Internet Interventions 6 (2016) 64–70

Contents lists available at ScienceDirect

Internet Interventions

journal homepage: www.elsevier.com/locate/invent

Working on self-compassion online: A proof of concept and feasibility study

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ARTICLE INFO

Article history:
Received 5 August 2016
Received in revised form 28 September 2016
Accepted 2 October 2016
Available online 8 October 2016

Keywords:
Self-compassion
Self-criticism
Mindfulness
Online intervention

ABSTRACT

Objectives: Low self-compassion has repeatedly been associated with psychopathology. There are many promising face-to-face group format interventions focusing on self-compassion. We investigated the feasibility of an online self-compassion program.
Design: A feasibility and proof-of-concept study of an online adapted Mindfulness-based Compassionate Living (MBCL) program.
Participants: Self-referred participants suffering from harsh self-criticism (N = 39) were offered an online program and were asked to complete outcome measures at baseline, after 8 weeks (post-intervention) and after 14 weeks (follow-up).
Intervention: The online program consisted of seven sessions, including a first session introducing mindfulness and mindfulness meditation followed by a six-session adaptation of the MBCL program.
Primary and secondary outcome measures: The Self-Compassion Scale (SCS) was the primary outcome measure. Secondary outcome measures were the Forms of Self-criticizing/Attacking and Self-reassuring Scale (FSCRS), the Satisfaction with Life Scale (SWLS), the Comprehensive Inventory of Mindfulness Experience (CHIME), the Fear of Self-compassion (FSC), and the Perceived Stress Questionnaire (PSQ). Additionally, we assessed satisfaction with the program and negative effects related to the program. Furthermore, we used several measures of program usage (number of processed modules, number of logins, time spent in the program, number of diary entries, number of entries in completed exercises).
Results: Self-compassion, mindfulness, reassuring-self and satisfaction with life significantly increased whereas inadequate self, hated self, perceived stress and fear of self-compassion significantly decreased from pre- to the 8-week assessment. Results remained stable from post- to the 6-week follow-up. Pre-to-post within-effect sizes were medium to large (*ds* = 0.50–1.50) and comparable to those found within a face-to-face group format in a similar sample. Time spent in the program significantly predicted self-compassion at post.
Conclusions: The results of this pilot study are promising. However, they must be seen as preliminary since replication in a randomized controlled trial, with clinical measures/diagnoses and a longer follow-up period, is necessary.

1. Introduction

The general tendency to criticize oneself harshly and not treat oneself with compassion when facing personal failure or having a hard time has repeatedly been linked to psychopathology, such as depression, eating, bipolar, and social anxiety disorders (Krieger et al., 2013; Werner et al., 2011; Døssing et al., 2015; Blatt and Zuroff, 1992; Kelly et al., 2014; MacBeth and Gumley, 2012). Low levels of self-compassion and high levels of self-criticism have repeatedly been found to predict psychological symptoms in longitudinal studies (Krieger et al., 2016; Sbarra et al., 2012; Terry et al., 2013; Luyten et al., 2007; Dunkley et al., 2009). Furthermore, self-compassion has also been shown to be an important resilience factor and to be associated with more positive affect and well-being (Trompetter et al., 2016; Krieger et al., 2015; Neff and Vonk, 2009; Zessin et al., 2015).

In a comprehensive review, Hofmann et al. (2011) concluded that loving kindness meditation and compassion meditation may provide potentially useful strategies for targeting a variety of different psychological problems. During the last years, several specific loving kindness and self-compassion training programs have been developed and studied in clinical and non-clinical samples (Fredrickson et al., 2008; Jazaieri et al., 2012; Neff and Germer, 2012; Shahar et al., 2014b;

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http://dx.doi.org/10.1016/j.invent.2016.10.001

Wallmark et al., 2013; Pace et al., 2009; van den Brink and Koster, 2015; Gilbert and Irons, 2004; Gilbert and Procter, 2006). A recent meta-analysis came to the conclusion that kindness-based meditation showed evidence of benefits for the health of individuals in various samples through its effects on well-being and social interaction (Galante et al., 2014).

A recently developed compassion-focused training is Mindfulness-based Compassionate Living (MBCL; van den Brink and Koster, 2015). The MBCL program builds on established mindfulness skills and consists of eight thematic sessions and a silent session with guided meditations. MBCL integrates secular adaptations from traditional practices, such as loving kindness meditation, compassionate breathing and other interventions such as compassionate imagery and dealing with the *backdraft* phenomenon (Germer, 2009) and fear of compassion (Gilbert, 2010), within a theoretical framework of Gilbert's evolution-based theory of three primary affect regulating systems (Gilbert, 2010). Main components of the program are theoretical inputs, instructions for formal meditation practices, by the trainer during sessions and aided by audio-material during home practice, and guidance on informal practice and observational exercises in daily life. During sessions there is, like in basic mindfulness training programs, opportunity to further explore with the trainer what came up during exercises by means of mindful dialogue or inquiry. Recently, MBCL has been tested in an open trial in a mixed psychiatric outpatient sample ($n = 33$). All participants had followed a mindfulness-based stress reduction (MBSR) program or a mindfulness-based cognitive therapy (MBCT) program beforehand. Since the developers of MBCL recommend to have a grounding in mindfulness before undergoing MBCL. Results of this pilot study indicated that the program significantly reduced depressive symptoms and increased mindfulness and self-compassion (Bartels-Velthuis et al., 2016). Furthermore, there is a large trial underway comparing MBCL plus treatment-as-usual (TAU) versus TAU in recurrent depression (Schuling et al., 2016).

It can be assumed that people with increased levels of self-criticism and low self-compassion suffer from increased self-stigmatization and feelings of shame. Most of the programs that focus on self-compassion mentioned above are offered in a face-to-face group setting. However, a face-to-face and/or group setting may pose an important barrier and discourage people with low levels of self-compassion from seeking support in such programs. In support of this assumption, a recent review and meta-analysis showed that internalized stigma is significantly negatively associated with help-seeking behavior (Clement et al., 2015). Therefore, it seems essential to test a low-threshold intervention, such as an internet-based intervention, in order to offer people suffering from low self-compassion and high self-criticism the opportunity to work on these issues.

During the last decade, internet-based interventions have drawn significant attention and have shown efficacy in trials for several psychiatric disorders and related conditions and problems, such as perfectionism and procrastination (Andersson, 2016). Internet-based interventions have numerous advantages including greater accessibility, anonymity, convenience and cost-effectiveness. So far, there are several studies of online interventions targeting mindfulness, which have shown promising results (Glück and Maercker, 2011; Cavanagh et al., 2013; Krusche et al., 2013), further confirmed by recent meta-analyses (Cavanagh et al., 2014; Spijkerman et al., 2016). However, to the best of our knowledge, so far there is no study that has investigated the feasibility and the efficacy of a self-compassion online intervention program. Despite this lack of research in internet interventions for self-compassion, it is important to mention that there are promising results from studies testing shorter interventions focusing on self-compassion without contact to a therapist or coach (McEwan and Gilbert, 2015; Kelly et al., 2009; Shapira and Mongrain, 2010).

The main goal of the present study was to test the feasibility of an internet-based 7-week program for people suffering from low self-compassion and harsh self-criticism and its effect on a broad set of constructs in an open pilot trial. Furthermore, we wanted to investigate whether program usage was predictive for the outcome.

2. Methods

2.1. Recruitment and procedure

Participants who judged themselves as being too self-critical were recruited in Switzerland, Austria and Germany through a study website. After registration on the study website, individuals received an email with detailed information on the study procedure and an informed consent form and were invited to ask questions about the study by phone. The inclusion criteria were 1) a subjective feeling that one treats oneself too self-critically, and 2) being at least 18 years of age. Those who returned the signed consent form were asked to complete questionnaires and to provide demographic information online. Subsequently, participants received an account for the self-help program. The study was approved by the local Ethics Committee of the Faculty of Human Sciences at the University of Bern, Switzerland.

2.2. Participants

Out of 56 individuals who received the detailed study information, 39 participants returned the signed informed consent and filled out the questionnaires at baseline. Participants were on average 30.15 years of age ($SD = 9.30$; range: 18–57). Thirty-five participants (89.7%) were females. Of the sample 51.3% were single ($n = 20$), 46.1% were married or in a relationship ($n = 18$), and 2.6% were widowed ($n = 1$). Regarding highest education, 66.7% indicated 'university degree' ($n = 26$), 23.1% 'high school' ($n = 9$), 5.1% 'apprenticeship' ($n = 2$) and 5.1% 'compulsory school' ($n = 2$). We asked participants whether they had any experience regarding meditation, 56.4% ($n = 22$) indicated that they have some experience, 12.8% ($n = 5$) indicated that they regularly practice some kind of meditation, and 30.8% ($n = 12$) indicated that they have no experience at all with meditation.

2.3. Intervention

The intervention consists of a 7-week internet-based program that included an interactive self-help guide with text, audio files and a diary function. The program can be accessed on any computer and smartphone. We use SSL (Secure Sockets Layer) encryption to secure all internet-based communication, and participants are identified using anonymous login names and passwords. The program is interactive in the sense that participants can freely navigate through the web pages and repeat exercises and sessions whenever they want to.

The intervention was an adaption of the MBCL program by van den Brink and Koster (2015). Since the authors recommend previous experience with mindfulness meditation before doing MBCL, we created a first module that consisted of a text-based introduction into mindfulness and mindfulness meditation along with audio files for formal practice (available online and downloadable) and information on possibilities of informal practice. The next six modules are a shortened version of the MBCL program. Participants have to work through the program in a sequential order. Each module builds upon the previous one, and takes approximately 50 min to an hour to complete. Participants are asked to complete one module per week. Theoretically, all modules can be completed at once, thus, they were not gradually made available over the 7-weeks. However, apart from working through the lessons, participants are asked to repeat the exercises and to use the online diaries as often as possible. The intervention was unguided, but participants could receive guidance/assistance for the program from a psychologist on request. They were informed that the psychologist would respond within three working days.