28.6.2017

Feasibility of the intervention „Compassion as key to happiness, beyond stress and self-criticism“

Bachelor thesis Psychology

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Index

Abstract 2
Introduction 3
1.2 Compassion focused therapy 3
1.3 Feasibility of Compassion focused therapy 5
1.4 Current study 7
Methods 8
2.1 Study design 8
2.2 Participants and procedure 8
2.3 The intervention 10
2.4 Materials 11
2.5 Data Analyses 12
Results 14
3.1 Participants' perceptions of the intervention and e-mail guidance 14
3.2 Perceived changes throughout the intervention 15
3.3 Self-reported facilitators and barriers to intervention completion 16
3.3.1 Perceived facilitators 16
3.3.2 Perceived barriers 17
3.4 Suggestions for improvement 18
Discussion 19
4.1 Summary of the most important results 19
4.2 Key discussion points 20
4.3 Strong and weak points of the current study 22
4.4 Practical implications 23
4.5 Recommendations for further research & Conclusion 24
Appendix 27
References 31

Abstract

The current study is the first one to explore the feasibility of a self-help compassion focused therapy (CFT) intervention based on a large, recent randomized controlled trial. The intervention, "compassion as key to happiness, beyond stress and self-criticism", consisted of the eponymous book in combination with email guidance. The focus of the present research is 'acceptability', an aspect of feasibility that addresses individuals' perceptions of a given intervention. Data from the intervention group of the RCT was used, analysing the perceptions of 107 participants regarding overall satisfaction with the intervention, perceived changes through the intervention, facilitators and barriers to completion of the intervention and suggestions for future applications of the intervention. Results suggest that the intervention was generally perceived very positively. Especially the email guidance served as extra motivation for the completion of the intervention. However, some participants felt time pressure, as they were not able to try out all material present within the intervention. Other participants felt that they needed extra (digital) support, particularly for doing meditation exercises. In sum, for female, mostly high-educated and non-clinical participants, the intervention constituted an acceptable intervention for increasing compassion. In future research, it should be examined if similar acceptability is achieved in different populations, such as populations prone to psychological problems like the ones characterized by a low socio-economic status. Furthermore, options for a fully digitalized version of the intervention should be analysed in terms of feasibility as well. .

Introduction

´Positive psychology´ is one of the latest tendencies within the field of psychology that aims to examine the nature of psychological, social and emotional well-being and ultimately boost the quality of life of human individuals (Seligman & Csikszentimihalyi, 2000). Compassion is one of the frequent occurring constructs from positive psychology that is believed to play a key role in this process. Gilbert (2014) defines compassion as a sensitivity to the suffering of oneself and others combined with a commitment to prevent or alleviate suffering. Three different forms of compassion can be distinguished: Compassion we express towards other people, compassion we can receive from others and compassion we direct at ourselves, called self-compassion (Gilbert, 2014).

From an evolutionary perspective, scientists believe that compassion is a distinct emotional state, but neither do they refer to it as distress nor as sadness nor love (Haidt, 2003). For them, compassion can be evaluated within its evolutionary function: As every organism strives to survive, so do humans. In order for a human being to survive it is necessary that one knows where to obtain help from and how to defend against threats. Therefore, it is inevitable that human beings possess an inborn, motivational system that leads to the fulfilment of this necessity. Compassion results from this motivational system and is a mechanism that involves recognizing other individuals' needs and reacting to them in an appropriate manner in order to reduce suffering and increase survival chances (Gilbert, 2014).

1.2 Compassion focused therapy

Based on this evolutionary perspective, compassion focused therapy (CFT) was developed and can act on the three types of compassion outlined above (Gilbert, 2009). According to Gilbert (2010), humans possess three systems that regulate their emotions: The threat system, the drive system and the soothing system. Each of these systems elicits certain emotions which are the driving force in order for someone to fulfill the purpose of that emotion regulation system. The threat system aims to detect and protect from danger. Anger and anxiety are emotions regulated by the threat system in order to achieve that goal. The drive system motivates humans to seek resources, it activates feelings of 'wanting' or 'pursuing' something. The soothing

system elicits feelings of contentment, safety and trust in order to regulate distress and promote bonding (Gilbert, 2013).

In CFT, it is assumed that imbalanced emotion regulation systems cause reduced well-being (Gilbert, 2009). Individuals who participate in CFT undergo various methods that ultimately enable participants to learn about compassion aspects and develop compassion skills (Gilbert, 2010). Its ultimate goal is to enhance quality of life by reducing problematic patterns of cognitions and emotions related to e.g., anxiety, shame and self-criticism (Gilbert, 2009).

CFT makes use of a variety of techniques derived from cognitive behavioral therapy, for example identifying, tracking and evaluating safety strategies or techniques that promote balanced reasoning, and combines them with concepts from e.g. developmental psychology and social psychology (Gilbert, 2014). The key idea of CFT is to teach individuals several compassion attributes and skills (Gilbert, 2009). There are six compassion attributes and six compassion skills. The six compassion attributes are *care for well-being (for others), sensitivity*, *sympathy*, *distress tolerance*, *empathy* and *non-judgement* (Gilbert, 2009). The first attribute, care for well-being, is the general motivation of someone to aid another individual in need in coping with his or her perceived distress. The second attribute, sensitivity, which is the individuals' ability to detect and differentiate another persons' feelings and needs. The next attribute, sympathy, is the successful signalizing of emotional engagement with the individuals feelings of distress. Another attribute, distress tolerance, refers to the ability to endure high levels of emotion instead of feeling lost with them. Empathy is the attribute referring to the ability of taking someone's standpoint. It involves the actual understanding of another individual's perception and feelings. The last attribute is non-judgement, which means accepting the individuals' problems and difficulties as they are (Gilbert, 2009).

Next to the six attributes of compassion, Gilbert (2009) conceptualizes six skills of compassion: First, *compassionate attention* involves the ability to direct one's attention (from unpleasant thoughts or circumstances) to positive personal resources. *Compassionate reasoning* teaches how to refrain from one-sided reasoning to a more even reasoning. *Compassionate behavior* involves the ability to apply kindness and compassion to any activity, even if it is uncomfortable. *Compassionate imagery* enables people to create compassionate feelings for themselves, whereas *compassionate feeling* also includes being able to perceive compassion from other

individuals and giving compassion to other individuals. The last skill, *compassionate sensation*, relates to the ability to detect compassionate feelings within the body at the moment one displays compassionate behavior (Gilbert, 2009).

Practicing compassion has been shown to increase happiness and self-esteem (Mongrain, Chin & Shapira, 2010). Research on individuals who are self-compassionate shows that they tend to have a significantly better mental health in comparison to those individuals who are not self-compassionate. For example, self-compassionate individuals experience reduced levels of anxiety (Neff, Kirkpatrick & Rude, 2007) and perfectionism (Neff, Hseih & Dejitthirat, 2005) and greater optimism, positive affect and wisdom (Neff, Rude & Kirkpatrick, 2007). In their meta-analysis, Leaviss and Uttley (2014) analyzed the intervention outcomes of 14 CFT studies, three of which were randomized and controlled. They found that CFT is promising for the reduction of symptoms of a variety of mood disorders, especially those associated with high levels of self-criticism, such as depression and anxiety (Leaviss & Uttley, 2014). A more recent meta-analysis shows that CFT interventions are not only effective in the reductions of dysfunctional symptoms in clinical populations, but also in non-clinical populations (Kirby, 2016).

1.3 Feasibility of Compassion focused therapy

Although the effectiveness of CFT regarding the improvement of mental health is increasingly examined, feasibility studies and studies related to the subjective experience regarding CFT are barely available. Feasibility studies facilitate research progress and assure intervention suitability (Bowen, 2009). According to Bowen (2009), highly controlled studies, for example randomized controlled trials (RCTs), focus extremely on internal validity, which often results in neglecting external applicability. Internal validity is the degree to which a causation between two variables can be accurately demonstrated. Internal validity depends on three aspects: 1) the cause antecedes the effect; 2) cause and effect are related and 3) alternative explanations are ruled out (Anderson-Cook, 2005). Whereas internal validity especially concerns the causal relations within an experiment, feasibility studies focus on the “real world” application of interventions, taking into account the circumstances under which a particular intervention was conducted and therefore examine their external relevance (Bowen, 2009). There are 8 areas of focus in feasibility studies: Acceptability, demand, implementation, practicality, adaptation, integration,

expansion and limited-efficacy testing (Bowen, 2009). *Acceptability* concerns how individuals react to the intervention. This is also the focus in the current study, which examines the acceptability of a self-help CFT intervention. Acceptability studies can focus on the general satisfaction with the intervention, its appropriateness for the target group (that includes how suitable the target group perceives the intervention) and the intent to use the intervention in the future (Bowen, 2009). *Demand* examines in how far an intervention is needed by e.g. collecting data regarding the estimated use of the intervention or evaluating to what extent an actual intervention was used. *Implementation* describes to what extent the proposed intervention can be fully executed as intended, whereas *practicality* focuses on the delivery of the intervention when resources are limited. *Adaptation* deals with the flexibility of an intervention, its main concern is: Can the intervention be modified in order to fit it in a different environment? *Integration* studies examine to what extent an intervention fits into an existing infrastructure and how sustainable it is in it. *Expansion* analyzes in how far an already-successful intervention would be useful in another context. *Limited-efficacy testing* describes feasibility studies that explore interventions in a restricted manner. For example, 'limited-efficacy testing' studies may only focus on intermediate outcomes instead of final results (Bowen, 2009).

The feasibility of CFT has been examined in a number of studies mainly focusing on acceptability and demand. In a recent individual unguided self-help CFT intervention study with thirty-nine non-clinical Swiss participants, mostly female and highly educated, Krieger et al. (2016) show that time spent on the program significantly predicts the level of self-compassion and ultimately well-being after the intervention. In another feasibility study, seven British participants that all suffered from post-traumatic stress disorder and from which four completed a group CFT intervention and three an individual CFT intervention stated that the success in developing self-compassion is influenced by the relationship towards other group members and especially towards the therapist (Lawrance & Lee, 2013). Important aspects regarding the therapeutic relationship included feeling cherished and comprehended. Another feasibility study of an experimental one-session brief compassion focused imagery intervention based on a German sample with fifty-one psychotic participants revealed a positive non-significant trend regarding the perceived benefit of the intervention (Ascone et al., 2016). In a feasibility study executed by Heriot-Maitland et al. (2014), a British group of inpatients on an acute

mental health hospital found the topics addressed in the CFT intervention (i.e. compassion skills and compassion attributes) helpful (Heriot-Maitland et al., 2014).

1.4 Current study

Although a number of small-scale pilot studies examined aspects of feasibility of CFT interventions in different settings and populations, this is the first study to examine the feasibility of CFT in the context of a large randomized controlled trial (RCT) conducted in a real-life setting. As already mentioned, acceptability shall be the feasibility focus in the current study.

The CFT intervention to be evaluated on its feasibility consists of a self-help book combined with e-mail guidance by a counsellor. Its goal was to increase well-being in Dutch adults with low to moderate levels of well-being. The short-term and long-term effectiveness of this CFT intervention was investigated in a two-arm parallel RCT. Compared to a waitlist control group, that only received the self-help book and no email guidance after a waiting period of six months, the CFT group showed superior improvement on well-being and psychological distress (e.g., depressive/anxiety symptoms, stress, self-criticism), until six months after baseline (i.e. three month follow-up). At nine month follow-up, positive changes within the CFT group were either maintained or extended (Sommers-Spijkerman et al, under review).

However, the following question remains unanswered: To what extent did the participants perceive the CFT self-help intervention as an acceptable intervention for increasing their compassion? In order to answer this question the current research specifies four research questions that are linked to the three aspects of acceptability outlined above:

1) What are participants' perceptions of the intervention and the e-mail guidance provided?
2) What personal changes did participants experience throughout the intervention?
3) What are facilitators and barriers to completing the intervention according to the participants?
4) What suggestions do participants make in order to improve the CFT intervention in the future?

Methods

2.1 Study design

The current study analyzed data of a two-arm parallel RCT consisting of an intervention group and a waitlist control group. The experimental condition received the self-help course “Compassion as key to happiness, beyond stress and self-criticism” with weekly e-mail support.

Evaluation assessments regarding feasibility were made directly after the intervention (T1; 3 months after baseline). This assessment concerned only the intervention group, since the control group received the intervention not until 6 months after baseline (T2). Hence, only data from the intervention group was used to assess feasibility of the intervention in the current study.

The RCT from which data is analyzed in the current study got approval from the Faculty of Behavioral Sciences Ethics Committee and was registered in the Netherlands Trial Register (NTR5413).

2.2 Participants and procedure

Participants were recruited via a positively formulated advertisement in two national Dutch newspapers. The advertisement contained a link to the research webpage which comprised detailed information regarding the purpose and process of the study. On this webpage, people could sign up by filling out an online screening questionnaire that also contained an informed consent.

Inclusion criteria for the intervention were: 1) an age of 18 years or older; 2) low to moderate levels of well-being according to the Mental Health Continuum-Short Form (MHC-SF; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011); 3) access to the internet (either with tablet, laptop or computer), 4) possession of a valid e-mail address; 5) sufficient Dutch language proficiency and 6) informed consent, meaning that participants agreed to the nature of the intervention/study. Criteria that led to the exclusion of participants were: 1) flourishing, as indicated by the MHC-SF (Lamers et al., 2011); and 2) moderate to severe depressive and/or anxiety symptoms, indicated by a score > 11 on the depression or anxiety subscale of the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983).

Of 470 participants who initially completed the screening questionnaire on the research webpage, 216 were excluded, because of either insufficient Dutch language

proficiency (n = 1), incomplete screening data (n = 48), flourishing (n = 36) or due to scores higher than 11 on the HADS-A/D, indicating moderate to severe depression (n = 132). Furthermore, nine participants were excluded because of incomplete baseline assessments (n = 11). A total of 121 individuals were then allocated to the experimental group (CFT) and 122 to the waitlist control group (WCG). One hundred and seven participants from the intervention group answered the evaluation form to be analyzed in this study. They had a mean age of 52.78 years (*SD* = 9.87, range 20 – 78). All participants were Dutch. Most were female (80.4%), highly educated (84.2%), married (51.4%) and cohabited (62.6%). For more detailed information about the participants of the complete RCT see Sommers-Spijkerman et al. (under review)

Table 1.

Baseline characteristics of the participants that answered the evaluation sheet

	CFT (n = 107)
Age, years	
Mean (SD)	52.78 (9.87)
Range	20 – 78
Gender, n (%)	
Male	18 (19.6)
Female	89 (80.4)
Nationality, n (%)	
Dutch	107 (100)
Other	-
Marital status, n (%)	
Married/registered partnership	54 (51.4)
Not married (never married, divorced, widowed)	53 (48.6)
Living Situation	
With partner	67 (62.8)
Without partner	40 (37.2)
Education level (higher level completed), n (%)	
Low (primary school, lower vocational education)	4 (3.7)
Intermediate (secondary school, vocational education)	13 (12.1)
High (higher vocational education, university)	90 (84.2)

Note: CFT = Compassion focused therapy

2.3 The intervention

Participants within the experimental condition received the self-help book “Compassion as key to happiness, beyond stress and self-criticism” (Hulsbergen & Bohlmeijer, 2015) at their home address. The self-help course consisted of seven lessons that could be completed within seven weeks, although participants had nine weeks to complete it in sequential order. The lessons were: (1) self-criticism and self-compassion; (2) emotion systems; (3) developing kindness; (4) making use of resources for compassion; (5) addressing youth experiences; (6) changing circumstances and (7) compassion for others. The ultimate goal of the intervention was to aid participants in the cultivation of more self-compassion and well-being.

Each lesson consisted of psycho-educational information on an important aspect of compassion and several exercises. For example, one exercise consisted of actively perceiving the particular target of one’s self-criticism (What am I criticizing?), noticing its bodily effects and finally strengthening self-kindness. Another exercise, was aimed at creating a personal medium (a painting, a text, a photograph, or whatever suits the participant best) that expresses compassion and having participants looking at it frequently.

For every lesson, one core exercise was suggested, for lesson one till four also offered in the form of audio exercises via e-mail. Even though participants were encouraged to engage in different exercises, they could freely choose between whatever exercises they felt were appropriate given their current personal situation and decide how much time they would spend on each of these exercises. Participants within the intervention group received weekly e-mail guidance, in order to increase adherence and motivate participants to engage in daily compassion practice. Motivating through emails worked by positively reinforcing participants, answering questions about the information or exercises, advising participants about how to deal with upcoming difficulties and introducing next week’s lesson. Two graduated psychologists, two Master students Psychology and one PhD candidate trained and supervised by two experienced healthcare psychologists provided email guidance. A more detailed overview regarding the intervention content is summarized in Table 2.

Table 2.

Schematic overview of the CFT intervention

	Lesson	Compassion attribute	Compassion skill
1.	Chronic stress and the importance of compassion	Sensitivity	Compassionate sensation
2.	Emotion systems and their link to compassion	Care for well-being Sensitivity	Compassionate imagery Compassionate reasoning Compassionate sensation
3.	From self-criticism to self-kindness	Non-judgment	Compassionate attention Compassionate reasoning Compassionate feeling Compassionate sensation
4.	Identifying and using resources for compassion	Sensitivity Sympathy	Compassionate feeling Compassionate attention Compassionate reasoning
5.	Compassion for childhood experiences	Distress tolerance	Compassionate reasoning Compassionate imagery Compassionate feeling Compassionate sensation
6.	Addressing circumstances that contribute to chronic stress	Distress tolerance	Compassionate behaviour
7.	Compassion for others	Care for well-being Sensitivity Sympathy Empathy Non-judgment	Compassionate feeling Compassionate reasoning Compassionate behavior

2.4 Materials

In order to collect the necessary data from participants; an evaluation form was created that contained questions and statements regarding 1) satisfaction with the intervention and e-mail guidance, for example: “The course fit my personal wishes and needs”; 2) perceived changes throughout the intervention; 3) perceived facilitators and barriers regarding completion of the interventions and; 4) an invitation to make

suggestions for improving in the current intervention. Research question 1 was answered based on quantitative data, whereas research questions 2, 3 and 4 were answered based on qualitative data (open questions). The qualitative data was especially used to deepen the information extracted from the quantitative data of research question 1. The complete questionnaire can be found in the Appendix A.

2.5 Data Analyses

Since the present data involves both quantitative and qualitative data, a mixed-method analysis was used. In order to analyze the quantitative data, SPSS 24.0 was used. For questions to be rated on Likert scales, frequencies per question were calculated and summarized in tables.

For the qualitative data (4 open questions), an inductive content analysis was performed. Inductive content analysis is especially applicable to the present research, since it focuses on creating theory about the data instead of outlining an already existing phenomenon or theory. An inductive content analysis is a qualitative analyses technique that aims to transform a greater mass of audio or written material into smaller, more manageable data, usually by identifying recurring themes (codes) within the given data (Elo & Kyngäs, 2008). The analysis involves five steps, namely: 1) preparing the data, which usually means transcribing verbal information (if applicable); 2) defining the unit of analysis or deciding if code units should be individual themes or an actual present linguistic unit within the data (e.g., a word or a phrase that frequently arises); 3) developing categories and a coding scheme, that is categorizing the present data in categories and code units; 4) testing the coding scheme on a sample of text; and 5) coding the whole text (Zhang and Wildemuth, 2009). In the current research, these five steps were applied as follows: Step 1 consisted of ordering all answers participants gave relating to the particular question. Transcribing was not necessary, since all information was provided in written form. In step 2, the unit of analysis was defined, in this case individual themes. This made sense, since participants had different backgrounds and education levels and therefore, it was not expected that they would use the same words to describe the same phenomena (For example, some participants had more experience reading and writing texts and were therefore likely to have a broader vocabulary than others). Only in this case literal linguistic units could have made sense. The codes were then defined in step 3 by looking at the actual data (e.g. one code is called “positive perspective”).

Step 4 involves testing the codes on a sample of the data and step 5 applying it on the whole. However, since participants gave relatively short answers to each questions, the last steps were merged. One coder worked on coding the entire data. The way codes are presented in the Results section is in a descending order, beginning with the most frequent codes descending to the less frequent codes. To determine the frequency of a code, the number of quotes belonging to the particular code were count. An overview of all the codes can be found in the Appendix B.

Results

3.1 Participants' perceptions of the intervention and e-mail guidance

The overall grade assigned to the intervention by the participants was 7.7, indicating a positive attitude towards the intervention. Summarizing table 1 further specifies which parts of the intervention were evaluated positively (or negatively). The intervention generally fit participants' personal wishes and was also perceived as easy to follow. The e-mail support was also generally received well and was rated with an average grade of 7.3 by the participants Participants were most satisfied about the comprehensibility of the information and exercises.

Despite overall positive perception of the intervention, participants were less unanimous about the exercise difficulty. Although slightly more than half of the participants (53.2%) found the exercises easy to complete, 29.2% were neutral and 16.6% did not agree to the statement that the exercises were easy to complete.

Table 3

Frequency values of questions regarding personal experiences with the CFT intervention (n = 107)

	Strongly disagree n (%)	Disagree n (%)	Neither Disagree Nor Agree n (%)	Agree n (%)	Strongly Agree n (%)
The course fit my personal wishes and needs.	0 (0)	8 (7.5)	16 (15)	59 (55.1)	24 (22.4)
I found the course easy to follow	0 (0)	2 (1.9)	21 (19.6)	56 (52.2)	26 (24.3)
The course yielded new information for me.	5 (4.7)	8 (7.5)	17 (15.9)	56 (52.3)	21 (19.6%)
I could understand the information/exercises.	0 (0)	1 (0.9)	7 (6.5)	57 (53.3)	42 (39.3)
I found the exercises easy to complete.	0 (0)	18 (16.6)	32 (29.9)	47 (43.9)	10 (9.3)
I am happy with the amount of information and exercises I received	0 (0)	8 (7.5)	16 (15)	58 (54.2)	25 (23.4)
It felt good working with the book.	0 (0)	7 (6.5)	10 (9.3)	49 (45.8)	41 (38.3)

I thought: “This is something for me.”	1 (0.9)	8 (7.5)	19 (17.8)	53 (49.5)	26 (24.3)
The course gave me tools on how to increase my (self-)compassion and/or well-being	0 (0)	3 (2.8)	9 (8.4)	51 (47.7)	44 (41.1)
I found the email support useful	0 (0)	13 (12.1)	17 (15.9)	50 (46.7)	27 (25.2)
I found the email support helpful	0 (0)	9 (8.4)	25 (23.4)	50 (46.7)	23 (21.5)
I found the email support stimulating	2 (1.9)	9 (8.4)	19 (17.8)	48 (44.9)	29 (27.1)

With respect to the duration of the course, the data revealed that nearly a quarter perceived the intervention as too short (24.4%, *n* = 26) and the remaining 75.7% (*n* = 81) found the duration adequate.

3.2 Perceived changes throughout the intervention

Five recurring themes were most remarkable within the answers given to the question if and what changes participants did perceive. These themes are called *new activities and incorporated exercises*, *self-kindness*, *awareness*, *compassion for others* and *positive perspective*.

With new activities the current study refers to new habits participants adopted during or after the intervention. Participants mention specific activities, such as taking “more time to relax, riding the bike, reading, [fostering] social contacts”, doing volunteer work as, e.g., a nurse or listening (more) to music. However, most of the time participants made general statements as “I have become more active and take better care of myself”. Incorporated exercises is part of the theme, since it illustrates how participants incorporated the actual exercises learnt within the intervention into their daily lives. They frequently do breathing exercises, sit consciously or meditate.

With self-kindness we mean the ability to overcome the inner critic, or as one participant calls it, the “critical voice”. It is remarkable on how many different levels participants saw themselves as being able to deal with self-condemning thoughts after the intervention. One participant said that he goes to work with less stress, because he focuses on doing his best, which he evaluates as good enough even in the face of apparent failure. Another participant made significant progress in terms of accepting his emotions: “During my check-up, I received an anomalous cardiogram. That made

me anxious. Instead of judging myself for this, I cherished myself and explained to me that it is logical that there are these feelings.” The general attitude that one can retrieve from the all the statements is that participant’s judge themselves to a lesser extent.

Another frequent recurring theme within participants’ answers was *awareness*. Participants stressed that they have become more attentive regarding their emotions, thoughts, environment and body “I am more aware of the tension in my body and try to relax consciously.”

Compassion for others refers to kindness towards other people. Not only to strangers or acquaintances, but also to family members. As one participant states: “I have more compassion for my brothers and sisters.” Compassion for others does not only include the general increased sympathy for others, but also the performance of acts of kindness, as two participants frame it: “I approach the citizens I encounter at my workplace with more compassion. I try to make less assumptions, judge less and be open to the other”.

Positive perspective is a theme that represents a new acquired hope for the future. Many participants emphasize that at the end of the course they started to believe there is still a lot to gain from life in general. One statement summarizes this tendency as follows: “It switched from ‘I did everything I could’ to ‘There is a whole world to win’”.

3.3 Self-reported facilitators and barriers to intervention completion

3.3.1 Perceived facilitators

Four facilitating factors within the intervention were recognized by the participants: *Weekly duty*, *positive reinforcement of the counsellor*, *doing exercises*, and *writing reflective emails*. Weekly duty describes how participants cherished the weekly ‘obligation’ of writing a reflective email to their counsellor. Many participants perceived this as “een stok achter de deur” meaning that the frequent e-mail correspondence motivated them to complete the intervention: “I feel/felt responsible for completing the program for you [the intervention designers and tutors], but also for myself […]”.

Positive reinforcement of the counsellor portrays the general positive attitude regarding the supervisors and their support and does also show that support via email worked for the participants: “Receiving immediate feedback regarding personal reflections is especially stimulating […]”. That positive reinforcement made a significant difference is well illustrated within the following statement: “I found the support that I received valuable. Without support, I would have put the book on the pile”.

Doing exercises illustrates 1) participants’ general positive attitude regarding the execution of exercises, 2) happiness about the variation of exercises from which one could choose and 3) contentment regarding particular exercises. The general positive attitude regarding exercises is reflected in statements such as “I found doing exercises nice, since you kept it rolling this way”. A lot of participants praised the diversity and the associated advantages, as for example one participant stated that “you were free not to do all the exercises but only the ones you personally liked most or worked best for you”. Additionally, some participants explained which exercises exactly they perceived as helpful, for example meditation or positive visualization.

Writing reflective emails refers to the participants’ contentment about having the possibility to reflect more on their weekly experiences with the intervention, being able to put these experience in a context by writing an email to the particular counsellor: “Especially the writing and being focused on it worked well for me”.

3.3.2 Perceived barriers

Two intervention barriers were identified by the participants, namely: “Exercise difficulties” and “time pressure”. Exercise difficulties contains three major points: Firstly, some participants stated that many exercises did not fit their personal needs: “Some exercises stood too far away from me, which made completion more difficult for me”. Secondly, several participants found the implementation of meditation exercises hard: “Reading and doing exercises at the same time was difficult, if not impossible. Audio records work better for me”. Thirdly, the amount of new exercises participants received every week was sometimes perceived as overwhelming: “Since there were so many new exercises every week it was hard to choose from the ones I had already perceived as nice or useful and implement them in daily life”.

Another major intervention barrier reported by the participants was time pressure. A lot of participants found one week to complete a book chapter, including new exercises every week too short: “I noticed that at one point the course went too fast. I did not have enough time to process and implement everything […]”, “The pressure to keep going with the following chapter after just one week while I felt I needed more time to internalize the foregoing [was a barrier]”. Some participants suggested two weeks for every chapter. From these reported barriers follow several recommendations for improving the intervention, which are discussed in section 3.4

3.4 Suggestions for improvement

Three types of suggestions were made by the participants: *Extending course duration*, *extending digital media* and *tutor transparence and support depth*. The first two themes refer to the two major barriers pointed out by the participants. As indicated by a lot of participants, a longer course duration would have been preferred to be better able to internalize the exercises and the corresponding theoretical background. Most participants would prefer two weeks per topic, or at least a more flexible approach that enables participants to choose how much time they need for one topic. Also, some participants suggested that the intervention could be enhanced by using digital media besides the self-help book. The most recurring suggestion was making use of audio files, especially for meditation. Other suggestions regarding the use of digital media concerned implementing a website including a forum and making an app that always describes the current week goal and works as a reminder.

With regard to the counsellors, two types of suggestions were made. On the one hand, some participants wanted to know more about the counsellors with whom they had contact via mail: “It has to ‘click’ with the tutor. I did not really know with who I was communicating, which did not create a save space that enabled me to share things via mail”, “I would have preferred to read the CV from my tutor”. On the other hand, some participants stressed that the email support could have been more in depth. They actually wanted more challenge: “I missed some depth […], I did not feel that my problems (panic attacks) were really understood. The positive feedback was relatively excessive”, “I did not receive any ‘back chat’, no critique […]”. Other participants desired more frequent contact with the tutor.

Discussion

4.1 Summary of the most important results

The current study attempted to investigate the feasibility of a guided CFT self-help intervention called “compassion as key to happiness, beyond stress and self-criticism” (Hulbergen & Bohlmeijer, 2015). The intervention included a book and weekly email correspondence with a counsellor and took nine weeks in total. The focus of the current study was on ‘acceptability’, one out of eight feasibility facets that concerns individual reactions to a given intervention (Bowen et al., 2009). Four research questions guided the mixed-method analysis, asking for the overall impressions on the intervention, perceived changes through the intervention, perceived facilitators and barriers concerning the completion of the intervention and suggestions for improvement of the intervention.

Overall, the participants were satisfied with both the book and the email support. Results suggest participants developed more joy of living, more body and emotional awareness, integrated more compassionate behaviors in their daily life and increased their (self-)compassion. Furthermore, the course generally fit participants’ personal wishes and was also perceived as easy to follow. Participants perceived the weekly obligation of writing an email as stimulating, the writing process itself as positive reflection routine, the counsellor reinforcement as extra motivation and doing exercises as beneficial. According to the participants, all these aspects facilitated the intervention completion. However, participants also reported some barriers. Many participants found the meditation exercises difficult to complete, because of missing (digital) help, such as audio records. Time pressure was a second important barrier reported by the participants. Some stated that they were not able to try out and integrate (new) exercises the way they wanted it. When asked for suggestions, participants indicated that they would like to have more media that could aid them in the completion of particular exercises, such as meditation, more information about and more contact with the tutors and more time for the intervention lessons.

4.2 Key discussion points

As one of the most important results one can highlight the overall positive feedback on the email support. Not only did the email support facilitate the completion of the intervention, it also seemed to have created the necessary structural setup that was cherished by a large amount of participants. The positive perceptions concerning the email support matches multiple meta-analyses that show minimal contact with a counsellor through a medium (e.g. email or phone) can outperform self-help interventions without additional support (Cuijpers & Schuurmans, 2007; Hirai & Clum, 2006). The data did also contain evidence regarding a link between the intervention acceptability and the email support. Since many participants explicitly stated that they would not feel motivated to go through the intervention without the email support, one can assume that the email guidance played a core role in the overall intervention acceptability. Furthermore, it was remarkable that many participants cherished the intervention form (i.e. book and e-mail counselling) while at the same time remaining relatively silent in terms of the actual intervention content. This could be an indicator that participants especially wanted to be listened to, that they wanted somebody that takes their individual problems into account. This assumption would support the claim that the email guidance played a key role regarding the intervention acceptability.

Negative critique points concerned the missing digital media for meditation exercises and perceived time pressure. The first one and the suggestions involved (more digital media) reach out to a higher level of discussion, namely: In how far is e-mental health on its rise? Since participants stated that they wanted to have more digital support to be more successful with the exercises, one could expect that guided self-help e-health CFT interventions have a lot of potential. This expectation finds support in an earlier pilot study that examined the acceptability of practising compassionate imagery online in a non-clinical population (McEwan & Gilbert, 2015). Results suggested significant improvements on self-compassion and self-reassurance and reductions of e.g. depression and anxiety symptoms. It is the increasingly interconnected world, the greater use of technology, the demand for more cost-effective health care services and especially the greater need for flexible accessibility that make e-health services more and more attractive (Reguerio et al., 2016). Benefits of e-health services include greater accessibility, convenience, more

anonymity and a better cost-effectiveness ratio (Krieger et al., 2016). However, even with the apparent advantages of e-health it needs to address relevant challenges, such as the acceptability of e-health. Based on a large sample of 490 British, mostly female participants between the age of 18 and 78 Mursiat et al. (2014) found that most participants had unfavourable attitudes about e-health and reported that they were not likely to use it in the future. The most important factor was that participants doubted the effectiveness of computerized therapies in comparison to face-to-face interventions. These preconceptions even outweighed the common benefits of e-health, such as anonymity. As suggested by Musiat et al. (2014) and as logical consequence from the current research, it is important to create awareness regarding the evident effectiveness of e-health and the growing evidence regarding e-health as acceptable form of intervention. For online mindfulness meditation interventions in particular however, perceptions are more favourable. As indicated by Wahbeh, Svalina and Oken (2014) in their cross-sectional survey among 500 adults in the United States, participants preferred online formats for mindfulness meditation interventions above group formats.

The second critique point, perceived time pressure, actually expresses more about participants' disposition than the actual intervention reality. Participants did not have to complete one lesson in one week, they could spend more time on it if needed. Therefore, they were actually in charge of their own intervention speed. It is plausible that participants set a high, and therefore stressing standard for themselves (e.g., wanting to try out all possible exercises within one week), which could be interpreted as a mild form of perfectionism, a persons' attempt to achieve flawlessness and the tendency to set high performance standards usually in combination with both critical self-assessments and critical assessments regarding other individuals' performance (Flett & Hewitt, 2002). Although arguing about pathological perfectionism in some participants within the current study would be highly speculative, perfectionism in psychological therapies is not uncommon and can even lead to poorer treatment results (Shahar et al., 2003; Blatt et al., 1995). However, the presumed self-induced high performance pressure does not have to be of clinical nature. Participants that took part in the intervention were likely to have elevated levels of self-criticism. However, since the intervention addressed self-criticism effectively (Sommers-Spijkerman et al., under review), the statements about not being able to try out all exercises as intended should be related to the point in time when participants wanted

to try out all of them. In the beginning of the intervention, levels of self-criticism were still high and only decreased in the course of the intervention. From that follows that the aforementioned concerns regarding exercise difficulties are a reflection of how participants felt when trying out the exercises. Furthermore, one has to point out that although self-criticism is a risk factor for psychopathology, especially depression (Joorman & Berking, 2015), participants were screened before the intervention and high levels of depressive symptoms can be excluded as explanation. Another possible explanation for the perceived time pressure could be goal hierarchy conflicts. For example, if a particular goal (e.g., developing more self-kindness through meditation) competes with a different goal (e.g., wanting to cook healthy for ones' children after work) related to time, energy or finances, then clients are less likely to sustain it (Riediger & Freund, 2004). When addressing the time related critique point, it is important to note that while some participants were partly overwhelmed by the exercises, others enjoyed the broad variety of exercises from which they could choose. This is in accordance with the autonomy aspect of the self-determination theory (SDT). According to SDT, three basic needs are key factors in human motivation: Competence, autonomy and psychological relatedness (Ryan & Deci, 2000). Competence involves the perception of control over the outcome of one's actions. Autonomy includes the need to be the agent of one's life and actions. Relatedness refers to the need of being connected to others. However, while SDT argues that these three needs are universal, individual differences can result in need variances. Some people are motivated when they perceive more autonomy. For example, increasing participants' options and choices were shown to increase ones intrinsic motivation (Zuckermann et al,, 1978). However, if autonomy is not a need that has to be satisfied primarily, but, for example, competence, no more motivation would be the result of such a means.

4.3 Strong and weak points of the current study

The present study was the first to demonstrate participants' perceptions of the acceptability of a self-help guided CFT intervention in a large RCT. The findings suggest that CFT as guided self-help is an acceptable intervention for highly educated, mostly female non-clinical participants, who aim to increase their level of compassion. This constitutes a valuable addition to earlier findings of Krieger (2016), who studied the feasibility of an online CFT intervention in a population with similar

characteristics and found positive perceptions regarding the content of the intervention.

The strongest point of the current study is that it constitutes the first feasibility study of a CFT self-help intervention based on a larger sample size. Since one does not only want to know if an intervention is effective but also if the target group would perceive it as beneficial, the present study fills in a research gap that needed to be addressed. Furthermore, data was analysed using a mixed-methods approach, which greatest advantage is triangulation. By using both quantitative and qualitative data more validation is gained (Bodgen & Biklen, 2003). Since qualitative and quantitative data were consistent and complimented each other, using both sources led to stronger evidence regarding participants' real perceptions of the intervention.

A first limitation of the current study concerns the generalizability of the findings. Although the intervention yielded a diverse age range (20 - 78), all participants were Dutch, and around 80% female and highly educated. Based on the current findings, one cannot assume that the intervention would gain a similar level of acceptability in any population.

A second limitation concerns the coding procedure. As only one coder coded all data one could criticise the validity of the findings. However, since participants gave relatively short answers, often not even exceeding one sentence, it is less likely to misinterpret statements or put them in the wrong context.

4.4 Practical implications

The intervention achieved high acceptability in a non-clinical Dutch population characterized by mostly female and highly educated individuals. It is therefore advisable to confidently integrate self-help CFT interventions in the Dutch health care system as reliable means to increase the mental well-being of the aforementioned target population. However, not only should the Dutch health care system consider an implementation. As indicated by the pilot study of Krieger et al. (2016), also a Swiss population with similar characteristics to the Dutch population under analysis indicated high acceptability. Therefore, officials in other Western countries could also consider if a significant part of their populations, namely with the aforementioned characteristics, would benefit from a self-help CFT intervention.

However, when applying the intervention again, one has to take into account the three key discussion points that came up as a result of the analysis: The benefits of

email guidance, time pressure and participants' need for more digital media, especially audio records for meditation exercises. The first aspect is a confirmation that implementing an email guidance in "compassion as key to happiness, over with self-critique" was a fruitful decision and should be part of future applications of the intervention.

The second aspect is more complicated to address, since the reason for the perceived time pressure of some participants is not obvious. If the reason is clinical perfectionism, a professional psychological treatment seems to be the most reasonable option. If elevated, non-pathological levels of self-criticism is the reason, a more intense and personalized compassion focused training could be beneficial. If goal hierarchy conflicts are part of the problem, then helping clients examining barriers and facilitators of goals should be part of the intervention (Nowak, 2017). Additionally, Kruglanski et al. (2002) emphasize that when clients' goals have more than a single payoff, they tend to pursue them since doing so maximizes the result mobilizing the same effort (e.g., working on one's self-kindness has benefits for one's own mental state, while simultaneously improving relationships with family, friends and strangers). Emphasising that could motivate participants to make the extra time needed to try out the exercises they wanted. In the end, one could also extend the duration of the course if the resources are available.

The intervention should also take participants suggestions regarding digitalization into account. Of special interest were audio files for meditation exercises. Implementing an app with the appropriate media should eliminate future concerns about missing support while doing mediation in this CFT intervention.

4.5 Recommendations for further research & Conclusion

Data from a control group is available but has to be analysed in order to contextualize the acceptability of the intervention expressed by the participants. The control group did not receive weekly email guidance, but independently worked through the self-help book. A first suggestion is analysing how acceptable the non-guided version of the intervention is in order to compare both levels of acceptability and determine the distinctive nature of the email guidance.

The second suggestion is based on the fact that the intervention group was relatively homogenous regarding their nationality/cultural background. In order to examine the generalizability of the findings one could integrate another aspect of

feasibility into the research, namely ‘expansion’. Expansion examines in how far an already-successful intervention would be useful in another environment (Bowen, 2009). Since the intervention turned out to be feasible and successful regarding the improvement of mental health in the present intervention group (Sommers-Spijkermann, under review), examining ‘expansion’ would constitute a logical consequence based on the present findings. If it turns out to be useful in another setting, one can also study the acceptability and finally determine if the intervention seems generalizable. For example, another possible target group for the intervention would be individuals living in poverty, since poverty is associated with an elevated risk for psychological problems (Santiago et al., 2012). At this point it is important to highlight the importance of the email guidance again. If a highly educated population like in the current study evaluates the email guidance as apparently indispensable, a poorer and less educated population would probably need the support even more.

A further recommendation concerns another feature of the population in the current research. The population examined in the present study was non-clinical. It is not clear if the intervention would achieve a comparable acceptability in a clinical population. Determining in how far a clinical population would perceive the intervention as an acceptable form of support could be the task of future research.

A last suggestion deals with digitalization. Many participants were happy about the email support and even suggested new aspects of digital media one could implement to improve the intervention. A logical consequence could be analysing in how far the intervention would be effective regarding the improvement of self-compassion and whether it is feasible when offered completely digitalized. Online interventions have many benefits. Next to the general advantages of e-health systems, like accessibility, anonymity or convenience a whole new level of intervention could be realized, namely the possibility of creating an intervention based on persuasive technology. Toinen & Oinas-Kukkonen (2009) article, which gives a theoretical framework on how to create technology that persuades the user to acquire new attitudes and behaviours could serve as a guideline. A self-help CFT online intervention could also be distributed more cost-efficiently, because no physical material like a book would be necessary. The digital nature of the intervention would probably attract more people, because offering the intervention online could go hand in hand with online advertisement and other communicative means to create more awareness regarding the existence of the intervention.

The present study showed that a guided self-help CFT intervention can be an acceptable means in order to help non-clinical, highly educated females who struggle with elevated self-criticism and an overall lack of compassion. The task is now to examine in how far there is more evidence for the acceptability of the current intervention in other populations like individuals with a lower socio-economic status if further digitalization of the intervention would constitute a fruitful step in the development of the guided self-help CFT intervention.

Appendix

A

COMPLETE EVALUATION QUESTIONNAIRE

Socio-demographic charactersitcs

- Bent u een man of een vrouw?
  [] Man [] vrouw

- Wat is uw leeftijd in jaren?
  _____

- Wat is uw nationaliteit?
  [] Nederlands [] Anders, namelijk

- Nationaliteit anders
  _____

- Wat is uw burgerlijke staat?
  [] Getrouwd of geregistreerd partnerschap
  [] Gescheiden
  [] Weduwe/weduwnaar
  [] Nooit getrouwd geweest

- Wat is uw woonsituatie?
  [] Alleen
  [] Samenwonend met partner en kind(eren)
  [] Samenwonend met partner zonder kind(eren)
  [] Alleen met kind(eren)
  [] Bij ouders
  [] Met ander(en)

- Wat is de hoogste opleiding die u hebt afgerond?
  [] Geen opleiding afgerond
  [] Basisonderwijs, lagere school
  [] Lager beroepsonderwijs (LBO), huishoudschool
  [] VMBO, MAVO, (M)ULO, 3 jaar HAVO of VWO
  [] Middelbaar beroepsonderwijs (MBO), MTS, MEAO
  [] Hoger voortgezet onderwijs: HAVO, VWO, HBS, Atheneum, Gymnasium,
  [] Lyceum, MMS
  [] Hoger beroepsonderwijs (HBO), HTS, HEAO
  [] Wetenschappelijk onderwijs (Universiteit)
  [] Anders, namelijk

- Opleiding anders
  _____

Open questions

Welke verandering(en) heeft u bij uzelf opgemerkt sinds u met de zelfhulpcursus 'Zelfcompassie als sleutel tot geluk' bent gestart?

Wat waren bevorderende factoren bij het doorlopen van de zelfhulpcursus?

Wat waren belemmerende factoren bij het doorlopen van de zelfhulpcursus?

Heeft u suggesties voor het verbeteren van de zelfhulpcursus 'Zelfcompassie als sleutel tot geluk'?

Satisfaction with the intervention

De cursus sloot goed aan bij mijn persoonlijke wensen en behoeften.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

Ik vond de cursus prettig om te volgen.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

De cursus bevatte nieuwe informatie voor mij.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

Ik kon de informatie/oefeningen goed begrijpen.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

Ik vond de oefeningen gemakkelijk om te doen.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

Ik ben tevreden over de hoeveelheid informatie en oefeningen die ik gekregen heb.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

Het voelde goed om met het boek aan de slag te gaan.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

Ik dacht: "Dit gaat over mij"
[] Helemaal mee oneens [] mee onees [] noch me eens, noch me oneens. [] me eens [] helemaal me eens

De cursus gaf me handvatten voor het vergroten van mijn (zelf)compassie en/of welbevinden.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

Email support perceptions

Ik vond de e-mail begeleiding nuttig.
[] Helemaal mee oneens [] mee oneens [] noch mee eens, noch mee oneens. [] mee eens [] helemaal mee eens

Ik vond de e-mail begeleiding behulpzaam.
[] Helemaal mee oneens [] mee onees [] noch me eens, noch me oneens. [] me eens [] helemaal me eens

Ik vond de e-mail begeleiding stimulerend.
[] Helemaal mee oneens [] mee onees [] noch me eens, noch me oneens. [] me eens [] helemaal me eens

Overall grades assigned by participants

Welk rapportcijfer geeft u de cursus als geheel?

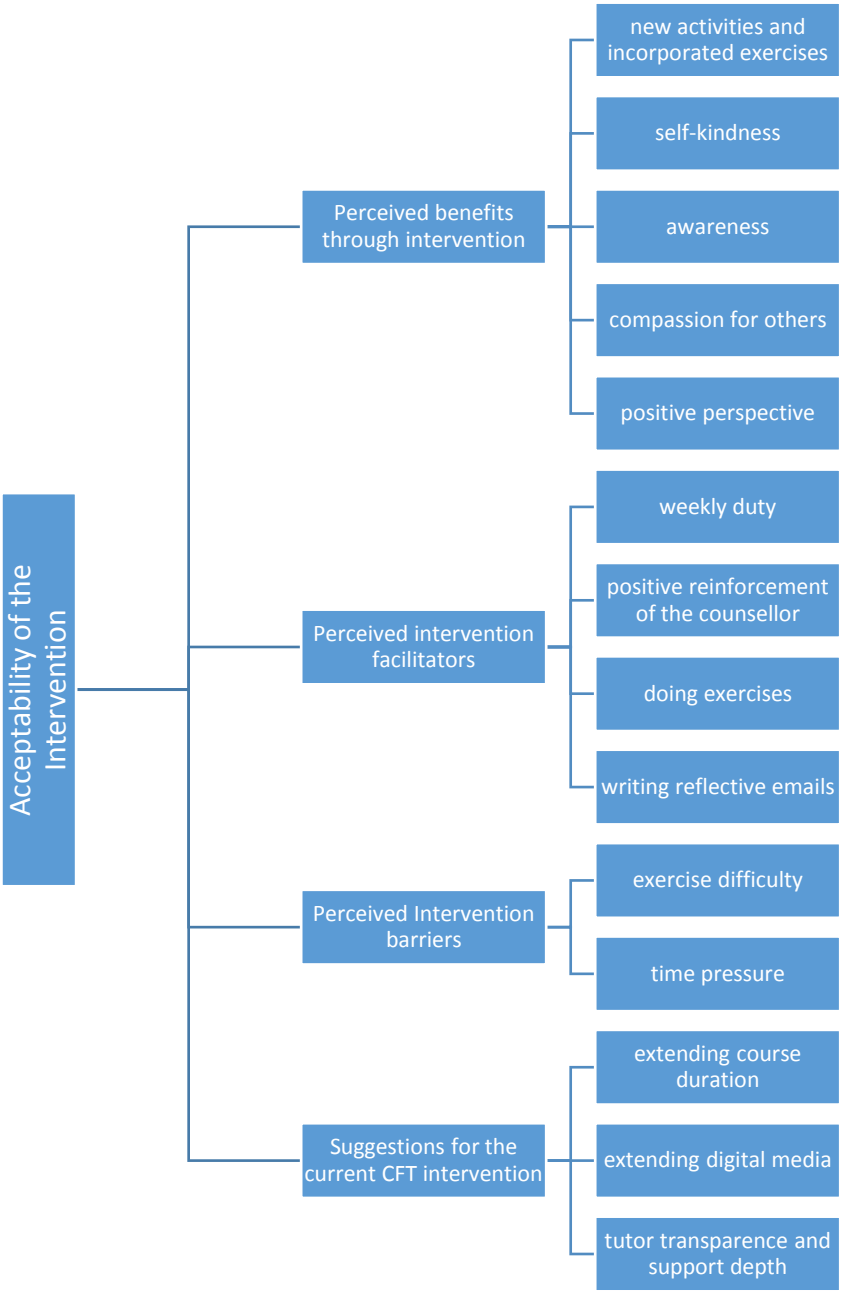
Welk rapportcijfer geeft u de e-mailbegeleiding door uw persoonlijk begeleider?

Extra

Wat vindt u van de duur van de cursus (7-9 weken)?
[] te kort [] precies goed [] te lang

B

COMPLETE CODE TREE



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