (SD)*		*M (SD)*	*M (SD)*		*M (SD)*	*M (SD)*	
Self-Compassion	57.25 (16.79)	57.20 (13.57)	$t(444) = .04$, $p = .972$	58.79 (16.95)	55.63 (16.55)	$t(230) = 1.44$, $p = .152$	57.48 (13.01)	56.91 (14.10)	$t(243) = .33$, $p = .742$
Compassion to others	58.27 (16.73)	72.62 (15.14)	$t(475) = -9.83$, $\mathbf{p < .001}$	59.58 (16.48)	56.89 (16.96)	$t(230) = 1.22$, $p = .222$	71.98 (15.29)	73.28 (15.01)	$t(243) = -.67$, $p = .503$
Compassion from others	55.74 (16.39)	59.08 (15.54)	$t(475) = -2.29$, $\mathbf{p = .023}$	56.51 (16.45)	54.92 (16.35)	$t(230) = .74$, $p = .461$	57.55 (15.49)	60.68 (15.50)	$t(243) = -1.58$, $p = .116$
Fear of compassion to others	31.12 (5.67)	28.02 (6.94)	$t(456) = 5.36$, $\mathbf{p < .001}$	31.45 (5.67)	30.78 (5.67)	$t(230) = .90$, $p = .372$	28.16 (7.27)	27.88 (6.60)	$t(243) = .321$, $p = .749$
Fear of compassion from others	38.59 (8.78)	32.60 (10.18)	$t(471) = 6.89$, $\mathbf{p < .001}$	39.87 (9.42)	37.24 (7.87)	$t(230) = 2.30$, $\mathbf{p = .022}$	33.18 (10.57)	31.99 (9.76)	$t(243) = .91$, $p = .364$
Fear of self-compassion	42.11 (10.90)	36.76 (13.54)	$t(463) = 4.76$, $\mathbf{p < .001}$	43.53 (10.89)	40.61 (10.75)	$t(230) = 2.05$, $\mathbf{p = .041}$	36.89 (13.51)	36.63 (13.63)	$t(243) = .15$, $p = .883$
Inadequate self	17.44 (5.31)	21.36 (7.36)	$t(444) = -6.68$, $\mathbf{p < .001}$	17.93 (5.38)	16.93 (5.22)	$t(230) = 1.44$, $p = .151$	21.51 (7.71)	21.19 (7.02)	$t(243) = .34$, $p = .734$
Reassured self	17.80 (5.12)	16.19 (5.89)	$t(475) = 3.18$, $\mathbf{p = .002}$	18.26 (4.92)	17.32 (5.30)	$t(230) = 1.41$, $p = .162$	16.45 (5.97)	15.93 (5.81)	$t(243) = .70$, $p = .488$
Hated self	2.04 (.66)	1.91 (.75)	$t(473) = 2.12$, $\mathbf{p = .035}$	2.12 (.70)	1.96 (.61)	$t(228) = 1.77$, $p = .078$	1.94 (.75)	1.88 (.75)	$t(243) = .64$, $p = .525$
External shame	49.81 (12.16)	46.19 (13.29)	$t(475) = 3.10$, $\mathbf{p = .002}$	50.85 (12.56)	48.71 (11.67)	$t(230) = 1.34$, $p = .181$	46.36 (13.57)	46.01 (13.05)	$t(243) = .21$, $p = .836$

	Differences between countries			**Differences between conditions**					
	SL	UK		Sri Lankan Sample			UK Sample		
	N = 232	N = 245	**Difference Tests**	**CMT**	**WLC**	**Difference Tests**	**CMT**	**WLC**	**Difference Tests**
	M (SD)	*M (SD)*		*M (SD)*	*M (SD)*		*M (SD)*	*M (SD)*	
Social safeness	34.49 (7.07)	35.81 (8.13)	$t(472) = -1.90$, $p = .058$	35.09 (7.19)	33.85 (6.92)	$t(230) = 1.34$, $p = .181$	35.95 (8.18)	35.66 (8.11)	$t(243) = .28$, $p = .778$
Anxiety	15.93 (3.75)	17.02 (5.32)	$t(439) = -2.61$, $\mathbf{p = .010}$	16.00 (4.00)	15.85 (3.48)	$t(230) = .31$, $p = .761$	17.10 (5.28)	16.94 (5.39)	$t(243) = .23$, $p = .821$
Depression	19.45 (5.04)	20.23 (6.18)	$t(465) = -1.52$, $p = .128$	19.54 (5.29)	19.35 (4.78)	$t(230) = .28$, $p = .782$	19.94 (6.05)	20.54 (6.32)	$t(243) = -.77$, $p = .444$
Well-being	43.72 (9.22)	42.08 (9.18)	$t(475) = 1.94$, $p = .052$	43.97 (9.87)	43.46 (8.52)	$t(230) = .42$, $p = .677$	42.56 (9.23)	41.58 (9.24)	$t(243) = .83$, $p = .406$

6.3.3 Efficacy of the CMT: Sri Lankan Participants

Results of the mixed factorial 2 x 2 ANOVA showed a significant time × group (T1 vs T2; CMT vs WLC) interaction among all three flows of compassion (self-compassion, compassion to others, and compassion from others), with small effect sizes in the ITT analysis and large effect sizes in the PP analysis. This indicates that participants in the CMT group reported significant improvements in all three flows of compassion across time upon receiving the CMT as compared to the WLC group.

In addition, significant interactions were found for fear of compassion from others, fear of self-compassion, inadequate-self, reassured-self, social safeness and pleasure, and well-being with small effects in the ITT and large effects in the PP in all interactions. This indicates that facilitators of compassion (reassured-self, social safeness and pleasure, and well-being) significantly increased in the CMT group at T2, and the inhibitors of compassion (fear of compassion from others, fear of self-compassion, and inadequate-self) significantly reduced, when compared to the WLC group at T2 (see Table 6.5 for mean differences and ANOVA results of the ITT, and Table 6.6 for equivalent PP results). Some significant main effects of time (on hated self, and anxiety) were also identified.

Table 6.5. Pre-Post Intention to Treat Analyses of the Sri Lankan Participants.

Measure	**Time**	**CMT Group** (T1n = 119) ***M (SD)***	**WLC Group** (T1 n = 113) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Self-Compassion	T1	58.79 (16.95)	55.63 (16.55)	$F_{(1, 230)}$ = 6.41, ***p* = .012**, η_p^2 = .03	$F_{(1, 230)}$ = 6.95, ***p* = .009**, η_p^2 = .03	$F_{(1, 230)}$ = 4.52, ***p* = .035**, η_p^2 = .02
	T2	61.43 (16.48)	55.58 (16.39)			
Compassion to others	T1	59.58 (16.48)	56.89 (16.96)	$F_{(1, 230)}$ = 8.30, ***p* = .004**, η_p^2 = .04	$F_{(1, 230)}$ = 9.80, ***p* = .002**, η_p^2 = .04	$F_{(1, 230)}$ = 4.08, ***p* = .045**, η_p^2 =.02
	T2	62.57 (15.63)	56.77 (16.68)			
Compassion from others	T1	56.52 (16.45)	54.92 (16.35)	$F_{(1, 230)}$ = 5.72, ***p* = .018**, η_p^2 = .02	$F_{(1, 230)}$ = 7.56, ***p* = .006**, η_p^2 = .03	$F_{(1, 230)}$ = 2.17, *p* = .142, η_p^2 = .01
	T2	59.18 (15.45)	54.73 (16.19)			
Fear of compassion to others	T1	31.45 (5.67)	30.78 (5.67)	$F_{(1, 230)}$ = .05, *p* = .827, η_p^2 =.00	$F_{(1, 230)}$ = .26, *p* = .614, η_p^2 = .00	$F_{(1, 230)}$ = .66, *p* = .416, η_p^2 = .00
	T2	31.40 (5.60)	30.88 (5.65)			
Fear of compassion from others	T1	39.87 (9.42)	37.24 (7.87)	$F_{(1, 230)}$ = .96, *p* = .327, η_p^2 = .00	$F_{(1, 230)}$ = 5.65, ***p* = .018**, η_p^2 =.02	$F_{(1, 230)}$ = 3.79, *p* = .055, η_p^2 =.02
	T2	39.27 (9.43)	37.49 (7.96)			
Fear of self-compassion	T1	43.53 (10.89)	40.61 (10.75)	$F_{(1, 230)}$ = 3.27, *p* = .072, η_p^2 = .01	$F_{(1, 230)}$ = 9.47, ***p* = .002**, η_p^2 = .04	$F_{(1, 230)}$ = 2.31, *p* = .130, η_p^2 = .01
	T2	42.24 (10.72)	40.95 (10.55)			

Measure	**Time**	**CMT Group** (T1n = 119) ***M (SD)***	**WLC Group** (T1 n = 113) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Inadequate self	T1	17.93 (5.38)	16.93 (5.22)	$F_{(1, 230)} = 1.95$, $p = .164$, $\eta_p^2 = .01$	$F_{(1, 230)} = 5.98$, $\mathbf{p = .015}$, $\eta_p^2 = .03$	$F_{(1, 230)} = 1.10$, $p = .297$, $\eta_p^2 = .01$
	T2	17.48 (5.32)	17.05 (5.18)			
Reassured self	T1	18.26 (4.92)	17.32 (5.30)	$F_{(1, 230)} = 4.84$, $\mathbf{p = .029}$, $\eta_p^2 = .02$	$F_{(1, 230)} = 4.10$, $\mathbf{p = .044}$, $\eta_p^2 = .02$	$F_{(1, 230)} = 3.65$, $p = .057$, $\eta_p^2 = .02$
	T2	18.90 (4.90)	17.35 (5.30)			
Hated self	T1	2.12 (.70)	1.96 (.61)	$F_{(1, 230)} = 6.11$, $\mathbf{p = .014}$, $\eta_p^2 = .03$	$F_{(1, 230)} = .00$, $p = .949$, $\eta_p^2 = .00$	$F_{(1, 230)} = 3.22$, $p = .074$, $\eta_p^2 = .01$
	T2	2.09 (.70)	1.94 (.60)			
External shame	T1	50.85 (12.56)	48.71 (11.67)	$F_{(1, 230)} = 2.04$, $p = .155$, $\eta_p^2 = .01$	$F_{(1, 230)} = .02$, $p = .877$, $\eta_p^2 = .00$	$F_{(1, 230)} = 1.85$, $p = .175$, $\eta_p^2 = .01$
	T2	50.76 (12.38)	48.59 (11.53)			
Social safeness	T1	35.09 (7.19)	33.85 (6.92)	$F_{(1, 230)} = 6.13$, $\mathbf{p = .014}$, $\eta_p^2 = .03$	$F_{(1, 230)} = 9.41$, $\mathbf{p = .002}$, $\eta_p^2 = .04$	$F_{(1, 230)} = 4.70$, $\mathbf{p = .031}$, $\eta_p^2 = .02$
	T2	36.34 (7.15)	33.72 (6.69)			
Anxiety	T1	16.00 (4.00)	15.85 (3.48)	$F_{(1, 230)} = 5.02$, $\mathbf{p = .026}$, $\eta_p^2 = .02$	$F_{(1, 230)} = 1.91$ $p = .168$, $\eta_p^2 = .01$	$F_{(1, 230)} = .00$, $p = .963$, $\eta_p^2 = .00$
	T2	15.66 (4.04)	15.77 (3.29)			

Measure	**Time**	**CMT Group** (T1n = 119) ***M (SD)***	**WLC Group** (T1 n = 113) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Depression	T1	19.54 (5.29)	19.35 (4.78)	$F_{(1, 230)} = .09$, $p = .762$, $\eta_p^2 = .00$	$F_{(1, 230)} = 1.61$, $p = .206$, $\eta_p^2 = .01$	$F_{(1, 230)} = .02$, $p = .877$, $\eta_p^2 = .00$
	T2	19.44 (5.30)	19.42 (4.82)			
Well-being	T1	43.97 (9.87)	43.46 (8.52)	$F_{(1, 230)} = 3.78$, $p = .053$, $\eta_p^2 = .02$	$F_{(1, 230)} = 9.81$ ***p* = .002**, $\eta_p^2 = .04$	$F_{(1, 230)} = 1.28$, $p = .260$, $\eta_p^2 = .01$
	T2	45.33 (9.95)	43.14 (8.71)			

Table 6.6. Pre-Post Per Protocol Analyses of the Sri Lankan Participants.

Measure	**Time**	**CMT Group** (T2n = 21) ***M (SD)***	**WLC Group** (T2n = 17) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Self-Compassion	T1	61.00 (21.06)	66.12 (13.20)	$F_{(1, 36)} = 7.19$, ***p* = .011**, $\eta_p^2 = .17$	$F_{(1, 36)} = 7.90$, ***p* = .008**, $\eta_p^2 = .18$	$F_{(1, 36)} = .41$, $p = .529$, $\eta_p^2 = .01$
	T2	75.95 (9.36)	65.76 (12.10)			
Compassion to others	T1	58.71 (21.95)	71.65 (12.20)	$F_{(1, 36)} = 10.70$, ***p* = .002**, $\eta_p^2 = .23$	$F_{(1, 36)} = 13.00$, ***p* < .001,** $\eta_p^2 = .27$	$F_{(1, 36)} = .94$, $p = .338$, $\eta_p^2 = .03$
	T2	75.67 (10.20)	70.82 (10.43)			
Compassion from others	T1	57.43 (22.38)	66.71 (9.40)	$F_{(1, 36)} = 6.28$, ***p* = .017**, $\eta_p^2 = .15$	$F_{(1, 36)} = 8.71$, ***p* = .006**, $\eta_p^2 = .20$	$F_{(1, 36)} = .09$, $p = .770$, $\eta_p^2 = .00$
	T2	72.57 (9.23)	65.47 (9.05)			

Measure	**Time**	**CMT Group** (T2n = 21) ***M (SD)***	**WLC Group** (T2n = 17) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Fear of compassion to others	T1	33.05 (6.23)	33.65 (6.27)	$F_{(1, 36) =}$ .07, p = .800, η_p^2 = .00	$F_{(1, 36)}$ = .27, p = .610, η_p^2 = .01	$F_{(1, 36)}$ = .38, p = 543, η_p^2 = .01
	T2	32.81 (5.88)	34.35 (5.78)			
Fear of compassion from others	T1	44.10 (9.19)	37.47 (8.17)	$F_{(1, 36)}$ = .70, p = .407, η_p^2 = .02	$F_{(1, 36)}$ = 5.91, ***p* = .020**, η_p^2 = .14	$F_{(1, 36)}$ = 2.16, p = .151, η_p^2 = .06
	T2	40.71 (10.27)	39.12 (8.52)			
Fear of self-compassion	T1	48.14 (12.67)	39.47 (13.09)	$F_{(1, 36)}$ = 3.21, p = .082, η_p^2 = .08	$F_{(1, 36)}$ = 11.29, ***p* = .002**, η_p^2 = .24	$F_{(1, 36)}$ = 1.01, p = .322, η_p^2 = .03
	T2	40.81 (12.77)	41.71 (11.94)			
Inadequate self	T1	21.05 (5.00)	20.76 (5.40)	$F_{(1, 36)}$ = 1.67, p = .205, η_p^2 = .04	$F_{(1, 36)}$ = 6.29, ***p* = .017**, η_p^2 = .15	$F_{(1, 36)}$ = .84, p = .365, η_p^2 = .02
	T2	18.48 (5.69)	21.59 (4.37)			
Reassured self	T1	18.41 (6.25)	20.81 (5.24)	$F_{(1, 41)}$ = 5.68, ***p* = .022,** η_p^2 = .12	$F_{(1, 41)}$ = 4.81**, *p* = .034**, η_p^2 = .11	$F_{(1, 41)}$ = .25, p = .621, η_p^2 = .01
	T2	21.86 (5.20)	20.95 (5.15)			
Hated self	T1	2.33 (.80)	1.89 (.74)	$F_{(1, 38)}$ = 6.73, ***p* = .013**, η_p^2 = .15	$F_{(1, 38)}$ = .02, p = .898, η_p^2 = .00	$F_{(1, 38)}$ = 3.70, p = .062, η_p^2 = .09
	T2	2.19 (.81)	1.74 (.65)			

Measure	**Time**	**CMT Group** (T2n = 21) ***M (SD)***	**WLC Group** (T2n = 17) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
External shame	T1	54.09 (13.18)	48.29 (13.88)	$F_{(1, 37)} = 2.11$, $p = .154$, $\eta_p^2 = .05$	$F_{(1, 37)} = .09$, $p = .763$, $\eta_p^2 = .00$	$F_{(1, 37)} = 2.00$, $p = .166$, $\eta_p^2 = .05$
	T2	53.59 (12.33)	47.53 (12.95)			
Social safeness	T1	34.62 (7.90)	38.71 (6.51)	$F_{(1, 36)} = 7.08$, $\mathbf{p = .012}$, $\eta_p^2 = .16$	$F_{(1, 36)} = 11.72$, $\mathbf{p = .002}$, $\eta_p^2 = .25$	$F_{(1, 36)} = .01$, $p = .943$, $\eta_p^2 = .00$
	T2	41.67 (4.87)	37.82 (5.34)			
Anxiety	T1	18.05 (3.92)	16.12 (4.74)	$F_{(1, 36)} = 5.11$, $\mathbf{p = .030,}$ $\eta_p^2 = .12$	$F_{(1, 36)} = 1.63$, $p = .210$, $\eta_p^2 = .04$	$F_{(1, 36)} = .93$, $p = .342$, $\eta_p^2 = .03$
	T2	16.14 (4.72)	15.59 (3.64)			
Depression	T1	21.14 (6.42)	19.47 (7.02)	$F_{(1, 36)} = .046$, $p = .841$, $\eta_p^2 = .00$	$F_{(1, 23)} = 1.55$, $p = .222$, $\eta_p^2 = .04$	$F_{(1, 36)} = .29$, $p = .591$, $\eta_p^2 = .01$
	T2	20.57 (6.61)	19.88 (7.18)			
Well-being	T1	45.62 (10.45)	47.12 (8.35)	$F_{(1, 36)} = 3.86$, $p = .057$, $\eta_p^2 = .10$	$F_{(1, 36)} = 11.92$, $\mathbf{p = .001}$, $\eta_p^2 = .25$	$F_{(1, 36)} = 1.79$, $p = .189$, $\eta_p^2 = .05$
	T2	53.33 (6.32)	45.00 (10.24)			

6.3.4 Efficacy of the CMT: UK Participants

Results of the mixed factorial 2 x 2 ANOVA showed a significant time × group (T1 vs T2; CMT vs WLC) interaction among all three flows of compassion with a large effect size for self-compassion, and small effect sizes for compassion to others and compassion from others in the ITT and PP analyses. This indicates that participants in the CMT group reported significant improvements in all three flows of compassion across time upon receiving the CMT as compared to the WLC group.

In addition, significant interactions were reported for all three types of fears of compassion (fear of compassion to others with a small effect size in ITT and medium effect size in PP, fear of compassion from others with small effect sizes in ITT and PP, and fear of self-compassion with small effect sizes in ITT and PP). Significant interactions with small effect sizes were also reported for external shame, anxiety, and depression in the ITT and PP analyses, and a significant interaction with a medium effect size was found for inadequate self in the ITT and PP analyses. The results indicated that the inhibitors of compassion reduced, although no significant improvements were reported for the facilitators of compassion (e.g., reassured self, social safeness, well-being). A significant main effect of time was identified on social safeness (see Table 6.7 for ITT and Table 6.8 for PP analyses).

Table 6.7. Pre-Post Intention to Treat Analyses of the UK Participants.

Measure	**Time**	**CMT Group** (T1n = 125) ***M (SD)***	**WLC Group** (T1n = 120) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Self-Compassion	T1	57.48 (13.08)	56.91 (14.10)	$F_{(1, 243)}$ = 14.51, ***p* < .001**, η_p^2 = .06	$F_{(1, 243)}$ = 34.22, ***p* < .001**, η_p^2 = .12	$F_{(1, 243)}$ = 4.37, ***p* = .038**, η_p^2 = .02
	T2	62.49 (14.13)	55.85 (15.04)			
Compassion to others	T1	71. 98 (15.29)	73.28 (15.01)	$F_{(1, 243)}$ = 7.57, ***p* = .006**, η_p^2 = .03	$F_{(1, 243)}$ = 7.09, ***p* = .008**, η_p^2 = .03	$F_{(1, 243)}$ = .02, *p* = .880, η_p^2 =.00
	T2	74.04 (15.35)	73.32 (14.90)			
Compassion from others	T1	57.55 (15.49)	60.68 (15.50)	$F_{(1, 243)}$ = 9.23, ***p* = .003**, η_p^2 = .04	$F_{(1, 243)}$ = 7.67, ***p* = .006**, η_p^2 = .03	$F_{(1, 243)}$ = .61, *p* = .436, η_p^2 = .00
	T2	60.97 (16.00)	60.83 (16.70)			
Fear of compassion to others	T1	28.16 (7.27)	27.87 (6.60)	$F_{(1, 243)}$ = 13.79, ***p* < .001**, η_p^2 =.05	$F_{(1, 243)}$ = 10.15, ***p* = .002**, η_p^2 = .04	$F_{(1, 243)}$ = .49, *p* = .484, η_p^2 = .00
	T2	26.20 (8.16)	27.73 (6.90)			
Fear of compassion from others	T1	33.18 (10.57)	31.99 (9.76)	$F_{(1, 243)}$ = 11.54, ***p* < .001**, η_p^2 = .05	$F_{(1, 243)}$ = 6.71, ***p* = .010**, η_p^2 =.03	$F_{(1, 243)}$ = .09, *p* = .765, η_p^2 =.00
	T2	31.32 (10.87)	31.74 (9.70)			

Measure	**Time**	**CMT Group** (T1n = 125) ***M (SD)***	**WLC Group** (T1n = 120) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Fear of self-compassion	T1	36.89 (13.51)	36.63 (13.63)	$F_{(1, 243)} = 8.72$, ***p* = .003**, $\eta_p^2 = .04$	$F_{(1, 243)} = 8.60$, ***p* = .004**, $\eta_p^2 = .03$	$F_{(1, 243)} = .34$, $p = .563$, $\eta_p^2 = .00$
	T2	34.38 (14.61)	36.63 (13.67)			
Inadequate self	T1	21.51 (7.71)	21.34 (6.96)	$F_{(1, 243)} = 22.75$, ***p* < .001**, $\eta_p^2 = .09$	$F_{(1, 243)} = 15.08$, ***p* < .001**, $\eta_p^2 = .06$	$F_{(1, 243)} = 1.14$, $p = .287$, $\eta_p^2 = .00$
	T2	18.99 (7.86)	21.06 (7.03)			
Reassure self	T1	16.45 (5.97)	15.93 (5.81)	$F_{(1, 243)} = 3.83$, $p = .051$, $\eta_p^2 = .02$	$F_{(1, 243)} = .01$, $p = .919$, $\eta_p^2 = .00$	$F_{(1, 243)} = .55$, $p = .459$, $\eta_p^2 = .00$
	T2	16.74 (5.58)	16.19 (5.79)			
Hated self	T1	1.94 (.75)	1.88 (.75)	$F_{(1, 243)} = .99$, $p = .321$, $\eta_p^2 = .00$	$F_{(1, 243)} = .03$, $p = .858$, $\eta_p^2 = .00$	$F_{(1, 243)} = .47$, $p = .495$, $\eta_p^2 = .00$
	T2	1.96 (.78)	1.89 (.75)			
External shame	T1	46.36 (13.57)	46.01 (13.05)	$F_{(1, 243)} = 8.49$, ***p* = .004**, $\eta_p^2 = .03$	$F_{(1, 243)} = 5.81$, ***p* = .017**, $\eta_p^2 = .02$	$F_{(1, 243)} = .17$, $p = .682$, $\eta_p^2 =.00$
	T2	44.07 (14.46)	45.79 (12.76)			
Social safeness	T1	35.95 (8.18)	35.66 (8.11)	$F_{(1, 243)} = 19.52$, ***p* < .001**, $\eta_p^2 = .07$	$F_{(1, 243)} = 2.61$, $p = .107$, $\eta_p^2 = .01$	$F_{(1, 243)} = .57$, $p = .451$, $\eta_p^2 = .00$
	T2	37.73 (8.54)	36.48 (8.36)			

Measure	**Time**	**CMT Group** (T1n = 125) ***M (SD)***	**WLC Group** (T1n = 120) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Anxiety	T1	17.10 (5.28)	16.94 (5.39)	$F_{(1, 243)} = 16.84$, ***p* < .001**, $\eta_p^2 = .07$	$F_{(1, 243)} = 8.45$, ***p* = .004**, $\eta_p^2 = .03$	$F_{(1, 243)} = .55$, $p = .459$, $\eta_p^2 = .00$
	T2	15.58 (5.17)	16.68 (5.21)			
Depression	T1	19.94 (6.05)	20.54 (6.32)	$F_{(1, 243)} = 15.72$, ***p* < .001**, $\eta_p^2 = .06$	$F_{(1, 243)} = 6.39$, ***p* = .012**, $\eta_p^2 = .03$	$F_{(1, 243)} = 2.37$, $p = .125$, $\eta_p^2 = .01$
	T2	18.50 (5.81)	20.22 (6.47)			
Well-being	T1	42.56 (9.13)	41.58 (9.24)	$F_{(1, 243)} = 3.50$ $p = .062$, $\eta_p^2 = .01$	$F_{(1, 243)} = 1.60$, $p = .207$, $\eta_p^2 = .01$	$F_{(1, 243)} = 1.47$, $p = .227$, $\eta_p^2 = .01$
	T2	43.64 (10.11)	41.79 (9.53)			

Table 6.8. Pre-Post Per Protocol Analyses of the UK Participants.

Measure	**Time**	**CMT Group** (T2n = 73) ***M (SD)***	**WLC Group** (T2n = 54) ***M (SD)***	**Tests of within-subject effects**		**Tests of between-subject effects**
				Time	**Time × Group**	**Group**
Self-Compassion	T1	57.99 (12.76)	58.24 (13.54)	$F_{(1, 125)} = 11.05$, ***p* = .001**, $\eta_p^2 = .08$	$F_{(1, 125)} = 34.06$, ***p* < .001**, $\eta_p^2 = .21$	$F_{(1, 125)} = 5.25$, ***p* = .024**, $\eta_p^2 = .04$
	T2	66.56 (13.12)	65.89 (15.74)			

Measure	Time	CMT Group (T2n = 73) *M (SD)*	WLC Group (T2n = 54) *M (SD)*	Tests of within-subject effects: Time	Tests of within-subject effects: Time × Group	Tests of between-subject effects: Group
Compassion to others	T1	74.82 (12.12)	75.28 (11.53)	$F_{(1, 128)} = 6.44$, ***p* = .012**, $\eta_p^2 = .05$	$F_{(1, 128)} = 5.94$, ***p* = .016**, $\eta_p^2 = .04$	$F_{(1, 128)} = .44$, $p = .509$, $\eta_p^2 = .00$
	T2	78.34 (11.15)	75.35 (11.22)			
Compassion from others	T1	58.32 (15.01)	61.53 (16.16)	$F_{(1, 128)} = 8.01$, ***p* = .005**, $\eta_p^2 = .06$	$F_{(1, 128)} = 6.38$, ***p* = .013**, $\eta_p^2 = .05$	$F_{(1, 128)} = .03$, $p = .859$, $\eta_p^2 = .00$
	T2	64.16 (15.16)	61.86 (16.53)			
Fear of compassion to others	T1	28.23 (7.21)	27.56 (6.74)	$F_{(1, 128)} = 12.39$, ***p* < .001**, $\eta_p^2 = .09$	$F_{(1, 128)} = 8.50$, ***p* = .004**, $\eta_p^2 = .06$	$F_{(1, 128)} = .48$, $p = .488$, $\eta_p^2 = .00$
	T2	24.88 (8.44)	27.25 (7.32)			
Fear of compassion from others	T1	31.34 (9.99)	31.21 (9.57)	$F_{(1, 128)} = 10.40$, ***p* = .002**, $\eta_p^2 = .08$	$F_{(1, 128)} = 5.33$, ***p* = .023**, $\eta_p^2 = .04$	$F_{(1, 128)} = .55$ $p = .461$, $\eta_p^2 = .00$
	T2	28.16 (9.73)	30.68 (9.39)			
Fear of self-compassion	T1	35.33 (13.15)	34.75 (13.79)	$F_{(1, 128)} = 7.43$, ***p* = .007**, $\eta_p^2 = .06$	$F_{(1, 128)} = 7.31$, ***p* = .008**, $\eta_p^2 = .05$	$F_{(1, 128)} = .47$, $p = .496$, $\eta_p^2 = .00$
	T2	31.03 (14.32)	34.74 (13.80)			
Inadequate self	T1	22.12 (8.15)	21.84 (6.79)	$F_{(1, 128)} = 21.62$, ***p* < .001**, $\eta_p^2 = .15$	$F_{(1, 128)} = 13.02$, ***p* < .001**, $\eta_p^2 = .09$	$F_{(1, 128)} = 1.66$, $p = .200$, $\eta_p^2 = .01$
	T2	17.81 (8.24)	21.30 (6.96)			
Reassure self	T1	16.36 (6.47)	15.77 (6.05)	$F_{(1, 128)} = 3.86$, $p = .052$, $\eta_p^2 = .03$	$F_{(1, 128)} = .01$, $p = .920$, $\eta_p^2 = .00$	$F_{(1, 128)} = .29$, $p = .594$ $\eta_p^2 = .00$
	T2	16.86 (5.83)	16.33 (6.01)			

Measure	**Time**	**CMT Group** (T2n = 73) ***M (SD)***	**WLC Group** (T2n = 54) ***M (SD)***	**Tests of within-subject effects** **Time**	**Time × Group**	**Tests of between-subject effects** **Group**
Hated self	T1	1.90 (.77)	1.70 (.73)	$F_{(1, 128)} = .96$, $p = .329$, $\eta_p^2 = .01$	$F_{(1, 128)} = .01$, $p = .939$, $\eta_p^2 = .00$	$F_{(1, 128)} = 2.49$, $p = .117$, $\eta_p^2 = .02$
	T2	1.95 (.81)	1.74 (.74)			
External shame	T1	45.01 (13.42)	43.42 (12.29)	$F_{(1, 128)} = 7.45$, $\mathbf{p = .007}$, $\eta_p^2 = .06$	$F_{(1, 128)} = 4.67$, $\mathbf{p = .033}$, $\eta_p^2 = .04$	$F_{(1, 128)} = .00$, $p = .949$, $\eta_p^2 = .00$
	T2	41.10 (14.35)	42.96 (11.53)			
Social safeness	T1	35.89 (8.52)	35.51 (7.91)	$F_{(1, 128)} = 19.55$, $\mathbf{p < .001}$, $\eta_p^2 = .13$	$F_{(1, 128)} = 1.46$, $p = .230$, $\eta_p^2 = .01$	$F_{(1, 128)} = .55$, $p = .461$, $\eta_p^2 = .00$
	T2	38.93 (8.92)	37.25 (8.38)			
Anxiety	T1	17.18 (5.37)	17.42 (5.57)	$F_{(1, 128)} = 15.73$, $\mathbf{p < .001,}$ $\eta_p^2 = .11$	$F_{(1, 128)} = 6.71$, $\mathbf{p = .011}$, $\eta_p^2 = .05$	$F_{(1, 128)} = 2.25$, $p = .136$, $\eta_p^2 = .02$
	T2	14.59 (4.94)	16.88 (5.23)			
Depression	T1	19.85 (6.03)	20.72 (5.99)	$F_{(1, 128)} = 14.77$, $\mathbf{p < .001}$, $\eta_p^2 = .10$	$F_{(1, 128)} = 4.84$, $\mathbf{p = .030}$, $\eta_p^2 = .04$	$F_{(1, 128)} = 3.37$, $p = .069$, $\eta_p^2 = .03$
	T2	17.40 (5.34)	20.05 (6.33)			
Well-being	T1	43.26 (8.77)	41.53 (8.00)	$F_{(1, 128)} = 3.09$, $p = .081$, $\eta_p^2 = .02$	$F_{(1, 128)} = 1.18$, $p = .280$, $\eta_p^2 = .01$	$F_{(1, 128)} = 2.79$, $p = .097$, $\eta_p^2 = .02$
	T2	45.11 (10.25)	41.96 (8.70)			

6.3.5 Maintenance of Efficacy of the CMT at Follow-Up: Sri Lankan Participants

A repeated measures ANOVA was used to investigate whether the efficacy of CMT was maintained at follow-up (T3) two weeks after completing the CMT[1]. Results indicated that all changes observed at post-intervention were maintained at follow-up.

Results for each of the three flows of compassion showed self-compassion, compassion to others, and compassion from others differed significantly across the three time points, with large effect sizes. Bonferroni corrected tests indicated that all three flows of compassion increased significantly from T1 (baseline 1) to T2 (post-intervention), and T1 (baseline 1) to T3 (follow-up), but not from T2 (post-intervention) to T3 (follow-up). Similarly, fear of compassion from others, fear of self-compassion, and inadequate self also changed significantly with large effects across the three time points, again with significant changes between T1 to T2 and T1 to T3, but not with T2 to T3. Although no changes were reported post CMT, anxiety and depression scores indicated a significant change with a large effect across time at follow-up, with only a significant change from T1 to T3 in anxiety (although there was an overall significant ANOVA for depression, none of the pairwise comparisons were significant). Significant large effects were indicated for reassured-self with a significant change from T1 to T2 but not from T1 to T3 or T2 to T3. Social safeness and well-being outcomes changed significantly with large effects, indicating significant increases from T1 to T2, and T1 to T3, but not from T2 to T3 (Table 6.9).

[1] T3 was different for the CMT and WLC groups in which only the CMT group completed follow-up measures at T3. Only PP analyses were carried out at T3 for the CMT group.

Table 6.9. Changes across Time in the Sri Lankan Participants.

Measure	**Time**	**CMT Group** (n_{T1}= 119, n_{T2} = 21, n_{T3} = 19) **M (SD)**	**Tests of within-subject effects**	**T1 vs T2**		**T1 vs T3**		**T2 vs T3**	
			Time	***MD***	**Sig.**	***MD***	**Sig.**	***MD***	**Sig.**
Self-Compassion	T1	60.32 (22.04)	$F_{(1, 19)}$ = 9.37, ***p* = .006**, η_p^2 = .34	-15.42	**.013**	-14.74	**.027**	.68	1.000
	T2	75.74 (9.47)							
	T3	75.05 (10.15)							
Compassion to others	T1	57.26 (22.49)	$F_{(1, 19)}$ = 14.37, ***p* = .001**, η_p^2 = .44	-17.37	**.003**	-17.16	**.005**	.21	1.000
	T2	74.63 (10.17)							
	T3	74.42 (11.45)							
Compassion from others	T1	57.37 (23.59)	$F_{(1, 19)}$ = 7.90, ***p* = .010**, η_p^2 = .31	-15.26	**.030**	-15.05	**.037**	.21	1.000
	T2	72.63 (9.73)							
	T3	72.42 (10.80)							
Fear of compassion to others	T1	32.74 (6.47)	$F_{(1, 24)}$ = .06, *p* = .879, η_p^2 = .00	-.21	1.0	.16	1.0	.37	1.000
	T2	32.95 (5.65)							
	T3	32.58 (7.17)							
Fear of compassion from others	T1	44.74 (9.30)	$F_{(1, 21)}$ = 8.17, ***p* = .007**, η_p^2 = .31	3.84	**.038**	4.68	**.022**	.84	.346
	T2	40.89 (10.28)							

Measure	Time	CMT Group (n_{T1}= 119, n_{T2} = 21, n_{T3} = 19) M (SD)	Tests of within-subject effects	T1 vs T2		T1 vs T3		T2 vs T3	
			Time	*MD*	Sig.	*MD*	Sig.	*MD*	Sig.
	T3	40.05 (11.56)							
Fear of self-compassion	T1	48.89 (12.77)	$F_{(1, 19)}$ = 14.62, ***p* < .001**, η_p^2 = .45	7.74	**.005**	8.63	**.002**	.90	.189
	T2	41.16 (13.10)							
	T3	40.26 (13.28)							
Inadequate self	T1	21.11 (5.24)	$F_{(1, 26)}$ = 9.29, ***p* = .002**, η_p^2 = .34	2.84	**.010**	3.21	**.015**	.37	1.000
	T2	18.26 (5.90)							
	T3	17.89 (6.94)							
Reassure self	T1	18.00 (6.10)	$F_{(1, 25)}$ = 7.32, ***p* = .007**, η_p^2 = .29	-4.42	**.003**	-3.47	.121	.95	.855
	T2	22.42 (5.06)							
	T3	21.47 (5.93)							
Hated self	T1	2.32 (.82)	$F_{(2, 36)}$ = 2.52, p = .095, η_p^2 = .12	.16	.248	.053	.992	-.11	.488
	T2	2.16 (.83)							
	T3	2.63 (.87)							
External shame	T1	54.37 (14.09)	$F_{(2, 27)}$ = 2.94, p = .082, η_p^2 = .14	.32	1.000	1.84	.239	1.53	.232
	T2	54.05 (13.09)							
	T3	52.53 (13.41)							

Measure	Time	CMT Group (n_{T1}= 119, n_{T2} = 21, n_{T3} = 19) M (SD)	Tests of within-subject effects	T1 vs T2		T1 vs T3		T2 vs T3	
			Time	*MD*	Sig.	*MD*	Sig.	*MD*	Sig.
Social safeness and pleasure	T1	34.16 (8.01)	$F_{(1, 21)}$ = 16.43, ***p* < .001**, η_p^2 = .48	-7.37	**.002**	-7.47	**.002**	-.12	1.000
	T2	41.53 (5.10)							
	T3	41.63 (5.91)							
Anxiety	T1	17.63 (3.89)	$F_{(1, 22)}$ = 6.80, ***p* = .012**, η_p^2 = .27	1.90	.051	1.84	**.037**	-.053	1.000
	T2	15.74 (4.74)							
	T3	15.79 (4.88)							
Depression	T1	21.26 (6.05)	$F_{(2, 36)}$ = 3.41, ***p* = .044**, η_p^2 = .16	.53	.140	.63	.126	.11	1.000
	T2	20.74 (6.09)							
	T3	20.63 (6.30)							
Well-being	T1	45.63 (10.86)	$F_{(1, 20)}$ = 11.12, ***p* = .002**, η_p^2 = .38	-7.37	**.009**	-7.16	**.010**	.211	1.000
	T2	53.00 (6.57)							
	T3	52.79 (6.48)							

Note. MD = Mean Difference, Sig. = Significance level

6.3.6 Maintenance of Efficacy of the CMT at Follow-Up: UK Participants

A repeated measures ANOVA was used to investigate whether the efficacy of CMT observed for the UK sample was maintained at follow-up (T3) two weeks after completing the CMT. Results indicated that not only were all the changes observed at T2 were maintained at T3, but also further improvements were observed at T3 (Table 6.10).

Results for each of the three flows of compassion indicated significant improvements across the three time points, with large effect sizes in self-compassion and compassion to others, and a medium effect size in compassion from others. Bonferroni corrected tests indicated that each of the three flows of compassion increased significantly from T1 to T2. Self-compassion also increased from T1 to T3, but not from T2 to T3. Similarly, all three types of fears of compassion also changed significantly across the three time points with large effect sizes in fear of compassion to others and fear of compassion from others, and a medium effect size in fear of self-compassion. Other inhibitors of compassion such as inadequate self, external shame, anxiety, and depression also changed significantly across the three time points with a medium effect in external shame and large effects in the other outcomes. Of the facilitators of compassion, social safeness and pleasure increased significantly with a large effect size, which was not reported at post CMT. Significant changes were observed from T1 to T2, T1 to T3, and T2 to T3 in the fear of compassion to others. Significant changes were only observed from T1 to T3 in the fear of compassion from others. For inadequate self, anxiety, and depression, significant changes were found from T1 to T2, and T1 to T3, but not from T2 to T3. A significant change was observed from T1 to T2, but not from T1 to T3 or T2 to T3 in the social safeness and pleasure scores.

Table 6.10. Changes across Time in the UK Participants.

Measure	**Time**	**CMT Group** (n_{T1}= 125, n_{T2} = 73, n_{T3} = 36)	**Tests of within-subject effects**	**T1 vs T2**		**T1 vs T3**		**T2 vs T3**	
		M (SD)	**Time**	***MD***	**Sig.**	***MD***	**Sig.**	***MD***	**Sig.**
Self-Compassion	T1	58.89 (12.66)	$F_{(2, 55)}$ = 21.51, ***p* < .001**, η_p^2 = .38	-9.31	**<.001**	-9.53	**<.002**	-.22	1.000
	T2	68.19 (14.89)							
	T3	68.42 (15.94)							
Compassion to others	T1	76.73 (10.91)	$F_{(2, 72)}$ = 9.08, ***p* < .001**, η_p^2 = .20	-14.35	**<.001**	-1.70	.366	2.65	**.021**
	T2	81.08 (10.23)							
	T3	78.43 (10.95)							
Compassion from others	T1	57.73 (15.96)	$F_{(2, 72)}$ = 4.58, ***p* = .013**, η_p^2 = .11	-6.22	**.028**	-5.37	.109	.84	1.000
	T2	63.95 (16.68)							
	T3	63.11 (16.33)							
Fear of compassion to others	T1	28.43 (7.43)	$F_{(2, 72)}$ = 13.75, ***p* < .001**, η_p^2 = .28	-3.14	**.037**	5.43	**<.001**	2.30	**.047**
	T2	35.30 (9.43)							
	T3	23.00 (8.13)							
Fear of compassion from others	T1	30.03 (8.86)	$F_{(1, 49)}$ = 6.10, ***p* = .010**, η_p^2 = .15	2.97	.129	4.14	**.018**	1.16	.289
	T2	27.05 (10.46)							
	T3	25.89 (19.99)							

Measure	Time	CMT Group (n_{T1}= 125, n_{T2} = 73, n_{T3} = 36)	Tests of within-subject effects	T1 vs T2		T1 vs T3		T2 vs T3	
		M (SD)	Time	*MD*	Sig.	*MD*	Sig.	*MD*	Sig.
Fear of self-compassion	T1	34.59 (11.82)	$F_{(1, 44)}$ = 4.45, ***p* = .033**, η_p^2 = .11	4.19	.083	4.14	.129	-.05	1.000
	T2	30.41 (14.56)							
	T3	30.46 (14.36)							
Inadequate self	T1	22.05 (8.56)	$F_{(1, 52)}$ = 13.38, ***p* < .001**, η_p^2 = .27	4.47	**.003**	5.18	**<.001**	.71	.815
	T2	17.58 (8.83)							
	T3	16.87 (8.83)							
Reassure self	T1	15.97 (7.02)	$F_{(2, 59)}$ = .09, *p* = .885, η_p^2 = .00	.03	1.000	.19	1.000	.17	1.000
	T2	15.94 (6.21)							
	T3	15.78 (5.11)							
Hated self	T1	1.92 (.80)	$F_{(2, 72)}$ = 2.70, *p* = .074, η_p^2 = .07	-.03	1.000	.14	.173	.16	.170
	T2	1.95 (.85)							
	T3	1.78 (.82)							
External shame	T1	45.00 (14.07)	$F_{(1, 54)}$ = 3.75, ***p* = .042**, η_p^2 = .09	4.41	.077	4.73	.164	.32	1.000
	T2	40.59 (15.53)							
	T3	40.27 (16.19)							
Social safeness and pleasure	T1	35.30 (9.01)	$F_{(2, 61)}$ = 7.66, ***p* = .002**, η_p^2 = .18	-4.49	**.002**	-3.00	.094	1.49	.328

Measure	**Time**	**CMT Group** (n_{T1}= 125, n_{T2} = 73, n_{T3} = 36)	**Tests of within-subject effects**	**T1 vs T2**		**T1 vs T3**		**T2 vs T3**	
		M (SD)	**Time**	***MD***	**Sig.**	***MD***	**Sig.**	***MD***	**Sig.**
	T2	39.78 (9.76)							
	T3	38.30 (10.38)							
Anxiety	T1	17.19 (6.35)	$F_{(2, 57)}$ = 8.13, ***p* = .002**, η_p^2 = .18	2.38	**.018**	2.76	**.007**	.38	1.000
	T2	14.81 (5.69)							
	T3	14.43 (5.44)							
Depression	T1	20.05 (6.55)	$F_{(1, 52)}$ = 7.45, ***p* = .004**, η_p^2 = .17	2.73	**.028**	2.81	**.009**	.08	1.000
	T2	17.32 (5.64)							
	T3	16.24 (5.70)							
Well-being	T1	42.97 (9.79)	$F_{(2, 72)}$ = 2.79, p = .068, η_p^2 = .07	-2.89	.142	-2.92	.256	-.03	1.000
	T2	45.86 (11.19)							
	T3	45.89 (11.23)							

Note. MD = Mean Difference, Sig. = Significance level

6.3.7 Feedback on the CMT Engagement

Most of the participants in both countries reported that they were able to engage in the CMT practices “quite well” (ranging from 40% to 46.22%) or “very well’ (ranging from 22.68% to 33.57%) every day, across the 14-day period of the intervention.

In addition, most participants from both countries “strongly agreed” that the CMT was helpful, accessible, and feasible, implying that participants may have had a positive experience from engaging in the CMT practices (Table 6.11). One distinction was that majority of the UK participants only “slightly agreed” that they were able to bring their compassionate self every day (29.9%) post CMT, although majority of the UK participants “strongly agreed” (40.2%) that they were able to continue to bring a compassionate self at follow-up. However, only a few participants from both countries completed the post-intervention (n = 37 Sri Lankan, and n =88 from UK) and follow-up (n = 19 Sri Lankan, and n = 36 UK) feedback questions.

Table 6.11. CMT Engagement Feedback Questions and the Most Common Answers.

Feedback question	Most common answer (%)	
Post-Intervention Feedback	**Sri Lankan sample**	**UK sample**
The psychoeducational video at the beginning of the study was helpful	Strongly agree (63%)	Strongly agree (39.3%)
I found the online CMT practices accessible	Strongly agree (56.5%)	Strongly agree (47.9%)
The CMT practices were feasible to do within the time frame given	Strongly agree (52.2%)	Strongly agree (44.4%)
Going through the CMT practices was worth my time	Strongly agree (34.8%)	Strongly agree (32.5%)
The length of the audio/video materials were too long	Strongly disagree (28.3%)	Strongly disagree (23.9%)
I would be willing to continue practicing the CMT practices frequently	Strongly agree (39.1%)	Strongly agree (34.2%)
I would recommend the CMT practices to my colleagues	Strongly agree (47.8%)	Strongly agree (38.5%)
The CMT practices were unnecessarily complex	Strongly disagree (54.3%)	Strongly disagree (42.7%)
It was easy to adhere to the instructions of the CMT practices	Strongly agree (54.3%),	Strongly agree (46.2%)
I was able to bring my compassionate self to my everyday life	Strongly agree (37%)	Slightly agree (29.9%).
The CMT practices were helpful	Strongly agree (50%)	Strongly agree (41%)
Follow-up Feedback		
I would have liked to have continued with intervention (CMT practices)	Mostly agreed (50%)	Strongly agree (38.5%)
I would like to use the CMT practices again in the future	Mostly agreed (34.8%)	Strongly agree (41.9%)
I continue to feel the benefits of the CMT practices from two weeks ago	Mostly agreed (52.2%)	Strongly agree (41.9%)
I was able to continue to bring my compassionate self to my everyday life	Mostly agreed (43.5%)	Strongly agree (40.2%)

6.4 Discussion

This study explored the efficacy of a brief two-week online CMT, in a non-clinical, cross-cultural group of Sri Lankan and UK participants. As predicted, the CMT significantly increased participants' compassion across the three flows regardless of their cultural background. In consideration of the second research question, significant increases were indicated in the facilitators of compassion (e.g., self-reassurance, social safeness and pleasure, and well-being) and significant decreases were found in the inhibitors of compassion (fears of compassion, self-inadequacy, external shame, anxiety, and depression) with some cross-cultural similarities (e.g., fear of self-compassion, fear of compassion from others, self-inadequacy) and differences (e.g., fear of compassion to others, self-reassurance, social safeness and pleasure, external shame, anxiety, depression, and well-being). In relation to whether all post CMT changes would be maintained at follow-up, the results found that not only all post-CMT changes were maintained, but also additional improvements were observed in some variables that did not change at post-CMT as reflected in the reduced depression and anxiety in the Sri Lankan group and increased social safeness and pleasure in the UK group. In addition, although most participants dropped out before completing the CMT, those who completed the feedback questions indicated that they found the CMT useful, easy to access, and that they would recommend the CMT to others. This suggests that the CMT is a feasible practice for the public, which was also demonstrated in previous cross-cultural studies (Maratos et al., 2020; Matos et al., 2021, 2022a). The following sections will discuss the implications of the results in more detail.

6.4.1 Efficacy of the CMT on Compassion

6.4.1.1 CMT on Compassion in Sri Lankan Participants

Significant improvements in self-compassion, compassion to others, and compassion from others were reported in the Sri Lankan CMT group immediately post CMT, with large effect sizes (in the per-protocol analyses) in all three flows.

6.4.1.2 CMT on Compassion in UK Participants

Significant improvements in self-compassion, compassion to others, and compassion from others were reported in the UK CMT group immediately post CMT. However, only self-compassion increased with a large effect size, and compassion to and from others increased with small effect sizes.

A possible explanation for the differences in effect sizes between the Sri Lankan and UK CMT groups is that, whilst there was no significant difference in self-compassion between the two countries at baseline-1, UK participants indicated significantly higher levels of compassion to and from others prior to starting the CMT. A similar UK CMT study found significant increases in self-compassion, but not in compassion towards and from others, and emphasised that many participants described being already "too compassionate" prior to the CMT and therefore, the CMT was mostly effective in increasing self-compassion (Irons & Heriot-Maitland, 2021). In fact, UK participants indicated highest baseline scores for compassion to others, and lowest baseline scores for self-compassion. In addition, whilst the CMT includes practices to improve all three flows of compassion, the focus is weighted towards improving self-compassion (Irons & Heriot-Maitland, 2021, Timings, 2022), which may be a reason why compassion to or from others did not improve with large effect sizes in the UK group who already had relatively higher scores (compared to the Sri Lankan group) prior to CMT. Despite the different effects, results are in line with previous studies (Irons & Heriot-Maitland, 2021; Matos et al., 2017a; Maratos et al., 2020), that the CMT can improve people's compassion towards themselves and others in not just Western cultures, but Eastern

cultures as well. Improvements in compassion across the three flows were also maintained at a two-week follow-up, supporting the lasting effects of the CMT (Gilbert & Procter, 2006; Irons & Heriot-Maitland, 2021).

On the other hand, the significant increase in all three flows of compassion with large effect sizes in the Sri Lankan group, provides evidence for the valuable cross-cultural impact of CMT in Asian cultures. This is because whilst there were no significant differences in self-compassion between Sri Lankan and UK groups at baseline-1, Sri Lankan participants' levels of all three flows of compassion were relatively low. In fact, the present study, and a previous study (Kariyawasam et al., 2021) reported that of the three flows of compassion, compassion towards others was lowest in the Sri Lankan participants. Therefore, the fact that all three flows of compassion increased with large effect sizes encourage the use of CMT in Sri Lankan people.

6.4.2 Efficacy of the CMT on Facilitators and Inhibitors of Compassion

6.4.2.1 Differences in the Facilitators and Inhibitors of Compassion in Sri Lankan Participants

Significant increases in self-reassurance, social safeness and pleasure, and well-being were reported immediately post CMT in the Sri Lankan CMT group. In addition, fear of compassion from others, fear of self-compassion, and inadequate-self scores significantly reduced. However, fear of compassion to others, hated-self, anxiety, or depression did not reduce immediately post CMT. Whilst results were maintained at two-weeks follow-up, anxiety and depression significantly reduced, which were not reported immediately post CMT.

6.4.2.2 Differences in the Facilitators and Inhibitors of Compassion in UK Participants

In the UK CMT group, fear of compassion to others, fear of compassion from others, fear of self-compassion, inadequate-self, external shame, anxiety, and depression significantly reduced post CMT. Results were maintained at follow-up, whilst social safeness and pleasure significantly increased at follow-up, which was not reported immediately post CMT. Although compassion across

the three flows increased after the CMT, significant improvements were not observed in the facilitators of compassion such as self-reassurance, social safeness and pleasure, or well-being in the UK CMT group, which is in direct contrast to the Sri Lankan participants. This finding directly contradicts previous CMT studies that found increases in self-reassurance (Gilbert & Procter, 2006; Irons & Heriot-Maitland, 2021), and well-being (Irons & Heriot-Maitland, 2021) in UK people. This, however, is not an indication that the CMT used in the present study was not as effective in the UK sample, as the inhibitors: fears of compassion, self-inadequacy, external shame, depression, and anxiety reduced in the UK people.

Self-reassurance in the Sri Lankan participants was significantly higher than UK participants at baseline-1 (T1), which highlights the presence of subtle cultural differences. This was also replicated in a previous study where self-reassurance was greater in Sri Lankan participants than UK participants, which attributed the cultural difference to the strong Buddhist influence in the Sri Lankans (Kariyawasam et al., 2022). This could be a possible reason for the increased self-reassurance post CMT in the present study, given that majority of the Sri Lankan participants were Buddhists (51.7%) and the CMT included practices similar to Buddhist meditation (e.g., mindfulness practices). In contrast, this could also partially explain the non-significance in self-reassurance in the UK group as only 2% of the UK group were Buddhists.

Levels of self-inadequacy significantly reduced in both Sri Lankan and UK groups post CMT. This was expected for the Sri Lankan group as their self-reassurance, the opposite of self-inadequacy (Gilbert, 2014), significantly increased. Whilst this is in line with previous CMT studies (Irons & Heriot-Maitland, 2021; Matos et al., 2022a, b), it is an important finding, as increased self-reassurance and reduced self-criticism have indicated reduced psychopathology and increased well-being (Irons & Heriot-Maitland, 2021), which were also evident in the present study post CMT (as well-being increased in the Sri Lankan group and depression and anxiety reduced in the Sri Lankan group at follow-up and UK group post CMT). On the other hand, UK participants' reduced self-

inadequacy suggests that although their self-reassurance did not increase significantly, their self-criticism may have reduced, which is also in line with a previous CMT conducted in a UK sample (Irons & Heriot-Maitland, 2021). Moreover, reductions in self-inadequacy are comprehensible given that self-inadequacy is negatively associated with higher self-compassion and both Sri Lankan and UK participants' self-compassion significantly increased (Gilbert et al., 2014).

Significant increases in well-being and social safeness and pleasure scores were also observed in the Sri Lankan participants, post CMT, which is in line with the emphasis by Irons and Heriot-Maitland (2021), that CMT practices are not only effective in reducing distress and mental illness, but also in increasing positive affect and well-being. In fact, the goal of CMT is to facilitate people's well-being by promoting compassion for the self and others, and by reducing distress and psychopathology (Gilbert, 2020). Supporting this, several CMT studies have reported increases in well-being (Kirby et al., 2017).

The increased social safeness and pleasure add a valuable contribution to the impact of CMT among collectivistic societies such as Sri Lanka, as previous studies indicate that people in such cultures can feel insecure in their social relationships and feel that they are constantly judged by their society (Kariyawasam et al., 2021; Van-Hoorn, 2015). This is because social shame and criticism are encouraged in such cultures during one's shortcomings and failures, to motivate people to not repeat mistakes (Kitayama & Uchida, 2003; Obeyesekera, 1984). This, however, increases people's fears towards others and causes a feeling of lack of warmth and safeness (Gilbert et al., 2014; Kariyawasam et al., 2021, 2022). Whilst a qualitative study emphasised how Sri Lankan people perceive their society to be the biggest inhibitor of their compassionate experiences (Kariyawasam et al., 2021), Sri Lankans also indicated significantly low levels of social safeness and high levels of fears of compassion, when compared to UK people in another study (Kariyawasam et al., 2022). This is in line with the present study as significantly higher levels of fears of compassion across the three flows of compassion were reported in the Sri Lankan group at baseline-1 (prior to starting CMT).

Therefore, the increased social safeness and pleasure scores in the present study in the CMT group, indicates that the CMT may potentially have been helpful in reducing the barrier of social insecurities faced by Sri Lankan participants.

Although social safeness and pleasure increased post CMT, external shame, which was significantly higher in the Sri Lankans than UK participants at baseline-1, did not significantly reduce post CMT. It is important to understand that some Asian collectivistic cultures consider shame as a valuable concept towards perfection and believe that social shame guides people to correct their mistakes (Geaney, 2004; Huang et al., 2021; Neff et al., 2008). Therefore, although external shame in the present study was considered as an inhibitor of compassion, it is possible that Sri Lankan participants may have perceived it as an important indicator of well-being as social shame is embedded in the Sri Lankan culture (Abeyasekera & Marecek, 2019). In addition, studies have found that people in Asian collectivistic cultures turn only to their family and closest friends when seeking social support, whereas people in Western individualistic cultures refer to a broader circle of family, long term and recent friends, and acquaintances when seeking social support (Huang, 1994; Perez, 1997). Therefore, whilst the Sri Lankan group may have referred to society in general when reporting their perceived external shame, there is a possibility that they only considered family and closest friends when reporting social safeness. Shame experiences have shown associations with the activation of the threat system, which causes heightened fears and negative self-evaluations, and the underdevelopment of the soothing system, which causes negative perceptions that others are not safe and trustworthy (Gilbert, 2009a, b; Liotti, 2004; Matos et al., 2015). In line with this, despite completing the CMT, Sri Lankan participants external shame or fear of compassion towards others remained unchanged. In contrast, significant reductions were reported for external shame in the UK participants post CMT, which was reflected in their reduced fear of compassion towards and from others. Significant reductions in external shame post CMT, have also been observed in previous UK studies (Gilbert & Procter, 2006; Muftin et al., 2022).

Significant reductions in all three flows of fears of compassion (fear of compassion to and from others, fear of self-compassion) in the UK CMT group implies that the CMT not only increases compassion across the three flows, but also has the capacity to reduce the fears associated with these flows. It is important for future research to explore the direction of its functionality (e.g., whether the reduction in fears of compassion leads to an increase in compassion, or vice versa, or there may be another mechanism that facilitates these changes). In line with the findings, an American CFT study reported that the intervention significantly reduced all three flows of the fears of compassion while increasing self-compassion and compassion from others (Fox et al., 2020).

Anxiety in the UK group was significantly higher than the Sri Lankan group at baseline-1, and both depression and anxiety scores in the UK participants significantly reduced post CMT. In partial support, studies found that CMT reduced depression but not anxiety in non-clinical populations (Irons & Heriot-Maitland, 2021; Kelman et al., 2018) and both depression and anxiety reduced in clinical populations (Andersen & Ramussen, 2017; Kelman et al., 2018). In fact, CMT has found to be more effective in reducing depression than Cognitive Behavioural Therapy (CBT), which specifically targets on reducing depression (Kelman et al., 2018).

All post-CMT improvements were maintained at a two-week follow-up in both countries further supporting for the lasting effects of the CMT (Gilbert & Procter, 2006; Irons & Heriot-Maitland, 2021). Another clinically relevant finding is that levels of anxiety and depression reduced in the Sri Lankan group, and social safeness and pleasure increased in the UK group at follow-up, which is particularly noteworthy given that these emotions did not improve immediately post CMT. The reductions in anxiety and depression scores in both Sri Lankan and UK people is a very important impact of CMT, as the average scores in both countries met the cut-off screening points for depression and anxiety at baseline-1 (Manea et al., 2012; Spitzer et al., 2006). The COVID-19 climate during the time of data collection could be a possible reason for these high depression and anxiety scores at baseline-1 (Jia et al., 2020), and the reductions of these upon completing the CMT suggests

that CMT is a timely and cross-culturally effective intervention for reducing distress and psychopathology.

Additionally, compassion to others and fear of compassion to others in the UK group improved further at follow-up. This not only highlights the potential of CMT to have a positive influence of these emotions in the longer-term but also that the positive effect may be delayed. In fact, most existing CMT studies have explored the long-term effects rather than short-term effects (Zessin et al., 2015). Irons and Heriot-Maitland (2021) stated that improvements observed post CMT were not only sustained, but also continued to improve, although they emphasised that improvements need to be carefully interpreted, as there is a high possibility that people who completed the follow-up stage are more likely to be participants with a high enthusiasm for the CMT.

6.4.3 CMT Engagement Feedback Questions

The majority of participants who completed the feedback questions strongly agreed that the CMT was feasible, accessible, and helpful. This is in line with focus group, daily diary, and acceptability accounts of previous CMT studies that discussed how useful participants found the CMT (e.g., Beamount et al., 2017, 2021; Maratos et al., 2019). Interestingly, whilst Sri Lankan participants “strongly agreed” that they brought their compassionate-self daily, the majority of the UK participants only “slightly agreed” that they were able to bring their compassionate-self every day post CMT. However, the majority of UK participants then “strongly agreed” that they were able to continue to bring their compassionate-self every day at the two-week follow-up, further suggesting the delayed impact of the CMT. Although self-compassion in UK participants increased post CMT, compared to other practices aimed at compassion to and from others, practicing self-compassion may have been a challenge, which was reflected in their lack of self-reassurance. This was supported in a previous UK CMT, which discussed that whilst compassion improved, participants discussed having initial doubts about the benefits of self-compassion (Maratos et al., 2019).

6.4.4 Strengths and Limitations

To the best of authors' knowledge, this was the first study to explore the impact of a CMT in a cross-cultural group including a South Asian sample. It used an RCT design, together with a series of validated questionnaires to measure a variety of aspects of compassion using an online CMT as a potentially effective mode of delivery. The use of an already established CMT, which has been recognised to be effective in Western communities (e.g., Matos et al., 2017a) was a further advantage of this study. The improved outcomes of the online CMT suggest that although CMT was developed as a group-based therapy (Gilbert & Irons, 2004), the intervention was accessible to a larger non-clinical sample and has the potential to be as effective as an in person CMT. The incorporation of a practice engagement feedback questionnaire further strengthens the methodological rigour.

One of the biggest limitations of this study is the high attrition rate. The completion rate of the CMT group at post-intervention was only 17.6% and 58% among Sri Lankan and UK participants respectively. This further reduced to a 15.9% in the Sri Lankan group and a 28.8% in the UK group at follow-up (T3). Dropout rates were relatively similar for the WLC groups in the two countries. However, high attrition is a common concern among many online interventions (Eysenbach, 2005; Mak et al., 2018) and was expected considering the level of commitment required for the intervention (Halamova et al., 2020). More importantly, the high attrition rate was expected as data collection took place during the COVID-19 period in both countries, and during a political and economic crisis in Sri Lanka (Al-Jazeera, 2022; World Bank, 2021). It is possible that only those with a motivation and interest in the intervention may have completed the study (Halamova et al., 2020). The large dropout rate also resulted in the small sample size and was a reason for conducting intention-to-treat analyses to understand the intervention efficacy (Arimitsu, 2016). It is, however, important to note that despite the low attrition rate, many participants from both countries (44.5% in Sri Lankan and 79.2% in the UK group) completed the two-week CMT practices, although they did

not complete the post-intervention or follow-up measures. This raises the question whether it was the series of questionnaires that influenced the higher attrition in the study.

In line with previous research (e.g., Matos et al., 2017a, 2022a), this study incorporated self-reported measures that directly accessed elements addressed by the CMT. This may have increased the risk of potential demand characteristics upon participants (Matos et al., 2022a), in addition to the increased social desirability effect (Guan et al., 2021). It was beyond the scope of this study to go into detail about the impact of each component of the CMT, such as psychoeducation, imagery and breathing, which Matos et al. (2017a), demonstrated would be useful for future studies to address. Additionally, this study was conducted among general public with most participants from both countries being female and university students. Therefore, this study cannot be generalised to the Sri Lankan and UK populations. Prospective studies should replicate this study with a clinical sample to investigate the accessibility and feasibility, and effectiveness of an online CMT in clinical samples towards reducing psychopathology (Halamova et al., 2020).

6.4.5 Clinical Implications

This study provided promising evidence for the cross-cultural applicability and effectiveness of CMT, particularly in the Sri Lanka community, which has been predominantly applied in Western settings. Whilst the CMT increased compassion across its three flows, there were some similarities and some differences in the impact on the inhibitors and facilitators of compassion between the two countries. The cross-cultural differences and religion should be accounted when tailoring interventions and treatments. For instance, external shame was significantly higher in Sri Lankan participants, and anxiety was significantly higher in UK participants prior to the CMT. Therefore, a CMT aimed at a Sri Lankan group could incorporate more practices to reduce the impact of social shame (e.g., by adding friendly voice tones, imagery tasks of compassionate others: Matos et al., 2017a), whilst a CMT aimed for a UK group could add practices to minimise levels of anxiety (e.g., soothing rhythm breathing: Matos et al., 2017a). Clinicians should closely look at baseline findings to

understand which practices are needed to balance the affective regulatory system. For instance, if both fears and social safeness are significantly higher at baseline, this maybe an indicator that activities to reduce the threat system (e.g., mindfulness: Matos et al., 2017a) should be prioritised over activities to induce the soothing system, for that specific sample. Prospective studies should also consider taking a mixed-method approach by incorporating qualitative interviews, to better understand the feasibility of CMT, challenges faced, and to explore possible reasons for the large attrition rates (Maratos et al., 2019).

6.4.6 Conclusion

This study found that a brief two-week CMT was effective in enhancing compassion for self and others, and receiving compassion from others, in both Sri Lankan and UK participants. This supports the cross-cultural applicability and efficacy of the CMT approach (Maratos et al., 2020). Although some similarities and some differences were present across the two countries, the results indicated that, taken together, the Sri Lankan and UK participants benefited from the CMT in consideration of reducing distress and increasing well-being. The CMT was not only effective at post-intervention, but also at follow-up, providing evidence for its lasting impact with some additional outcome variable improvements at this stage. Furthermore, a two-week online version seemed more practical, due to its accessibility and appeared to be as effective as an in-person CMT in the non-clinical populations. Therefore, whilst this was an initiative step towards exploring the cross-cultural applicability of CMT, and further research is required, this study provides promising evidence of the use of CMT to increase emotional well-being in both cultures.

Chapter 7 General Discussion

The aim of this chapter is to further discuss the findings and implications of the programme of research presented in this thesis. This chapter begins with a general summary of each paper and then critically evaluates the findings in more depth addressing any areas of omissions that were needed in order to comply with the word limits and/or the strict guidelines of the journals that the papers were submitted to. In addition, general theoretical, clinical, and research implications are discussed.

7.1 Paper Findings

7.1.1 Paper 1: A meta-analysis to explore whether compassion-based interventions lead to increased levels of compassion in people living in Asian communities.

To answer the research question, whether compassion-based interventions can lead to increased levels of compassion in people living in Asian communities, a meta-analysis of RCTs was conducted. The findings of eight RCTs gathered from 1012 participants across Thailand, Japan, China, and Hong Kong suggested that the existing compassion-based interventions in the Asian cultures, can in fact increase self-compassion in the Asian communities.

7.1.1.1 Additional Strengths and Limitations

The findings of this meta-analysis take a preliminary step towards providing a scientific overview of the value of using compassion-based interventions in the Asian context. The inclusion of RCTs, which are considered as the gold standard of evidence-based research strengthened the methodological rigour of this study (Bondermark & Ruf, 2015).

The meta-analysis focused solely on quantitative research, and it is important to note that incorporating qualitative and mixed methods data in a meta-synthesis could benefit future reviews to help further explore the barriers and difficulties of engaging in the interventions and highlight the

areas that need to be targeted to improve treatment (Arimitsu, 2016; Joseph & Bance, 2019). Qualitative data can also provide findings that the quantitative analyses might not indicate. For instance, the interviews in a Japanese study discussed in the meta-analysis (Arimitsu, 2016) uncovered the fear of being happy as an inhibitor of participants' self-compassion, which was not measured in the questionnaires. This fear of compassion was often reported in CFT (2000, 2009a), leading Gilbert and colleagues (2011) to identify it as one of the biggest inhibitors of compassion. Participants also explained that practicing mindfulness tasks as homework was difficult, and they felt that was the reason their mindfulness level did not increase (Arimitsu, 2016). Thus, future studies should perhaps consider whether to incorporate homework tasks, and if they do, design them to be more interactive and engaging. It is results such as these, that highlight the importance of incorporating qualitative discussions, in addition to the quantitative analyses, to gain a deeper understanding of the efficacy of compassion-based interventions.

This meta-analysis only included intervention studies with a specific focus on compassion. This means that any compassion-integrated interventions with a different focus, such as Group Cognitive Behaviour Therapy with Compassion Training (GCBT with compassion training: Asano et al., 2017), Mindful Lovingkindness Compassion Programme (Noh & Cho, 2020), and Compassion Mindfulness Therapy (C-MT: Lo et al., 2015) were excluded. Although compassion integrated interventions have shown to increase self-compassion and/or compassion for others (e.g., Anuwatgasem et al., 2020; Asano et al., 2017; Centeno & Fernandez, 2020; Finlay-Jones et al., 2018; Guo et al., 2020; Ivtzan et al., 2018; Joseph & Bance, 2019), the problem with using an integrated intervention is that in the absence of a comparator control group to assess the impact of the compassion-integrated approach (e.g., mindfulness in C-MT, and CBT in the GCBT with compassion training), it is difficult to differentiate the impact of compassion from the impact caused from the other integrated approaches (Kirby et al., 2017). Therefore, incorporating studies with a compassion-enhancing focus only was a strength of this meta-analysis, as it provided a more precise estimate of the true impact of the compassion intervention on increasing compassion.

Additionally, some studies have indicated that compassion-based interventions are more effective in increasing compassion, than other compassion-integrated interventions. For instance, Yip (2018) compared a mobile phone-based self-compassion programme with a mobile phone-based mindfulness programme in participants from Hong Kong. They found that self-compassion increased more in participants of the self-compassion programme than participants in the mindfulness programme, signifying the self-compassion programme as a better predictor of enhancing self-compassion. These discussions emphasise the importance of developing more compassion-specific approaches. Therefore, prospective researchers should investigate whether compassion-focused approaches compared to other interventions (e.g., C-MT) may be more effective in enhancing well-being in Buddhist influenced Asian societies, such as Japan and Sri Lanka.

7.1.2 Paper 2: A qualitative investigation to explore the views and lived experiences of compassion in Sri Lankan students.

This paper focused on exploring the views and lived experiences of compassion in Sri Lankan students, to understand their experiences of offering and receiving compassion using Gilbert's (2014) theoretical perspective as a basis for questioning. To the author's knowledge, there had been no compassion-based research that had been conducted in Sri Lanka, and therefore, it was important to understand participants' general views of compassion and to explore whether Sri Lankan people are familiar with the term and concept of compassion. This study found that Sri Lankan participants were familiar with the concept of compassion and have experienced being self-compassionate and offering compassion to others, as well as receiving compassion from others. Interestingly, the qualitative interviews facilitated an in depth understanding of participants' perceived facilitators and inhibitors of compassion, of which, religion was the most discussed facilitator of compassion whilst, social judgment and criticisms appeared to be the strongest inhibitor of compassion. This was an interesting discussion as participants were from various

religious backgrounds (e.g., Buddhist, Christian, Catholic, Hindu, and Muslim) and yet, apart from one student who self-identified as atheist, all the other students discussed how their religion influenced them to be compassionate. This implied that compassion is not only discussed in Buddhism, but across various religions as an important concept for well-being (Vivino et al., 2009). Mixed ideas were shared on the impact of culture, where participants who felt highly socially connected believed their culture influenced greater compassionate experiences, while those who feared their society felt less secure in their social relationships and discussed how culture restricts people from being openly compassionate to everyone as one. Participants also discussed their understanding of the reasoning behind their compassion to others, as well as others' compassion towards them.

Although Paper 2 discussed the key findings in depth, the following sections will discuss other findings in more detail (that were only briefly discussed in Paper 2 due to the word limit). One such finding that needs a thorough investigation is how less likely participants were to accept compassion from themselves or others. The in-depth nature of the semi-structured interviewing and IPA analysis provided a thorough interpretation of the reasons behind why participants were hesitant to feel compassion for themselves. Many participants were reluctant to accept compassion from others not because they did not believe that compassion would be helpful, but because they were fearful of how they would be viewed by society. Stigma and lack of awareness of mental health difficulties, insecure attachments with significant others, and previous negative experiences with others all seemed to significantly affect participants' likelihood of receiving self-compassion and compassion from others, and at times their likelihood of offering compassion to others too.

From an evolutionary perspective, affiliative emotions help people feel secure and form connections with others in society, and absence of these affiliative emotions could lead to perceived threat, social isolation, and longing to be in relationships and feelings of inner loneliness (Bowlby, 1980; Gilbert 2000, 2007, 2010a). In general, it is perceived that individuals from secure backgrounds are more likely to accept compassion and perceive others as trusting, soothing sources of support,

whereas individuals with broken relationships and insecure backgrounds are either more avoidant and detached from others or maintain dysfunctional relationships that are not making them feel safe or soothed (Collins, 1996; Collins & Read, 1990; Meyer et al., 2005). Inner loneliness and grief could be triggered by not receiving warm feelings from significant others. This in return urges people to be overwhelmed and dissociate with longing for positive emotions (Bowlby, 1980; Gilbert, 2010a). Furthermore, humans have a tendency to act in a way that would create a positive impression of themselves in the minds of others (Catarino et al., 2014). Often known as *mirroring*, this tendency leads people to change their behaviour by displaying a positive, loved, and a desired image of themselves to others inducing positive emotions in others' minds (Kohut, 1977). This would in turn help them to be accepted, supported, and loved by others (Cacioppo & Patrick, 2008). However, the desire to be liked by others could be jeopardised in the presence of mental illness. This is because mental illness often induces fears of being judged, disliked, ashamed, rejected or even harmed by others as opposed to being desired or liked (Gilbert, 2007). These reasons could possibly explain the hesitance of some participants in Paper 2 who reported experiencing mental health difficulties, in disclosing their struggles and accepting compassion from others, especially when they recalled weak or negative relationships with parents and significant others.

Social barriers included social judgments and criticisms, stereotypic views and social norms held by society, and social stigma. Participants felt fearful or discouraged by certain societal views on their compassionate actions and elaborated how these social judgments make it difficult to genuinely help or show compassion to someone. Social judgments appeared to be so intense, to the extent that one male participant explained how showing genuine compassion to someone is often misunderstood by society including his own parents ("*My parents sometimes misunderstand that I have many girlfriends. But that's not true. I want to help them"* – Heshan, aged 27). In contrast, another participant discussed how stereotypic views towards women in general, make it difficult for a woman to seek or receive compassion, as women are often blamed for their suffering. Many young

women are often discriminated against their clothing and harassed (Chandradasa & Rathnayake, 2018), while 90% of Sri Lankan women report being sexually harassed when using public transport (UNFPA, 2017). Gender based cultural norms mostly affect younger women in the collectivistic overprotective parenting context of Sri Lanka, where parents would often speak on behalf of their daughters when accessing mental health facilities, not allowing the daughters to speak for themselves (Freeman, 1997). However, Bartholomeusz (1994) stated that Buddhism endorses gender equality and as a result, gender-based inequalities should be irrelevant to the majority of the Buddhist followers in Sri Lanka.

Reflecting on the participants' answers, this paper discussed how mental illness is a taboo topic in Sri Lanka, and that people, therefore, attempt to hide mental illness and refrain from help seeking, to avoid stigma and discrimination (Lauber & Rosser, 2007). What is also important to consider is how participants normalised or justified this stigma at the cost of their own well-being. For instance, one participant was compassionate about his mother's lack of awareness of his mental illness and statements such as "*just get over it*" (Mathew, aged 26), whist another participant accepted that she could not seek help for her depression from her father or society, "*because of the way this society is*" and because "*in Sri Lanka, people don't really know much about mental health*" (Sonali, aged 25). This implies the risk that unless addressed the issue of stigma on mental illness, people will continue to suffer in silence and resist seeking help even if new treatment methods and compassion-based interventions are introduced to Sri Lanka, highlighting the fundamental importance of providing psychoeducation to the Sri Lankan public.

7.1.2.1 Additional Strengths and Limitations

The use of an IPA analysis provided in-depth information on the facilitators and inhibitors of compassion. This method provides an idiographic approach (interpretation of subjective, unique, and often cultural phenomena) as opposed to a nomothetic approach (interpretations gained from objective, generalisable phenomena) (Salvatore & Valsiner, 2010). Although a quantitative study with a series of measures would have given some understanding (as was done in Paper 3), the in-

depth nature of IPA (described in greater detail in Chapter 2 on methodology) discovered how various fears, especially those associated with social shame and judgment are generated and act as inhibitors towards people experiencing compassion for themselves and others. In fact, Gilbert (2020) emphasised that quantitative approaches are not sufficient to understand the complex processes of compassion.

Whilst participants had an understanding of how society in the form of stigma and stereotypes inhibit help seeking behaviour, it is important to note that the convenience sampling only included psychology undergraduates in Sri Lanka, who may have had a better understanding of stigma and stereotypic views, as part of their psychology education. Therefore, further research is needed to see if other Sri Lankan populations share similar views and understandings.

7.1.3 Paper 3: An exploration of cross-cultural differences in compassion, and the facilitators and inhibitors of compassion between Sri Lankan and UK participants.

This paper aimed to investigate whether there will be any differences in the levels of compassion, and facilitators and inhibitors of compassion between Sri Lankan participants (from a collectivistic, Buddhist influenced Asian country), and UK participants (from an individualistic, Western country) where many compassion-based interventions have been tested and found to be effective (e.g., Irons & Heriot-Maitland, 2021). This study also investigated which facilitators and inhibitors of compassion would predict each of the three flows of compassion for each country separately, to identify whether there will be cross-cultural differences in the predictors of compassion in the Sri Lankan and UK participants. The results indicated that Sri Lankan participants were significantly more self-compassionate although no significant differences were reported for compassion to others, and compassion from others between the two cultures. In addition, of the facilitators of compassion, Sri Lankan participants were significantly more self-reassured and UK participants reported significantly higher levels of social safeness and pleasure. Of the inhibitors, Sri

Lankan participants indicated greater fears of compassion across the three flows, and higher external shame whilst no significant differences were reported for anxiety, and depression scores between the two cultures. There were some similarities (e.g., self-reassurance predicted self-compassion, and social safeness predicted compassion from others in both countries) and some differences (e.g., higher fear of self-compassion and self-inadequacy in the Sri Lankans and lack of fear of compassion to others and higher anxiety in the UK group predicted compassion to others) in the factors that predicted each flow of the three flows of compassion in Sri Lankan and UK people. One interesting finding is that majority of the Sri Lankans were Buddhist participants, and self-identifying as a Buddhist predicted higher self-compassion in the Sri Lankan participants.

The finding that following Buddhism predicted self-compassion is in line with Paper 2 in which, religion was recognised as a protective factor for increased compassionate experiences. Therefore, Paper 3 further strengthens the potentially important role of religion in developing levels of compassion and that this should not be overlooked when addressing compassion and implementing compassion-based approaches to countries such as Sri Lanka. In addition, the finding that higher levels of fear of self-compassion predicting higher compassion towards others in Sri Lankan participants in Paper 3, was also reflected in the results of Paper 2. Participants in Paper 2 reflected on how, despite being fearful of self-compassion and struggling to show compassion, they were at times compelled to show compassion to others, so that they would not be rejected or judged by people in their society. Thus, the finding of Paper 3, that fear of self-compassion predicted higher compassion to others, might imply that Sri Lankan participants may have shown submissive compassion to others (compassion offered to be liked by others or to avoid rejection rather than to be genuinely helpful: Catarino et al., 2014), so that they would be socially accepted for their behaviour.

Although it was originally expected that Sri Lankan people would display higher levels of compassion towards and from others (due to their social connectedness and collectivistic cultural background), results did not find any significant differences in relation to compassion towards or

from others between the Sri Lankan and UK samples. Some cross-cultural studies have found that people in Western individualistic cultures (e.g., Australia), reported higher compassion towards and from others than Singaporeans (Steindl et al., 2020), whilst other studies have found contradictory findings that people in collectivistic cultures (e.g., Portugal) are more compassionate towards and from others than people in individualistic cultures such as the UK (Gilbert et al., 2017). While possible explanations for these differences were discussed in Paper 3, it is important to note that cross-cultural studies are severely lacking in the compassion research field, and all the existing studies have been conducted within the last couple of years. Therefore, as this paper was the first compassion related cross-cultural study to investigate a Sri Lankan group in comparison to a Western UK group, further research is recommended.

In addition, social safeness in the UK group was significantly higher than the Sri Lankan group, and higher social safeness also predicted higher compassion from others in the UK group. This is an important finding as the higher social safeness in the individualistic UK group and higher external shame in the collectivistic Sri Lankan group suggests that social interconnectedness or being in a collectivistic society is *not* an indicator of feeling safe or content within one's social relationships (Perez, 1997). In addition, in an attempt to review Western individualistic and Eastern collectivistic perceptions of social support, Perez (1997) discussed that social support in collectivistic cultures such as Japan, refer to the support from one's closest members of the inner circle such as family and friends, whereas social support for people in Western cultures refer to support from not only family, but also recent friends or acquaintances (Huang, 1994).

7.1.3.1 Additional Strengths and Limitations

As cross-cultural differences of compassion are an under researched area, this study did not form any directional hypotheses and conducted exploratory analyses where clarifications were needed. For instance, the initial regression analyses indicated that higher external shame predicted greater self-compassion in the UK group. However, further exploratory analyses discovered that self-

reassurance was a strong predictor of self-compassion in the UK group, and that it mediated the impact of external shame. In other words, the exploratory analysis determined that self-compassion increased even in the presence of higher external shame, when participants had the ability to reassure themselves. Therefore, the exploratory mediational analysis strengthened the study results and highlighted the significant role of self-reassurance when predicting self-compassion.

Another strength of this study is that this was one of very few studies to explore all three flows of compassion: self-compassion, compassion to others, and compassion from others. While some studies have found associations between the three flows (e.g., Lutz et al., 2008; Neff & Pommier, 2012), it was important to assess each flow independently, as the present study along with several other studies (e.g., Leary et al., 2007; Lopez et al., 2018) did not find a relationship between self-compassion and compassion towards and from others.

Although several studies have discussed the relationship between compassion and well-being (e.g., Gilbert, 2020; Irons, 2014) this study did not incorporate a well-being measure to assess this relationship. Therefore, future studies should incorporate well-being measure in to understand how compassion is linked to well-being (Austin et al., 2020). Considering this limitation, Paper 4 incorporated a well-being measure to discuss its relationship with compassion.

7.1.4 Paper 4: A brief Compassionate-Mind Training (CMT) to increase compassion in a cross-cultural group of Sri Lankan and UK people.

This study tested the cross-cultural applicability of CMT, in a sample of Sri Lankan and UK people. This was the first compassion-based intervention conducted in Sri Lanka, and the results indicated that compassion across all three flows improved post CMT, in both Sri Lankan and UK groups, indicating its successful cross-cultural applicability.

One of the findings throughout this programme of research (in Papers 2, 3, and 4) was that external shame was consistently and significantly higher in Sri Lankan participants. This high external shame did not change after completing the CMT, although improvements were reported in all three

flows of compassion, and several other factors (e.g., self-reassurance, well-being, fears of self-compassion and compassion to others, social safeness, self-inadequacy, anxiety, depression). One explanation for this could be that some cultures value the concept of shame as a means to perfection and view shame as a guiding tool towards correcting mistakes (Geaney, 2004; Huang et al., 2021; Neff et al., 2008). Huang et al. (2021) emphasised that such cultural values on shame can negatively affect one's self-compassion although the Buddhist influence in countries such as China can in turn promote a self-accepting mindset. It is possible that these social norms can be applied to Sri Lanka, providing a rationale for how external shame persisted despite increased levels of self-compassion and compassion to/from others post CMT. Therefore, whilst it is possible that Sri Lankan participants perceived external shame, as a predictor of their well-being (in line with Geaney, 2004; Huang et al., 2021; Neff et al., 2008), it is also important to note that majority of the Sri Lankan participants self-identified as Buddhist (51.7%) and Buddhism may have played a significant role in increasing their self-compassion as also reflected in findings of Paper 2 and 3 (in line with Huang et al., 2021), in addition to the CMT.

7.1.4.1 Additional Strengths and Limitations

This was the first cross-cultural study to implement a compassion-based intervention to a Sri Lankan sample. This study incorporated a psychoeducation video to increase participant engagement and to facilitate a clear understanding of the psychoeducation material (Matos et al. 2017a, Timings, 2022).

Although the qualitative investigation in Paper 2 and the cross-cultural study in Paper 3 were conducted as part of this thesis, the CMT used for Paper 4, was not adapted based on the findings of these studies. This is because as this was the first CMT study to be implemented to a Sri Lankan population, and an already established and effective intervention (which has also been tested in Western populations) appeared more suitable for the purpose of this study. However, the questionnaires used for this study were influenced by findings of Papers 1-3. Therefore, future

studies could closely consider these findings to refine the intervention design by tailoring it more closely to the Sri Lankan target population.

The CMT used for Paper 4, was available to access online using both mobile phones, and computers (and laptops, iPads, and tablets etc.) with access to internet. Berry et al. (2016) conducted a review investigating the use of internet-based interventions and concluded that interventions delivered via mobile phones were more accepted, than interventions delivered using other online formats. Therefore, the delivery of this study via both mobile phones and other online formats, increased the accessibility and possibly the acceptability of the CMT.

7.1.4.1.1 Attrition Rate and Strategies to Reduce it

Attrition rate is defined as "*incomplete ascertainment of the primary outcome for participants randomised in the trial*" (Akl et al., 2009, p2). An increased attrition, or in other words dropout rate, can reduce the power of a study to explore the true disparity between the control and the intervention group, and reduce overall quality of the study findings (Brueton et al., 2011). This could in turn provide exaggerated interpretations of the effects of the treatment or control condition, and affect the generalisability of the findings (Fewtrell, 2008; Schulz, 2002). Large attrition rates of 82.4% in the Sri Lankan CMT group and 42% in the UK CMT group were reported in the CMT study of Paper 4. In addition, attrition rates increased to an 84.1% in the Sri Lankan CMT group and 71.2% in the UK CMT group at a two-week follow-up.

Several reviews and studies have discussed strategies to minimise attrition and increase participant retention (e.g., Brueton et al., 2011; Davis, 2002; Robinson et al., 2007). Some of these involve strategies to motivate participants to continue participating once they have been randomised to a study group, help participants to recognise the value of completing a study, and strategies to directly coordinate with participants to encourage participation (Brueton et al., 2011). The CMT study of this thesis followed several of these strategies to actively prevent participation attrition. As the majority of the UK participants were University of Southampton undergraduate students, those who completed the CMT were offered 38 credits as part of their course credit. To

motivate Sri Lankans to participate, the study advert notified that 40 £5 worth Amazon vouchers will be distributed to the participants on a first come first serve basis. In addition, after signing up for the study, based on the condition that they were randomised into, participants received email reminders to complete the CMT. In addition, to increase participant interest and motivation, a visual psychoeducation material (Timings, 2022) was incorporated in the first and fifth days of the two-week CMT. Finally, to reduce attrition rate in the control group, participants in the wait-list control group were notified at the beginning of the study that materials to practice the two-week CMT would be made available to them after data collection had been completed.

Providing incentives (e.g., Amazon vouchers and course credit) have been linked to increased response rates with no significant difference between providing monetary and non-monetary inducements (Booker et al., 2009). In addition, reminding participants to continue participation (e.g., email reminders) have also been associated with increased responses (Booker et al., 2009; Brueton et al., 2001). Edwards et al. (2009) also recommended contacting people prior to starting the interventions and keeping the questionnaires short as methods to increase retention. Although many of these strategies were followed for Paper 4, there was a significant attrition rate in participants across cultures (Sri Lanka and UK). However, it is noteworthy that Paper 4 included eight different questionnaires, in addition to a feedback questionnaire and a participant engagement questionnaire. Therefore, the length of the questionnaires and having to complete the same lengthy measures at three different time points could be a possible reason for the large attrition. This was also anecdotally mentioned by a few participants. Brueton et al. (2011) also emphasised that the condition or the group participants are randomised into might also cause higher attrition as this might not be their preferred choice of group. This could be particularly true for the control group in Paper 4, as they had to complete the series of questionnaires after a two-week waiting period from the initial completion of the questionnaires, without having experienced the two-week CMT yet. This must have felt repetitive, and they must have felt no use of continuing the study as they had to wait

two-weeks to receive the materials for the CMT. Future research could consider incorporating more visual materials instead of the audio materials and enhance monitory incentives to increase participant engagement and consider using short questionnaires. There is, however, no clear evidence to support that shorter questionnaires are better than longer questionnaires, although offering monitory incentives in return of completed questionnaires, and offering a certain amount of money at the beginning of data collection with the promise of offering another amount of money at the end of completion of questionnaires were most effective in reducing attrition rate and enhancing retention rate (Brueton et al., 2013).

7.1.4.2 Recommendations for Intervention Development

A key recommendation for intervention development is that researchers should consider the cross-cultural factors discussed across the studies in this thesis when developing interventions for culturally diverse populations. Whilst the similarities in compassion, and facilitators and inhibitors of compassion between the two countries tentatively suggest that Western compassion-based approaches (e.g., CFT and CMT) would be applicable to collectivistic cultures such as Sri Lanka, clinicians should closely investigate the cross-cultural differences. These factors should be carefully considered to tailor intervention design and treatment delivery for the targeted population (Austin et al., 2020; Kirby, 2016). For instance, protective factors such as religion in the Sri Lankan people, and social safeness in the UK people should be accounted when making adaptations to the content of the interventions. Making such adaptations are assumed to bridge the void between the context in which the intervention was originally developed and the context in which the target population will be administered (Stirman et al., 2013; Wensing et al., 2011). Austin et al. (2020) discussed in a meta-synthesis that participants in fact found the tailored elements of the interventions helpful for their specific needs. However, they suggested that more research is necessary as majority of the interventions are untailored.

Whilst the CMT study reported in Paper 4 was delivered online and found to be effective, the CMT intervention was adapted from a previous intervention design for a Western sample by

Matos et al. (2017a). Mobile interventions of compassion are still at an early developmental stage and comprehensive uses of mobile technology are yet to be investigated. For instance, Austin et al. (2020) recommended that online features such as providing compassion exercises via push notifications or offering personalised feedback and practice recommendations should be investigated. Additionally, both online and in person interventions discussed in the meta-analysis of this thesis were found to be equally effective. Therefore, replications could assess both online and in-person studies to see if there are any evident differences in the intervention efficacies. If no differences are reported, online approaches would seem more suitable considering their reliability with cost, time, staffing, and space etc (Chi, 2013; Mak et al., 2018). In fact, online studies might be particularly suitable for the use of cultures such as Sri Lanka where disclosing mental illness is stigmatised and considered a taboo topic (De Zoysa, 2013; Kariyawasam et al., 2021).

In addition, the CMT design used in this thesis was an online study delivered for individual participants. Although this study reported significant improvements of compassion and well-being, results from a meta-analysis of self-compassion RCTs concluded that group-based delivery produced a larger effect on increasing self-compassion (Ferrari et al., 2019). Based on this, Huang et al. (2021) suggested that group-based interventions might be more suitable to increase compassion in cultures such as the Chinese culture, where a strong collectivistic cultural orientation exists. Whilst this could be the case for Sri Lankan people given the collectivistic cultural environment, it is also important to consider the strong external shame and increased fear of compassion towards others observed in Sri Lankan people, as this might inhibit participants from engaging in the intervention if the delivery method was based on a group format. Therefore, prospective researchers should conduct CMT studies in both individual and group settings in cross-cultural samples, to see which format would be more appropriate. CMT compared to CFT is better suited for larger samples and possibly for samples that have not undergone compassion-based interventions before, given that CMT prioritises on psychoeducation (Matos et al., 2017a).

7.2 Theoretical Implications

Overall, this thesis addressed and signified the importance of exploring several areas of research that are highly scarce such as cross-cultural compassion studies particularly in the Asian communities, explorations of compassion across the three flows (self-compassion, compassion to others, and compassion from others) and inhibitors and facilitators of compassion, and importance of exploring the impact of protective factors such as religion on compassion. In line with the theoretical frameworks, this thesis provided evidence for the importance of considering cultural differences when tailoring treatments and conducting methodologically rigorous compassion-based interventions to increase well-being and reduce distress and psychopathology in people from diverse cultural backgrounds.

The theoretical basis for this programme of research was informed by the research and Social Mentality Theory (SMT) by Gilbert (1989, 2000, 2010a). Gilbert explored compassion across the three flows: self-compassion, compassion to others, and compassion from others and emphasised that whilst these flows influence one another, each flow has psychological and physiological effects. For instance, people who are highly compassionate towards others tend to be more self-compassionate and more likely to accept compassion from others. However, people who might be highly compassionate to others, but hesitant to accept others' compassion, are less likely to be self-compassionate (Hermanto & Zuroff, 2016). This was reflected in the findings of this thesis, where participants who were hesitant to accept compassion from others were generally less self-compassionate. The qualitative explorations in Paper 2 discovered that people who were generally fearful of others due to social shame and criticism were least likely to accept compassion from others. In fact, where there was perceived external shame, participants internalised shame and criticism of society and were self-critical rather than self-compassionate in times of distress. However, Papers 2, 3 and 4 all indicated that despite external shame and criticism, those who were highly self-reassured were most self-compassionate. These findings highlight the importance of studying each of the three flows of compassion separately (Gilbert et al., 2017b).

Gilbert (1989, 2000) viewed social mentalities as complex, and reciprocal social motives, and emphasised that social mentalities of caring and compassion are role focused and evolved to feed basic survival needs. Strong caregiving and care-receiving relationships with parents at a young age can lead to independence and greater self-reassurance as adults (Gilbert, 2020). On the other hand, weak and insecure early relationships with parents can lead to mental illnesses and anti-social behaviour, caused by the lack of ability to self-reassure and form social safeness, later in life (Lippard & Nemeroff, 2020). Individuals with insecure early attachments are more likely to be self-critical and self-destructive (Gilbert & Irons, 2005), which are formed through the activation of the threat system and in the absence of an active soothing system (Gilbert, 2020). The interview data of this thesis in Paper 2 discovered that Sri Lankan participants with negative parental experiences were self-critical, felt fearful of forming relationships, more avoidant and resistant to the love and care of others, and as a result, were less likely to accept compassion from others. In line with this, the quantitative analysis of the cross-sectional study reported that social safeness was significantly less likely, and external shame and fears of offering and receiving compassion were significantly more likely to be displayed in the Sri Lankan participants when compared to the UK participants. A related study found that an avoidant attachment style is strongly linked to criticising others than a criticising self (Mikulincer & Shaver, 2016), indicating the strong influence of external shame and attachment issues. In comparison to the Sri Lankan participants, UK participants across the cross-sectional and CMT studies reported higher compassion towards and from others. In addition, lack of fears of compassion and higher social safeness predicted compassion in both Sri Lankan and UK participants, providing evidence for the strong influence of secure parental attachments on increased compassion regardless of cultural differences.

When discussing the affect regulation systems, Gilbert (1989, 2000) discussed how people can find a sense of safeness in the absence of threat and in the perception of supportive others. In fact, the perception of supportive others who provide a feeling of safeness can suppress the threat

system processing and promote compassion across the three flows (Gilbert, 2020; Gilbert et al., 2017). Supporting this, the present thesis found that fears of compassion were negatively associated with social safeness, and self-compassion and compassion from others were predicted by higher social safeness. In contrast, participants in the qualitative study discussed how their compassionate tendencies were inhibited by weak relationships and heightened fears related to external shame.

CFT (Gilbert, 2000, 2010b) was originally developed for people with mental health difficulties, specifically focusing on those with high levels of shame and self-criticism. Gilbert (2010b) identified that CFT would be particularly useful for those who come from traumatic and difficult backgrounds, and display fears and/or trust issues towards compassion from others and/or oneself. Considering the higher levels of shame and fears of compassion reported in the Sri Lankan participants across the studies in this thesis, CFT therefore, sounds promising for increased compassion and well-being in Sri Lankan participants. CFT also appears suitable for UK people, considering that higher social safeness and lack of fears of compassion to and from others predicted greater compassion to and from others in them.

Compassion can be experienced for one's loved ones and strangers (Sprecher & Fehr, 2005). From an evolutionary perspective, compassionate actions are motivated by one of two reasons: *kin-based* and *reciprocal relations* (Gilbert, 2020). The idea behind kin-based compassion, is that people are generally more likely to show compassion to someone they know closely and well. On the other hand, reciprocal compassion is offered with an expectation for the favour to be returned (Colqhoun et al. 2020; Gilbert, 2020). In line with these theoretical underpinnings, participants in the qualitative study of this thesis emphasised that they are more likely to show compassion to a loved one due to their perceived sense of social safeness and belonging. On the other hand, they were sceptical about accepting compassion from others, when they recognised that some people offered them compassion with an expectation for it to be returned (reciprocal). This was further evident in the cross-sectional study as lack of fear of compassion to and from others predicted higher compassion to and from others respectively in the UK participants, whilst increased compassion from others was

predicted by higher social safeness in both Sri Lankan and UK participants. In addition, the CMT intervention increased compassion across all three flows, reduced fears associated with these flows (except fear of compassion to others in Sri Lankan participants) and increased social safeness in participants from both cultures.

7.3 Research and Clinical Implications

This thesis explored and evaluated the cross-cultural applicability of compassion-based approaches, to inform the planning and delivery of prospective compassion-based interventions. Studies of this thesis focused on participants from Sri Lanka, a South Asian collectivistic culture with a Buddhist influence where no known compassion research has been conducted prior to this thesis. Findings from the multitude of mixed methods approaches suggest that Western compassion-based approaches can be successfully applied across non-Western cultures although, culture specific factors should be considered when tailoring interventions and treatments to specific populations such as Sri Lanka.

There are five key takeaway messages from this thesis, which emphasise the importance of:

1. Psychoeducation
2. Addressing fears and other inhibitors of compassion
3. Addressing protective factors and facilitators of compassion
4. Exploring the delayed and lasting effectiveness of CMT and using online methods
5. Conducting mixed methods studies

The first key takeaway message from this thesis is the importance of psychoeducation in intervention development and treatment delivery to engage more participants to practice compassion. This is because studies have discussed an initial reluctance of people to practice compassion, especially self-compassion, due to the misconception of self-compassion as a self-indulgent concept (Gilbert et al., 2011). This reluctance to practice self-compassion due to the

perception that self-compassion is a selfish or a self-indulgent concept is particularly common in Western communities (Gilbert et al., 2011; Maratos et al., 2019). In fact, Paper 3 and Paper 4 indicated that of all three flows of compassion, UK people indicated lowest scores for self-compassion. In addition, self-compassion was significantly lower in the UK participants than the Sri Lankan participants in Paper 3. Furthermore, some Asian (e.g., Lo, 2014) and Western (e.g., Maratos et al., 2019) studies have discussed that people are doubtful of the importance and/or benefits of cultivating compassion, as compassion-based interventions are generally scarce. Therefore, psychoeducation is essential to create awareness of the importance of compassion on well-being, and to help people understand how practicing compassion can tackle their dysfunctional thoughts in more detail (Asano et al., 2017). Incorporating psychoeducation material would be particularly helpful to countries such as Sri Lanka, where there appears to be a significant lack of compassion-based research (Kariyawasam et al., 2021). In line with this, results of the papers discussed in the present thesis, particularly Paper 2 strongly implied the need of extensive psychoeducation to address issues surrounding stigma, stereotypical views (on mental illness and gender-based views etc.), and harmful social norms, and the need to normalise help seeking behaviour to facilitate compassionate experiences.

Next, this thesis emphasises the importance of addressing the challenges and inhibitors associated with compassion practice. One of the biggest challenges of delivering compassion-based interventions such as CFT is encouraging people to engage in such interventions (Gilbert, 2005, 2010a). This is because fear of compassion is a common inhibitor of compassion, which makes people resist from experiencing compassion and/or disclosing their personal struggles to others (Gilbert, 2010a). This fear of compassion across all three flows of compassion (self-compassion, compassion to others, and compassion from others) was observed throughout the papers discussed in this thesis particularly in the Sri Lankan participants. However, Gilbert and Procter (2006) established that if participants can develop the motivation to engage in compassion-based interventions, significant intervention effects of CMT have been observed in overcoming fears and

resistances to compassion. This was also evident in the CMT study of Paper 4, as significant decreases of fears of compassion across all three flows of compassion were reported in the UK participants, and significant decreases of fear of self-compassion and fear of compassion from others were reported in the Sri Lankan participants post CMT. Therefore, it is important for future researchers to address these fears and other inhibitors of compassion and provide psychoeducation of the importance of practicing compassion, to engage participants in the interventions and psychotherapy.

Whilst CMT reduced the fears of self-compassion and compassion from others, it was interesting to note that external shame or the fear of compassion to others did not reduce post CMT in the Sri Lankan participants. Levels of compassion towards and from others were significantly lower in the Sri Lankan participants whilst their levels of the fears of compassion across all three flows and external shame were significantly higher when compared to UK participants at the baseline, prior to engaging in the CMT. These intervention results were consistent with participants' subjective interpretations in the qualitative study, and the statistical analyses of the cross-sectional study of this thesis, which indicated that high levels of fears of compassion, and social shame appeared to be the prominent inhibitors of compassion in the Sri Lankan participants. In fact, higher compassion was predicted when the fears were lower (e.g., lack of fear of self-compassion predicted higher self-compassion) in both Sri Lankan and UK participants. A similar Iranian CMT study reported that self-criticism did not reduce post CMT and discussed how self-criticism is embedded into the culture of the Iranian people (Noorbala et al., 2013). This Iranian study emphasised that whilst a brief CMT increased self-compassion, it was not sufficient to change the long-lasting cultural limitations of self-compassion (Noorbala et al., 2013). Therefore, in line with this, it could be presumed that the impact of a brief CMT of the present thesis was not sufficient to break the barrier of external shame in the Sri Lankan group. Thus, where such cultural limitations are reported, CMT interventions should focus more on addressing these inhibitors, and interventions should be

implemented across a more extended period to possibly increase the impact of CMT on reducing such compassion inhibitors (Austin et al., 2020; Noorbala et al., 2013).

In addition to addressing the inhibitors of compassion, it is important to explore protective factors that enhance people's well-being and the ability to practice compassion. Religion, particularly Buddhism appeared to be a protective factor for Sri Lankan people across the studies of this thesis. Therefore, clinicians could discuss with clients and explore and incorporate these protective factors into psychotherapy. In fact, previous studies have found a positive relationship between religion, spirituality, and health (Hage et al., 2006), and emphasised that the question is no longer whether to incorporate religion and spirituality with religious and spiritual clients in psychotherapy, but rather, when, and how these factors could be addressed and incorporated into psychotherapy (Post & Wade, 2009). Furthermore, a review with both clients and clinicians reported that clinicians are open to discuss religious and spiritual issues, clients are open to adhere to these in therapy, and that incorporating religious and spiritual matters into interventions can be effective for some clients (Post & Wade, 2009). Therefore, results of this thesis highlight the importance of taking religious and culture-specific factors into consideration when implementing treatment and compassion-based interventions.

Another key implication of this thesis is that Compassionate Mind Training continued to show its efficacy over time highlighting the importance of testing CMT over extended periods. For instance, Paper 4 indicated that improvements of some variables were reported at a two-week follow-up, which were not reported immediately post CMT. Anxiety and depression scores, which were not reduced immediately post CMT, significantly reduced at the follow-up in the Sri Lankan participants, whilst social safeness and pleasure, which did not increase immediately post CMT, significantly increased in the UK participants at the follow-up. Consistent with these study results, a previous Iranian study found that depression and anxiety scores did not reduce immediately post CMT, although significant reductions were reported at a two-week follow-up (Noorbala et al., 2013). In fact, a systematic review discussed that depression and anxiety significantly reduced in

comprehensive compassion interventions (which were lengthy in duration), whereas no significant changes in depression and anxiety scores were reported in brief compassion interventions (Austin et al., 2020). This is an important implication for future researchers and clinicians to consider as it indicates that longer follow-ups should be included to explore the potential lasting effects of the CMT and its effects over time (Austin et al., 2020; Zessin et al., 2015). However, considering that the clinical implications of this are a greater time and cost to services, online interventions with no clinical input (self-administered interventions) would be more convenient and feasible to assess the effectiveness of CMT over time (Austin et al., 2020).

The importance of conducting mixed-methods research is another key implication that was discussed across the studies in this thesis. As findings of the qualitative study in Paper 2 complemented and corroborated with the findings of the cross-sectional and CMT studies in Papers 3 and 4, prospective studies should incorporate a mixed methods approach to fully understand the cross-cultural differences of compassion, and challenges of completing the CMT. Qualitative investigations would further facilitate clinicians' understanding of the extent to which protective factors, such as religion, play in enhancing one's compassion. For instance, although self-identifying as a Buddhist predicted higher self-compassion in the Sri Lankan group, it is not known whether participants actively follow the Buddhist religion, engage in Buddhist practices such as meditation, or whether they self-identified as Buddhist because they were born to Buddhist families. If the latter was the case, further explorations will be needed to explore why self-identifying as Buddhist influenced self-compassion (e.g., whether there was another factor influencing greater compassion). Incorporation of qualitative studies can also help researchers to discover areas that quantitative results might not produce. For instance, Arimitsu (2016) did not find increased levels of mindfulness after a seven-week long Enhancing Self-Compassion (ESP) programme and assumed that the scale used to measure mindfulness may not have been effective. However, upon analysing the qualitative group discussions, Arimitsu found that participants reported difficulty in practicing the mindfulness

tasks at home. Thus, incorporating a mixed methods approach would help future researchers to make improvements on intervention sessions that participants had most difficulty engaging in, so that better outcomes would be produced with possibly less attrition rates. Whilst the mixed methods studies provided encouraging results for the cross-cultural applicability of compassion studies, these studies were conducted in general populations with majority of the participants being university students in Sri Lanka and the UK. Therefore, replications of these studies could assess both clinical and non-clinical samples from diverse backgrounds.

7.4 Conclusion

The concept and facets of compassion are a growing area of research within psychology and psychotherapy. Although the psychotherapeutic benefits of compassion practice are predominantly tested in the Western context and is severely lacking in the Asian context, this thesis discovered that the existing compassion-based interventions can be effective for increasing self-compassion in Asian communities. Whilst compassion research is severely lacking In Sri Lanka, a Buddhist influenced Asian country, Sri Lankan people acknowledge the benefits of compassion for their well-being. However, higher external shame and fears of compassion appear to significantly inhibit Sri Lankan people's compassionate experiences. Several cross-cultural similarities and differences of compassion, and facilitators and inhibitors of compassion were reported between Sri Lankan and UK participants. Despite these cross-cultural differences, a brief online Compassionate Mind Training was highly effective for increasing compassion and well-being, and reducing distress and psychopathology in both Sri Lankan and UK participants. Therefore, this thesis suggests that Compassionate Mind Training is can be an effective and cross-culturally applicable delivery for the improvement of compassion and well-being and inhibition of distress and psychopathology. Psychoeducation is essential to increase participant awareness of the importance of practicing compassion, and to address cultural limitations of compassion. Prospective research should also

investigate the protective factors such as the religious and social influences of compassion when conducting research across diverse cultural backgrounds.

Appendix A Risk of Bias within Studies (Paper 1)

1. Anuwatgasem et al. 2020	**Risk of bias**	**Author judgment**
Random sequence generation (selection bias)	Low risk	Computer generated block randomisation with two b locks, one for intervention group and one for active control group
Allocation concealment (selection bias)	Low risk	Random allocation
Blinding of participants and personnel (performance bias)	unclear	
Blinding of outcome assessment (detection bias)	unclear	
Incomplete outcome data (attrition bias)	Low risk	MSc had better compliance with a lower dropout rate (18.18%) compared to the control group
Selective reporting (reporting bias)	Low risk	All pre-specified outcomes were reported
Other bias	unclear	
2. Arimitsu 2016		
Random sequence generation (selection bias)	Unclear	Not specified
Allocation concealment (selection bias)	Low risk	Random allocation
Blinding of participants and personnel (performance bias)	High risk	Participants were not blind to their condition
Blinding of outcome assessment (detection bias)	unclear	
Incomplete outcome data (attrition bias)	High risk	Authors mention a large and differential dropout rate (20% intervention, 40% control)
Selective reporting (reporting bias)	Low risk	All pre-specified outcomes were reported
Other bias	unclear	
3. Guan et al. 2021		
Random sequence generation (selection bias)	low risk	unclear
Allocation concealment (selection bias)	High risk	Random allocation
Blinding of participants and personnel (performance bias)	High risk	Study was un-blinded
Blinding of outcome assessment (detection bias)	High risk	Un-blinded
Incomplete outcome data (attrition bias)	Low risk	Current study had only one dropout prior to the

		intervention due to a health issue
Selective reporting (reporting bias)	Low risk	All pre-specified outcomes were reported
Other bias	unclear	
4. Guo et al. 2020		
Random sequence generation (selection bias)	Low risk	Random numbers were generated from random number tables.
Allocation concealment (selection bias)	Low risk	Randomised study
Blinding of participants and personnel (performance bias)	Low risk	The independent researcher who randomised participants had no knowledge of the subject's information
Blinding of outcome assessment (detection bias)	Unclear	
Incomplete outcome data (attrition bias)	Low risk	Overall attendance rate was 91.8%
Selective reporting (reporting bias)	Low risk	All pre-specified outcomes were reported
Other bias	unclear	
5. Huang et al. 2021		
Random sequence generation (selection bias)	unclear	
Allocation concealment (selection bias)	Low risk	Random allocation
Blinding of participants and personnel (performance bias)	unclear	
Blinding of outcome assessment (detection bias)	High risk	Assessors were not blind to hypotheses of the study
Incomplete outcome data (attrition bias)	Low risk	Attrition analyses revealed no significant differences
Selective reporting (reporting bias)	Low risk	All pre-specified outcomes were reported
Other bias	unclear	
6. Mak et al. 2018		
Random sequence generation (selection bias)	Low risk	A simple randomisation to 1 of the 3 conditions was performed by a computer system automatically
Allocation concealment (selection bias)	Low risk	Random allocation
Blinding of participants and personnel (performance bias)	High risk	Participants knew which intervention they received
Blinding of outcome assessment (detection bias)	unclear	
Incomplete outcome data (attrition bias)	High risk	There was a high attrition rate

Selective reporting (reporting bias)	Low risk	All pre-specified outcomes were reported
Other bias	unclear	
7. Tung 2020		
Random sequence generation (selection bias)	Low risk	Randomisation explained
Allocation concealment (selection bias)	Low risk	Random allocation
Blinding of participants and personnel (performance bias)	Unclear	
Blinding of outcome assessment (detection bias)	Unclear	
Incomplete outcome data (attrition bias)	High risk	Dropout rate was 43%
Selective reporting (reporting bias)	Low risk	All pre-specified outcomes were reported
Other bias	unclear	
8. Wong & Mak 2016		
Random sequence generation (selection bias)	unclear	
Allocation concealment (selection bias)	Low risk	Random allocation
Blinding of participants and personnel (performance bias)	Low risk	Participants and assessors were blind to the condition assignment
Blinding of outcome assessment (detection bias)	Low risk	Participants and assessors were blind to the condition assignment
Incomplete outcome data (attrition bias)	Low risk	No significant difference
Selective reporting (reporting bias)	Low risk	All pre-specified outcomes were reported
Other bias	unclear	

Appendix B Participant Information Sheet (Paper 2)

Study Title: Exploring the understanding of the concepts of compassion in Sri Lankan students

Researcher: Majuwana Gamage Lasara Kavindi Kariyawasam
ERGO number: 49326

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This research is conducted as part of my PhD. I am a first year psychology PhD student at the University of Southampton, UK. I aim to understand whether the notion of compassion is a culturally sensitive concept among Sri Lankan students. The research will involve me asking general questions about your thoughts around compassion and the possible influence that your upbringing, society/social relationships and religion may have on your understanding of this concept. The questions will involve exploring what participants think of the terms compassion and self-compassion, whether they consider themselves to be compassionate and whether they believe that their upbringing, society and religion have taught them to be compassionate towards themselves and others. The objective of this study is to understand whether compassion is a common concept understood by the Sri Lankan student community. This will provide the foundation for future studies aiming at introducing culturally sensitive practices using the compassionate framework with people presented with psychological complications in Sri Lanka.

Why have I been asked to participate?
In this study, I aim to recruit up to 25 Sri Lankan students undertaking an undergraduate degree in psychology. Therefore, you have been asked to participate as an undergraduate student living in Sri Lanka. You should be above 18 years of age and Sri Lankan national. Participants will only be recruited if they are happy to be interviewed on a voluntary basis.

What will happen to me if I take part?
You will be invited to a face-to-face semi-structured interview with myself (primary researcher) in which you will be asked about your understanding of compassion. Prior to these questions, you will also be asked to state your age, gender, religion and nationality in a demographic sheet provided to you. There will be no right or wrong answers to the questions asked and therefore, please do **NOT** make any preparations to answer these questions. You are only expected to share your opinion/experience related to the questions being asked. You do not have to know the terms discussed. You will be given this information sheet before the interview and a debriefing sheet after the interview has been conducted. The interview will only begin once you have given your informed consent and completed the demographic sheet. Your participation in this study is completely voluntary and you do not have to participate if you do not wish to do so. The interview may take up to 60 minutes. You have the right to discontinue the interview or withdraw from the study anytime if you wish to do so without

providing a justification. You will only need to meet me (the interviewer) once for the study and the interview will take place in a quiet environment in your institute where no one could overhear the interview. You will not be contacted again regarding this study once the interview has finished. You can however contact me should you require more information about the study or should you wish to withdraw. Please note that anonymised information (information that you provide in the demographic sheet) cannot be withdrawn once the interview has been conducted. Your interview information/recordings can be destroyed and, this information can be withdrawn should you require this within one week from the date of the interview. Interview data will be transcribed after a week from the interview date and therefore, cannot be withdrawn after this one-week period. It is important that you are aware that the interview will be audio recorded using an encrypted audio device and, audio recordings are required for this study (for obtained qualitative data to be transcribed). The interview data will be transcribed and the audio recordings will be permanently destroyed afterwards. Once your data has been recorded and transcribed, your anonymised data will be analysed using the knowledge of Interpretative Phenomenological Analysis (IPA), to explore the Sri Lankan students' thoughts around the concepts of compassion. The demographic data and the information collected during the interview will not reveal your name or any identifiable information and therefore your confidentiality is guaranteed. The information collected from you (including the things discussed in the interview) will be saved under a number that is assigned to you and therefore, your name will not be revealed at any point of the study.

Are there any benefits in my taking part?
There is no direct benefit to you as a participant although I would be happy to answer any questions you may have regarding the study or discuss about the study once the interview has been conducted. I expect to meet you in person for the interview at your most convenient time in your educational institute (ICBT College) in the month of September, 2019, hoping that the interview would take place at your ease. Your participation is much appreciated and will contribute to the broadening of our understanding about compassion practice in the Sri Lankan student society.

Are there any risks involved?
This study is only conducted in the form of a face-to-face interview which will not result in any physical damage/risk. You will only be asked questions about your opinion and experience around the concepts of compassion and you are free to decide what you do or do not want to share in the interview. However, some of the questions discussed may lead you to recall unpleasant memories/ tough times and therefore, it is possible that you may feel slightly distressed. Therefore, if at any point do you feel uncomfortable, you may stop the interview or take a break. Additionally, once the interview has been conducted, you will be given a demographic sheet which will provide you a link to an online breathing exercise video, which will help you to calm down (I will be happy to show this video after the interview or you can decide whether you want to go home and watch the video after the interview). The debriefing sheet will also provide contact details of psychological helplines and a link to a self-help guide.

What data will be collected?
As the primary researcher, I will be collecting data. Firstly, participant's written informed consent form will be collected. Next, demographic information of participant such as age, gender and religion will be noted. Personal information such as gender and religion will be required to explore whether the understanding of compassion varies based on religion, age, gender and/or nationality etc. This type of information is considered as special category data according to data protection. Personal data will be handled with respect and stored securely. After noting the demographic information, interview will begin with the researcher asking the participant about their understanding of compassion and memories of giving and receiving compassion. The entire interview will be audio recorded as consented by the participants in the consent form, using an encrypted audio device.

We will require participants' email address to contact the participants to arrange a time and date for the interview only, and this information will be stored separately from the assigned

participant number. All email addresses will be stored in a password protected computer and deleted once the interview data has been analysed. You will not be contacted for any purpose other than for this particular study.

Will my participation be confidential?
Your participation and the information we collect about you during the course of the research will be kept strictly confidential. In fact, information collected from you (e.g., religion, nationality) will be kept confidential in line with the University of Southampton Ethics Policy and the Data Protection Act (1998).

Only members of the research team (researcher and research supervisors) and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

As previously detailed, participant information including the consent forms and audio recordings will be stored securely. You (participants) will only be referred to by a given number and participant names will not be required, noted or stored anywhere (other than in the consent form which will be stored securely in a separate place). Some of the statements given by you may be directly quoted in the reports although quotes will be referred by the number allocated to you and not by your identifiable name. The collected consent forms will always be stored in the researcher's research office room in a lockable cupboard and, audio recordings will be transferred to a password protected computer (original recordings recorded from the recording device will be deleted once these have been transferred to the computer). Recordings will then be transcribed and destroyed permanently once transcribed.

All the collected data will be stored with the researcher and only be shared with the supervisors if necessary.

The list of participants' email addresses will be noted in a document and stored separately on a password protected computer. The email addresses will be deleted from the computer once the study has been completed. In addition, the consent forms collected from you will be securely placed in a lockable cupboard with access restricted to the researcher and supervisors only.

Do I have to take part?
No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show that you have agreed to take part. You will be informed about this study by an email that will be forwarded to you via your university. This email will contain the information sheet comprising all the information necessary for you to understand the purpose of this study. This email will also contain my email address (primary researcher contact information) requiring you to contact me, should you wish to take part. I will then discuss with you about a convenient time and date for the interview via email.

What happens if I change my mind?
You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected.

If you agree to participate and then decide to withdraw before meeting me for the interview, you can inform me by emailing. If you wish to change the time and/or date of the interview you can also do so by emailing me. Once we meet for the actual interview and if you wish to withdraw right before, during or after the interview you can still do so by talking to me

verbally. We will then destroy the data collected up to that point and remove you from the study as per your request. If you decide to withdraw from the study after participating in the interview, you can do so by emailing me within a week from the date of the interview. Please note that the anonymised data (such as your age and religion) cannot be removed once they have been submitted. Interview recordings will be transcribed after a week from the interview date and therefore, interview information cannot be withdrawn after the one-week period. Thus, we will keep the information that we have already obtained for the purposes of achieving the objectives of the study only. As previously mentioned, your information will be kept confidential and your name or identity will not be revealed at any point of this study.

If you are interested in taking part in this study, please email me at lkk1n17@soton.ac.uk (Lasara Kariyawasam).

What will happen to the results of the research?
Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent. In fact, all the information that will be recorded or stored will only be recorded and stored under a random number that will be allocated to you. Therefore, your personal identity or name will not be exposed at any time during or after the study.

Once the data has been obtained and the study has been completed, this research will be submitted to the University of Southampton as part of my doctoral degree and be published in a peer reviewed journal. I would be happy to provide you a copy of the results if you require as such. Your personal details however will remain strictly confidential throughout and you will not be directly identifiable from any report or publication at any point.

Anonymised interview transcripts will be retained for future studies. These transcripts will always be stored in a password protected computer and will not contain any identifiable data of the participants.

Please see the contact details below should you wish to file a complaint.

Primary researcher (Lasara Kariyawasam)
Lkk1n17@soton.ac.uk

Primary supervisor
M.S.Ononaiye@soton.ac.uk

University of Southampton Research Integrity and Governance manager
rgoinfo@soton.ac.uk

Where can I get more information?
You can contact the primary researcher or research supervisor using the contact details below.

Researcher (Lasara Kariyawasam)
Lkk1n17@soton.ac.uk
Office 4115
School of Psychology
Shackelton Building
University of Southampton
SO17 1BJ

Primary supervisor (Dr. Margo Ononaiye)
M.S.Ononaiye@soton.ac.uk
Office 3089

School of Psychology
Shackelton Building
University of Southampton
SO17 1BJ

What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.

Researcher: Lasara Kariyawasam lkk1n17@soton.ac.uk
Primary Supervisor: Dr. Margo Ononaiye M.S.Ononaiye@soton.ac.uk

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice
The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you. Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at
http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it. Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you: I would sincerely thank you for taking your time to read the information sheet and considering taking part in the research.

Appendix C Participant Consent Form (Paper 2)

Study title: Exploring the understanding of the concepts of compassion in Sri Lankan students

Researcher name: Majuwana Gamage Lasara Kavindi Kariyawasam
ERGO number: 49326

Participant Identification Number*:*

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (*16/07/2019, version 1)* and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I agree to take part in this study in the form of a face-to-face interview	
I understand that taking part in the interview involves audio recording which will be transcribed and then destroyed for the purposes set out in the participation information sheet.	
I understand that special category data such as my gender, age and religion will be recorded for the purpose of this study only, and I consent to give this information about me.	
I understand that my participation is voluntary and I may withdraw at any time for any reason without my participation rights being affected.	
I understand that my personal information collected about me such as my name and my email address which was used to contact me will not be shared beyond the study team.	
I understand that should I withdraw from the study then the anonymised information collected about me up to this point may still be used for the purposes of achieving the objectives of the study only.	

Appendix C

I understand that if I wish to withdraw from the study and should I wish all the collected information during the interview to be withdrawn, I may contact the researcher within one-week of the date of the interview and information cannot be removed after this one-week period.	
I understand that I may be quoted directly in reports of the research and my statements may be presented in quotes although, I will not be directly identified (e.g. that my information will be allocated to a random number and my name will not be used).	
I understand that the information collected from me will be stored for future studies in the form of anonymised transcripts and I give permission to this and for my special category data (age, gender and religion) to be stored in the form of anonymised survey database as described in the participant information sheet so it can be used for future research and learning.	

Name of participant……

Signature of participant…….

Date…….. ……

Name of researcher….Majuwana Gamage Lasara Kavindi Kariyawasam

Signature of researcher …….

Date……..

Appendix D Debriefing Form (Paper 2)

Exploring the understanding of the concepts of compassion in Sri Lankan students
Debriefing Statement (written) (Version 1, 16/07/2019)
ERGO ID: 49326

The aim of this research is to explore the basic understanding of compassion and its link to religion, society and upbringing among a group of Sri Lankan students, to understand whether compassion to and from others as well as compassion towards the self is a culturally sensitive concept, understood and practiced within the Sri Lankan student community. This study hypothesises that Sri Lankan students would have a basic understanding of the concept of compassion and that religious and cultural upbringing would have shaped their level of compassion. Your data will help our understanding of whether Sri Lankan students are aware of compassion and their experience around this concept. As mentioned in the information and consent forms, completion of this study will not include your name or any other identifiable characteristics. This research did not use deception. You may have a copy of this summary if you wish and, you may also request a summary of research findings by contacting the researcher once this project has been completed.

If you have any further questions, please contact me (researcher: Lasara Kariyawasam) at lkk1n17@soton.ac.uk

For further queries, you may also contact the research supervisor, Dr. Margo Ononaiye at M.S.Oninaiye@soton.ac.uk.

The questions asked in this study were not intended to cause any distress. However, if you feel distressed, please watch the following video for a short breathing exercise that will help you calm down.
https://www.youtube.com/watch?v=4_nioG63OSs&index=6&list=PLFbeQlTqQPGTLAmNgKs0srX9Vau7mctFf
If you wish to seek any assistance, the following website provides a list of self-help strategies to deal with difficult situations.
https://web.ntw.nhs.uk/selfhelp/

Additionally, the below will be available to assist you with any concerns:

- National Institute of Mental Health http://www.ncmh.lk/ncmh_Counselling.htm
- Sumithrayo Organization http://sumithrayo.org/

Thank you for your participation in this research.

Signature _____ Date _____

Name: Majuwana Gamage Lasara Kavindi Kariyawasam

Appendix E Interview Guide (Paper 2)

First, I would like to thank you again for helping with my research.

Double check/ remind the participant:

- The interview will take between approximately 30 minutes to one hour and may be shorter than this – is that okay with them?
- Their responses will be kept confidential, quotes will be used in the results but their name will be changed
- They can change their mind about taking part in the study and stop the interview at any point
- They can have a break if they want to at any point and ask them half way through the interview if they would like a break
- Ask if the participant has any questions

The purpose of this interview is to investigate whether compassion and self-compassion are culturally understandable concepts in Sri Lanka. I am also interested in whether this is influenced by things such as your family and friends, your religion, your upbringing, your school experience – anything like that. So before we start, I just wanted to remind you that there are no right or wrong answers, and this interview is about finding out about your experiences and views.

So for the first question….

1. Can you tell me what the term **compassion** means to you?
    - Prompts - when you hear the word compassion – what does it make you think of?
    - It doesn't matter if you don't know the exact definition – what do you think it might be?

2. Can you talk about your understanding of **self-compassion**?
    - Prompts - when you hear the word self-compassion – what do you think of?
    - It doesn't matter if you don't know the exact definition – what do you think it might be?

The next set of questions are going to focus on three aspects of compassion. The first one is how we show compassion to other people, the second is how others show compassion to us, and the third is how we are compassionate towards ourselves.

So for the first one…

3. I'd like you to think about one or two occasions when a loved one was going through a tough time or difficult situation. (this could be a family member or close friend)
    - (e.g., this could be when they were sick, failed an exam, lost a loved one or anything that upset them)

        a. Can you tell me if you showed compassion towards them?
        b. Could you tell me why (or why not)?
        c. Can you tell me the things that you did or said to them? (keep probing – you've told me about x and x – did you do or say anything else?)
        d. What were your feelings and thoughts towards them?

        e. And then afterwards…. How did your words and actions affect them?
        f. How about you? Was there an impact on you?
            - How did it make you feel?
            - Were there any consequences for you and your life?
        g. If the same thing happened again, would you do and say the same things?
            - If so, why / if not, why not?

        h. Are there any factors that facilitate or help you to be compassionate towards others? (prompt - circumstances, people or influences in your life)

        i. Are there any barriers that make it difficult to be compassionate towards others? (prompt - circumstances, people or influences in your life)

Great! So you've told me about how you are compassionate towards other people. Now we're going to talk about how others show compassion to you.

4. I am now going to ask you to think about another time – when **<u>you</u>** were going through a difficult situation (or two).
    - (e.g., this could be when you were sick, failed an exam, lost a loved one or anything that upset you)

        a. Can you tell me if anyone showed compassion towards you?
        b. Why do you think that was (or why not)?

c. Can you tell me the things that they did or said to you? (keep probing – you've told me about x and x – did you do or say anything else?)
d. What were your feelings and thoughts towards them?

e. And then afterwards…. How did their words and actions affect you?
   - How did it make you feel?
f. How about them - How did it make them feel?
   - Were there any consequences for them?
g. If the same thing happened again, would you want them to do and say the same things?
   - If so, why / if not, why not?
h. Are there any factors that facilitate or help others to be compassionate towards you? (prompt - circumstances, people or influences in your life)

i. Are there any barriers that make it difficult for others to be compassionate towards you? (prompt - circumstances, people or influences in your life)

We are on to the third aspect now, which is about how we are compassionate towards ourselves.

5. This time I am going to ask you to continue thinking about occasions when **you** were going through a difficult situation.

   a. Do you think that you were compassionate towards yourself?
   b. Why do you think that was (or why not)?
   c. What were your thoughts and feelings towards yourself? (prompt -e.g. were you kind and supportive, or judgemental?)
   d. How did you treat yourself? (prompt – What did you do to look after yourself?) (keep probing –did you do anything else?)

   e. Were there any consequences for you from treating yourself the way you did? What were they?
   f. If the same thing happened again, would you do and think the same things about yourself?
      - If so, why / if not, why not?

   g. Are there any factors that facilitate or help you to be compassionate towards yourself? (prompt - circumstances, people or influences in your life)

   h. Are there any barriers that make it difficult to be compassionate towards yourself? (prompt - circumstances, people or influences in your life)

Debrief : Thank participant for taking part in the interview – give them the debrief form.

Appendix F IPA Coding Draft (Paper 2)

	Question	Theme	Quote	Notes
	What is compassion	Kindness, sympathy, understanding, empathy, love, consideration towards needs Conditional (to the person, their society), born with, gifted, essential human quality, go out of your way to help	And being compassionate is something gifted as I said before and in the modern world I think compassion is kind of an artificial thing. That's it.(P6)	P6 implied that people in the modern world use compassion as a fake/artificial thing
	What is self-compassion	Understanding about the self, taking care of the self, attending to personal needs, love and kindness for self, process, common humanity	I think it's all about calming ourselves when we go through a big problem and then thinking it's okay, it's fine like every human being has to go through these stuff.(P7)	
Compassion to others				
	Have you shown compassion to others	Yes	Umm.. Yes.. Umm actually umm at a time like that you need to be umm non judgmental and try to understand their problem, try to umm I mean go in to their shoes and try to understand as if it has umm happened to me and then umm think like what will I do if I I'm the person who's going through this right now(P3)	
	Why did you show/didn't show compassion to others?	Because they were going through a difficult time Because they came to me for help Nobody else was there if not for me, my responsibility, because	Yeah. Later I realised that is my weakness, one of my weaknesses. So.. but I can't control myself when I become compassionate, I get truly attached to that person's emotions, ok? And I see things according to that person's view and	P6 stated that compassion he gives to others is also his weakness

	I love them, care for them Because I have been through the same situation	get that problem to make my my problem, ok. And.. that's it. (P6) Yeah so I had my friend in my class who was in a relationship for three long years and that guy like left her for no reason and at that situation everybody in my class blamed her saying like you're the one who has (unclear) or you're lying or you are doing a drama and everybody left her out. So I was with her and I felt she needs love, she needs support and someone who will understand her. So I was with her at that time like throughout 6 months and my own best friend left me for that.(P7)	People left due to showing compassion
How did you show compassion?	Compassionate words (if you need anything I'm here, everyone makes mistakes) Compassionate actions (listening, going out for dinner, being non-judgmental, making sure they weren't alone, relate to personal experiences)	Umm first thing is that I made sure that they didn't feel judged or, that they didn't feel like they were being scrutinised for something that they did. Umm that's something I did, so. And something I said would be something like like you are only human, people do people make mistakes and you have the space to make everyone has the space to make mistakes and so do you. And then sometimes you need to give yourself that opportunity to learn from it, and yeah.(P2)	Common-humanity
What were your thoughts and feelings towards them?	Sympathy, sad, sorry, kindness, bad, hurt, relatedness		

What was the impact on them from the way you treated?	It helped, felt better, not felt alone, saw the bigger picture, resolved the problem, happy, relieved, comfortable, calmed, grateful	Yeah of course. I mean I like it's when when somebody is talking about their problems and, most of the time you can always relate to it, their problems or mistakes you can most of the time always relate to it. So yeah I thought about how at that time I thought about how I dealt with the situation and basically I told that person not to be as not to be so harsh on yourself as I was with myself, so I learned from my mistake and was able to help or tell them how not to beat themselves when they make mistakes or yeah when they feel guilty about something, I was able to relate to it. (P2) Because one thing if.. because one thing I know that particular person. The second thing is I don't I wouldn't want even an enemy of mine to go through a situation like that. So if I can help that person by talking to her her or him and by supporting that person, I would I wouldn't think about the impacts that I have, I would also I would solely go and help that person because I know that me talking to that person would actually make a difference.(P10)	Learned from the past and helped the other person, don't be harsh on yourself as I was with mine
What was the impact on you from treating	Positive impact (Felt good about the self, relatedness to the	I honestly I feel that a little bit better about myself you know being able to help someone like that. Its	What about showing compassion to a stranger then?

them the way you did?	persons problem, self satisfaction) Positive vibe Negative impact (responsible, distracting, irritated, relating to the self: what if this happened to me?, I end up being the bad person), depressed, emotionally down	always very rewarding when you can do that for someone. especially for a person that you really care about (P1) . I feel like like whenever I become whenever I'm compassionate to someone, I I feel like this thing, umm I feel like this vibe going out of me. So I feel good whenever I can show love to someone or maybe talk in a friendly way, talk kindly or do some helpful act. Like I it is like a self-satisfying thing for me personally(P4) And I also felt kind of after talking to them I also felt kind of responsible if they felt worse about the situation afterwards because you always que question yourself, right? If you might have said the wrong thing or if you might have sounded a little judgmental, but then like I did question myself about that but I didn't I didn't have a negative impact as such, I guess. (P2) so sometimes it's actually being a little distancing as well because they keep coming back to me often or calling me, so sometimes with with my work I feel distracting. But umm at the same time I don't I don't show them that that it's it's distracting but I try to I try to help them in whatever way when they contact me.	Sense of responsibility when showing compassion (what if I made the situation worse/could be a barrier) People get used to showing compassion and can be irritating when they keep coming back for help (refer to fears of compassion scale)

		Umm sometimes to tell you the truth, sometimes in one or two cases I have been like kind of irritated. But.. but I .. I .. I don't try I don't show them that I'm irritated and I just try to quickly quickly tell them something or just.. talk about the situation and dismiss them. (P3) I have so many experiences umm I'm not going to talk about them now. Umm.. most of the time at the end of the day I'm the worse person in this world, to them. To them. To them because with their reactions I can understand that according to them I'm the bad person. Most of the times, ok. But.. umm. Yeah.(P6) I felt very like I was a bit depressed like thinking about her. She was always crying(P7) Yes. Many people blame me for like going and supporting her and talking to her. Many people ignored me, my best friend like totally ignored me she's not even talking to me and that affected me a lot and still it's affecting me.(P7) And.. I understood that you can't give compassion all the time. Because there might be some people who don't want to give it at all. Cause when it comes to my incident I'm like 50% 50% to be very	

		honest. Sometimes I don't wanna.. compassion because at that time I'm in a bad mood. So when I need compassion I can't give compassion to another person. But at times I can.. So yeah.(P8) I was very I would say I was emotionally down because I was…And it's a memory that I will never be able to erase from my mind because it's not me who went through it, it's that particular person, but I felt really depressed, down and I... I didn't have an ape appetite for a couple of days when that particular situation happened and I rea.. that was one instance that I felt really helpless and that I didn't I honestly felt that there was no purpose of living. Umm.. yeah.(P10)	
Would you say/do the same in future?	Yes (show compassion) Yes (if help is required) Yes change actions (talk less, listen more, be more non-judgmental) Depends (situational, person's personality) Depends (on the person's personality and thinking)	So, I'd listen more and if they need anything specifically rather than you know going and trying to directly medal in their business. If they want some specific favours, specific help then I'll see if I can do that and if I can then get that done as well. (P1)	If specific help is required. So wouldn't you show compassion if not required by the other?
Facilitators of compassion to others?	Culture Religion	Umm our culture is a very umm communal community based culture where people tend to you know look into other peoples' worries and difficulties and stick to like the family is a more stronger unit and even the	Participant was not sure if it was okay to speak

	Negative Experiences Positive experiences Learning from animals Parents	extended families and friends and relations and everyone are much more closely tight together(P1) Yeah. So one thing is my religion. Can I talk about religion in this? (P4) So In my religion which is Christianity, we are always taught that we should show compassion to others and it is something that you grow with. It is not something you should do, but it is something you should get from within you(P4) As I was raised in a Buddhist family, we we've been teaching how to be compassionate to people. And.. ummm I actually I I don't expect someone to react in a good way after I show them compassion. I don't expect anything. Umm.. I.. for me being compassionate to someone it gives me kind of a relief. And I get satisfied, I become really happy oh I did I really help that person, I showed compassion, so that person is happy, I'm happy. That's why actually I use it as a stress relief.(P6) I'll say experience first. So experience is what… I have experienced… I said when I didn't receive any compassion is one of the main reason why I love to give compassion to other people.(P8)	about their religion

		Umm.. so my father is not my father is not a compassionate person I would say. So he himself.. so when I talk about my father that brings up you know my whole history from the time I remember up to now. So from the time I remember, all I learned and cared about is being kind to others, being good to people, knowing trying to be the best person I am and trying to help people the best way I can. So that was the reason for me to I would say, that was the main reason for me to be this compassionate or kind people person or to be able to relate to a person. That quality came through my experiences in my past.(P10) And how they would help me out and from that I would learn how to reciprocate that and I guess religion also plays a role because religion kind of teaches you certain values saying you know this is how you are supposed to you know if you have a friend in a dire situation you are not supposed to turn your backs on them you are supposed to support them. Cause if you do it is pretty much one of the highest in terms of the good things you can do like the good deeds you can do in religion. And its not just that they say that you are supposed to do those	

		things. They say those are the right things those are the things that are rewarded. So in itself it kinda teaches you how to go about doing and the value of umm being compassionate and the value of being helpful to others. (P1) And (laughs) as stupid as this sounds also animals make you compassionate because their un the unconditional love they show you kind of makes you question everything and question your ability to dedicate yourself to something. So, definitely animals as well. Like pets, dogs and (P2)	
Barriers of compassion to others?	Helping someone who is not close Social barriers	Because I'm not sure how exactly to explain this one. So.. one thing is like it's easier to sympathise umm you know show sympathy towards a person you know closely and well. So that personal relationship you have with that person also plays a role. Because you when a person is closer to you you understand what kind of things they are going through because you understand them, their life is going in a particular way, you know you understand their kind of relationships they have, the strengths they have and the weaknesses that they possess, and because of that sympathising towards a person who's closer to you is somewhat	Not knowing a person can stop someone from showing compassion, you don't know what you are getting into, it is a matter of invading their privacy.

	Anxiety about helping Religion Culture Social attribution of mental illness Social class Financial difficulties People who do wrong	easier whereas when you're trying to sympathise towards a person that you don't really know that well, it's a bit difficult and there's social barriers as well. Because it's okay to approach a person you know closely because you know you you kind of share an amount of personal space. But if you try to help a stranger, then there is a matter of invading their privacy and things like that. And sometimes you don't know what you're getting into(P1) You know in Sri Lanka, when suppose I try to help a girl, people see it as a different thing ok? My parents too. And there are so many friends who comes to me when they need a help, mostly girls. My parents sometimes misunderstand, my son has so many girlfriends like that. But that's not true. I want to help them. That is my that is my kind of hobby. And.. if we consider about other people, I mean the society, they are very they see it as a real different thing. Because they are in a frame called tradition, yeah.(P6) So if they need any help any kind of help I would help them with anything. Even if it's a stranger, I would. Sometimes umm umm sometimes umm helping stops when there's a lot of people around and I'm a bit shy too. Because in crowds I'm a I get I get I	

		don't know if it's a phobia (laughs). Yeah then I'm I get I stop there and umm yeah.(P5)	
	Personal factors (mood, day)	Ah but then there's this thing, like say when you walk on the road. It's on casual day when you want to show say when you want to show compassion, you also feel insecure or you doubt if the, specially in Sri Lanka like you can't say, you can't trust anybody easily. So say you show compassion, like we don't know how the person will take it right? So yeah. So some people would like to be helped or may not like to be helped, or some people wouldn't like to be shown compassion maybe.(P4)	
	Some people around	…. and I fell into this depression where I felt like a rain cloud was following me everywhere…. So I told my mom I'm feeling like this and all that. But they are old school. They are old school, born in the 50's in an era when people told to just get over it. And.. but my mother.. she had to be compassionate all her life. She was one of seven. And both parents weren't there.. she had to look after other siblings since she was like five. Cooking, cleaning, looking after little ones. So I told her this is what I was going	

		through and she said why don't you just get over it.. I know your normal reaction is angry. I understood, I understand if I grew up in that era where people went through…. Life is easier for us these days they had to go through a lot more and they just got over it, they had to. It's not by choice.. So I said I felt like a foreigner in the country I was born. I feel like that now. Nobody would understand unless you have been through the same thing. (P9) Having having been religious before, has actually taught me how how I can be compassionate even without religion or without the teachings of a religion. So, and.. and culture of course I mean definitely influences people and has influenced me as well. Because, like for example if I talk about the culture that I am living in, people are compassionate, but if you start comparing this culture and another culture, it's definitely different they they are only compassionate towards people who share their same beliefs and their same and who are in their same belief system. But when that changes a little bit, you are either from a different religion, or different racial background or different educational or socio-	

		economical background, I think that compassion kind of changes. so obviously this compassion is very conditional towards wherever whatever the background of the person is. So that's how I see culture has culture influences in this society. But for me, I am able to see it as like everybody, I think compassion also comes with acceptance of who people are and like that everyone is different and that's okay. So culture has definitely affected me more like in the sense that it has taught me like sometimes it has taught me how not to be. You know.. and same with religion. That you don't have to be cultural or religious to be compassionate towards something. (P2) Umm I'd say people who have done me wrong. It's very hard to for me to show compassion to those people. Like every time they are like oh I have this problem, my head is like you did it to me last time so you deserve it(P8) Yes. Something like for example like if when people commit or when people do things that are really really hard for you to accept like for example being cruel to animals or being mean to kids or being being judged for being a woman for wearing something the	

			society thinks is indecent or uncultured and those things are very like when people are mean to you, it's hard to be compassionate towards them. You know, because like why should I be compassionate to you when you're being so mean to me (P2) They were like you're not the godmother to go and explain people and make them understand. You can just be on your own, why do you have to worry about them go and talk to them like that.(P7)	
Compassion from others				
	Have you received compassion from others?	Yes		
	Why do you think that was	Positive reasons (They care Genuinely concerned, nice in general, love, worried, wanted to be there, non-judgmental, empathetic) Personal reasons (friends, connected) Negative reasons (personal agendas, reciprocal obligations)	Because I think they care right? Otherwise would they really bother you know worrying about what I'm going through or offer their help in the first place. I think they genuinely care and they are genuinely concerned about my wellbeing. So I guess that connection is what leads them to help(P1) Ummm.. They just… actually that's kind of a fake thing. I feel that sometimes. They just say oh just just ignore that, you're a good person, see you're a counsellor for us and don't try to be too emotional, when we're in	Again talks about the connection implying that compassion for someone not connected would be different?

	They could relate, have been through the same situation	a situation you're the one who help us, they say so. But I think it's because I help them, it's not because they want me to be happy. They sometimes they fake. I feel that umm… and they just say just ignore that but they.. when I meet them they tell me ohh.. but then they don't they don't pay much attention to my problem, ok. I need.. you know when someone is in a problem, that person needs kind of attention for a time, but they just say they just say ah ignore that, you're a good person and say blah blah blah.(P6) from the people I met in my past, I haven't met even relatives who are truly kind in a way without having an agenda(P9) Umm.. some people solely because they cared about me. And some were because umm.. I feel I felt like they were you know they felt like they were obliged to understand and help me out.(P10) The ones who showed compassion actually understood the situation. They are people who actually understand me and they listened to me and they have gone through the same thing. I know that for a fact. Some of my family members have been through the same things that I have gone through. So I know	

		that they understand. But for the people who didn't, I saw it as jealousy, I saw it as not understanding, being very narrow minded, have only one point of view and not being broad minded like at all. Rude I'll say.(P8)	
What did they do/say?	Compassionate words (are you going through something, is there anything we can do) Compassionate actions (checking if they are ok, follow up)	if I'm not speaking to them they would find someone like a loved one or someone like that and ask them(P1)	People who genuinely care, even when being avoided/rejected, they still went and found other ways to show compassion Even if participant didn't speak to them, the fact that they checked on him in other ways made him feel better, although he does not show he needs them to care it appears that he does
What were your feelings and thoughts towards them?	Felt highly of them, felt fortunate to have them, grateful, I'm meant to have them, relaxed Initially bad, later grateful and positive	Basically I felt very highly of them. Because I actually felt fortunate that I have people like that in my life. I'm not so certain that everyone does, just … just because I do have people like that made me special in a way. And there are people who care enough to come during my difficult time and try to figure out what's going on and to offer their help in anyway possible, I guess that's a very good thing(P1) At the moment obviously I'd be like oh no.. everything will go wrong and no nothing will be	Reluctant to receive compassion but later grateful they had it

		fine .when you are in when you're having a problem and when people tell you things like you don't really accept it at that moment right.. but later when I think about it afterwards it it made sense it it helped a lot.(P2) I was like okay there's someone for me who would show me love and understand me.(P7)	
Was there an impact on them from treating you that way?	Positive feelings (Happy to be able to help, Felt better, satisfied) Sense of reciprocity	I.. I'm not sure if they had it in mind when they did help.. but I think they might have because you know like just as I had them when I needed them, if I'm also there when they need me, I guess the fact that they helped me would you know eventually be of use for them. Or just having me as a friend I guess in the long run they might like that fact better. And I'm pretty sure they also feel good about helping me. So I guess, yeah. (P1) Umm.. fake people may think ah okay okay he become compassionate towards us when we are in bad mood, okay now we did our duty, they might think like that. But good people, they might feel as the same as me. I think they get a kind of a happiness by showing their compassion to me.(P6)	Some people help out of the kindness/goodness in them. Others show compassion with the expectation of compassion in return or because they feel obliged to show compassion

		I'm sure they felt good about themselves too. And specially because some of those people had gone through similar issues in life so they were more than.. you know they were more than rendering a favour to other person, they were also you know thinking about themselves and those people were honestly doing themselves a favour(P10)	
Was there an impact on you from the way they treated you?	Compassion did not resolve the problem Compassion helped feel better	There were sometimes, where their help and even the words of advise and their concern didn't seem like that it mattered much because maybe my situation was that dire or maybe my situ the fact that they didn't really understand my situation or at least my perspective into my situation(P1) the reason I'm strong at this point is because I know there are people out there who do support me(P8) So it's like it's not just that I'm grateful for having them, I know that my life is made better because I have them in my life, that kind of people who would actually talk to me you know and make. There were situations where I was given certain advice that actually directly did help. (P1) yeah it helped a lot and it kind of makes you reflect on like again I keep saying this like the fact that you feel like you are not alone	Even if other people showing compassion at times may not have been helpful to resolve the issue, them being there have helped the person emotionally

		and that this things happens to everybody and the fact that you can relate to somebody else and the confidence that you get that okay they got through it maybe I can too. So that feeling really helps. (P2) No they did. Their actions, their words their their actions and words basically you know they helped me a lot. My sadness reduced, tension reduced, like I could be who they wanted at the end. So they wanted me to be the happy girl I am like normally. So it did not take so many days for me to recover from that you know like within a few days say like a week, I was totally recovered. (P4) It made a bad situation tolerable. It didn't change the circumstances, it wouldn't. But it made the bad circumstances easier to face. That's what(P9) So those words of kindness, those words that actually brought me ..brought.. actually made me a strong person you know the person I am. And I feel through those terrible hardships that I have gone through in life I am who I am is because of those(P10)	
Would you expect the same thing from them in future?	Yes Unsure	So.. like I don't like to tell them and I don't like them to feel sad about me. I just want to be you know	

			nobody should feel bad about my life.(P7)	
	Facilitators?	Their upbringing, school, society, religion, personal experiences, culture, loving parents, relationship with the person, personal qualities like sensitivity Personal factors (attitude, relationship with the person, day, mood, personal experiences) Culture Family	Culture (Mm I guess you know the culture pretty much says that you know in order for our society to survive you know in order for our society to come to a better place and that we need to be there for each other) (P1) Their family background, how they are brought up and. How they are brought up in the sense from small days, if if one can know the importance of compassion towards themselves and to others, like I said before it would not they would not have to put an effort to show compassion. It is something that you get from within you, so yeah. (P4)	
	Barriers?	Social barriers Lack of knowledge Financial barriers Every day's factors (bad mood, exhausting day) Personal factors (attitude towards the person, personal commitments)	But like some some of them are married. And then sometimes they have their family commitments, so whenever if I need to talk right now, sometimes they won't be able to talk to me. (P3)	
Compassion for self				
	Have you shown compassion to yourself?	Unsure No Yes		
	Why?	There have been time I showed little	So like if I was in a bad situation if I had thought	

	compassion and times when no compassion was given at all I love myself Can't show compassion to others if not compassionate to self Love myself	you know ok I'm in a bad situation what can I do to make this situation better or get myself out of this situation, I would have been more compassionate about myself and umm you know I would have done something to improve the situation. But rather, I just saw the pain and I just wanted to inflict more pain on myself and the others around me. So I guess that in itself was not so self-compassionate. (P1) Umm I think it's because I kind of tend to blame yourself a lot for something that goes wrong even if that thing is beyond your control. You still try and put blame on something right? So you tend to blame yourself. And I blamed blamed myself a lot and in that process I lost my compassion for myself and then I for forgot to just give myself some space to make mistakes.. yeah. (P2) So.. I went through a breakup. It was a very bad breakup. I caught my boyfriend cheating on me for more than five times. And then my parents are difficult parents who worry about what other people will think, so they got me engaged to a guy who I don't know. So that guy was like I told him, I am already affected with that person and I am not ready to accept your thing. And he was like okay, I've	

		gone through the same thing, so I'll support you, I'll be with you, I'll be your best friend, I'll take everything whatever you feel and I'll share the feelings. So he was with me like he told me this is life, whatever happen to us and he like came a long way with me. Because I thought like when it comes to my ex boyfriend's story, I thought I wasn't good enough, that's the reason he chose five other girls instead of me like I was like always torturing myself like I don't look good, I don't like I'm not good at anything and that's the reason why people keep hurting me and going for another girl.(P7) Felt like I deserved it. I felt like you are here in this situation because of the decisions you made(P9) I understand that umm if if I don't show compassion to myself, umm I can't expect it from others (P3) It is with time that I have learned that it is important to love yourself, it is important to treat yourself, it is important to say nice things to yourself. And So yeah it is something that I have learned with time. And with time I have learned, in order to show compassion to others, you should have something inside yourself and that is	

		compassion to yourself.(P4)	
What were your thoughts and feelings when you were going through that?	Mixed emotions Positive (common humanity, mindfulness, understanding) Negative (harsh, judgemental, critical thinking, self-blame, guilt, terrible,regret, guilt)	Umm.. things like I don't know like umm why why would I do it or why would I keep doing it even when I know it's wrong or when I know it's not working.. and.. like it's just constant blame and constant feeling of like you know you're not good enough or you're not it's only things go wrong because you're not good at it or you're not good enough or you're not great enough to do this or to pull this off. (P2) I was really unhappy with myself, I was really sad because I know that I could umm.. get this part of happiness, I'm not reaching it. So I felt very sorry about myself. And.. umm more than sorry I was very angry with myself too. So it was anger and sorry and all that negative feelings.(P8) Umm.. I regretted. First I thought that it is my mistake. But then later on with time I understood that it just happens and it's not only me who went through it. But a lot of people go through similar issues like that and that it's okay to you know go through it and I.. I perceived it as a learning experience for myself.(P10)	
How did you treat yourself?	Negative behaviour (Distancing the self from others, push the	most of the time I would be harsh on myself, very judgmental, very critical	

	self down, ignore priorities, self-destruction, ignoring health, no exercise, no sleep, skipping meals, drinking) Positive behaviour (sought help, reached out, good diet, exercise, medicine, hobbies)	thinking like you know how could I let you know let this happen to me and things like that and you know if I was feeling guilty I would do more things to kind of make my like I would try to wallow in it rather than trying to resonate myself from it. (P1) I think it's just that not giving myself enough space to breathe and enough space to just relax a little bit.. and then like I didn't take care of myself like health wise. I just let go and I just completely went you know just completely went overboard.. didn't exercise.. didn't drink enough water didn't eat.. didn't sleep properly. Didn't care enough to sleep properly.. and that affected my like my physical and mental health a lot not getting enough sleep. (P2) I starve (very softly). I starve myself. For a day sometime.(P5) Like.. I don't know I shouldn't have done this to me but I was really bad for myself like I.. I feel so guilty for doing that to me. I shouldn't have cared about all these stuff. I should have like thought that thank god I came out of this shit and such toxic relationship. But it was a really bad thing I did to myself telling that it's all my mistake, it's all my this thing that it shouldn't have been that way.(P7)	Help of the religion Both P6 and P8 said that when they didn't receive the compassion they needed from others they learned to give it to themselves

		I always prefer to blame myself for my faults.. like keep telling myself it's my fault.. then after a while being angry at myself, then I come to a stage where I'm like it's not helping, it's not changing it's only making me feel way worse.. and umm.. then after a while I realise.. I don't know if I've truly ever shown compassion to myself, I haven't forgiven myself for some of the things I have done.(P9) and I must say the drinking was never something that gave me any pleasure, never something I when I wanted to get drunk or anything. The thing drinking did to me was it made me forget for a while(P9) not good at all. I was.. like I said before I was pretty down. And I.. I didn't self harm. But I was having thoughts of you know I had suicidal thoughts, but I.. I was I would say I was not gutty enough to you know go ahead with that. But if I was a person who would harm myself, I would have definitely gone to it, done it. But umm.. I was in the verge of doing it but I never had the guts to do it. I was feeling very down and I just didn't know how to get out of it. That was the worst feeling ever.(P10)	

		Okay so, some of the good things I've done is like you know I I figured out that the situation I was in was not good, so I reached out you know to get help from friends. Umm you know to get help from.. Once there was a situation that I actually went and got help from a priest(P1) Umm so I can actually I can be quite mindful about my thoughts because because I practice mindfulness, so it helps.(P3) Most of the time, I have felt that umm.. umm.. I talk to myself. Umm.. it says look at you, you have no one, sometimes you have no one like you were for others when when people are in a bad mood, I used to go and help them, I used to go and ask are you okay and fully check with them and help them. But to me, not like that, people don't come towards me. So.. I feel a little bit sad about myself sometimes, but I become so strength via that. And.. I strengthen my thoughts and try to get rid of that stressful situation somehow.(P6) . Umm.. So what I did was I started getting a lot of quotes on strength, and I watched a lot of videos,.. and there's this thing called life quotes on instagram. I used to read them and I used to compare with them they went through this, so I can get through this too. So.. I drew like I said I created	

		stuff. So that's to reduce my stress. So.. continuously I was doing that while doing some studies as well on the process. So mostly encouraging my own self saying do this, and be okay. Because what I wanted to hear from others, when I didn't get that I just gave it to myself. This is what I want to hear from others, they are not going to tell me, so I will give it to myself.(P8) One of the main escapes I have is driving.. I like driving. It's just you and the car. When I'm driving I don't have voices telling me I'm shit when I'm driving(P9)	
Was there an impact on you from treating yourself the way you did?	Positive behaviour helped Negative behaviour made the situation worse	. If I if I did help myself instead of the situations where I didn't, the outcome was mostly positive. So you know if it was illness or something like that I recovered much faster and in the situation of that moral dilemma I was going that moral umm situation also the advice that priest offered did help to a certain extent, (P1) Yeah, guitar is my best friend. I actually can't even think of living without that instrument. Whenever I feel sad, stressed or bad feelings, I'm just going towards my guitar and take it and play it in a dark place.(P6) Yeah so I felt relaxed and then the problem is still	

		there. But then when I'm relaxed my my brain works better like I can concentrate more on things, and then I don't take things as much seriously as I used to these troubles and things, and then then I try I try to umm look at them in a in a better point of view. (P3) It's like like a a cycle of like you you treat yourself without compassion and then you go back to being worse and then again you treat yourself so it's a cycle of blame and it keeps happening again and again until you come to the realisation that like you need to get your acts together. But definitely consequences like you know you.. you.. you're not able to concentrate properly you're not able to ta talk to other people properly. You're not able to maintain.. it affects your relationship with other people. It affects your relationship with like other things like your education, your social life, you're your hobbies, things you like. You know just your daily routine gets disrupted because you're not being because I was not being compassionate with myself(P2) Yeah. So all what I thought I was ugly and fat and I wasn't fat but then I actually became fat. So those negative feelings made me become the person I thought I was.(P7)	

		Treated myself? Ah right. Yeah yeah.. I just felt like I'm wasting my life.. felt like time is the only thing you can't get back. I was aware of the fact I was wasting my time but I felt like I had no other escape, no other choice. Any other thing I was thinking of doing was worse…So I would play video games and sleep again(P9)	
Would you show compassion to yourself in future?	Yes (show more compassion in future) Not sure	I yeah I think I I guess you know trying to be a more little bit more compassionate indeed would benefit me rather than trying to be self-destructive. Because I really can't think of a situation where my self-destructive practices benefited me in anyway. But self umm self-compassion and being understanding as to what I need to make myself or get myself into a better situation actually has helped. So I would actually try to be a little bit more positive and little bit more compassionate towards myself. (P1) there's definitely a chance that that might happen because we are all human and I think it tends to happen that we blame ourselves more than we should.(P2)	
Facilitators?	Amount of understanding and sympathy towards the self Upbringing	Umm actually I learned about compassionate, like I experienced it through umm meditation. Because I've been doing meditation	

	Religion Society Self-reflections Thinking clearly Being non-judgmental Learning from others Meditation Acceptance Childhood experiences God	like for the past 10 years. So through meditation, I it's it's all about this Buddhist meditation, like "vipassana" (a Buddhist term) mostly. So it it gives you a deep understanding of the things in mind and matter. So you're able to umm you are able to analyse and understand things that it's happening because of this and then what needs to be changed, and umm or if if it cannot be changed, you have to just accept. So most of the time it's it's all about accepting, accepting the present moment and umm just living in the present moment, going step by step and going with the flow. (P3) Yeah. Yeah definitely. Because I respect Lord Buddha's philosophy, and he's a very compassionate person. And even when we consider about Jesus, Jesus is also a person with high compassionate level. And being compassion is something gifted, it is something very nice. It is a very nice quality, it is it is a good human quality(P6). Yes. My god actually. So whenever I ask him for something.. so l feel like he has created me not to go and like beg for something or cry for someone. He he is there with me, so why do I need other shit people in my life?(P7)	

		yeah religion too. But I don't solely depend as in I don't think that religion is the only way for a person to be compassionate. I know that religion teaches all these good things about it. But it's how you perceive it and it's how you.. you know also there are people who are very religious but are not compassionate.. so it's how you perceive it.. it's how you let everything else affect your actions. So yeah.(P10)	
Barriers?	Inability to see the emotions Lack of knowledge high expectations for the self other people being mean Social norms/stereotypic views People being rude to you	And then.. umm.. also things like.. like again external factors like.. other.. also I think when other people are mean to you or judgmental to you it's difficult for you also to be compassionate towards yourself. You kind of take other peoples' views into account of how you should treat yourself as well. So.. that also.. Suddenly when somebody is mean to you when you're sad.. you kind of start thinking okay maybe it's my fault, maybe what I did was so wrong that I cannot forgive myself. So.. I think that also matters(P2) you know the the.. stereotypic view towards women.. I think.. like if if if I go out for example, if I go out at night and I get assaulted.. it's because the	

	Other people's opinions Low self-esteem, depression, overweight	mistake is mine because I went out at night because girls are not supposed to go out at night. But, if the same thing happened to a boy, it's probably the fault of whoever committed the assault. So.. things like that societal, stereotypes and stigma towards women towards religion, race, culture, language everything I think is a is is a problem that affects peoples' compassion towards others. (P2) Umm.. like people have understood myself as a as a.. how do you say as a different person. I mean as a bad person, sometimes they have understood like that. And.. as a result of that thought they have been they have showed me kind of a rudeness sometimes and ummm.. so I feel guilty most of the times when I have to face such a situation(P6) . Yes. As I said.. umm.. people like.. they call me overconfident when I be that way (self-loving). So that was kind of affecting me but at some point I was like I don't care about what people tell. So that way..(P7) I embrace a lot of negativity. So then it's very hard for me to think and show compassion to myself because I'll be worrying about how the others will think.. at times I rely on others. so when I rely on others and they are not there for me, I'm like.. I'm lost. I just lose	

		hope. But it takes a really long time for me to understand that I don't need others, I have myself, that's it.(P8) I think low self-esteem. Depression and overweight doesn't help. And I think that's what low self-esteem. I'm not someone who shows it. I'm not the person to show it. I don't show that I am down. I've always been down in a way but I don't want other people to feel down because of me. I never want to add to anyone's problems. I don't want my parents you know.. and for me to even tell my momma that I was going through depression was huge.. I don't tell anyone.(P9)	
Was there a difference in showing compassion to someone else and showing compassion to yourself?	Big difference	I guess helping another person comes a little bit more easier to me than trying to help myself. Because umm like you know you feel a lot of sympathy when you see something you know bad happening to someone else. It's that that same level of sympathy is very difficult to have towards yourself when you're in a difficult situation. You tend to be a little bit more critical and you know you tend to feel a lot of more guilt and things like that so your personal judgments about the way you acted in that situation and the guilt you have and you know maybe the part you have in	

		the difficulty that you have landed yourself in. All of those kind of prevents yourself from sympathising towards yourself. So not having that sympathy makes it difficult for you to help yourself because you are kind of not putting yourself in the victim shoes I guess. So you are kind of seeing yourself as partly responsible so you don't really feel like you deserve the help also. So you know when you see someone else in trouble you don't really try to think like that too much you see them in you know in difficult situations you see them as victims and you try to help a victimised person to get better as much as you can but when you are on the umm hot seat basically when you are thinking okay I did these things and this is why I am in this bad situation, it is kind of difficult to feel bad about yourself and try to help yourself. (P1) But I.. I think I think I think we all always put ourselves at a point that we all keep ourselves in a box where we're so protected and then we are so guarded but then we don't want we want each and every one of our efforts to be impressed, or be acknowledged, or you know be recognised and so we always give don't give that space to ourselves as much as we do for others and for the society. So.. I think we are	Shows how much a person needs validation

		always harsh on ourselves and we judge ourselves harder harder than we judge other people. But I don't know if that's for everybody. But yeah that's why.(P2) Because, I don't know. I always have this thing of not, I don't have positive feelings about me, I always have negative feelings about me like you're not good at this, you're not good at that I don't appreciate myself for anything, I barely appreciate myself. Because even if I do something great, my parents don't appreciate me. So that has like come into me as well and I don't appreciate anything. (P7)	

Appendix G Information Sheet (Paper 3)

Study Title: An exploration of the concepts of compassion in UK and Sri Lankan students.

Researcher: Majuwana Gamage Lasara Kavindi Kariyawasam
ERGO number: 52533

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This research is conducted as part of my PhD. I am a first year psychology PhD student at the University of Southampton, UK. I aim to understand the differences of levels of compassion and concepts related to compassion (such as barriers and facilitators of compassion and other influences), among a cross cultural group of British and Sri Lankan students. I also aim to understand the relationship between compassion and Depression, and compassion and Anxiety. The research will involve a battery of questionnaires starting with a demographic questionnaire. The objective of this study is to understand whether compassion levels and its concepts differ based on culture. This will provide the foundation for future studies aiming at introducing culturally sensitive practices using the compassionate framework with people presented with psychological complications in Sri Lanka.

Why have I been asked to participate?
In this study, I aim to recruit British and Sri Lankan students undertaking an undergraduate degree in psychology. To participate in this study, you should be above 18 years of age, pursuing an undergraduate degree in psychology and be either Sri Lankan or British national. Participants will only be recruited if they are happy to participate on a voluntary basis.

What will happen to me if I take part?
Data will be gathered through an online survey. Once you click on the link to the survey, you will receive an information sheet and a page to provide your consent. Participation for this study is voluntary and you do not have to take part if you do not intend to. Once you click on a box that requires your consent, you will be directed to a demographic page and the questionnaires. First, you will be asked to state your age, gender and nationality and religion. Then you will be directed to the series of questionnaires. The whole study will take approximately 30 minutes. Once you submit your answers, you will be directed to a debriefing sheet which will provide you further information of the study, contact details of the researcher and contact details of psychological helplines. You will also be provided with a link to an online self-help page which will be useful with everyday psychological problems. In addition, a link to an online breathing exercise video, which will help you to calm down if you feel distressed.

Are there any benefits in my taking part?
There is no direct benefit to you as a participant although British students will be given 4 credits for their course. Although there is no direct benefit of taking part, your participation is much appreciated

and will contribute to the broadening of our understanding about levels of compassion and its influences across two different cultures.

Are there any risks involved?
There should be no major risks involved in taking part in this study. However, if you experience any distress during the completion of the questionnaire or if you wish to learn about 'self-help' in relation to depression, anxiety or any psychological distress, we have provided a self-help guide and links to support services along with a debriefing statement. A link to an online breathing exercise video will also be available in the debriefing statement. You can either click on the link and watch the video or terminate the study by closing the tab once you have read the debriefing statement.

What data will be collected?
All data will be collected in the form of a quantitative online survey. Firstly, participant's informed consent will be collected. Next, participants will be required to state demographic information such as age, gender, nationality and religion. Personal information such as gender and religion will be required to compare and contrast the influences of these factors on participants' levels of compassion across the two countries. This type of information is considered as special category data according to data protection. Personal data will be handled with respect and stored securely. After the demographic information has been obtained, participants will be directed to the next page containing the questionnaires. Participants' names or identifiable characters will not be required or recorded anywhere and all the collected information will be stored under a random allocated number. All email addresses used to contact the participants will be stored in a password protected computer and deleted once the study has been conducted. You will not be contacted for any purpose other than for this particular study.

Will my participation be confidential?
Your participation and the information we collect about you during the course of the research will be kept strictly confidential. In fact, information collected from you (e.g., religion, nationality) will be kept confidential in line with the University of Southampton Ethics Policy and the Data Protection Act (1998) and the university policy.

Only members of the research team (researcher and research supervisors) and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.
As previously detailed, will be stored securely under a random allocated number in a password encrypted computer. You (participants) will only be referred by the number allocated to you and your name will not be required, noted or stored anywhere. You are also allowed to withdraw your participation at any time and withdraw your consent for us to use your information. Gathered information will be stored in a password protected computer where only the researcher and research supervisor will have access to.

The list of participants' email addresses (only for Sri Lankan participants) will be noted in a document and stored separately on a password protected computer. The email addresses will be deleted from the computer once the study has been completed.

Do I have to take part?
No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to tick a box, indicating your consent to take part. If you are studying in Sri Lanka, you

will be informed about this study by an email that will be forwarded to you via your university. This email will contain this information sheet comprising all the information necessary for you to understand the purpose of this study. This email will also contain my email address (primary researcher contact information) should you have any concerns or questions prior to taking part. The email sent to you will provide you with a link to the study. Once you click on the link, you can tick the consent box and continue your participation.
If you are a student of the University of Southampton, a study advert will be posted on eFolio, where you can click on and sign up. Once you sign up, you will be directed to the study starting with a consent statement that needs to be ticked (as proof of your consent). Once this consent box has been ticked, you will be directed to the questionnaires for your participation.

What happens if I change my mind?

You may withdraw your participation at any time during the study with no penalty as your participation is strictly voluntary. If you decide to withdraw any information you have provided it will not be used in the study. Therefore, please note that you have all the right to withdraw your consent for your data to be used after you have participated in the study without providing any justification. If you have any questions or concerns, please contact me (Lasara) via lkk1n17@soton.ac.uk

What will happen to the results of the research?
Results of the research will be submitted to the University of Southampton as part of my PhD research. This study is also expected to be published in a peer reviewed journal. If you wish to receive a copy of the results, you can contact the researcher at lkk1n17@soton.ac.uk.
Gathered anonymous data will be stored for a minimum of 10 years abided by the University of Southampton policy and deleted completely from the database afterwards.

Anonymised interview transcripts will be retained for future studies. These transcripts will always be stored in a password protected computer and will not contain any identifiable data of the participants.

Please see the contact details below should you wish to file a complaint.

Primary researcher (Lasara Kariyawasam)
Lkk1n17@soton.ac.uk

Primary supervisor
M.S.Ononaiye@soton.ac.uk

University of Southampton Research Integrity and Governance manager
rgoinfo@soton.ac.uk

Where can I get more information?
You can contact the primary researcher or research supervisor using the contact details below.

Researcher (Lasara Kariyawasam)
Lkk1n17@soton.ac.uk

Office 4115
School of Psychology
Shackelton Building
University of Southampton
SO17 1BJ

Primary supervisor (Dr. Margo Ononaiye)
M.S.Ononaiye@soton.ac.uk
Office 3089
School of Psychology
Shackelton Building
University of Southampton
SO17 1BJ

What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.

Researcher: Lasara Kariyawasam lkk1n17@soton.ac.uk
Primary Supervisor: Dr. Margo Ononaiye M.S.Ononaiye@soton.ac.uk

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice
The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you.
I would sincerely thank you for taking your time to read the information sheet and considering taking part in the research.

Appendix H Consent Form (Paper 3)

Study title: An exploration of the concepts of compassion in UK and Sri Lankan students.

Researcher name: M. G. Lasara Kavindi Kariyawasam

ERGO number: 52533

Please read the following statements and tick the box below if you agree to the statements and consent to voluntarily take part in this research.

I have read and understood the information sheet (*21/08/19 /version 1 of participant information sheet*) and have had the opportunity to ask questions about the study.

I agree to take part in this research project and agree for my data to be used for the purpose of this study.

I understand my participation is voluntary and I may withdraw at any time for any reason without my participation rights being affected.

☐ Please tick (check) this box to indicate that you have read the above statements and that you consent to taking part in this survey.

Appendix I Debriefing Sheet (Paper 3)

An exploration of the concepts of compassion in UK and Sri Lankan students
Debriefing Statement (written) (Version 1, 21/08/2019)
ERGO ID: 52533

The aim of this research is to explore the concepts of compassion and its relationship with Depression and Anxiety in a cross cultural group of British and Sri Lankan students. Findings will facilitate the investigation of any differences in these concepts among culturally diverse populations. Your data will help our understanding of whether Sri Lankan and British students share similar levels of compassion and whether concepts of compassion vary across these cultures. As mentioned in the information and consent forms, completion of this study will not include your name or any other identifiable characteristics. This research did not use deception. You may have a copy of this summary if you wish and, you may also request a summary of research findings by contacting the researcher once this project has been completed.

If you have any further questions, please contact me (researcher: Lasara Kariyawasam) at lkk1n17@soton.ac.uk

For further queries, you may also contact the research supervisor, Dr. Margo Ononaiye at M.S.Oninaiye@soton.ac.uk.

The questions asked in this study were not intended to cause any distress. However, if you feel distressed, please watch the following video of a short breathing exercise that will help you calm down.
https://www.youtube.com/watch?v=4_nioG63OSs&index=6&list=PLFbeQlTqQPGTLAmNgKs0srX9Vau7mctFf
If you wish to seek any assistance, the following website provides a list of self-help strategies to deal with difficult situations.
https://web.ntw.nhs.uk/selfhelp/

Additionally, For Sri Lankan participants, the below will be available to assist you with any concerns:

- National Institute of Mental Health http://www.ncmh.lk/ncmh_Counselling.htm
- Sumithrayo Organization http://sumithrayo.org/

For British participants, please read the below links available to assist you with any concerns:
-University of Southampton: University Counselling Service, Nightline, 023 8059 5236 (free from halls (78)25236) or visit http://nline.susu.org/)
- Find a therapist on http://www.cbtregisteruk.com/Default.aspx

Thank you for your participation in this research.

Signature _____ Date _____

Appendix J Information Sheet and Consent Form (Paper 4)

Study Title: Exploring the Transcultural Applicability of a Brief Compassionate Mind Training: A study comparing the UK and Sri Lankan Communities

Researcher: Lasara Kariyawasam
ERGO number: 57128

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate, you will be asked to confirm that you consent to participate in the study by checking the consent box below.

What is the research about?
I am a doctoral student currently undertaking a PhD in Psychology at the University of Southampton. This research is part of my doctoral thesis attempting to apply a brief 2-week Compassionate Mind Training (CMT practices) to increase compassion and wellbeing among UK and Sri Lankan nationals. Compassion focused therapeutic activities have shown significant results in improving participant and patient wellbeing. Most of these interventions have been limited to western countries and researchers still question how culturally appropriate these Western practices would be in the Asian context. Furthermore, cross-cultural studies conducting these tasks remain scarce indicating the void to conduct research. Therefore,primary aim of this study is to conduct a brief compassionate mind task with the aim to reduce levels of depression and anxiety and increase the wellbeing among UK and Sri Lankan nationals. We aim to conduct this study between UK and Sri Lankans to test if there are any significant differences between the levels of compassion, depression and anxiety among these populations in the first instance, and to monitor if CMT intervention would bring any significant differences to these levels. Findings of this study will also improve our understanding on whether CMT practices would be transcultural and transdiagnostic.

A randomised control trial design will be conducted including a brief two-week online CMT based intervention and a wait-list control group. University students and general populations in UK and Sri Lanka will be invited to voluntarily participate. There will be four groups: Sri Lankan Intervention Group, Sri Lankan Control Group, UK Intervention Group, UK Control Group. Data will be collected pre- and post-intervention and at a two week follow-up after the intervention. The study will last four weeks in total and quantitative analyses will be conducted. The wait-list control group will be given access to the intervention at the end of their participation. The results will be disseminated in an appropriate format to the services involved and also for peer reviewed academic publication and conferences.

Why have I been asked to participate?

This study is targeted towards Sri Lankan and UK nationals as cross-cultural research exploring the three flows of compassion (compassion towards others, from others and towards the self) remain unexploited while compassion related studies have not yet been conducted among Sri Lankans. You have been asked to participate because you responded to an advertisement regarding participation in this study and you may meet the full eligibility criteria outlined below.

Eligibility Criteria

Inclusion Criteria:

You are eligible to participate in this study if you are a Sri Lankan national or a UK national and are above 18 years of age. You will also need to have internet access to access the online questionnaires/CMT practices; this is also mobile friendly. You will also need to have a good level of English to be able to access the online questionnaires/CMT practices; if you are able to read through this information sheet and understand the consent statements below, your English is considered sufficient.

Exclusion Criteria:

Unfortunately, if you are currently participating in a compassion focused intervention for yourself at the time of this study, you will not be eligible to participate in the study as this could affect the conclusions made about this intervention in this study. However, you will be able to access the CMT practices, without the questionnaires included, until the end of the study period. You will also not be eligible to participate in this study if you have difficulties with understanding or speaking English. This is because this study is an online-based study and the study materials will be presented in English, without translation or the use of interpreters being possible. However, if you have been able to read to this point, you will be considered to have sufficient English to be eligible to provide informed consent to participate in this study.

What will happen to me if I take part?

This study integrates a series of questionnaires and an online intervention. You also have the option to consent to be entered into a prize draw to win a £25 Amazon gift (if you are a UK participant), or earn 38 credits for your course (if you are a UK psychology undergraduate student), or earn a £5 Amazon gift voucher (if you are one of the first 40 Sri Lankan participants) as a thank you for your participation.

If you decide to take part in this study, you will be asked some demographic questions and will complete some questionnaires that will take approximately 20 minutes to complete. You will then be asked to participate in an online intervention, with your informed consent. If you decide to participate in the intervention part of the study, you will be randomly allocated to one of the two groups: group A or group B. If you are allocated to group A, you would be able to enter a 2-week long compassionate-mind training. Once you complete the training, you would be required to complete the same set of questionnaires you completed before, and do nothing for another 2-week period. Once this 2-week waiting period has passed, you would be invited to complete the same questionnaires once again for the third and final time.

If you are allocated to group B, you would be required to wait for a period of 2-weeks and complete the same set of questionnaires for a second time. Once you have completed the questionnaires, you would be able to access the compassionate mind training and engage in the CMT tasks for a period of 2-weeks. You will then be required to complete the same set of questionnaires for a third and final time.

The CMT training will include approximately a 30-minute long psychoeducational video, introducing you to the CMT practices on two occasions. You will then be asked to listen to brief audio-recorded CMT practice(s) each day two weeks; these will last no longer than 20minutes. An automatic reminder email to practice the CMT practices will be sent to you via the email address you provide daily. The CMT practices will be based online so you will be able to listen to the audio-recordings at a convenient time for you; these will be accessible via mobile phones also.

Are there any benefits in my taking part?

You will have access to a brief intervention that you may find beneficial for your psychological wellbeing. Your participation will also help improve our current understanding of the impact on this intervention on Depression, Anxiety and compassion as well as any differences among these cross culturally. Your participation will also improve the interventions aimed at reducing Depression and Anxiety and increasing compassion among the UK and Sri Lankan populations.

If you are a University of Southampton Psychology undergraduate student, you will receive 38 credits as course credits when you complete the study. If you are a Sri Lankan participant, you will receive a £5 Amazon gift voucher as a 'thank you' for participating in this study. Please note that only 40 participants from the Sri Lankan sample will receive the voucher on a first come first serve basis.

Are there any risks involved?

There are no major risks of participating in this study, although some of the questions in the questionnaires and the intervention may temporarily increase some temporary emotional discomfort and a heightened awareness of uncomfortable feelings (i.e. Depression). Any discomfort should be temporary, however, if you become too uncomfortable while participating, you are able to withdraw from the study at any point.

However, if you feel distressed, please watch the following video for a short breathing exercise that will help you calm down.
https://www.youtube.com/watch?v=4_nioG63OSs&index=6&list=PLFbeQlTqQPGTLAmNgKs0srX9Vau7mctFf

If you wish to seek any assistance, the following website provides a list of self-help strategies to deal with difficult situations.
https://web.ntw.nhs.uk/selfhelp/

Additionally, the below will be available to assist you with any concerns:

- National Institute of Mental Health http://www.ncmh.lk/ncmh_Counselling.htm (For Sri Lankan participants)
- Sumithrayo Organization http://sumithrayo.org/ (For Sri Lankan participants)

- Samaritans – 116 123 (call any time: For UK participants)

What data will be collected?

Demographic information such as your age, gender, religion and nationality will be collected. You will also be asked for your email address to send study reminders to, maintain contact during the study, and to match you to your data across the time points for the analyses.
Your participation in this study, data and the information we collect about you during the course of the research will be kept strictly confidential. Only members of the research team (my research supervisors) and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

All data will be stored securely on a password protected document in line with the General Data Protection Regulation (2018) and the University of Southampton policy and will be destroyed after 10 years. Details provided for the prize draw will be destroyed once the draw has taken place.

Will my participation be confidential?
Your participation and the information we collect about you during the course of the research will be kept strictly confidential. At no point your names will be collected or used for the purpose of this study or for any other study that we conduct. Furthermore, we will only keep your contact details (your email address) until this study has been completed. We will not use or store your contact details after the completion of this study for any other reason.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Do I have to take part?
No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to check the consent box at the bottom of this form to show you have agreed to take part. It is also up to you whether you want to be entered into the prize draw.

What happens if I change my mind?
Your participation is voluntary and you have the right to change your mind and withdraw at any time without giving a reason during the study. However, it may not be possible to remove your data after the data has been analysed, as your data will not be identifiable at this stage. If you wish to

withdraw before this stage, please email the Chief Investigator, using the email below, with your unique ID and your data will be removed from the dataset.

What will happen to the results of the research?

Your personal details will remain strictly confidential. It is possible that the results of this research will be published in a peer-reviewed academic journal, disseminated in staff newsletters/social media accounts of participating Trusts/organisations and presented at conferences. The research findings made available in any reports, publications or presentations will not include any information that can directly identify you. As per the University of Southampton policy, the data will be stored for a period of 10 years, and it will be permanently destroyed after this time.

Where can I get more information?

If you have any questions or require further information after reading this information sheet, please do not hesitate to contact the Chief Investigator at lkk1n17@soton.ac.uk

Contact details of the research team

Primary Research Supervisor

Dr Margo Ononaiye, m.s.ononaiye@soton.ac.uk

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the Chief Investigator or the research team who will do their best to answer your questions. If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Thank you for taking the time to read the participant information sheet and considering taking part in this research.

If you wish to participate in this study, please check the consent box below. By checking the box you are consenting that:

I. You have read and understood the above information and have had the opportunity to ask questions about the study.

II. You agree to take part in this research project and agree for your data to be used for the purpose of this study.

III. You understand your participation is voluntary and you may withdraw at any time during the data collection period without your legal rights being affected.

IV. You understand that should you withdraw from the study then the demographic information collected about you may still be used for the purposes analysing any group differences in those participating and withdrawing from the study.

V. You understand you will not be directly identified in any reports of the research

☐ Please check this box to indicate that you consent to participating in Part A of the study.

☐ Please check this box to indicate that you consent to be entered into a prize draw to win an Amazon gift voucher at the end of your participation; this is optional.

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Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

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Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in

the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

Appendix K Debriefing Sheet (Paper 4)

Study Title: Exploring the Transcultural Applicability of a Brief Compassionate Mind Training: A study comparing the UK and Sri Lankan Communities.

Debriefing Statement *(written)* (Version 1, 27/08/2020)
ERGO ID: 57128

Research has shown that improving self-compassion was linked to decreased levels of depression and anxiety. However, research exploring this phenomenon in a cross-cultural scale is limited. The aim of this research was to explore whether a brief online intervention aimed to increase the three flows of compassion (compassion to self, compassion to others and compassion from others) and in turn reduce depression, anxiety and self-criticism among a cross-cultural group of Sri Lankan and UK nationals.

The data collected for this research is currently being analysed. It is expected that participants who reported lower levels of compassion (to self, to others and from others) at the start of the study also reported higher levels of depression, anxiety and self-criticism. It is expected that by the end of their participation, participants will experience an increase in their levels of compassion and report a decrease in depression, anxiety and self-criticism.

Unfortunately, we are not able to provide individual results, however, your data will help improve our current understanding of this area and improve the interventions aimed at reducing, depression, anxiety and self-criticism among UK and Sri Lankan nationals. During the study you had the chance to tell us what your experiences of participating in the research was like, and we will take this into consideration for this and future studies.

This project did not use any deception. Once again, the results of this study will not include your name or any other identifying information.

You may print a copy of this summary if you wish and if you would like a summary of the final research findings once the project is completed, and did not state this on your initial consent statement, you can check the below.

Any discomfort resulting from the intervention or measures should be temporary, However, if you feel distressed, please watch the following video for a short breathing exercise that will help you calm down.
https://www.youtube.com/watch?v=4_nioG63OSs&index=6&list=PLFbeQlTqQPGTLAmNgKs0srX9Vau7mctFf

If you wish to seek any assistance, the following website provides a list of self-help strategies to deal with difficult situations.
https://web.ntw.nhs.uk/selfhelp/

Additionally, the below will be available to assist you with any concerns:

- National Institute of Mental Health http://www.ncmh.lk/ncmh_Counselling.htm (For Sri Lankan participants)
- Sumithrayo Organization http://sumithrayo.org/ (For Sri Lankan participants)
- Samaritans – 116 123 (call any time: For UK participants)

If you have any further questions, you can contact the Chief Investigator, Lasara Kariyawasam, via email on lkk1n17@soton.ac.uk.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Thank you for your participation in this research.

If you did not have access to the intervention before, or would like access to it again, please click on the following link which will be active until 30th September, 2021.

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Appendix L Questionnaires used in Papers 3 and 4

L.1 Demographic Questionnaire

Please complete the following sections

Age:

Gender:

Religion:

Nationality:

L.2 The compassionate Engagement and Action Scales

Self-compassion

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, we may cope with these in different ways. We are interested in the degree to which people can **be compassionate with themselves**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore, read each statement carefully and think about how it applies to you if you become distressed. Please rate the items using the following rating scale:

Never									**Always**
1	2	3	4	5	6	7	8	9	10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with distress when you experience it. So:

When I'm distressed or upset by things…

1. I am *motivated* to engage and work with my distress when it arises.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. I *notice,* and am *sensitive* to my distressed feelings when they arise in me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about my distress and try to distract myself and put it out of my mind.

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. I am *emotionally moved* by my distressed feelings or situations.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. I *tolerate* the various feelings that are part of my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

6. I *reflect on* and *make sense* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7 I do not tolerate being distressed.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. I am *accepting, non-critical and non-judgemental* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how you actively cope in compassionate ways with emotions, thoughts and situations that distress you. So:

When I'm distressed or upset by things…

1. I direct my *attention* to what is likely to be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. I *think* about and come up with helpful ways to cope with my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. I don't know how to help myself.

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. I take the *actions* and do the things that will be helpful to me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. I create inner feelings of *support, helpfulness and encouragement*.

Never **Always**

1 2 3 4 5 6 7 8 9 10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING 3

Compassion to others

When things go wrong for other people and they become distressed by setbacks, failures, disappointments or losses, we may cope with their distress in different ways. We are interested in the degree to which people can be **compassionate to others**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to you when **people in your life** become distressed. Please rate the items using the following rating scale:

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 1 – These are questions that ask you about how motivated you are, and able to engage with other people's distress when they are experiencing it. So:

When others are distressed or upset by things…

1. I am *motivated* to engage and work with other peoples' distress when it arises.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. I *notice* and *am sensitive* to distress in others when it arises.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. I avoid thinking about other peoples' distress, try to distract myself and put it out of my mind.

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. I am *emotionally moved* by expressions of distress in others.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. I *tolerate* the various feelings that are part of other people's distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

6. I *reflect on* and *make sense* of other people's distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7 I do not tolerate other peoples' distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. I am *accepting, non-critical and non-judgemental* of others people's distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how you actively respond in compassionate ways when other people are distressed. So:

When others are distressed or upset by things…

1. I direct *attention* to what is likely to be helpful to others.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. I *think about and come up* with helpful ways for them to cope with their distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3. I don't know how to help other people when they are distressed.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

4. I take the *actions* and *do the things* that will be helpful to others.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

5. I express feelings of *support, helpfulness and encouragement* to others.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

Compassion from others

When things go wrong for us and we become distressed by setbacks, failures, disappointments or losses, others may cope with our distress in different ways. We are interested in the degree to which you feel that **important people in your life can be compassionate to your distress**. We define compassion as "a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it." This means there are two aspects to compassion. The *first* is the ability to be motivated to engage with things/feelings that are difficult as opposed to trying to avoid or supress them. The *second* aspect of compassion is the ability to focus on what is helpful to us or others. Just like a doctor with his/her patient. The first is to be motivated and able to pay attention to the pain and (learn how to) make sense of it. The second is to be able to take the action that will be helpful. Below is a series of questions that ask you about these two aspects of compassion. Therefore read each statement carefully and think about how it applies to the **important people in your life** when you become distressed. Please rate the items using the following rating scale:

Never									**Always**
1	2	3	4	5	6	7	8	9	10

Section 1 – These are questions that ask you about how motivated you think others are, and how much they engage with your distress when you experience it. So:

When I'm distressed or upset by things…

1. Other people are actively *motivated* to engage and work with my distress when it arises.

Never **Always**

1 2 3 4 5 6 7 8 9 10

2. Others *notice* and *are sensitive* to my distressed feelings when they arise in me.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)3 Others avoid thinking about my distress, try to distract themselves and put it out of their mind.

Never **Always**

1 2 3 4 5 6 7 8 9 10

4. Others are *emotionally moved* by my distressed feelings.

Never **Always**

1 2 3 4 5 6 7 8 9 10

5. Others *tolerate* my various feelings that are part of my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

6. Others *reflect on* and *make sense* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

(r)7. Others do not tolerate my distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

8. Others are *accepting, non-critical and non-judgemental* of my feelings of distress.

Never **Always**

1 2 3 4 5 6 7 8 9 10

Section 2 – These questions relate to how others actively cope in compassionate ways with emotions and situations that distress you. So:

When I'm distressed or upset by things…

1. Others direct their *attention* to what is likely to be helpful to me.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

2. Others *think about* and come up with helpful ways for me to cope with my distress.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

(r)3. Others don't know how to help me when I am distressed

Never									**Always**
1	2	3	4	5	6	7	8	9	10

4. Others take the *actions* and do the things that will be helpful to me.

Never									**Always**
1	2	3	4	5	6	7	8	9	10

5. Others treat me with feelings of *support, helpfulness and encouragement.*

Never									**Always**
1	2	3	4	5	6	7	8	9	10

NOTE FOR USERS: REVERSE ITEMS (r) ARE NOT INCLUDED IN THE SCORING

L.3 Fears of Compassion Scale

Different people have different views of compassion and kindness. While some people believe that it is important to show compassion and kindness in all situations and contexts, others believe we should be more cautious and can worry about showing it too much to ourselves and to others. We are interested in your thoughts and beliefs in regard to kindness and compassion in three areas of your life:

1. Expressing compassion for others
2. Responding to compassion from others
3. Expressing kindness and compassion towards yourself

Below are a series of statements that we would like you to think carefully about and then circle the number that best describes how each statement fits you.

Please use this scale to rate the extent that you agree with each statement

0	**1**	**2**	**3**	**4**
Don't agree at all		**Somewhat agree**		**Completely agree**

Scale 1: Expressing compassion for others

1. People will take advantage of me if they see me as too compassionate	0	1	2	3	4
2. Being compassionate towards people who have done bad things is letting them off the hook	0	1	2	3	4
3. There are some people in life who don't deserve compassion	0	1	2	3	4
4. I fear that being too compassionate makes people an easy target	0	1	2	3	4
5. People will take advantage of you if you are too forgiving and	0	1	2	3	4

compassionate					
6. I worry that if I am compassionate, vulnerable people can be drawn to me and drain my emotional resources	0	1	2	3	4
7. People need to help themselves rather than waiting for others to help them	0	1	2	3	4
8. I fear that if I am compassionate, some people will become too dependent upon me	0	1	2	3	4
9. Being too compassionate makes people soft and easy to take advantage of	0	1	2	3	4
10. For some people, I think discipline and proper punishments are more helpful than being compassionate to them	0	1	2	3	4

Scale 2: Responding to the expression of compassion from others

1. Wanting others to be kind to oneself is a weakness	0	1	2	3	4
2. I fear that when I need people to be kind and understanding they won't be	0	1	2	3	4
3. I'm fearful of becoming dependent on the care from others because they might not always be available or willing to give it	0	1	2	3	4
4. I often wonder whether displays of warmth and kindness from others are genuine	0	1	2	3	4
5. Feelings of kindness from others are somehow frightening	0	1	2	3	4
6. When people are kind and compassionate towards me I feel anxious or embarrassed	0	1	2	3	4
7. If people are friendly and kind I worry they will find out something bad about me that will change their mind	0	1	2	3	4
8. I worry that people are only kind and compassionate if they want something from me	0	1	2	3	4
9. When people are kind and compassionate towards me I feel empty and sad	0	1	2	3	4

10. If people are kind I feel they are getting too close	0	1	2	3	4
11. Even though other people are kind to me, I have rarely felt warmth from my relationships with others	0	1	2	3	4
12. I try to keep my distance from others even if I know they are kind	0	1	2	3	4
13. If I think someone is being kind and caring towards me, I put up a barrier	0	1	2	3	4

Scale 3: Expressing kindness and compassion towards yourself

1. I feel that I don't deserve to be kind and forgiving to myself	0	1	2	3	4
2. If I really think about being kind and gentle with myself it makes me sad	0	1	2	3	4
3. Getting on in life is about being tough rather than compassionate	0	1	2	3	4
4. I would rather not know what being kind and compassionate to myself feels like	0	1	2	3	4
5. When I try and feel kind and warm to myself I just feel kind of empty	0	1	2	3	4
6. I fear that if I start to feel compassion and warmth for myself, I will feel overcome with a sense of loss/grief	0	1	2	3	4
7. I fear that if I become kinder and less self-critical to myself then my standards will drop	0	1	2	3	4
8. I fear that if I am more self compassionate I will become a weak person	0	1	2	3	4
9. I have never felt compassion for myself, so I would not know where to begin to develop these feelings	0	1	2	3	4
10. I worry that if I start to develop compassion for myself I will become dependent on it	0	1	2	3	4

11. I fear that if I become too compassionate to myself I will lose my self-criticism and my flaws will show	0	1	2	3	4
12. I fear that if I develop compassion for myself, I will become someone I do not want to be	0	1	2	3	4
13. I fear that if I become too compassionate to myself others will reject me	0	1	2	3	4
14. I find it easier to be critical towards myself rather than compassionate	0	1	2	3	4
15. I fear that if I am too compassionate towards myself, bad things will happen	0	1	2	3	4

L.4 The Forms of Self-Criticising/Attacking & Self-Reassuring Scale (FSCRS)

When things go wrong in our lives or don't work out as we hoped, and we feel we could have done better, we sometimes have *negative and self-critical thoughts and feelings*. These may take the form of feeling worthless, useless or inferior etc. However, people can also try to be supportive of them selves. Below are a series of thoughts and feelings that people sometimes have. Read each statement carefully and circle the number that best describes how much each statement is true for you.
Please use the scale below.

Not at all like me	A little bit like me	Moderately like me	Quite a bit like me	Extremely like me
0	1	2	3	4

When things go wrong for me:

1. I am easily disappointed with myself.	0	1	2	3	4
2. There is a part of me that puts me down.	0	1	2	3	4
3. I am able to remind myself of positive things about myself.	0	1	2	3	4
4. I find it difficult to control my anger and frustration at myself.	0	1	2	3	4
5. I find it easy to forgive myself.	0	1	2	3	4
6. There is a part of me that feels I am not good enough.	0	1	2	3	4
7. I feel beaten down by my own self-critical thoughts.	0	1	2	3	4
8. I still like being me.	0	1	2	3	4
9. I have become so angry with myself that I want to hurt or injure myself.	0	1	2	3	4

10. I have a sense of disgust with myself.	0	1	2	3	4
11. I can still feel lovable and acceptable.	0	1	2	3	4
12. I stop caring about myself.	0	1	2	3	4
13. I find it easy to like myself.	0	1	2	3	4
14. I remember and dwell on my failings.	0	1	2	3	4
15. I call myself names.	0	1	2	3	4
16. I am gentle and supportive with myself.	0	1	2	3	4
17. I can't accept failures and setbacks without feeling inadequate.	0	1	2	3	4
18. I think I deserve my self-criticism.	0	1	2	3	4
19. I am able to care and look after myself.	0	1	2	3	4
20. There is a part of me that wants to get rid of the bits I don't like	0	1	2	3	4
21. I encourage myself for the future.	0	1	2	3	4
22. I do not like being me.	0	1	2	3	4

L.5 Other as Shamer Scale (OAS)

We are interested in how people think others see them. Below is a list of statements describing feelings or experiences about how you may feel other people see you.

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.

0	**1**	**2**	**3**	**4**
Never	**Seldom**	**Sometime**	**Frequently**	**Almost always**

1. I feel other people see me as not good enough.	0	1	2	3	4
2. I think that other people look down on me	0	1	2	3	4
3. Other people put me down a lot	0	1	2	3	4
4. I feel insecure about others opinions of me	0	1	2	3	4
5. Other people see me as not measuring up to them	0	1	2	3	4
6. Other people see me as small and insignificant	0	1	2	3	4
7. Other people see me as somehow defective as a person	0	1	2	3	4
8. Other people look for my faults	0	1	2	3	4
9. People see me as striving for perfection but being unable to reach my own standards	0	1	2	3	4
10. I think others are able to see my defects	0	1	2	3	4
11. Others are critical or punishing when I make a mistake	0	1	2	3	4

12. People distance themselves from me when I make mistakes	0	1	2	3	4
13. Other people always remember my mistakes	0	1	2	3	4
14. Others see me as fragile	0	1	2	3	4
15. Others see me as empty and unfulfilled	0	1	2	3	4
16. Others think there is something missing in me	0	1	2	3	4
17. Other people think I have lost control over my body and feelings	0	1	2	3	4
18. For some people, I think discipline and proper punishments are more helpful than being compassionate to them	0	1	2	3	4

L.6 Social Safeness and Pleasure Scale

We are interested in how people experience pleasure, positive feelings and emotions in social situations. Below are a series of statements about how you may feel in various situations. Please read each statement carefully and circle the number that best describes how you feel.

Almost never		1	2	3	4	5		Almost all the time		
1.	I feel content within my relationships						1	2	3	4	5
2.	I feel easily soothed by those around me						1	2	3	4	5
3.	I feel connected to others						1	2	3	4	5
4.	I feel part of something greater than myself						1	2	3	4	5
5.	I have a sense of being cared about in the world						1	2	3	4	5
6.	I feel secure and wanted						1	2	3	4	5
7.	I feel a sense of belonging						1	2	3	4	5
8.	I feel accepted by people						1	2	3	4	5
9.	I feel understood by people						1	2	3	4	5
10.	I feel a sense of warmth in my relationships with people						1	2	3	4	5
11.	I find it easy to feel calmed by people close to me.						1	2	3	4	5

L.7 GAD-7: Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? (Use ✓ to indicate your answer).

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

L.8 PHQ-9: Depression

Over the last 2 weeks, how often have you been bothered by the following problems? (Use ✓ to indicate your answer).

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless…….……	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much..... ..... …….	0	1	2	3
4. Feeling tired or having little energy.....…… …	0	1	2	3
5. Poor appetite or overeating..... .....……	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down…….	0	1	2	3
7. Trouble concentrating on	0	1	2	3

things, such as reading the newspaper or watching television…… ……				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual..... ……. ……	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way..... ……	0	1	2	3

L.9 The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

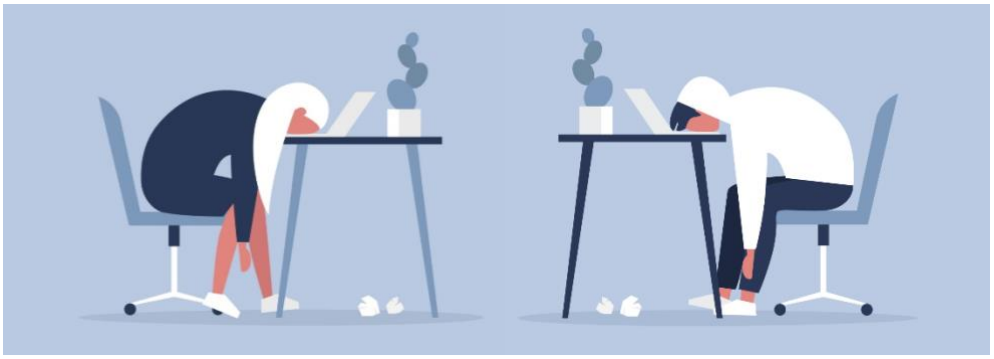
Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Appendix M Study Advert and Email distributed for Participants (Paper 4)

PARTICIPANTS NEEDED FOR
Online Compassion Intervention



PARTICIPATE AND GET THE CHANCE TO WIN a
£5 AMAZON GIFT VOUCHER!!

What is the study about?
Depression and Anxiety are common psychological difficulties that many of us experience despite our age, gender or nationality. Work stress, financial issues and other difficulties and distress could lead to these conditions especially when one lacks compassion. Compassion related studies on Depression and Anxiety are sparse especially among cross-cultural samples. This study aims to further our understanding of the impact of compassion on Depression and Anxiety among university aged populations with the use of a brief online Compassionate Mind Training intervention.

What will I be asked to do?
You will be asked to complete some questionnaires and you will then have the **option** to try out a brief 2-week Compassionate Mind Training practices, taking approximately 20 minutes, that may help improve your psychological wellbeing,. You will then complete the questionnaires again at the end of the 2 weeks and then once again 2 weeks later.

Can I participate?
Yes - If you self-identify as a UK or Sri Lankan national, over the age of 18, you are more than eligible to participate. You can find out more information via the link below. You will also need to have internet access via either a smart phone, tablet or computer to access all aspects of the study.

How do I express my interest?
If you would like to find out more information about the study, please click on this link:
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Contacts
Chief Investigator: Lasara Kariyawasam (lkk1n17@soton.ac.uk)
Main Supervisor: Dr Margo Ononaiye (m.s.ononaiye@soton.ac.uk)

Email to be sent out with attachment of the 'study advertisement'

Email Title:
PARTICIPANTS NEEDED for Online Compassion Intervention

Email:

Appendix M

Dear students,
I am a 2nd year Psychology PhD student from the University of Southampton and I am writing to you to ask you to take part in my research study. This study aims to understand the levels of compassion, anxiety and depression and their differences between a cross cultural group of UK and Sri Lankan students.
Please find attached the study advert and if you are interested in participating, you can click on the link in the advertisement where you can find out further information about the study and how to participate.
I hope that you would like to take part in this important research area and please do not hesitate to email me on lkk1n17@soton.ac.uk if you have any questions.

Best Wishes,
Lasara Kariyawasam
PhD Candidate
University of Southampton

Appendix N CMT Participation Statements on the Qualtrics Website for each stage (Paper 4)

Statement for individuals allocated to the intervention group, after the measures have been completed at baseline:

Thank you for completing the measures!

The next part of the study involves accessing the Compassionate Mind Training (CMT practices) where you will be asked to engage with the guided practices by listening to the brief audio recordings (maximum 20 minutes) each day over a period of two weeks.

Once you click on the arrow sign at the bottom right corner of this page, we will send you an email to the email address you provided containing links to the audio recordings for your practices. You will also be sent daily reminder emails. You will be sent another email in a week's time with the links to the audio recordings for your second week of practice.

We recommend that you listen to all of the audio recordings as per the instructions in the email and the link on their respective days.

It is also important that you listen to the audio recordings from start to finish, for the software to record data that you were able to listen to the recordings.

After you have completed your two weeks of practice, we will email you another link which will give you access to the post-intervention questionnaires. You will be sent a final email with follow-up questionnaires 2 weeks after this.

Should you encounter any difficulties or questions, please do not hesitate to contact me on lkk1n17@soton.ac.uk . I would be very happy to help you with any issues you may be experiencing throughout the study.

Please remember to use the same device for the entire duration of the study, as responses collected on different devices cannot be uploaded back to the same survey.

Once again, thank you very much for participating in this study. Your participation means a lot to us, and we are hopeful that many people will benefit as a result of this study.

Statements for the psychoeducation video for the intervention group:

Welcome to the first day of the intervention. Today you will be presented with an educational video about the compassionate mind training and the reasons for how it can be helpful.

Before proceeding to watch today's recording, we kindly ask you to enter your email address in the text box below. You will be asked to enter your email address every time you listen to the audio-recorded practices over the next two weeks.

It is important that you provide the same email address every time you listen to a recording. This is because, as you have noticed, you have been emailed several different links to the audio-recorded practices. You will be emailed further links for the second week of the intervention.

Each of these links will give you access to a separate survey containing the daily audio-recorded practice(s) and a question asking you how you got on with the daily practice(s). By providing us with your email address every time you access each link, we can then use your email address to identify which surveys belong to which participant. Importantly, this will enable us to analyse the data for each participant taking part in this study.

It is, therefore, important that you make sure that you enter the correct email address and that you use the same email address for the whole duration of the study.

Please remember to use the same device for the entire duration of the study, as responses collected on different devices cannot be uploaded back to the same survey.

If you encounter any difficulties or have any questions, please do not hesitate to contact me on lkk1n17@soton.ac.uk

Thank you very much for your support.

[insert email]

Please click the orange 'play' button or the 'Listen in browser' option (depending on which option is provided by the device you are using) to listen to the educational audio.

Statements for the CMT practice audio-recordings for the intervention group:

Welcome to practice day (insert number here).

Please enter your email address in the text box below before proceeding to listen to today's audio-recorded practice(s). **Please make sure that you enter the correct email address and that you use the same email address for the whole duration of the study.** Please also use the same device for the entire duration of the study, as responses collected on different devices cannot be uploaded back to the same survey.

[insert email]

Please click the orange 'play' button or the 'Listen in browser' option (depending on which option is provided by the device you are using) to listen to today's practice(s).

How well were you able to engage with today's practice(s)?

5-point likert scale – not very well - very well

Thank you for your responses. In order to make the most of these practices, please also try to bring in your developing compassionate self into your everyday life, for example, in a stressful situation slow down your breath and think how you would like to act or think in this moment if you were at your compassionate wisest and strongest. You may find this become easier as you practice.

Statement at post-intervention for measures for the intervention group:

Thank you for your continued engagement with this study. You will now be asked to complete the same measures as you completed at the start of the study, as well as a few additional questions about your experiences of the 2-week Compassionate Mind Training (CMT practices). Please also note that you will be asked to complete the measures once more in two weeks' time by email. Please remember to use the same device for the entire duration of the study, as responses collected on different devices cannot be uploaded back to the same survey.

Please enter your email address in the text box below before proceeding to the post-intervention study questionnaires. **Please make sure that you enter the correct email address and that you use the same email address for the whole duration of the study.**

Statement at follow-up for measures for the intervention group:

Thank you for your continued engagement with this study. You will now be asked to complete the same measures as before for the **final** time, as well as a few additional questions about the 2-week Compassionate Mind Training (CMT practices).

Please remember to use the same device for the entire duration of the study, as responses collected on different devices cannot be uploaded back to the same survey.

Please enter your email address in the text box below before proceeding to the post-intervention study questionnaires. **Please make sure that you enter the correct email address and that you use the same email address for the whole duration of the study.**

Statement at baseline for individuals allocated to the wait-list control group, after the measures have been completed at baseline:

Thank you for completing the measures!

You will have access to the 2-week Compassionate Mind Training (CMT practices) in one month. Would you kindly note, that you will be asked to complete the same measures on a couple more occasions (in two weeks' time, and again in four weeks' time) via email before having access to the CMT practices. Thank you for your interest in this study.

Should you encounter any difficulties or have any questions, please do not hesitate to contact me on lkk1n17@soton.ac.uk or (+44(0)7504683948: available on WhatsApp as well). I would be very happy to help you with any issues you may be experiencing throughout the study.

Please remember to use the same device for the entire duration of the study, as responses collected on different devices cannot be uploaded back to the same survey.

Once again, thank you very much for participating in this study. Your participation means a lot to us, and we are hopeful that many people will benefit as a result of this study.

Statement at post-intervention for measures for the wait-list control group:

Thank you for your continued engagement with this study. You will now be asked to complete the same measures as you completed earlier during the study. You will be asked to complete these measures again in 2 weeks' time via email, after which you will be able to access the 2-week Compassionate Mind Training (CMT practices).

Please enter your email address in the text box below before proceeding to the post-intervention study questionnaires. **Please make sure that you enter the correct email address and that you use the same email address for the whole duration of the study.**

Please remember to use the same device for the entire duration of the study, as responses collected on different devices cannot be uploaded back to the same survey.

Please enter your email address in the text box below before proceeding to the post-intervention study questionnaires. **Please make sure that you enter the correct email address and that you use the same email address for the whole duration of the study.**

Statement at follow-up for measures for the wait-list control group:

Thank you for your continued engagement with this study. You will now be asked to complete the same measures as before for the **final** time and you will then be able to access the 2-week Compassionate Mind Training (CMT practices).
Please remember to use the same device for the entire duration of the study, as responses collected on different devices cannot be uploaded back to the same survey.
Please enter your email address in the text box below before proceeding to the post-intervention study questionnaires. **Please make sure that you enter your correct email address and that you use the same email address for the whole duration of the study.**

Statement for email addresses to link data across time points at start of study:
Please enter your email address in the text box below. Please make sure that you enter your **correct email address** and that you use the **same email address** throughout the study.
Your email address will be used to be able to email you the links for the CMT practices over the next two weeks; your email address will be stored on a highly secure survey platform and will be treated with strict confidentiality.

Also, although this survey can be accessed from any device with an internet connection, it is really important that you use the **same device** throughout the study. This is because responses collected on different devices cannot be uploaded back to the same survey.

It is also recommended that you use the **latest version** of your browser of choice. The web browsers which are compatible with the survey software used for this study are Mozilla Firefox, Internet Explorer, Google Chrome, and Apple Safari.

If you have any questions, please do not hesitate to contact me on e.atuk@soton.ac.uk.

Save and continue later instructions:
Next, you will be asked to complete some questionnaires which should take you approximately 30-35minutes.

If you do not have the time to complete all of the questionnaires in one sitting, you can close the survey page, and come back to it within **24 hours** to continue where you left off. If you do not come back to the survey within 24 hours, you will need to start the survey again from the beginning if you wish to participate.

You can come back to the survey by re-clicking the same survey link which we emailed to you.

Should you encounter any difficulties or have any questions, please do not hesitate to contact me on lkk1n17@soton.ac.uk or (+44(0)7504683948: Available on WhatApp as well).

You may now leave this page and click the arrow sign in the bottom right corner of the screen to proceed to the questionnaires.

Thank you!

Statement for Prize Draw:
By clicking on the **"I accept"** box below, you are consenting to take part in the prize draw. Please insert your email address in the box below.

If you do not wish to take part in the prize draw, please click on the arrow sign at the bottom right corner of the screen.

Statement for access to intervention for wait-list control group and non-eligible participants:

You now have access to the 2-week Compassionate Mind Training (CMT practices); the links will be emailed to you.
Would you kindly note, that you will only have access to the links for the audio recordings and will not be asked to complete any of the measures again. The links will be active until 30th September 2022.
Please click the orange 'play' button or the 'Listen in browser' option (depending on which option is provided by the device you are using) to listen to the practices.

Appendix O Consort checklist of information to include when reporting a randomised trial*

Section/Topic	Item No	Checklist item	Reported on page No
Title and abstract			
	1a	Identification as a randomised trial in the title	129
	1b	Structured summary of trial design, methods, results, and conclusions	129
Introduction			
Background and objectives	2a	Scientific background and explanation of rationale	130-133
	2b	Specific objectives or hypotheses	133-134
Methods			
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio	134
	3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons	135
Participants	4a	Eligibility criteria for participants	134
	4b	Settings and locations where the data were collected	134
Interventions	5	The interventions for each group with sufficient details to allow replication, including how and when they were actually administered	140
Outcomes	6a	Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed	136-140
	6b	Any changes to trial outcomes after the trial commenced, with reasons	-
Sample size	7a	How sample size was determined	-
	7b	When applicable, explanation of any interim analyses and stopping guidelines	
Randomisation:			
Sequence generation	8a	Method used to generate the random allocation sequences	134
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	134
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered	134

		containers), describing any steps taken to conceal the sequence until interventions were assigned	
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	134
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how	-
	11b	If relevant, description of the similarity of interventions	-
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes	141
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses	141
Results			
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, were analysed for the primary outcome	142
	13b	For each group, losses and exclusions after randomisation, together with reasons	141
Recruitment	14a	Dates defining the periods of recruitment and follow-up	140
	14b	Why the trial ended or was stopped	-
Baseline data	15	A table showing baseline demographic and clinical characteristics for each group	142, 144-145
Numbers analysed	16	For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups	142
Outcomes and estimation	17a	For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval)	142-162
	17b	For binary outcomes, presentation of both absolute and relative effect sizes is recommended	-
Ancillary analyses	18	Results of any other analyses performed, including subgroups analyses and adjusted analyses, distinguishing pre-specified from exploratory	-
Harms	19	All important harms of unintended effects in each group (for specific guidance see CONSORT for harms)	-
Discussion			
Limitations	20	Trial limitations, addressing sources of potential bias; imprecision, and, if relevant, multiplicity of analyses	177-178
Generalisability	21	Generalisability (external validity, applicability) of the trial findings	178

	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	178
Other information			
Registration	23	Registration number and name of trial registry	-
Protocol	24	Where the full trial protocol can be accessed, if available	-
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	-

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