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ORIGINAL PAPER

Feasibility, Acceptability and Preliminary Outcomes of the Self-Compassion for Children and Caregivers Program

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Abstract

Caregivers of elementary-aged children are instrumental in shaping children's understanding of and ability to regulate difficult emotions (e.g., sadness, anger, shame). Self-compassion has emerged as a useful skill in promoting adaptive responses to difficult emotions in adults and teens but has been minimally explored in child and family contexts. This study used both qualitative and quantitative data to examine the feasibility, acceptability, and preliminary outcomes of a new online, synchronous program called Self-Compassion for Children and Caregivers (SCCC). This program offers six sessions of group-based co-learning for caregivers and their school-aged children. Twenty-eight caregivers (79% female, 79% White) recruited through university advertisements and a community-based organization completed close-ended surveys pre and post program and provided open-ended written feedback about their experience with the program. The program was feasible, with 93% of completers attending at least 5 of 6 classes. Content analysis of caregivers' open-ended responses suggested high acceptability, with caregivers citing improvements in communication about and support for difficult emotions and caregiver-child bonding. However, the online learning format was not ideal for all dyads. Suggested changes may improve engagement and outcomes. Quantitative analysis confirmed qualitative findings, showing significant improvements in caregivers' self-compassion, parenting stress, mindful parenting, and caregivers' assessment of their children's depression pre- versus post-program. Implications for intervention refinements and future studies are discussed.

Keywords Self-compassion · Caregivers · Children · Co-regulation · Parenting stress

Highlights

- The online dyadic Self-Compassion for Children and Caregivers (SCCC) program is feasible and acceptable.
- SCCC participation is associated with improvements in caregiver stress, self-compassion, and mindful caregiving.
- Dyadic participation may improve relational health and communication about emotions.
- Future work should explore if SCCC improves child coping and mental health trajectories into adolescence.

During middle to late childhood (considered roughly ages 6–12), children make considerable cognitive, behavioral and socioemotional gains as they approach the transition to adolescence (Carr, 2011). In the context of socioemotional development, children in this age range become more emotionally aware, communicate about emotions in a more nuanced way compared to earlier in childhood and develop new skills to cope with difficult emotions (Carr, 2011). Middle childhood is an opportune time to bolster emotional regulation competencies and coping skills, given the transition into adolescence is associated with increasing stress (e.g., academic pressure, peer relationships), physiological changes which heighten emotionality, and a sharp rise in prevalence of mental health symptoms (Rapee et al., 2019).

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Between 2008 and 2018, US data show a steep rise in numbers of adolescents, particularly females, that have depressive symptoms, express suicidality, and are completing suicide (Twenge et al., 2018). The COVID-19 pandemic has further compounded stressors experienced by young people and their caregivers (Weeland et al., 2021), leading the US surgeon general to declare youth mental health a national crisis (US Department of Health and Human Services, 2021). The current context highlights the urgent need for methods to equip children with coping skills early, *prior* to adolescence when possible, as this may disrupt poor mental health trajectories and prevent or mitigate negative outcomes.

Caregivers play a critical role in supporting healthy emotional development and help children to learn strategies for coping with difficulties. According to attachment theory, a caregiver's warm, attuned and supportive interactions with their child, particularly during moments of child distress, foster the child's secure attachment and strengthen the child's own capacities to manage difficult emotions independently (Cassidy, 2008; Zimmer-Gembeck et al., 2017). Other research suggests caregivers influence child emotional regulation skills in three main ways (Morris et al., 2007). First, caregivers serve as models, given children observe and indirectly learn from how caregivers handle their own difficult emotions. Second, caregivers influence children's learning about emotions and appropriate ways for handling them directly through the ways in which they respond to the child's emotional expressions. Finally, caregivers provide an "emotional climate" through the quality of their relationship with the child and their overall parenting style. Thus, when considering the emotional development of children, caregivers' own emotional regulation, attitudes, and interaction with their children in the context of difficult emotions are important (Eisenberg et al.,1998; Rutherford et al., 2015).

Practicing self-compassion is a promising way for both caregivers and their children to manage stress and support themselves when experiencing difficult emotions while simultaneously fostering compassionate interactions between caregiver and child in the context of child distress. Self-compassion is considered a personal resource, modifiable through intervention, that encourages warm self-directed responses to difficult emotions like sadness, anger, or shame (Neff, 2003a). This study is grounded in Neff's conceptualization of self-compassion, which differs in ways from others' definitions of self-compassion and compassion (e.g., Gilbert, 2020; Strauss et al., 2016). Framed informally as treating yourself the way you would treat a good friend when struggling, Neff's formal definition of self-compassion entails responding to difficulties through increasing compassionate self-responding while simultaneously decreasing uncompassionate self-responding (Tóth-Király & Neff, 2021). Compassionate self-responding includes the components of: (a) *mindfulness*, or having a balanced awareness and acceptance of one's emotions, (b) *common humanity*, or recognizing that experiencing difficult emotions are an expected and understandable part of life for everyone, and (c) *self-kindness*, or having an attitude and taking actions that are supportive to oneself. Uncompassionate self-responding includes: (a) *overidentification*, or exaggerating and catastrophizing the difficulty of the situation, (b) *isolation*, or feeling alone in these experiences of difficulty; and (c) *self-judgement*, or harshly criticizing and blaming oneself for the experience of difficulty. By increasing compassionate self-responding and decreasing uncompassionate self-responding, one raises overall self-compassion and can better cope with the inevitable emotional challenges of life.

Self-compassion is linked to a host of psychological benefits, including decreased stress, increased well-being and lower levels of anxiety and depression in adults and adolescents (MacBeth & Gumley, 2012; Marsh et al., 2018; Zessin et al., 2015), improved coping (Allen & Leary, 2010) and the ability to regulate unpleasant emotions (Inwood & Ferrari, 2018). In adolescents, self-compassion may be particularly relevant given adolescents' tendencies for negative self-evaluations, social comparison, and feelings of isolation (Neff & McGehee, 2010). Self-compassion protects against the negative impacts of stress on adolescent mental health (Lathren et al., 2019) and is linked to curiosity and resilience (Bluth et al., 2018). Furthermore, a recent meta-analysis which included 18 studies concluded that self-compassion is a useful resource to both prevent and treat depressive symptomatology in adolescence (Pullmer et al., 2019).

Meanwhile, in caregivers, being self-compassionate may help effectively cope with the stresses of caregiving and increase their capacity to support children as they experience difficulties. For example, self-compassion is associated with lower levels of parenting stress (Gouveia et al., 2016) and greater capacity to maintain a gentle, understanding view of their children's challenging behaviors (Neff & Faso, 2015; Psychogiou et al., 2016). Caregivers who report higher levels of self-compassion also endorse higher levels of mindful parenting (Moreira et al., 2016). Mindful parenting includes attitudes and practices comprising five main elements: (1) listening with full attention; (2) non-judgmental acceptance of self and child; (3) emotional awareness of self and child; (4) self-regulation in the parenting relationship; and (5) compassion for self and child (Duncan et al., 2009). Together, these components promote behaviors which are warm, attuned and responsive to the needs of a distressed child. Not surprisingly, mindful parenting is associated with the child's secure attachment (Medeiros et al., 2016), authoritative parenting style

(Gouveia et al., 2016), and higher levels of child well-being (Moreira et al., 2018). Thus, self-compassion may not only provide caregivers with tools to improve their *own* mental health and coping under distress, but also may increase caregivers capacity for sensitive and supportive behaviors towards their distressed child (Lathren et al., 2020).

In recognition of the value of compassion for promoting well-being, a variety of programs have been developed with the aim of broadly cultivating compassion for both oneself and for others in adult community and clinical populations (Kirby, 2017); some examples are compassionate mind training (Matos et al., 2017) and compassion cultivation training (Jazaieri et al., 2013). Recently, there have been calls for integration of compassion-based programing into settings reaching children and their caregivers, such as schools and families (Kirby, 2020; Lavelle Heineberg, 2016). In addition, several parent/caregiver-targeted mindfulness interventions, which naturally include elements of compassion, have been developed and tested (see Shorey & Ng, 2021 for a recent review). However, to date, programming with an explicit *self*-compassion focus, such as the evidence-based Mindful Self-Compassion program for adults (Neff & Germer, 2013) and the Mindful Self-Compassion program for Teens (Bluth et al., 2015), has not been explored in the *dyadic* caregiver-child context. To advance this literature, this study uses both quantitative and qualitative data to examine the feasibility, acceptability and preliminary outcomes of a novel program called Self-compassion for Children and Caregivers (SCCC). This program was developed by adapting evidence-based curricula from the adult Mindful Self-Compassion program (Neff & Germer, 2013) in order to be developmentally appropriate and engaging for simultaneous participation by both caregivers and elementary school-aged (approximately 7 through 10 year-old) children in a group setting. This co-learning format is advantageous because it may bolster individual coping skills and well-being of the child prior to the challenges of adolescence, while also enhancing caregivers' ability to support children when experiencing difficult emotions. Given pandemic precautions, the program was adapted to be offered online via synchronous audiovisual conferencing, a format that has been successful for self-compassion programming in other contexts (e.g., Campo et al., 2017).

Our aims for this study were two-fold. Our first aim was to examine implementation outcomes, including the feasibility and acceptability of SCCC, using both quantitative (e.g., program retention and attendance study records) and qualitative (e.g., post-program open-ended feedback about experience with the program) data (Proctor et al., 2011). Given SCCC is a new program, we chose to concurrently collect qualitative and quantitative data to provide a more comprehensive and nuanced understanding of barriers and facilitators to successful implementation, as well as participants' experience with the program (Aschbrenner et al., 2022). We hypothesized that the program would be generally feasible and acceptable for caregivers and children, however, we expected refinement to the program and protocols would be indicated. Second, using quantitative methods, we aimed to explore preliminary caregiver and child outcomes associated with participation. We hypothesized that we would find post-program improvement in caregiver self-compassion, parenting stress, perceived levels of mindful parenting, and caregiver report of child depressive symptoms.

Method

Participants

Participants were 28 caregivers (79% female, 79% White, see Table 1 for details) of school-aged children (Mage 8.7, 36% female) who were enrolled in one of 3 cohorts of an online Self-Compassion for Children and Caregivers (SCCC) program at a University Mindfulness and Compassion Center or a non-profit community organization February through June 2021. The non-profit community organization is described as offering natural healing and wellness services at affordable costs, serving populations who might otherwise have limited access to these services due to cultural, language, or income barriers. The program was advertised through a university mass email system, local school system electronic flyers, and through advertisements within the community organization. As the program was offered online, anyone in the local or wider community was able to register for the course. The cost of participation was $298 for the university-based program. The community organization offered the program for $8 with scholarships available for families unable to afford the $8 fee.

Procedure

Once caregivers enrolled themselves and their children in the program, they received an email inviting them to participate in the research study that was associated with the program. The email invitation indicated that they would receive a link to a Qualtrics survey a few days prior to the first session, and if they were interested, they could click on the link. At that point, they had access to a consent form. At the bottom of the consent form they were told that if they proceeded past the consent form, they were indicating that they were agreeing to participate in the research study. Once past the consent form, they had access to the online survey.

Within a day of the end of the last class, participants were again emailed a link to access the post-survey. The post-survey contained the same measures as the pre-survey, except for the demographic questions, which were omitted. Also, the post-survey included open-ended questions which

Table 1 Demographics of Sample

	Baseline[a] ($n = 37$)	Intervention sample[b] ($n = 28$)
Female % (n)	83.8% (31)	78.6% (22)
Age M (SD)	42.84 (4.54)	43.5 (4.68)
Hispanic/Latinx ethnicity % (n)	10.5% (4)	7.1% (2)
Race % (n)		
Black or African American	5.3% (2)	7.1% (2)
White	76.3% (29)	78.6% (22)
Asian	2.6% (1)	3.6% (1)
Other	2.6% (1)	3.6% (1)
Education Level % (n)		
Some college or college graduate	35.1% (13)	32.1% (9)
Master's degree	44.7% (17)	42.9% (12)
Doctorate or professional degree	18.4% (7)	25.0% (7)
Household yearly income % (n)		
Less than $50,000	8.8% (3)	3.6% (1)
$50,001–$100,000	26.3% (10)	25.0% (7)
$100,001–$150,000	21% (8)	25.0% (7)
More than $150,000	34.3% (13)	39.3% (11)
Age of child M (SD)	8.62 (1.65)	8.72 (1.69)
Gender of child		
Female	39.5% (15)	35.7% (10)
Male	55.3 (21)	64.3% (18)
Non-binary	2.6% (1)	

[a]Baseline sample includes all participants who completed pre-intervention survey

[b]Intervention sample includes all those who completed pre- and post-intervention survey

gave participants the opportunity to provide qualitative feedback about the course. As compensation for taking part in the research study, participants could opt to receive a photobook created by the program developer that highlighted aspects of the program. These procedures were approved by the university IRB.

Measures

Self-compassion Scale-Short Form (SC-SF)

(Raes et al., 2011) is a 12-item scale that was used to assess self-compassion. The SC-SF is a brief version of the full 26-item Self-Compassion Scale (Neff, 2003b), and has a near perfect correlation with it at $r = 0.97$. Items are rated on a 5-point Likert scale ranging from 1 (almost never) to 5 (almost always). Examples of items include: *When something upsets me, I try to keep my emotions in balance*, and *When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people*. As this study is grounded in Neff's conceptualization of self-compassion, a total self-compassion score was computed. This was done by reverse-scoring negatively worded items and summing all items. The range of scores is between 12 and 60, with higher scores indicating greater self-compassion. Reliability of this scale is good, with reported Cronbach alpha's ≥ 0.75 (Bluth et al., 2016; Marshall et al., 2015; Raes et al., 2011).

Short Mood and Feelings Questionnaire, parent version (SMFQ-P) (Messer et al. 1995)

Caregivers completed the well-established SMFQ-P to assess their child's depressive symptoms. The SMFQ-P is a unidimensional scale, comprised of 13 items which ask (parents) how their child felt over the last two weeks, with responses on a 3-point Likert scale from 0 (*not true)*, 1 (*sometimes)*, and 2 (*true*). The range of scores is between 0 and 26, with higher scores signifying greater depressive symptoms. Examples of items are: *S/he felt miserable or unhappy* and *S/he cried a lot*. Content, criterion, and discriminant validity have been established (Messer et al., 1995; Sharp et al., 2006), and Cronbach's alpha has been reported as 0.87 (Messer et al., 1995).

Parenting Stress Scale (PS) (Berry & Jones, 1995)

Caregivers also completed the 18-item PS scale, which measures the degree to which parents feel their role as a parent is stressful. Items are measured on a 5-point Likert scale ranging from 1 (strongly disagree), 2 (disagree), 3 (undecided), 4 (agree) to 5 (strongly agree). After reverse scoring negatively worded items, all items are summed and range of total score is from 18–90. Higher scores indicate higher level of parenting stress. Examples of items include "*I am happy in my role as a parent*" and "*I feel overwhelmed by the responsibility of being a parent*" (reverse scored). Reliability and validity have been established (Berry & Jones, 1995) and Cronbach's alpha has been reported between 0.86 and 0.88 (Holly et al., 2019).

Interpersonal Mindfulness in Parenting Scale (IMP) (Duncan et al., 2009)

The 29-item version of this scale originates from the original 31 item scale. According to Burgdorf and Szabó (2021), the 31-item scale had a poor fit with data and therefore was not validated; the recommendation was to eliminate two items, #3 and #6. The 29-item scale was shown to have good fit indices and was then validated (Burgdorf & Szabó, 2021). We therefore used the 29-item scale in all analyses. The 29 items measure five dimensions of mindful parenting,

represented by 5 subscales: 1) listening with full attention, or being attuned to the child so that the child's behavioral cues elicit an appropriate parental response; 2) nonjudgmental acceptance of self and child, or accepting that which is taking place in the moment rather than having pre-conceived ideas of how a given situation should unfold; 3) emotional awareness of self and child; 4) self-regulation in the parenting relationship; and 5) compassion for self and child. Examples of items from each of these subscales are, respectively: 1) *I pay close attention to my child when we are spending time together*; 2) *It is easy for me to tell when my child is worried about something*; 3) *When my child does something that upsets me, I try to keep my emotions in balance*; 4) *When things I try to do as a parent do not work out, I can accept them and move on*; 5) *I try to be understanding and patient with my child when he/she is having a hard time*. Participants respond to the 29 items using a 5-point Likert scale ranging from 1 (never true), 2 (rarely true), 3 (sometimes true), 4 (often true), and 5 (always true). After reverse scoring negatively worded items, scores are summed to calculate a total score. Subscale scores were also calculated by summing items within each subscale.

Feasibility

Our benchmarks for feasibility were acceptability and practicality as described by Bowen et al. (2009): (1) at least 75% of those invited to participate in the program would complete consent and pre-survey processes; (2) at least 75% of those who took the pre-survey would stay throughout the program and take the post-survey; and (3) at least 75% of those who completed the program would attend at least 5 out of 6 classes. Attendance was taken at the beginning of each class by the instructor.

Post-Survey Qualitative Data/Acceptability

In the post-survey, open-ended questions were included and collected concurrently with quantitative data to ascertain participants' experiences of the program, whether they found the program beneficial and relevant to their lives, and to identify potential facilitators and barriers to implementation. The five questions included: (1) aspects that they liked and (2) did not like about the program, (3) recommendations to improve the program, (4) whether/how the program impacted themselves as a caregiver and/or their relationship to their child, and (5) whether/how the program impacted their participating child.

Intervention

Self-Compassion for Children and Caregivers (SCCC) was adapted from the adult Mindful Self-Compassion program (Neff & Germer, 2014). The SCCC intervention consisted of six "live" online sessions, with caregiver-child pairs meeting for one hour once a week over the course of six weeks with other caregiver-child pairs. The course was taught by the developer of the program, who is also a certified Mindful Self-Compassion (MSC) instructor. As an MSC certified instructor, she has completed a 40-hour training, 10 peer consultations, and 15 one-on-one sessions with a mentor. The instructor is also a master's degree level elementary school educator with over a decade of experience teaching mindfulness and self-compassion to children, adults, teens and families. As of the writing of this article, the SCCC program curriculum has been reviewed by the Center for Mindful Self-Compassion, and after minimal refinement to the sessions as presented here, has been approved as an official adaptation of the adult MSC program.

To be accessible and developmentally appropriate for children, significant modifications to the adult MSC program were made. For example, props such as stuffed animals, blankets, and small objects to represent emotions were integrated throughout the various exercises. Mindful movement was incorporated in every session to help children with attention and engagement. Modifications were also made so that the program would be appropriate for caregiver-child dyads rather than individuals. For example, several times during each session, children and their caregivers were asked to mute themselves so that they could engage with each other privately in response to various exercises. In one exercise, pairs took turns describing a recent "down" moment and practicing offering compassion to one another. These private dyadic conversations encouraged pairs to communicate about emotions, helped to illustrate the universality of difficult emotions (e.g., even my mom feels embarrassed sometimes!) and provided structured opportunities for caregivers to practice sensitive responses to child distress. In this way, caregivers and children were "co-learners" as they navigated difficult emotions and practiced self-compassion together. Additionally, each session of SCCC incorporated mindfulness and self-compassion instruction, practice, movement, and a fun content-related game or activity. Emails were sent prior to each class to inform participants of props needed for the session. Suggestions for home practice were provided and encouraged. An outline of each session follows:

- Session 1 explores the universality of emotions and introduces the concept of being self-compassionate when experiencing difficult emotions. Caregiver-child pairs use multi-colored objects to represent a range of emotions, and then wrap their difficult emotions in a small cloth as a metaphor for holding them with self-compassion. Session 1 also introduces mindfulness

practices such as feeling the sensations of the soles of the feet, and caregiver-child pairs practice together by tracing each other's feet on a piece of paper. A story using a giraffe stuffed animal demonstrates how animals live in the present moment, but humans need mindfulness to help them come back to the present moment when their mind wanders to the past or future.

- Session 2 invites pairs to embrace and recognize the universality of having difficult experiences. While mindfully bending and straightening their knees to lower down to the floor and back up again, both alone and holding each other's hands, the pairs are reminded that everyone has ups and downs, and these times can be made easier with support. Developmentally appropriate practices using stuffed animal props elucidate how we tend to resist our difficult emotions, and how this emotional resistance can be problematic over the long-term. Trauma sensitive topics and exercises encourage participants to allow themselves to open to emotions gradually and with awareness of one's emotional readiness, rather than resisting or avoiding difficult emotions. Language such as wrapping difficult feelings in compassion "bit-by-bit" and "offering yourself compassion for forgetting to be self-compassionate" helps participants pace themselves as they develop these skills.
- Session 3 provides caregiver-child pairs with opportunities to understand and practice the three components of self-compassion—mindfulness of difficult emotions, common humanity, and self-kindness. Participants are invited to notice the differences in how they treat a friend when they are having a hard time versus how they treat themselves when they are struggling. Caregivers and children are invited to discover how they would like to treat themselves when things do not go as expected. The pairs practice different ways of self-soothing including offering themselves kind words and engaging in supportive touch such as resting one's hands on their heart, stroking the cheek, or giving themselves a hug.
- Session 4 helps caregivers and children understand and respond skillfully to difficult emotions that can sometimes surface when offering oneself kindness and self-compassion. Feelings of discomfort are named and normalized, and caregivers and children are encouraged to slowly build their self-compassion practice. Additionally, pairs are introduced to a wide range of strategies for helping themselves to experience connection and well-being including kind actions (e.g., reading a book, playing outside), kind wishes (e.g., offering oneself and others wishes for health and happiness), and a guided visualization practice. This session ends with a game where caregivers and children mirror each other's actions to cultivate both mindful seeing and connection.
- Session 5 teaches skills for relating to difficult emotions. Practices include responding to anger with both courageous and tender self-compassion as well as identifying universal human needs and values that often underlie challenging emotions. Topics are illustrated with the use of props. For example, the instructor guides participants to use a hard plate to represent hard emotions like anger, to place a soft cloth underneath the hard plate to represent softer emotions like fear or sadness, and then to hide small 'jewels' (e.g., sparkling rocks) inside the soft cloth to represent universal needs and values. Pairs are invited to reflect on a common caregiver-child conflict scenario example (getting ready for school in the morning) by considering from the perspective of each person's feelings and needs/values. Participants are also invited to relate to their own strengths and weaknesses with common humanity and self-compassion.
- In the final session, the pairs practice gratitude for everyday goodness (e.g., nature, water, clothing) and being aware of and opening to positive emotions. Participants share experiences and photos that make them smile and practice sharing in each other's joy. Pairs reflect on their values and offer custom kind wishes both for themselves and others. They also identify practices and other ways that they would like to continue to incorporate self-compassion into their lives.

Home practices are suggested for each session, and participants are emailed a "picture review" of practices and ideas each week that they can incorporate together at home. Notably, while the primary focus of the SCCC program is to develop each participant's individual skill in self-compassion, the interpersonal format provides interwoven opportunities for caregivers to simultaneously gain skill in responding compassionately to their distressed child. Thus, we expect the SCCC program to secondarily encourage supportive, mindful parenting behaviors.

Qualitative Analysis

The first author used a qualitative content analysis approach (Hsieh & Shannon, 2005) to summarize the responses to open-ended survey questions regarding caregivers' experiences with the program, including implementation barriers/facilitators and satisfaction with program content. The first author is a white, middle-aged, mother of an elementary school-aged child; she is also a self-compassion researcher and practitioner with experience conducting qualitative analyses. Content analysis approach was chosen as it is a flexible method used to describe a phenomenon by allowing a "subjective interpretation of text data through the

systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005). A primarily inductive approach to coding was used, whereby codes were derived from the data; however, the four codes "likes", "dislikes/changes", "caregiver or caregiver-child relationship changes", and "child changes" were established a priori based on the questions asked and our desire to glean this information specifically.

Responses were imported into ATLAS Ti 23.0.6.0 for Windows. The analyst read through the data multiple times. The analyst then highlighted text segments that seemed to represent participants' expression of acceptability/appropriateness of the program. In an iterative process of assigning, merging and splitting codes, 41 codes were developed based on the content of text segment (e.g., "instructor," "communication," "connection to others," "engagement"). When possible, codes that were similar in content were grouped together into sub-categories. For example, under the overarching code "changes in caregiver or caregiver-child relationship," sub-codes labeled as "improved communication," "identify feelings," "listening" were grouped together to describe caregiver changes in "communication about and awareness of difficult emotions." The analyst continued the process of combining and splitting codes and categories until groupings/hierarchies were finalized. All but one participant provided open-ended feedback, and all comments given by participants were included in this summary.

Quantitative Analysis

First, descriptive statistics on all demographic and outcome variables were calculated, separating completers from non-completers. To determine whether non-completers differed from completers, t-tests and chi-square tests were conducted on the baseline levels of outcomes and demographic variables. Paired t-tests were conducted to assess the change in all measures from pre- to post-program, and Hedges' g was calculated to determine the effect size. Hedges g is similar to Cohen's d, but includes a correction factor for the small sample size (Rosenthal et al., 1994).

Results

Feasibility

Feasibility was measured by assessing recruitment, attendance and retention data. Of the 42 caregivers eligible to participate, thirty-seven enrolled (88%) and took the pre-intervention survey. Of those 37, 28 took the post-intervention survey and are considered "completers"; thus retention over the three cohorts was 76%. All subsequent analyses were conducted on "completers." Of the nine "non-completers" who only took the pre-survey, one did not attend any classes, four attended three or fewer classes, and four attended four or more classes. Reasons cited for missing classes or not completing the program were scheduling conflicts, such as unanticipated sports competitions. One caregiver-child pair who had attended the first four classes missed the last two classes (and did not complete post-survey) because a family member was hospitalized unexpectedly, and several others missed the last class due to a storm that affected their internet functionality. Among the 28 "completers," 93% attended at least five of the six classes.

Acceptability

We grouped caregivers' post-program responses to open-ended questions into four main categories that related to program acceptability and which mirrored the question prompts: (1) positive aspects of the program; (2) perceived changes (or lack thereof) in the caregiver or caregiver-child relationship; (3) perceived changes (or lack thereof) in the child; (4) areas for program improvement. Some categories are divided into sub-categories for ease of summarizing. Furthermore, to aid the reader in distinguishing different caregiver participant's comments from each other, we have assigned a participant number to each quote by using the notation "P" (for participant) and then an ID number.

Positive Aspects of the Program

Instructor

Numerous caregivers noted the instructor's qualities as warm, engaging, knowledgeable, relatable and supportive. One caregiver noted the instructor's candor about her own emotions and experiences was particularly useful. These qualities were helpful in creating an atmosphere of trust within the class and served to model the material.

Format/Logistics

Several caregivers described the format of learning alongside their child as a special bonding time, with one describing it as "precious and beautiful" (P514) and another describing it as "healing" (P101). Another noted that learning together, rather than typical roles where the caregiver imparts wisdom to the child, encouraged a more collaborative approach to the material:

> "Since the lesson came from someone other than a parent, it had a different level of acceptance by my kiddos. We were both students trying new things

together as opposed to a mom lecturing a child. It also helped me be a coach and support for my kids when things weren't going well." (P 206)

Others described being in a group with other caregiver-child pairs as beneficial and "a great relief" (P209) because the format helped them to realize they are not alone in their experiences. Finally, one caregiver noted that the online format was convenient (although not all caregivers preferred online participation, please see Areas for Program Improvement).

Content

Many caregivers had positive comments regarding the content of the course. Several commented that the content was presented in a way that was engaging and easy for children to understand, with a wide variety of strategies that reinforced the concepts. The tools were described as practical and "easy to implement" (P204) in daily life, with one caregiver citing the "playful props, games and images" helped to make the content "fun" (P205). Content that helped participants to "accept [feelings] as natural" (P208) and nuanced, to respond to difficulties as one would a friend, to be curious about needs underneath feelings, and to be less judgmental towards oneself when struggling were highlighted as particularly beneficial. Many comments described directly applying the program content in family life, with new caregiver and child skills relating to emotional vocabulary, emotional awareness, caregiver-child communication and responses to challenging emotions in oneself and in each other. These topics are discussed further below.

Perceived Changes in the Caregiver or Caregiver-Child Relationship

Many, but not all, caregivers described newfound skills and changes in their relationship with their child after program participation. These changes were grouped into four main areas: (1) communication about and awareness of difficult emotions; (2) caregiver's ability to support their child; (3) caregiver's ability to support themselves; (4) caregiver-child bond.

Communication about and awareness of difficult emotions

Many caregivers described post-program changes in how they talk to their child about difficult emotions. Experiencing the program together promoted a "common language" (P503) around concepts such as weaknesses as being human and worthy of care and tenderness, and how to manage difficult emotions. This new shared vocabulary was seen as valuable in supporting *both* themselves and their children when experiencing a challenging moment:

"This opened up conversations about our feelings and gave us a common set of concepts. I feel like it created a stronger bond and connection, and I especially loved the emphasis on accepting weaknesses, side by side emotions, and that everyone won't find the same things soothing or helpful and that it is ok. A very helpful framework moving forward to help us communicate about our feelings, and a reminder of the need to focus on the good. I feel like it has made me a more empathetic parent." (P203)

Not only did caregivers and children develop a common language around emotions, but for some, they also increased the frequency of conversations, had greater awareness of and ability to identify feelings in themselves and their child, and had greater overall comfort in talking about feelings in daily family life.

Caregiver's ability to support their child

Caregivers also described a growing capacity to support their child during their challenges or distress. For example, one caregiver found the program helped them to develop a better understanding of their child's self-critical tendencies, and to be more attuned and supportive in response:

"I liked learning that my child was being harder on herself than I realized. This makes me more aware of how she reacts to her failures so I can reassure her that she is good enough. I also make a point to highlight her talents and successes more than I have in the past. I also realized that I was being hard on my child because of my desire to want her to be successful which may have contributed to why she is so hard on herself. I have since learned to balance my conversations with her so that I am more positive and understanding. In addition, I am much more attentive to her during our conversations and when she tells me she is experiencing stress, I help her to deal with what she is feeling using some of the tools we learned in the sessions such as naming the fear or problem and then addressing the problem." (P 113)

Other caregivers described improvements in co-regulation skills, including the capacity to "calm and center [themselves]" (P503) in heated moments, "deescalate big feelings" (P206) in their child, "pause and try to understand [their child's emotion]" before reacting (P512), "coach [their child] through difficult emotions" (P515) and be more "forgiving with each other and ourselves" (P514) after

ruptures. Several described being more able to focus on the needs underneath their child's behavior, while others described having more empathy and patience, with one commenting that they now had "encouraging and compassionate language to say to myself and to [my children] as [they] struggle through different everyday situations" (P509). In all, many caregivers felt their behaviors towards their struggling child became more emotionally responsive after the program and implemented the skills regularly in family interactions.

Caregivers' ability to support themselves

While these comments were less frequent than the comments regarding child-directed support, caregivers also described improved self-directed support post-participation. One caregiver said they were "kinder" (P512) to themselves, while others stated they have developed more self-compassion and less perfectionistic tendencies; one mentioned they were motivated to model self-compassion for their child's learning. Some caregivers also cited improved awareness of their own emotional states and ability to process or "get curious about the why" (P209) behind their own feelings. For example, one participant noted: "It [the program] has given me tools to help calm and center myself and become more aware of what I am feeling" (P503).

Caregiver-child bond

Several caregivers cited a strengthened relationship and bonding with their participating child through the program. As one caregiver stated, their children have "enjoyed the feeling of closeness and connection that has been enhanced since starting the journey together" (P514). Another said: "I also enjoyed having some regularly scheduled one-on-one time doing our "special thing" with my child and the bonding that it provided" (P208), while a third said the program "has strengthened our already strong relationship" (P101). In one instance, the program provided one caregiver with time to "focus on our specific relationship" (P110), which was rare given she has two children. However, several caregivers did not feel any changes in their relationship were apparent.

Perceived Changes in the Child

A variety of child changes were noted by caregivers. For one caregiver, their son appeared to have gained more confidence, introspection and comfort with difficult emotions through participation:

> "I have observed that he has internalized many of the messages and it's really helping with his self-esteem, his ability to deal with difficult emotions, and helping him understand further that talking about your feelings and being curious about them are… not something weird, but something that is a normal part of human relationships, including his relationship with himself." (P101)

Similarly, for another, participation helped their child to gain a positive perspective and acceptance of her difficulties, which also helped her feel more connected to others and to cope with challenges:

> "I think the class helped validate her feelings - that it is ok to have side by side emotions, and that sometimes being sad is part of life. The focus on common humanity has helped her feel less alone, which was really important as she has been doing remote school. It also gave her some concepts to help her navigate her feelings, and the brain science info she liked, too." (P203)

Other caregivers described their child using strategies in the moment to manage emotions and be less reactive, being "a kinder, gentler person towards [themselves]" (P209) and their weaknesses, being more communicative about and aware of feelings, and improved ability to recognize their needs. One caregiver described their participating child developing greater empathy toward their sibling.

On the other hand, some caregivers did not notice changes in their child post-participation, but a few were hopeful that exposure to the concepts and practices would bring benefits in the future as the family continued to use the language and strategies they learned. A few noted that their child resisted participation, which limited child impact. For example, one caregiver described that "it was hard to get [their child] to attend the class sometimes and this was stressful" (P111). Another stated the child found it boring, and several noted that child engagement and participation may have been better in person (see below).

Areas for Program Improvement

Seven caregivers mentioned the online format was difficult for their child and that they would have preferred an in-person class as opposed to the online format. Although there were some benefits to the virtual format (accessibility, convenience), for some children and caregivers, virtual participation was a barrier to engagement, with one stating, "The online forum felt a bit disconnected for such a heartfelt topic…it was hard to keep my child engaged partially because of the online format" (P516). Several mentioned the late afternoon timeframe was not ideal, and for others, a shorter class would have been better for attention spans. Of

Table 2 Means and standard deviations of study variables

Variable	Pre-Program *M*(SD)	Post-program *M*(SD)	Cronbach's α pre, post	*p*	Hedges *g*
Self-Compassion (SCS) $n = 28$	2.97 (0.56)	3.35 (0.52)	0.69, 0.85	<0.001	0.67
Depressive Symptoms (MFQ) $n = 26$	20.39 (5.05)	17.31 (3.81)	0.85, 0.84	0.005	0.66
Mindful Parenting (IMP) $n = 27$	91.04 (9.34)	102.22 (10.52)	0.83, 0.89	<0.001	1.08
Listening with Full Attention	15.56 (2.61)	17.07 (2.62)		<0.001	0.56
Emotional Awareness of Self & Child	13.81 (2.08)	15.15 (1.96)		<0.001	0.64
Self-Regulation in Parenting Relationship	17.00 (2.91)	19.82 (3.28)		<0.001	0.88
Non-Judgmental Acceptance in Parenting	23.15 (2.93)	25.59 (3.02)		<0.001	0.67
Compassion for Self & Child	17.59 (3.13)	20.56 (2.93)		<0.001	0.94
Parenting Stress (PS) $n = 27$	44.15 (10.73)	39.56 (10.68)	0.89, 0.90	<0.001	0.42

n's of variables vary due to missing data; Hedges g is interpreted as 0.2 is small effect, 0.5 is medium effect, and 0.8 is large effect

SCS Self-Compassion Scale, *MFQ* Mood and Feelings Questionnaire (Parent report of Child), *IMP* Interpersonal Mindfulness in Parenting Scale, *PS* Parenting Stress scale

the caregivers who experienced difficulty with the online format, one admitted that they "would not have access to the class otherwise" (P518) and another offered that online might be more feasible once children are less overwhelmed with online learning due to the pandemic.

Feedback about breakout rooms was mixed. Several caregivers mentioned that the breakout rooms in which they were to talk with other families were awkward at times. Others felt the breakout rooms were helpful and desired more time to connect with other families and each other (caregiver-child pairs).

Other ideas offered for improvement included weekly handouts to summarize lessons and encourage home practice, more game-based activities, recording sessions for review/make-up classes, a program workbook, more time for parent-child discussion, and more strategies to help with children's angry emotions. Meanwhile, one participant felt there were too many strategies to choose from, and this made it difficult to know which ones to use at home; another child mentioned the instructor spoke too fast. Finally, one caregiver noted their child sensed that their participation meant something was wrong with them; this caregiver would have liked the instructor to make clearer that program participation was open to everyone, and not just for children who were experiencing a specific diagnosis or problem.

Quantitative Outcomes

No differences existed between completers and non-completers in self-compassion, caregivers' perceived level of child depression, parenting stress, or interpersonal mindfulness in parenting at baseline. Also, no differences existed between completers and non-completers in ethnicity, yearly household income, child's age, child's gender, or caregiver age. However, there was a difference between the two groups in level of education attainment; the completers had a greater level of education attainment than non-completers. For example, 25% ($n = 7$) of completers had a doctorate or professional degree, whereas none of the non-completers had a doctorate or professional degree. Also, 22% ($n = 2$) of non-completers did not have a college degree, whereas all the completers had at least a college degree.

Findings indicated that all variables improved significantly from pre- to post program, with medium to large effect sizes (Table 2). Notably, mindful parenting improved from pre- to post with a large effect size (Hedges $g = 1.08$).

Discussion

This study investigated the feasibility, acceptability, appropriateness and psychosocial outcomes of an online self-compassion program for children aged 7–10 and their caregivers. The program was adapted by a certified instructor of the adult Mindful Self-Compassion program and contained the core elements of that program; the program is now an official adaptation of the Mindful Self-Compassion program. Modifications were made to make it developmentally appropriate for this age group, and to be taught to caregiver-child pairs.

In response to the first research question, feasibility, acceptability, and appropriateness were largely attained, providing preliminary evidence that successful implementation of this program is achievable (Proctor et al., 2011). Our criteria for feasibility were met, as 88% of those eligible enrolled, and 76% of those who enrolled in the study (i.e., consented and took the pre-test) completed the program and took the post-test, and 93% of those who completed the program attended 5 of the 6 classes. Several participants indicated that they withdrew because of

unanticipated changes to their schedules; this is not unexpected in intervention studies that involve children and adolescents, as many are engaged in numerous extracurricular activities. Also, as five participants attended three or fewer classes, retention might be improved in future implementation of the program by explaining more clearly the nature, purpose, format, and content of the program prior to registration for the program. However, these findings have limited generalizability beyond the current sample. Caregivers self-selected to participate online and had the time and resources for participation in the program. It is not clear whether caregivers who do not have access to technology, or who do not have similar amounts of time, resources or backgrounds (e.g., racial, ethnic, socioeconomic), would similarly engage in this programming. Also, as a difference in education attainment was found between completers and non-completers, it may be that non-completers did not have the necessary resources, such as time, technology bandwidth or equipment, to successfully complete the program. This would need to be explored in future studies.

Responses to open-ended questions indicated high levels of caregivers' satisfaction with the SCCC program instructor, format, content and delivery, as well as relevance and usefulness of the skills learned for navigating difficult emotions in themselves and their children. Thus, feedback suggests overall program acceptability and appropriateness in this sample. One noted exception is the online format, with some caregivers reporting that in-person learning would be more effective and engaging for their child. Given the program was held during the COVID-19 pandemic, when many children were in virtual school, some children were likely tired of online learning. However, others noted that online programming was both convenient and accessible, making participation possible. As we navigate the post-pandemic era, having *both* formats as options and allowing caregivers to decide which modality works best for their child will offer the flexibility necessary to optimize both program reach and engagement. Other feedback suggests that adding more opportunities for group interaction (e.g., breakout rooms) and supportive resources (e.g., a workbook) may make the online format more engaging. Additionally, qualitative exploration regarding the needs and preferences of caregivers from diverse backgrounds in future work will allow for tailoring of the program to communities who may otherwise lack access.

From many caregivers' perspectives, gains were seen in both their own and their child's capacity for emotional awareness and self-compassionate responding; these individual skills appeared to be deepened and reinforced by learning together. By creating a set of common vocabulary and related strategies, some caregivers reported the capacity to model skills, have greater awareness of and open communication about emotions in daily life, and provide more compassionate support to their struggling child. These factors are important in promoting co-regulation between caregiver and child (Rosanbalm & Murray, 2017) and are linked to improved child socioemotional outcomes (Gentzler et al., 2005). Thus, impact on child well-being may be multi-dimensional, involving both bolstering the child's coping skills and providing a more optimal relational and family environment to support those new skills. Future studies could use quantitative methods to further explore how SCCC programming impacts caregivers' beliefs and attitudes about difficult emotions (Halberstadt et al., 2013), caregivers' behaviors when assisting their child to regulate emotions (Cohodes et al., 2022), and potential impact on sibling and co-parent relationships.

Quantitative results confirm shifts that were evidenced in qualitative findings. For example, results demonstrated significant increases in self-compassion and significant decreases in parenting stress after program completion. Participation in SCCC may help caregivers to use self-compassion skills to better cope with the demands of caregiving. This result is line with existing literature showing self-compassion in parents is associated with lower levels of parental stress in general community samples (Gouveia et al., 2016; Moreira et al., 2015), as well as lower distress and improved well-being in caregivers of children with unique needs (Neff & Faso, 2015; Robinson et al., 2017; Shenaar-Golan et al., 2021). Given parenting stress is linked to parenting behaviors, parent-child relationships, and child adjustment (e.g., see review in Louie et al., 2017), interventions which help caregivers to cope with parenting demands may have broad implications relating to their own parenting behaviors as well as their child's emotional health.

SCCC program participation was also associated with significant perceived changes in all aspects of mindful parenting, a finding that is in line with many of the qualitative comments regarding perceived changes to parenting. The five components of mindful parenting are posited to promote supportive caregiving behaviors (e.g., being emotionally attuned, being responsive to child cues and needs, having appreciation for the child, displaying an understanding attitude when parent or child 'falls short') while decreasing less supportive behaviors (e.g., dismissing child's emotions, misreading or ignoring child cues, having unrealistic expectations of the child, using harsh discipline) (Duncan et al., 2009). Together, mindfulness in parenting promotes relational well-being between caregiver and child, a finding also mentioned in the qualitative data. Meanwhile, in adolescence, mindful parenting has been linked to higher levels of caregiver-adolescent communication (Lippold et al., 2015), lower levels of adolescent risk behaviors (Turpyn & Chaplin, 2016) and lower levels of adolescent internalizing and externalizing symptoms (Parent et al.,

2016). Thus, as children approach the age of adolescence and its associated challenges, the benefits of this shift in caregiving approach may continue to grow.

We also found significant decreases in caregivers' assessment of their children's depressive symptoms post-program. Although limited by caregiver assessment rather than child report, these findings are promising, as they suggest participating children may be using newly learned self-compassion skills to help them manage difficult emotions. These findings are framed within the context of participation during the height of the pandemic, when many children were experiencing social isolation, limited access to mental health care and higher levels of psychological distress compared to pre-pandemic times (Fegert et al., 2020). Notably, given caregivers are simultaneously learning strategies to self-regulate and tend to themselves with care, it is plausible that children's depressive symptoms are also impacted *indirectly* through caregiver-level factors (Morris et al., 2007). Newly trained caregivers may be *modeling* self-compassion and *responding* to their child in a compassionate and supportive manner in the context of difficulties; these changes may also encourage the child's self-compassionate responding and overall ability to manage depressive symptoms. The potential links between parent and child self-compassion levels have been suggested elsewhere (Lathren et al., 2020), and could help to explain the 'passing down' of coping tendencies and emotional well-being generation after generation. Dyadic programming such as SCCC may offer a practical way to interrupt cycles of dysfunction.

In order to more fully explore program impact in caregiver-child pairs and establish directions of effects, future work which assesses outcomes at multiple time points is needed. Longitudinal studies will help answer questions such as: Do increases in self-compassion of the caregiver decrease their parenting stress and improve ability to be more mindful in their parenting behaviors? Or perhaps the temporal order is reversed – with lower stress, the caregiver is able to be more self-compassionate, which then allows them to engage in more mindful parenting. This, in turn, has an effect on their child's emotional well-being, including the level of their child's depressive symptoms. Alternatively, it may be that an improvement in the child's depressive symptoms reduces the stress that the caregiver experiences, which then allows them to be more mindful in their parenting, which subsequently allows them to be more understanding and kind to themselves – in other words, more self-compassionate. Further examination using a longitudinal study design can help tease apart these issues and determine the temporal order of the various constructs (e.g., see Krieger et al., 2016).

Given the pilot nature of this work, this study has notable limitations. The small sample size and lack of a control group limits the degree to which conclusions can be made about the outcomes of the program. An active control group would clarify whether positive outcomes were due to self-compassion learning itself or other factors, such as the social support that results from dyads meeting together. In addition, the group was relatively homogenous, with the majority of caregivers identifying as female, White and highly educated, limiting the generalizability of these results. The dyads participating in the program were self-selected as they paid for the program and had access to the necessary technology. Given the 9 participants from the community organization received the program at a significantly reduced cost, this could be a source of bias. It is also unclear if programming would be similarly feasible and acceptable in other circumstances, including in families without financial or technology access. Future work should use recruitment methods that will increase the diversity of participants including caregiver type (e.g., fathers and other types of caregivers), race, ethnicity, cultural background, socioeconomic status, and life experience (e.g., exposure to adversities such as childhood trauma and poverty), as these factors can impact feasibility and acceptability of program content and the outcomes on participating families. Moreover, given qualitative findings suggested that some pairs experienced less benefit, future studies could examine child or family-level factors (such as child temperament, caregiver-child attachment, adversity) that may influence the willingness to engage in emotion-related program material, participate via an online platform, and determine intervention effects. Additionally, future studies should directly measure the child's emotional state, self-compassion, and obtain qualitative feedback from the child about the program. This would result in a more complete assessment of the child's experience of the program, including changes in their emotional wellbeing. Finally, use of the short form of the self-compassion scale limits the ability to look separately at individual components or compassionate/uncompassionate responding subscales (Raes et al., 2011), a process that is recommended by some researchers (e.g., Muris & Otgaar, 2020). Future work in this area could consider the simultaneous use of other validated compassion scales (e.g., Gilbert et al., 2017), and/or use of the full 26-item self-compassion scale with subfactor analysis techniques, to allow a more nuanced understanding of changes in self-compassion.

In conclusion, this multiple methods pilot study suggests the SCCC program is feasible, acceptable, and associated with significant benefits to caregivers and their school-aged children. The unique dyadic format may be particularly beneficial for children in middle childhood and may bolster the caregiver-child relationship and solidify important emotion-coping skills prior to the challenges of adolescence. Findings also suggest that the co-learning model may encourage a

broader family culture that values emotional communication, expression, acceptance, and self-care. In this way, caregiver-child self-compassion training *dually* supports children: by strengthening both their individual capacity for self-directed support and the relational support they receive from caregivers. Expanding work in this area—such as including more diverse populations, direct child measurements, and a control group—is promising and will offer further insight into how and for whom this program is most beneficial.

Author Contributions J.L.T. provided the intervention. K.B. completed quantitative data analysis. C.L. provided qualitative data analysis. All authors contributed to the manuscript writing and approved the final paper.

Conflicts of Interest J.L.T. is the developer and owner of the SCCC program, certified self-compassion instructor and receives income from this program. C.L. has been trained to teach the SCCC program. K.B. is a certified self-compassion instructor and receives income from teaching self-compassion classes and workshops.

Ethical Approval This study was reviewed by the UNC IRB and considered exempt.

Informed Consent All participants completed a consent process prior to providing any data.

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