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Exploring Perceptions of Self-Compassion in Individuals with Complex Trauma Symptomology: A Qualitative Approach

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Exploring Perceptions of Self-Compassion in Individuals with Complex Trauma Symptomology:

A Qualitative Approach

A Dissertation Presented to the Faculty
of the Department of Psychology
West Chester University
West Chester, Pennsylvania

In Partial Fulfillment of the Requirements for the
Degree of
Doctor of Psychology

By
Brooke Roseman, M.S.

May 2024

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Abstract

The aim of the present study sought to explore the perceptions of self-compassion through the perspectives of individuals who experience complex trauma symptomology and low rates of self-compassion to inform and enhance trauma treatment. Despite a growing accumulation of studies implicating self-compassion as an integral construct for alleviating symptoms associated with complex trauma, most research designs were quantitative and did not investigate the internal processes occurring within the individual. Based on this gap, the current study expanded the scope of the current literature to include a qualitative thematic analytic approach to better understand the nuances of how this population relates to self-compassion prior to, during, and immediately following a brief self-compassion based intervention. Four eligible participants engaged in this brief self-compassion based intervention that incorporated a psychoeducational and experiential component prior to completing a semi-structured interview regarding their experiences and impressions. Thematic analysis of the semi-structured interviews revealed six superordinate themes: 1) avoidance perceived as realistic coping skill, 2) inner conflict creates discrepancy, 3) increased insight, 4) discomfort when confronting avoidance, 5) self-compassion perceived as beneficial, and 6) persisting barriers to self-compassion. Consistent with pre-existing research, these findings corroborate that individuals with complex trauma symptomology simultaneously perceive both barriers to and benefits of practicing self-compassion. Clinical implications and recommendations for addressing this ambivalence while attuning to the specific needs of this population are discussed.
Dedication

You do not have to be good.
You do not have to walk on your knees
for a hundred miles through the desert repenting.
You only have to let the soft animal of your body
love what it loves.
Tell me about despair, yours, and I will tell you mine.
Meanwhile the world goes on.
Meanwhile the sun and the clear pebbles of the rain
are moving across the landscapes,
over the prairies and the deep trees,
the mountains and the rivers.
Meanwhile the wild geese, high in the clean blue air,
are heading home again.
Whoever you are, no matter how lonely,
the world offers itself to your imagination,
calls to you like the wild geese, harsh and exciting -
over and over announcing your place
in the family of things.
-Mary Oliver
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You are the best boys.
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Chapter 1: Introduction

Many individuals suffering from the effects of trauma carry histories that hold various traumatic experiences rather than just one occurrence. Survey studies show that 77% of people receiving mental health services for trauma-related symptoms survived more than one traumatic experience (Kessler, 2000) and, consequently, are at an increased risk for developing severe impairments beyond those outlined under the Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition) (DSM-5) description of Post-Traumatic Stress Disorder (PTSD) (Briere & Scott, 2015). This is to say that above and beyond the distress that accompanies the avoidance of trauma-related reminders and persistent states of hyperarousal, individuals exposed to multiple traumas tend to suffer from disturbances in various critical life domains that are not included as PTSD diagnostic criteria. These impairments include emotion dysregulation, somatic distress (such as abdominal pain and migraines), identity disturbances, and persistent interpersonal difficulties (Courtois & Ford, 2009). Research consistently demonstrates that endorsement of these additional symptoms is associated with multiple adverse outcomes, including but not limited to drug and alcohol abuse, depressive disorders, personality disorders, and suicide (Briere, Godbout, & Dias, 2015; Karam, Friedman, & Hill, 2014; Ouimette & Brown, 2003).

Given these findings, therapeutic interventions designed to treat trauma must address all forms of trauma-related distress in order to be fully effective. To date, the research devoted to developing and validating these interventions relies heavily on individuals who exclusively present with PTSD symptoms to the detriment of those who struggle with comorbid features (Gleiser, Ford, & Fosha, 2008). Many treatment studies intentionally exclude these individuals from participating as they tend to demonstrate significantly poorer outcomes in the form of high attrition rates and stable or worsening of symptoms post-treatment (Hembree et al., 2003). As the
field of psychology continues to move towards trauma-informed care, fine-tuning our understanding of how to best meet the needs of all individuals struggling with trauma-related distress is a top priority.

Exploring the role of self-compassion may be a promising gateway into designing more effective treatment plans that target not only the symptoms of PTSD, but also the features associated with exposure to multiple traumas (Maheux & Price, 2015; Valedez & Lily, 2016). A meta-analysis conducted by Winders and colleagues in 2020 accumulated consistent evidence demonstrating that self-compassion is significantly associated with decreased PTSD symptomology. Additionally, various studies found encouraging evidence supporting the notion that self-compassion is associated with improved emotional regulation (Badour & Feldner, 2013; Barlow et al., 2017), a greater sense of interpersonal connectiveness (Aspy & Proeve, 2017), and a more accurate perception of both the self and the world (Bensimon, 2017), all critical domains associated with exposure to multiple traumas. Despite these promising findings, it remains imperative to better understand why some individuals exposed to multiple traumas report higher rates of self-compassion than others. Before the field can begin answering this broad question, first and foremost, information regarding the experiences of the individuals who report both trauma-exposure as well as low rates of self-compassion must be gathered. The purpose of this study is to take the preliminary steps towards doing so by utilizing qualitative methods.

**Research Question 1:** How does an understudied population – individuals with complex trauma symptomology who also endorse low rates of self-compassion – typically relate to themselves?

The first goal of the present study is to identify and further understand individuals with complex trauma symptomology by selecting participants from a pool of trauma-exposed individuals who
meet diagnostic criteria associated with Complex Post-Traumatic Stress Disorder (CPTSD), a newly recognized diagnosis included in the 11th edition of the *International Classification of Diseases* (ICD-11: World Health Organization, 2018). In this edition, PTSD and CPTSD are differentiated by the variety of symptoms endorsed by an individual. In order to receive a diagnosis of CPTSD according to the ICD-11, an individual must exhibit symptomology in the following six domains: (1) avoidance, (2) hypervigilance, (3) re-experiencing, (4) affective dysregulation, (5) negative self-concept, and (6) interpersonal difficulties. By focusing exclusively on individuals who endorse symptomology indicative of CPTSD, this study will promote the field’s understanding of an understudied and underrepresented population. In addition, in order to further understand how this particular group experiences the concept of self-compassion, this study exclusively selected participants who scored low on the Self-Compassion Questionnaire, a validated and reliable measure of an individual’s self-compassion (Neff, 2003). Additionally, I implemented a demographic questionnaire during the screening portion of the recruitment process to help increase understanding of this identified population.

**Research Question 2: How do individuals with both complex trauma symptomology and low rates of self-compassion react to psychoeducation and a brief application of the concept of self-compassion?**

The second objective of this study is to examine how these identified individuals feel about the prospect of self-compassion in order to acquire an understanding of relevant barriers or benefits. A study conducted by Boykin and colleagues (2018) found that individuals exposed to childhood trauma reported greater fear associated with self-compassion as a result of not feeling “worthy” enough to engage in it themselves. This study highlights the need to explore in further detail the potential resistance and/or receptivity individuals with complex trauma symptomology may
report upon being taught an overview of the concept. Using semi-structured interviews following the self-compassion application, this study looked for common themes in participants’ responses and reactions that will provide a further understanding into various reasons for resistance and/or receptivity to the application of self-compassion.
Chapter 2: Literature Review

Defining Trauma

Defining trauma and identifying its resulting symptomatic profile continues to be a point of contention throughout the psychological literature. The lack of a clear consensus derives from the sheer complexity and nuance that inherently encompasses the multifaceted nature of the human experience. To clarify, in order to establish some understanding into both what qualifies as trauma and how a person experiences life as a result of the trauma, one must take into consideration the dynamic and continuously-evolving interplay between biological, psychological, environmental, societal, and historical factors (Kimberg & Wheeler, 2019). Although this endeavor may seem intuitive in theory, in practice, the standardized tools used for assessing and diagnosing trauma-related disorders neglects to truly capture the necessary depth in terms of understanding how an individual is potentially impacted by trauma (Galatzer-Levy & Bryant, 2013).

For example, one of the most common ways both clinicians and researchers identify trauma and trauma-related responses is by utilizing the diagnostic criteria laid out under Posttraumatic Stress Disorder (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) (*DSM-5*; American Psychiatric Association [APA], 2013). In order to receive a diagnosis of PTSD, an individual must meet Criteria A, which entails “exposure to actual or threatened death, serious injury, or sexual violence.” A notable consequence of only including a limited scope of events that are formally recognized as “traumatic” is that individuals who experience other events not included within Criteria A may also directly develop distress that impacts various life domains. Some examples of events that do not meet the *DSM-5* Criteria A definition, but are referred to as “traumatic” in other literature, include racism and ethnoviolence (Helms, Nicolas, & Green, 2012), various forms of developmental trauma
including ongoing parental misattunement (Howell, & Itzkowitz (2016), and bullying victimization (Idsoe, et al., 2021) amongst others.

In addition to the excluded traumas, the diagnostic criterion does not include chronic trauma or ongoing trauma. Important to note, these identified traumas, and others characterized by a more chronic, pervasive, interpersonal nature, are associated with an increased risk for later developing complex symptoms (Karatzias et al., 2019). Therefore, as noted previously, the listed symptoms outlined under the PTSD diagnostic category fail to capture the true range of impairments that accompany exposure to multiple traumas (Herman, 1992).

**Clinical Implications**

The implications of this insular view of trauma permeates beyond the research realm and into the clinical one. Much of the empirically-based interventions designed to treat trauma-related disorders derived their data from a reliance on the *DSM-IV* definition of trauma, which considered PTSD an anxiety disorder (Cloitre, 2015; Shnyder, 2005). In addition, many of these studies also excluded individuals with co-morbid conditions or accompanying “complexities” such as high rates of dissociation or emotion dysregulation, presumably in order to establish stronger internal validity (Gleiser, Ford, & Fosha, 2008; Hembree et al., 2003). Considering that a previous epidemiological survey indicates that around 80% of individuals meeting diagnostic criteria for PTSD also meet diagnostic criteria for at least one other psychiatric condition, comorbidity is the rule rather and the exception (Brady, 1997). Specifically, PTSD is associated with high rates of co-occurring depressive disorders, substance use disorder, and personality disorders (Pagura et al., 2010).

The fact that individuals with complex trauma symptomology have been historically underrepresented in the research studies designed to develop valid and reliable interventions for
the treatment of trauma remains an on-going limitation. (Cloitre, 2015; Gleiser, Ford, & Fosha, 2008). The effects of this oversight can be seen throughout the published treatment research studies for trauma-related disorders as high attrition rates and either stable or worsening of symptoms from pre to post-treatment (Gleiser, Ford, & Fosha, 2008). Further research dedicated to understanding the experiences of the individuals who are disproportionately more likely to either not be included in these studies or drop out prior to completion could result in more effective treatment strategies going forward.

**Complex Posttraumatic Stress Disorder (CPTSD)**

Because of these significant limitations, some researchers and clinicians argued in favor of including an additional diagnosis within the *DSM-5* that would more adequately capture the heterogeneity in symptom expression exhibited by individuals exposed to multiple, and usually more chronic, forms of trauma (Van der Kolk, 2017). The term Complex PTSD (CPTSD) became the nomenclature that encapsulated this distinct presentation, as it included the three domains of symptom impairment outlined under PTSD (1) re-experiencing of the trauma in the here and now (2) avoidance of traumatic reminders and (3) a persistent sense of current threat that is manifested by exaggerated startle and hypervigilance, as well as additional symptom clusters as well. The World Health Organization (WHO, 2018) considers these additional symptom clusters as impairments in the following three domains (1) emotion dysregulation (2) negative self-concept and (3) interpersonal difficulties. These symptoms are associated with multiple adverse outcomes, including but not limited to: drug and alcohol abuse, depressive disorders, personality disorders, and suicide (Briere, Godbout, & Dias, 2015; Karam, Friedman, & Hill, 2014; Ouimette & Brown, 2003).
Due to the growing push and accumulation of data supporting a need for a more fitting diagnosis for individuals expressing distress beyond what is captured in the *DSM-5*, the WHO added Complex Post-Traumatic Stress Disorder (CPTSD) in their most recent edition of the *Classification of Diseases (ICD-11)* to formally recognize a separate trauma-related disorder that accounts for all six of the aforementioned domains. With the formal acknowledgement of CPTSD as a diagnosable disorder, the call to develop appropriate treatment interventions is louder than arguably ever before (Karatzias et al., 2019). Given that *ICD-11 CPTSD* is a newly recognized condition, much more research must be conducted before evidence can accrue regarding best interventions (Karatzias et al., 2019). In order to begin to fill this gap in the literature, efforts must be put towards determining not only what works for the three traditional PTSD symptom clusters, but also for the additional symptom clusters as well.

**Self-Compassion**

Within the previous decade, an increasing number of clinicians have moved towards “third wave” cognitive behavioral therapies for treating psychopathology. While differences exist across the kind of therapies categorized under this umbrella term, they all strive to facilitate change to individual’s relationship to their current problems (Gilbert, 2010; Hayes, Strosahl, & Wilson, 1999; Segal, Williams & Teasdale, 2002). In particular, one method that may be especially beneficial to trauma survivors is by engaging in a more compassionate attitude towards one’s self (i.e., self-compassion). Neff describes self-compassion as a self-reflective process that entails several subcomponents: (a) self-kindness, defined as extending warmth and understanding to oneself rather than harsh criticism or self-judgement; (b) common humanity, defined as seeing one’s experiences as part of the larger human experience rather than as separating and isolating; and (c) mindfulness, defined as holding one’s painful thoughts and
feelings in balanced awareness rather than overidentifying or avoiding them (Neff, 2003b; Neff, Hsich, & Dejitterat, 2005). Engagement in self-compassion is especially critical during times of suffering, which is considered an inevitable part of life (Germer & Neff, 2015).

**Self-Compassion Research for PTSD**

Much of the previous research looking into self-compassion as it relates to PTSD symptom severity shows negative correlations, with higher rates of self-reported self-compassion associated with lower rates of PTSD symptom severity (Barlow, Turow, & Gerhart, 2017; Maheux & Price, 2015; Thompson & Waltz, 2008). In fact, a very recent meta-analysis conducted by Winders and colleagues (2020) found consistent evidence across the included studies demonstrating that higher rates of self-compassion were negatively associated with PTSD symptomology. These findings make intuitive sense, as avoidance (a hallmark of PTSD) and self-compassion are theoretically incompatible; self-compassion encourages an acceptance of both unwanted thoughts and feelings, albeit held with a gentleness that prevents one from becoming overwhelmed (Neff et al., 2007). Another explanation of these findings derives from the previous research showing that PTSD symptom severity is negatively associated with emotion regulation, defined as the ability to identify, understand, accept, and manage emotions (Badour & Feldner, 2013; Scoglio et al., 2018). In numerous studies, self-compassion was also shown to be positively associated with measures of emotion regulation (Scoglio et al., 2018), a coping skill thought to be disrupted as a result of trauma.

**Self-Compassion research for CPTSD**

Due to the particular ways in which self-compassion appears to relate to PTSD, recently, researchers have speculated whether self-compassion may also be implicated as an important factor associated with CPTSD (Karatzias et al., 2019). Although there is currently a dearth in the
literature exploring self-compassion at it relates to CPTSD, a recent study did look at how the components of self-compassion relate to the components of CPTSD as it is defined in accordance with the *ICD*-11 definition. By comparing self-report measures of both self-compassion and *ICD*-11 CPTSD symptoms, results revealed that self-compassion was exclusively related to emotion dysregulation, negative self-concept, and dysfunctional relationships (Karatzias et al., 2019). In other words, statistical analysis found significant associations between rates of self-compassion and the symptom clusters associated with CPTSD, but not those associated with the *ICD*-11 criteria for PTSD. As it appears, self-compassion uniquely relates to the symptoms experienced by individuals diagnosed with CPTSD, which constitutes rationale for focusing on this concept as a potential component of trauma treatment for this particular group.

These findings provide additional evidence that support the findings derived from earlier research into this area of interest. Prior research into self-compassion and CPTSD symptom domains concluded that rates of self-compassion were positively associated with both interpersonal connectiveness (Aspy & Proeve, 2017) and a more accurate perception of oneself and the world (Bensimon, 2017). Taken together, these findings support the notion that self-compassion may be an area of interest in terms of developing interventions designed to meet the needs of individuals struggling as a result of exposure to multiple traumas.

**Compassion-Based Interventions**

Perhaps, in part, due to the sheer volume of accumulating evidence demonstrating correlations between self-compassion and symptom severity post-trauma exposure, interventions designed to promote one’s engagement with compassion/self-compassion have more recently been delivered to trauma-exposed populations in various treatment research studies. The meta-analysis conducted by Winders and colleagues (2020) identified eleven total intervention studies...
that utilized a Compassion-Based Intervention (CBI) in at least part of the total treatment intervention for individuals with trauma symptoms. CBIs are defined broadly in the literature as interventions designed to cultivate compassion (Kirby, Tellegen, & Steindl, 2017), a somewhat similar concept to self-compassion and that is defined variably across different theorists as either an emotion (Goetz et al., 2010), a multidimensional construct (Strauss et al., 2016), or a motivational system (Gilbert, 2014). Despite the subtle variations in the definition of compassion, they all share commonality by acknowledging the necessary role of both recognizing instances of suffering and then subsequently desiring to alleviate that suffering. Just as various definitions of compassion exist across the literature, various forms of interventions classified as CBI exist as well, at least six in total (Kirby, 2016).

Of the many variations that subsist within the nomenclature of CBI, the most commonly-cited implemented intervention is called Mindful Self-Compassion (MSC; Neff & Germer, 2013). This empirically-supported CBI also most closely resembles the teachings and underpinnings that embody Neff’s conceptualization of self-compassion. It is due to these two observations that I selected MSC, over the other CBIs, to derive my current research study. MSC is typically designed as an eight-week resource-building course, and prioritizes teaching general skills for cultivating self-compassion. Another significant component of MSC is providing psychoeducation about what the concept of self-compassion is (and is not) as well as the noted benefits individuals can directly derive from the process of engaging with it (Neff & Germer, 2013). MSC consists of both formal and informal practices and was developed to benefit both a clinical and non-clinical population (Neff & Germer, 2013). Formal practices include any activity in which an individual intentionally sets aside a specific block of time for practice engagement. More often than not, formal practices take the form of a guided or self-led meditation. Informal
practices, on the other hand, differ from formal practice in the sense that individuals partake in these activities as part of their daily lives (Neff & Germer, 2018). Instead of blocking off a specific duration of time to practice, individuals integrate the practice into whatever activity they were already engaging in. In a sense, the practice moves beyond simply existing as a separate activity and becomes a part of “who you are.”

An example of a guided meditation includes “Affectionate Breathing” (Neff & Germer, 2018), which individuals can engage in either on their own or by following a provided audio recording. During the Affectionate Breathing exercise, individuals connect with the sensations of their breath. They are invited to incorporate a “soothing touch”, such as placing a hand over the heart, and allowing themselves to feel soothed by the experience of noticing the breath in the body. As thoughts come up, individuals are reminded that minds can be “like a curious child or a little puppy” and are encouraged to gently bring their attention back to the rhythm of their breath. Notably, individuals are also explicitly encouraged to allow themselves to be “just as they are.”

In terms of the previously mentioned informal practice, one example includes an activity referred to as “compassionate self-talk.” During this informal practice, individuals reframe their self-critical judgments into statements that embody any or all of the three elements of self-compassion. For example, a woman may have the thought “I am a horrible mother.” To engage in the act of compassionate self-talk, the woman would first become aware of the fact that she is having a self-critical thought. Following this self-awareness, she would then try to soften this self-critical thought by saying to herself something along the lines of “I know that this thought’s intention is to help me, not hurt me. I am feeling hurt by it nonetheless. I would like to give voice to a more self-compassionate thought.” The final step is to rephrase the self-critical thought to allow space for more friendliness and care, which can be accomplished by imagining what one
would say to a good friend in the same situation. By the end of this practice, the woman may be able to think a more positive thought dialogue such as “I am feeling guilty, because I spoke to my son harsher than I intended to (mindfulness). I am sure many other parents have spoken to their children in a way they regret and have felt the way that I am feeling now (common humanity). May I allow myself forgiveness and kindness as I work towards making amends (self-kindness).

For the purpose of the current study, I chose to implement one of MSC’s informal practices entitled the “Self-Compassion Break.” This practice is generally covered in the first session of the eight-week course as it both applies and explains the three components of self-compassion within the context of the participants’ lives (Germer & Neff, 2019). My decision to include this particular practice also derived from my intention to recruit individuals with both complex trauma symptomology as well as low rates of self-compassion, which may make up a population of individuals who are more susceptible to experiencing a phenomenon called “backdraft.” Back-draft is explained as the distress that can arise when an individual experiences unconditional love, because it can remind one of the times when unconditional love was not given (Germer & Neff, 2019). Due to ethical and moral considerations, keeping my study’s “intervention” portion to solely the Self-Compassion Break can better ensure that participants are less likely to experience back-draft, which is covered within the MSC course only after delving deeper into more emotionally-charged practices (Germer & Neff, 2019).

Effectiveness of Compassion-Based Interventions for Trauma Symptoms

Of the eleven studies analyzed by Winders and colleagues (2020) that incorporated CBIs in at least part of the treatment intervention for trauma symptoms, only six of them examined the effectiveness of CBIs as the predominant treatment model. Of the six studies, three found
significant reductions in PTSD symptoms (Au, 2016; Kearney et al., 2013; Lang et al., 2017),
three found significant reductions in trauma-related guilt and shame (Au, 2016; Kearny et al,
2013; Lang et al., 2017; Muller-Engelmann et al., 2018) and all but one (Lang et al., 2017)
showed significant increases in self-compassion. This particular study incorporated the CBI
called Cognitively Based Compassion Training (CBCT; Negi, 2013), which was predominantly
focused on cultivating compassion directed towards others as opposed to towards the self.

All in all, despite these promising findings, there existed various limitations inherent to
each of the included studies and, thus, should be aptly recognized. First, the majority of the
studies included in the meta-analysis were described as feasibility studies and were likely
underpowered due to the small sample sizes. Additionally, the immense variation across each
study’s incorporated usage of the umbrella term “CBI” makes it difficult to discern which
properties and components from the selected interventions could be considered the causal
processes of change for the demonstrated results. Another noted limitation includes the under-
representation of participant-reported trauma exposure of more chronic natures, namely
emotional abuse and systematic racism. As previously mentioned, these forms of trauma are
more likely to contribute to an individual later developing symptoms of CPTSD rather than
PTSD (Karatzias et al., 2019). Ultimately, although these findings underscore the potential of
self-compassion as a key factor relevant to post-trauma exposure outcomes, these inconclusive
findings demand a call for more information.

Gaps in the Literature

As promising as the aforementioned findings are in terms of identifying an alternative
gateway into designing more effective trauma interventions, gaps in the literature still remain
with many conclusions necessitating further inquiry. These prior studies all highlight the notion
that, if individuals are able to engage in self-compassion, then they are more likely to experience positive outcomes post-trauma exposure. What remains to be understood is why some individuals with a trauma history are able to engage in self-compassion more easily than others, even when administered an intervention designed to cultivate it. The meta-analysis conducted by Winders and colleagues (2020) found that Compassion-Based Interventions (CBIs) led to improvements in psychological functioning in only a portion of the included studies. Keeping in mind the noted limitations discussed in the prior section, these mixed results may indicate that possible barriers preventing engagement in self-compassion not only exist for some individuals, but that these barriers are not being adequately addressed in the delivery of the current CBIs. An alternative explanation postulates that a direct focus on self-compassion is not a required process of change for helping select individuals heal from trauma. Without more information, attempting to answer these questions is not plausible.

The current gaps in the literature highlight the fact that, as a field, we still are unsure of how to both accurately, and appropriately, meet the needs of all individuals who have experienced trauma. Although interventions incorporating self-compassion within their treatment model appear promising, a lack of understanding around how to deliver these interventions to individuals who have difficulty building their self-compassion hinders the field’s overall ability to more effectively treat trauma. Because many of these studies exclusively looked at intervention outcome data, a deeper look into the lived experiences of these particular individuals may provide some of the missing information vital for developing and delivering effective trauma-informed CBIs for individuals with complex trauma symptomology.
Current Study

This study aimed to address these gaps in the literature by taking the foundational steps towards providing more information regarding the unique experiences of individuals who endorse both complex trauma-related symptomology and also low rates of self-compassion. In order to further understand how these individuals perceive and react to the topic of self-compassion, I utilized a qualitative-based methodology to better understand what barriers and/or benefits may be specifically associated with engagement in self-compassion. By virtue of its design, qualitative research is useful for identifying common themes in the responses of the selected individuals, which inform both treatment planning as well as treatment delivery (Chapman & Smith, 2002). Although the recent addition of literature looking into the role of self-compassion within trauma-exposed individuals provides evidence that suggests that self-compassion may serve a key factor implicated in fostering recovery, much more research needs to be done to inform the effective ways to incorporate it into treatment interventions.
Chapter 3: Methodology

Participant Recruitment

Participants recruited for the study were composed of individuals from a clinical population of trauma-exposed adults at least 18 years of age or older residing in Northeast United States. To qualify for the study, potential participants must have reported experiencing at least one traumatic event during their lifetime in addition to currently endorsing symptomology of complex trauma. Identification of the latter was established using the diagnostic criteria for CPTSD outlined in the International Trauma Questionnaire (ITQ: Cloitre et al., 2018) as a screening measure during recruitment. There was no requirement as to how long ago the traumatic event had to have occurred. All eligible participants must have indicated that they were fluent in English, but English did not need to be their native language. Exclusionary criteria consisted of self-reported prior, formal experience with self-compassion-based interventions as well as any individuals who were not currently, actively engaged in therapy.

The study initially aimed to recruit four participants using purposive sampling of outpatient adults who possess two specific targeted characteristics of interest: trauma symptoms associated with the ICD-11 definition of CPTSD and low self-reported self-compassion. The sample size was based upon three considerations: outreach challenges, data analysis manageability, and clinical sensitivity. Outreach challenges were anticipated not only due to the indirect nature of participant recruitment via clinical referrals and passive advertisements, but also due to limited likelihood of co-occurrence of the two targeted characteristics: there are limits on the incidence of trauma in the targeted outpatient clinical population (estimated at 20.5% in da Silva et al., 2019). To keep data analysis manageable, given the complexity of qualitative thematic analysis, limiting the number of participants enabled me to provide sufficient attention
to each in-depth interview while exploring themes both within and across interviews. Finally, given the clinical sensitivity of the population and subject matter, ethical considerations required me to limit my sample size to ensure that I have sufficient resources and time to carefully attend to and debrief all participants.

Recruitment of potential participants was accomplished remotely due to the health and safety considerations associated with the effects of the COVID-19 global pandemic. Considering the specificity of the participants I was interested in including in my study, I used a multi-phase recruitment process to ensure these characteristics were met. First, I forwarded two documents to the student clinicians and therapists providing teletherapy to clients at the West Chester Community Mental Health Service (CMHS): 1) a letter outlining participant eligibility criteria along with my study’s general procedures (see Appendix A), and 2) a flyer that the student clinicians could send to the clients they felt would be an appropriate match for my study (see Appendix B). These flyers included my email address, as well as my dissertation chair’s email address, as a way for individuals to communicate interest in potentially participating in the study. Recruiting in this manner sought to ensure that the participants were currently meeting with a therapist and were actively engaged in therapy.

Due to lack of response resulting from these aforementioned recruitment efforts, I transitioned to recruiting potential participants currently taking PSY100 *Introduction to Psychology* and PSY120 *Multicultural Psychology* classes. Prior to enacting this switch, IRB approval was re-granted (See Appendix C) after a scheduled meeting that explained how the updated population pool shared essential characteristics to the previous pool. This decision decidedly limited the diversity of certain demographics from potentially being included in the
study, but ultimately served to reach out directly to interested individuals as opposed to indirectly, and thus more reliably.

Recruitment of Psychology undergraduate students entailed two general phases. The first phase involved listing the combined screening surveys (see Measures Section and Appendices E, F, & G for full list) as an optional study onto the online server, Sona Systems, which PSY100 Introduction to Psychology and PSY120 Multicultural Psychology students are directed to when selecting which research study they would like to participate in for course credit. This phase of recruitment entailed administering the surveys via the software program Qualtrics (Qualtrics, Provo, Ut). The screening survey process could be accomplished from any device connected to Wi-Fi. Should they choose to provide informed consent (See Appendix D), they were then instructed to continue through the rest of the surveys by first indicating whether they were currently engaged in therapy or not. If a participant selected “no” in response to this question item, they were directed to the end of the survey and automatically received course credit. Participants who answered “yes” (i.e., met one of the inclusionary criteria) proceeded to provide basic information related to demographics (age, race, gender, etc.) then completed the various screening measures. The goal at this stage in the study was to identify individuals who rate low in self-compassion and indicate symptomology of CPTSD. A total of 310 responses to the screening surveys were received between November 2021 and November 2022.

Upon completing the measures, the participants were provided the numbers for Public Safety (610-436-3311) and the National Suicide Prevention Hotline (1-800-273-8255) in case of any psychological emergency (See Appendix H). They were given the option to supply their email if interested in participating in the second phase of the study, which consisted of the in-person interview and the “Self-Compassion Break.” They were also informed that, if invited,
they would receive a scheduling email from me to set up a date and time to meet. This email verified that each participant was still interested and re-informed them that financial compensation would be provided upon each participant’s completion of this portion study in the form of a $20 VISA gift card (See Appendix I). Participants who provided their email to communicate interest in participating in phase two, in addition to meeting the study’s inclusionary criteria per their survey results, were reached out to on a rolling basis. Decision-making regarding the selection of participants for phase two was determined by who responded back to the email. Once four participants completed phase two of the study, recruitment for phase two ceased.

**Measures**

*International Trauma Questionnaire*

The International Trauma Questionnaire (ITQ: Cloitre et al., 2018) is an 18-item self-report questionnaire that is used for diagnosing PTSD and CPTSD according to the guiding principles of the *International Classification of Diseases* (ICD-11: World Health Organization, 2018) following exposure to traumatic events as defined by both the CTQ and the LEC (See Appendix F). In this study, the ITQ was used to identify individuals exhibiting symptoms of CPTSD, rather than as a diagnostic tool; however, I used the same scoring procedure to determine the presence of complex trauma symptomology as it is used for formal diagnoses. Twelve of the 18 items measure the core PTSD symptoms clusters: 1) Avoidance (Av), 2) Hypervigilance (Th), and 3) Re-experiencing (RE). The remaining 6 items measure the additional symptoms associated with CPTSD: 1) Affective Dysregulation (AD), 2) Negative Self-Concept (NSC), and 3) Interpersonal Difficulties (DR). The respondents answer each PTSD item by how much they have been bothered by the symptom over the past month and each
CPTSD item in terms how they typically feel and think about themselves as well as how they typically relate to other people using a 5-point Likert scale from 0 “Not at all” to 4 “Extremely.” In order to meet diagnostic criteria for PTSD, an individual must endorse at least one of the two items from each of the three core symptoms cluster. An item endorsement is determined by a score of 2 or higher. In order to meet diagnostic criteria for CPTSD, an individual must already meet diagnostic criteria for PTSD, on top of an endorsement of one item from each of the additional three symptom domains. This measure has been validated in various studies (Hyland et al., 2017; Karatzias et al., 2016; Karatzias et al., 2017) and demonstrates internal reliability for the PTSD items and for the CPTSD items (Karatzias et al., 2019).

*The Self-Compassion Scale*

This study used the Self-Compassion Scale (SCS: Neff, 2003b), a 26-item self-report measure assessing an individual’s level of self-compassion across three subscales (See Appendix G), to identify participants with a “low” overall score. Low scores were determined by scoring within a range between 1 and 2.5, which aligns with the author’s instructed interpretation. The Self-Kindness Subscale evaluates how frequently one tends to respond to themselves with kindness as opposed to harsh criticism when feelings of inadequacy or suffering arises. An example of an item associated with this subscale is “When I’m going through a very hard time, I give myself the caring tenderness I need.” The Common Humanity Subscale refers to one’s ability to view their suffering as a part of humanity as opposed to viewing it as an isolating experience. An example item from this category includes “When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.” The Mindfulness Subscale assess one’s ability to hold painful thoughts with non-judgmental awareness without becoming overwhelmed by them or overidentifying with them. An example item from this
category includes “When I’m feeling down I try to approach my feelings with curiosity and openness.” Respondents answer items using a 5-point Likert scale from “Almost Never” to “Almost Always”, with higher scores reflecting higher rates of self-compassion. The SCS demonstrates good discriminant validity ($r = .43$) with other measures assessing for self-esteem (Neff, 2003b). Studies incorporating diverse samples saw consistently strong measures of internal validity (Arimitsu 2014; Azizi et al., 2013). The SCS also demonstrates strong test-retest reliability ($a = .93$) (Karatzias et al., 2019).

**Semi-Structured Interview Questions**

Semi-structured interview questions (See Appendix L) were implemented following the completion of the Self-Compassion Break, a format that allowed for simultaneous structure and flexibility in terms of inquiring into participant experience. The questions selected for the semi-structured interview were derived from existing literature on compassion and self-compassion (Germer & Neff, 2019; Pauley & McPherson, 2010) and were refined through incorporation of feedback from both peers and mentors. Feedback pertained to the following domains: the question’s overall conciseness, the order of the questions asked, the relevancy of each question to the main topic of interest, and the question’s ability to draw out nuances in participant experiences.

**Participants**

In order to familiarize the reader with the participants, I begin by providing a brief introduction for each participant. These introductions include each participant’s demographics, and identified trauma reported as part of the ITQ screening survey. These traumas were not directly addressed during the self-compassion intervention. A total of four participants participated in this study through its entirety. Participants ages ranged from 18-years-old to 21-
years-old. All participants identified as White/Caucasian. Half of the study participants identified their gender identity as non-binary and indicated preferred pronouns as either she/they \((n=1)\) or they/them \((n=1)\). The other half of participants identified as cis-gender women with preferred pronouns listed as she/her \((n=2)\). All participants scored “Low” on The Self-Compassion Scale \((SCS: Neff, 2003b)\) and met diagnostic criteria for CPTSD according to scores resulting from The International Trauma Questionnaire \((ITQ: Cloitre et al., 2018)\). Participants responses to the demographic questionnaire along with the dimensional scores resulting from the SCS and the ITQ are displayed in the tables below. To protect confidentiality, participants names will be replaced with pseudonyms.

**Participant Dani**

Dani is an 18-year-old, white, non-binary person (she/they pronouns) who reported experiencing emotional abuse by their parents as their index trauma. This event reportedly occurred between 5 and 10 years ago.

**Participant Alex**

Alex is an 18-year-old, white, non-binary person (they/them pronouns) who reported experiencing sexual abuse in the form of a trusted individual first soliciting then distributing explicit pictures containing nudity to a wide audience without consent as their index trauma. This event reportedly occurred between 6 and 12 months ago.

**Participant Emily**

Emily is an 18-year-old, white, cisgender woman (she/her pronouns) who reported her mother passing away as her index trauma. This event reportedly occurred between 1 to 5 years ago.

**Participant Sonia**
Sonia is a 21-year-old, White/Caucasian, cisgender woman (she/her pronouns) who reported experiencing an emotionally, sexually, and physically abusive romantic relationship spanning a year as her index trauma. This event reportedly occurred between 1 to 5 years ago.

**Table 1.**

*Dimensional Results from the International Trauma Questionnaire*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Participant Dani</th>
<th>Participant Alex</th>
<th>Participant Emily</th>
<th>Participant Sonia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total PTSD Score</strong></td>
<td>11</td>
<td>21</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td><em>Re-experiencing</em></td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td><em>Avoidance</em></td>
<td>4</td>
<td>8</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td><em>Hypervigilance</em></td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total DSO Score</strong></td>
<td>21</td>
<td>24</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td><em>Affective Dysregulation</em></td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><em>Negative Self-Concept</em></td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><em>Interpersonal Difficulties</em></td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

*Note: Dimensional scores for PTSD and DSO subscales range from 0-24. Dimensional scores for the factors underneath these major subscales range from 0-8.*
Table 2.

*Dimensional Results from the Self-Compassion Questionnaire*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Participant Dani</th>
<th>Participant Alex</th>
<th>Participant Emily</th>
<th>Participant Sonia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Self-Compassion Score</strong></td>
<td>1.52</td>
<td>1.46</td>
<td>2.35</td>
<td>2.10</td>
</tr>
<tr>
<td><strong>Self-Kindness</strong></td>
<td>1.00</td>
<td>1.80</td>
<td>1.00</td>
<td>1.20</td>
</tr>
<tr>
<td><strong>Self-Judgement</strong></td>
<td>4.60</td>
<td>4.80</td>
<td>4.40</td>
<td>3.60</td>
</tr>
<tr>
<td><strong>Common Humanity</strong></td>
<td>1.75</td>
<td>2.25</td>
<td>3.25</td>
<td>1.50</td>
</tr>
<tr>
<td><strong>Isolation</strong></td>
<td>4.25</td>
<td>5.00</td>
<td>3.00</td>
<td>2.50</td>
</tr>
<tr>
<td><strong>Mindfulness</strong></td>
<td>1.75</td>
<td>1.00</td>
<td>3.00</td>
<td>1.25</td>
</tr>
<tr>
<td><strong>Over-Identification</strong></td>
<td>4.50</td>
<td>4.50</td>
<td>3.75</td>
<td>3.25</td>
</tr>
</tbody>
</table>

*Note.* Dimensional scores fall within each of the following categorial ranges: Low: 1-2.5, Moderate: 2.5-3.5, High: 3.5-5

**Procedure**

After selecting four participants for the study using the purposive sampling method as mentioned prior, each participant was scheduled to meet with me for an hour in a graduate assistant lab. A noise cancellation device was placed outside of the room in order to protect confidentiality. During the interview portion, participants’ responses were audio-recorded so that their responses could be transcribed for analysis at a later date. During this time, the participants were introduced to the concept of self-compassion as defined by Neff (2003) (See Appendix J). They were walked through each of the three components. After this introduction, each participant was led through a “Self-Compassionate Break,” (See Appendix K) which is a five-minute guided meditation that invites individuals to bring to mind something challenging, but not overwhelming such as a work problem or an interpersonal problem that is in the mild to moderate range of stress. Using the “window of tolerance” framework (Corrigan, Fisher, & Nutt, 2011) to facilitate an individual’s selection of a problem helped to establish appropriateness, with
the understanding that if an individual became overwhelmed at any time, that person would be invited to engage in a grounding exercise (i.e., disengage from meditation and connect to a neutral sensory stimuli such as the feeling the soles of the feet or the breath in the chest) while I, the study administrator, would be present to co-regulate if need be.

After bringing this challenge to mind, participants were guided through implementing each of the three self-compassion principles. Following this exercise, each participant was asked follow-up questions in a semi-structured format (See Appendix L). These questions were based off prior qualitative research questions on self-compassion (Germer & Neff, 2019; Pauley & McPherson, 2010). Examples of follow-up questions are as follows: “Are there times when you find it easier or harder to be compassionate towards yourself?” “Can you think of any positives to being able to forgive/be kinder to yourself when life gets difficult?” “How would you apply self-compassion more in your life?” and “What was your reaction upon learning about self-compassion?” These questions were designed to explore and make sense of the experiences of individuals who reportedly struggle incorporating self-compassion into their lives. After the interview, the participants were debriefed and given an opportunity to ask any follow-up questions. Additionally, participants were given both the $20.00 VISA gift card along with information regarding various self-compassion related resources for continuing education, further practices, and crisis numbers in case of any residual discomfort.

**Qualitative Design**

In this study, I am interested in how adults with complex trauma symptomology and low self-compassion scores react to psychoeducation and an activity on the concept. As a qualitative study designed to seek an understanding into the experiences and perspectives of a selectively identified group of participants, a thematic analytic (TA) approach was implemented. This
approach to data analysis is useful for identifying and interpreting the patterns (i.e., “themes”) that arise in qualitative data (Clarke, Braun, & Hayfield, 2015). TA differentiates itself from alternative forms of qualitative data analysis by its emphasis on flexibility (Braun & Clarke, 2006). To elaborate, TA is unbound to any particular theoretical position, and thus, can be incorporated within different frameworks (or not at all), an advantage that can elucidate a rich and complex account of data (Braun & Clarke, 2006). In addition, the researcher conducting TA takes an active stance in the data analysis process, which translates to going beyond simply describing the emerging patterns by interpreting them as they relate to an evolving research question. It is inherently understood, though remains beneficial to explicitly acknowledge, that researchers conducting TA do not subscribe to a “naïve realist” paradigm of qualitative research where researchers claim to exclusively “give voice” to their participants (Fine, 1992). The various choice points that occur throughout the analytic process reflect, in some regard, the researcher’s own values and framework. As I conducted thematic analysis in this study, I strived to identify the various decisions made regarding which information received focus as relevant to the research question and, as such, should be recognized as decisions.

The overall data analytic process followed this format: (1) transcribe and become familiar with data, (2) generate initial codes, (3) search for themes, (4) review themes, (5) define and name themes, and (6) produce report by interpreting themes (Clarke, Braun, & Hayfield, 2015). After transcribing the interviews, I worked to identify codes within the data, which are described as the “building blocks” for developing subsequent themes (Clarke, Braun, & Hayfield, 2015). In essence, the codes are the smallest unit of analysis and are identified by their potential relevancy to the larger research question. The codes evolve into themes when patterns in the codes appear. As a qualitative study, no hard and fast rule exists determining which codes
begin to qualify as themes (Braun & Clarke, 2006). The researcher takes on the role as “arbiter” by using clinical judgment to determine a code’s pertinence to the research question. As previously mentioned, data are not coded in an “epistemological vacuum” (Braun & Clark, 2006, pg. 12). As the researcher, I worked to make explicit the instances where I established themes and document rationale for such decisions.

**Reflexive Statement**

As proposed by Braun and Clarke’s reflexive thematic analysis guidelines (2006), I reflected upon my own identities and experiences throughout the research process to consider how my subjectivity could affect the study’s findings. From the outset, my interest in researching this topic stemmed from an amalgamation of professional and personal experiences. My time learning about the current evidence-based practices for trauma as a doctoral student in clinical psychology made me increasingly aware of persistent gaps in the field. I noticed these gaps permeating into the clinical space as I progressively gained proficiency providing individual therapy to adult clients in a variety of treatment settings. The disconnect between the information gathered from highly-controlled research studies and the clinical realities that my clients presented to treatment with led me to critically consider the value of practice-based research. Through my direct clinical observations, I noticed a general trend towards high self-criticism amongst my clientele with extensive trauma histories. I decided to follow this inclination by exploring this relation through the perceptions of clients themselves with the hope that the gathered information would help bridge the research-to-practice gap.

My educational and clinical experiences likely influenced my presence during the semi-structured interview as drawing upon foundational therapy skills now happens nearly reflexively. Specifically, conveying non-verbal indicators of active listening and framing questions non-
judgmentally were skills I honed specifically for my work as a therapist, yet I likely invoked when sitting with participants. This effect may have encouraged the participants to share more than they might have had I presented with a relatively more neutral “blank slate” approach. Likewise, my theoretical orientation assumedly influenced my interpretation of the responses when developing themes. My proclivity towards conceptualizing through the lens of relational psychoanalysis and “3rd wave” CBT undoubtedly informed my meaning making process. Efforts to attend to this bias involved consistent meetings with the faculty advisor throughout the duration of the thematic analysis to help cross-reference reflections and allow space for objectivity.

**Reflexive Thematic Analysis**

Thematic analysis began with a transcription of the information collected from the audio-recordings during the interview portion of the study. I, the primary researcher, opted to transcribe the audio-recordings to enhance my familiarity with the data prior to generating initial codes, which aligns with Braun and Clarke’s (2006) guidelines. By intentionally transcribing the data myself, I engaged with the material in a slower and more focused way in contrast to the “habitual propensity for ‘quick and dirty’ reduction and synopsis” (Smith et al., 2009, p. 493).

The next step involved examining the resulting documents on an exploratory level while making initial notes. Attention at this stage in the thematic analysis was turned toward considering the semantics of the language within participant responses. During this phase I marked up the documents with annotated comments in addition to highlighting key words and phrases that were relevant to the research questions. Decision-making regarding how I discerned material of interest from the larger text derived from Smith et al. (2009) approach to interpretative phenomenological analysis (IPA) methodology. According to this theoretical
approach, the researcher should include the following: (1) descriptive comments, (2) linguistic comments, and (3) conceptual comments (Smith et al., 2009). Descriptive comments describe the content of participant response as well as identify the subject of the response. Linguistic comments note the nuances within each participants response, such as moments of repetition, pauses, and tone. Lastly, conceptual comments aim to capture the researcher’s understanding of the deeper meaning within participants’ responses from a more overarching lens (Smith et al., 2009). In total, I reviewed thirty single-spaced pages of transcripts.

To help illustrate how I implemented each type of comment, I provide the following examples below along with the corresponding comment category:

**Example 1:** “I think I realized that I am not nice to myself like I should be and that there’s a lot more ways that I should be nicer to myself and I’m not.”

Descriptive comments: Increased awareness of relationship to self

Acknowledged that she is not nice to self

Linguistic comment: Uses “should” throughout statement

Conceptual comment: She is engaging in self-criticism for being self-critical

**Example 2:** “I definitely do try to push the world away from me and try to figure it out myself because I don’t like inflicting my problems onto other people.”

Descriptive comments: Isolates as coping mechanism

Fear of harming others

Linguistic comment: “Inflicting” indicates an association to mistreatment

Conceptual comment: Belief that relational connectivity is dangerous

**Example 3:** “I think I hate feeling like this like it’s stupid like why am I feeling this because I grew up where parents would tell me they had it worse and other people have it worse (pause) I
don’t give myself the compassion that I need because I feel like I don’t deserve it like my problems aren’t bad enough.”

Descriptive comments: Reflected on history of invalidation

Thinks they don’t deserve compassion

Linguistic comment: Engages in thoughtful pause after reporting on their traumatic history

Conceptual comment: Internalized experiences of invalidation

The third step in thematic analysis involved converting the comments into initial codes. Drawing from the generated list of comments, I developed a list of words and short phrases that sought to encapsulate the essence of the material into distinguishable ideas (Smith et al., 2009). I ended up with a total of twenty-five initial codes along with the corresponding dialogue taken directly from the transcripts listed underneath each one. During this phase, I highlighted text that pertained to research question 2 in blue while leaving the text pertaining to research question 1 in black. This decision allowed for a more discernable, visual distinction between how participants reflected on themselves as individuals existing in the world and how they reflected on their experience during and after the self-compassion intervention.

The analytic process continued by combining the initial codes into emergent themes. Through examination, I began to perceive connections that combined various codes into condensed themes. This task was accomplished using Microsoft Word along with pen and paper. I grouped selected codes into clusters based on how they fit within a broader category. For example, the codes “avoidance,” “isolation as protective,” “distraction as coping skill,” and “distrust of others” transformed into the theme “avoidance perceived as realistic coping skill.” All of these codes revolve around the concept that avoiding situations, feelings, and people that
elicit discomfort often presents as the “go-to” method for dealing with them. Additionally, the theme also speaks to how the participants perceive that this approach is most viable even though they simultaneously acknowledge that doing so carries its own consequences. In other words, although avoiding is not considered ideal, it is still viewed as the course of action most likely to be taken.

After compiling the lengthy list of emergent themes, I engaged in peer review with my faculty advisor to discuss the themes’ relevancy as well as to ensure no overlaps existed. Meetings took place over various dates to ensure the refinement process resulted in a final list of themes that most comprehensively depicted the content from participant responses. Part of the refinement process involved the faculty advisor “blindly” studying the transcripts while writing down initial codes and themes before coming together and deliberating about what we both came up with. Over the course of these discussions it was decided that organizing the themes under different “time stamps” that delineated when in the participants’ lives (i.e. before intervention, during intervention, or into a projected future) their response referred to. It was decided this categorization could most authentically depict how participants understood themselves prior to the study and how they reacted to the self-compassion intervention. Moreover, systemizing the material in this particular way encouraged reflection back to the two main research questions. In the end, each time-stamp (Past, Present, and Future) contained two themes and various sub-themes. See Figure 1 for the final thematic map.
Figure 1.

Final Overarching Themes and Subthemes Developed from Self-Compassion Intervention Organized by Time-Stamps
Chapter 4: Results

In this chapter I report on what I learned about the experiences of individuals with complex trauma symptomology and low rates of self-compassion who participated in a brief self-compassion based intervention. As stated in Chapter 1, my primary research questions pertain to better understanding this understudied population of individuals as well as exploring their reactions to an introductory explanation and application of self-compassion derived from the Mindful Self-Compassion Intervention (MSC; Neff & Germer, 2013). Themes and subthemes categorized under the timestamp “Past” directly relate to the first research question by giving voice to each participant’s understanding of themselves and how they experience their relationship to self-compassion prior to the intervention. Themes and subthemes found under the time stamps “Present” and “Future” address the second research question by exploring the nuances of each participant’s experience and takeaways both during and post the MSC intervention.

I report on the results of the thematic analysis in greater detail further on in the chapter; however, a brief overview is provided here. Prior to participating in the study, each participant experienced themselves as self-critical, especially during moments of suffering. All of the participants described having a harsh inner-critic that resembled the voice and tone of individuals from their past who negatively impacted their view of and relationship to themselves. Avoidance as a primary coping skill appeared in all of the participants’ responses despite awareness of residual consequences. Contrary to their treatment of themselves, they all self-identified as nurturing care-givers in relation to those they care about. Interestingly, they appeared to have more self-confidence in their skills as care-givers than their description of their care-giving actually portrayed. In other words, they consider themselves more attuned than the supplemental
evidence suggests. Unconscious defensive processes at play, such as projection and introjection, appeared to contribute to the discrepancies found in the material.

During the intervention, all of the participants experienced discomfort. They noted both physical and emotional markers of discomfort that marginally alleviated with time. Importantly, none of the participants expressed feeling that confronting and sitting in the discomfort was overwhelming, which indicated that guiding participants to select issues within their “window of tolerance” helped to contain the invited discomfort. Following the Self-Compassion-Break, all of the participants considered the exercise as having been beneficial and determined that approaching the same issue again in the future would likely be less difficult.

When asked to consider how they might imagine themselves applying self-compassion more in their lives, all of the participants conveyed increased motivation to be kinder towards themselves. Notably, each participant named their deservingness of care. Some individuals were able to identify concrete ways that incorporating self-compassion could look like while others stated that it felt like wishful thinking. Societal stigma towards self-compassion and environmental factors were mentioned as ever-present barriers. Ultimately, all of the participants were interested to continuing learning about and implementing self-compassion in their lives moving forward.

PAST (Who They Are)

Theme 1 Avoidance Perceived as Realistic Coping Skill

The theme avoidance perceived as realistic coping skill reflects the tendency of all the participants to use avoidance as a primary method for navigating difficulties. Throughout each interview, participants consistently spoke about their frequent avoidance as a behavioral pattern
they know contributes to enduring problems while simultaneously continuing to engage in it as doing so provides some amount of relief.

“Um lately I have been watching a lot of Netflix and distracting myself um it’s like not the healthiest but it’s better than unhealthy coping skills like it’s something.”- Dani

“Drugs (laughs) yeah that is pretty much it. I am in therapy as well which is also helpful and I am on antidepressants but other than that drugs”- Alex

“…I try to avoid confronting the hard things that I have to deal with it so like instead of facing them head on I just don’t think about them which is part of the reason why I think I am in an endless loop sometimes like I am trying to push people away but then I also don’t take that time that space to think about what I’m doing and like have self-compassion.” - Emily

“I am very protective over myself and I think that I allow myself to not have certain experiences because I’m so afraid it’s going to end the way that it did in the past so I just like don’t open myself up to those things anymore and that sucks.”- Sonia

Overall, participants appeared aware of their propensity to avoid and spoke on this awareness with some degree of coinciding guilt. Underneath their admissions seemed to lie a desire for a different approach, yet a concurrent belief that a better approach is somehow unattainable. Within the general theme of avoidance, two sub-themes emerged that highlighted the different ways in which avoidance manifested.

A subtheme, **intrapersonal avoidance of discomfort**, arose from the participants’ reports on how avoidance occurred within themselves, namely, avoidance of certain thoughts and feelings. They described efforts to avoid having to think about current struggles in their lives as well as the emotional and physical experiences that accompany them.
“I tend to push away what’s happening to me and not focus on it um and when I do I think I hate feeling like this like it’s stupid like why am I feeling this?” - Dani

“It kind of reminded me of an issue in my life that I have to deal with that I haven’t dealt with yet” - Alex

“I have a hard time reaching out and asking for help because I do tend to shelter myself and push my issues away from” - Emily

“I don’t allow myself sometimes to be sad or angry which are all human feelings I don’t allow that because it’s like associated with something bad so I don’t want to feel those things” - Sonia

This subtheme depicts how intrapersonal avoidance can lead to issues becoming more persistent overtime as well as initial issues transforming into compounded ones that become increasingly personalized. A related subtheme, interpersonal avoidance as protective, captures how participants choose to avoid people in an effort to either protect themselves from others or protect others from themselves. In particular, Dani and Sonia disclosed that they isolate out of concern that their presence elicits negative impacts on those around them.

“I am worthless nobody wants to be around me and like things like that come up.” - Dani describing a frequent self-critical thought

“...in the moment if I can’t or I feel like there’s been a lot thrown at me I get really overwhelmed then I notice that I will take it out on other people or situations that really don’t have anything to do with it hence why like to be alone.” - Sonia

Emily primarily spoke of her motivation to isolate stemming from a place of general distrust towards others.
“Personally, my reaction is to distance myself from the world I try to like stay away from things that I know are going to like bother me especially when I have things going on in my mind.”

“…even if I try to talk about the issue to my friends every once in a while I don’t think they really get it so like it’s kind of dismissed.”

As demonstrated in the above quotes, relational connection during times of hardship is considered potentially dangerous. As a result, disconnection becomes the “safer” route to eventually resolving the issue.

**Theme 2. Inner Conflict Creates Discrepancy**

The theme *inner conflict creates discrepancy* speaks to the various instances when participants were both consciously aware of certain discrepancies while also unconsciously participating in maintaining said discrepancies or even unaware of the existence of others. These discrepancies relate back to how participants navigate the inner conflict between what they want and what they think they know. On one hand, each participant described a compassionate part of themselves that genuinely wants to both receive self-compassion and feel deserving of it. On the other hand, their responses also suggest the existence of a critical-self that often overpowers their desires as this self-state is experienced as more “true.”

“One of the thoughts that I have to work on is not like right away thinking of self-compassion as being selfish it’s just like what my mind immediately goes to even though it’s not true it’s something that my mind tells me.”- Dani

“Looking at the way I speak to other people the people that I love and then how I interact with myself in a very different way and how it does not make a ton of sense considering I am the same as the people around me and I am deserving of the same things.”- Alex
“Obviously maybe it’s not the best that I handle certain circumstances where I’m harsh on myself. Maybe it’s not the best but I feel like if I were to say that was fine then that’s also an issue.” - Emily

“I’m not nice to myself I wish I could be that nice to myself because I feel like and I don’t mean to toot my own horn but I feel like a lot of people always come to me for like advice or when they’re having a bad day I’m good at that stuff that’s what I want to do for living but when it comes to myself I’m not nice I’m not nice to myself about anything” - Sonia

A subtheme that falls under this category is conscious awareness of interpersonal discrepancy, which highlights the ways that participants could insightfully perceive instances of their inner conflict manifesting as deferential treatment towards others.

“I am very caring for other people but I don’t really show myself that same level of care um and that’s like a usual thing so it’s like very much a pattern.” - Dani

“Just that they’re very very opposite and not the same as it probably should be.” - Alex describing how they treat others compared to how they treat themselves

“I over contextualize myself my own issues instead of like if a friend needs my advice my help I one make them feel comfortable and after that attack the problem and be rational in a nice way.” - Emily

“I feel like I’m very judgmental of myself and I’m going to be honest everybody’s judgmental about other people at some point whether it’s in their head or out loud but I never caught myself being as judgmental of somebody else as I am to myself.” - Sonia

In all of the examples, participants noticed their tendency to treat others with more care than they treat themselves. Relatedly, the subtheme conscious awareness of intrapersonal discrepancy captures how participants also reflected on the ways in which they treat
themselves can be situationally influenced. Participants described their critical-self overpowering their compassionate-self during stressful situations.

“I think when I am in like a high like when I am not as down because then I am not in my emotions like I am not in that place where I give myself so many judgments like it’s still hard but it’s a little bit easier to talk back to those thoughts.”- Dani

“I feel like I’m able to be more compassionate to myself when I am in a setting where I am not stressed out and moving around all the time and like then I tend to struggle a little bit more and then when I’m struggling its harder to show some compassion for myself.”- Alex

“Situations where like my presence or my actions disservice people and put people like just like they’re not helping I guess that’s when I would be more harsh on myself and tell myself I’m just harsh with my words I guess I call myself things and such.”- Emily

“I blame myself for a lot of the anxiousness that I feel because I want to control it so bad and I feel like I’ve done so many things to help myself and sometimes I just feel like why isn’t this working why can’t you do this and sometimes I’m so self-critical and I’m just like stop and I can’t and that’s when like again the snowball effect so having anxiety is tough it’s not fun.”- Sonia

As previously stated, participants described themselves as self-critical during moments of suffering despite longings for increased self-compassion. A subtheme, *unconscious defensive processes* emerged from the data to represent the impact of the unconscious on sustaining their inner-conflict. Participants often described their critical-selves as reminiscent of individuals who had been responsible for their care, thus speaking to the effects of negative introjections on their self-worth.
“Very like reprimanding like if you like could imagine that your parents were like really upset at you or like they are scolding you and it’s like angry disappointed.” - Dani

“…the emotions that I’m feeling aren’t valid and that I am being stupid that I’m feeling the emotions that I am feeling and acting in the way that I’m acting or just my actions that I choose to move around the world and that that is inherently wrong for some reason.” - Alex

“Angry and like just a tone of voice of people who have impacted me negatively like I associate that with almost as if it is coming from people that have affected me negatively.” - Emily

“I feel like I’m talking down to myself so it’s a very stern and like angry negative nothing about it is positive like nothing about it is nice.” - Sonia

Projection as an unconscious defensive process also appeared within the material in regards to how participants related to others. When invited to describe how they care for those they value, all of the participants projected their own internal experiences and understandings onto the other person without accounting for individual subjectivity.

“I think it depends on the situation because if it is something more distressing I get more tense and upright and protective but overall carrying other peoples’ issues makes me tense like I am taking in what they are feeling and I feel in pain.” - Dani

“Kind of like a soft voice unless they’re like I don’t know being dumb about like a guy and then I will tell them they’re being stupid but otherwise I will be nice.” - Alex

“I feel like when somebody is struggling the worst thing they need is to feel like they are small in proportion to the people around them so I try to like make myself equal to them. I don’t want them to feel like even in the words I use I don’t want it to seem like I’m doing this about myself or I’m tying it back to this person or this person in that situation it’s all about them and
how they are feeling so I don’t want to switch the direction of the attention at all I want to make it directly about them and myself like I put myself in that situation too I want to make myself smaller.”- Emily

“I am very comforting I like to think of myself because I’ve been through certain things I’m good at giving advice. Unfortunately I don’t take my own advice but usually when my friends are upset I feel like I can either be a listener you know if they just want to talk about it but I’m also like the friend that’s going to be honest with you like I’m going to give you the advice that I think you need to hear.”- Sonia

To summarize, each of the participants believed that they were providing attuned care based off their assumptions of what the other person needed in the moment. Dani reacted to another’s distress by becoming “tense and protective” while also relinquishing her emotional boundaries. In other words, she associates care-giving with emotional enmeshment likely due to what had been historically modeled within her early relationships. Alex turned their negative introjections into projection by asserting that experiencing dating difficulties is “dumb and stupid” and that it is caring to alert the other person to that idea. Emily assumes that individuals who are struggling need to feel a specific “size” relative to the care-giver, which indicates that Emily has likely been hurt by the power differentials held by those who tried to care for her. Lastly, Sonia deems her “advice” is what the other person “needs to hear,” which demonstrates an overconfident assumption that she can know other people better than they could know themselves. Similar to the other participants, Sonia likely received care in this way during her earlier development. Overall, participants are unknowingly limited by unconscious defensive processes in regards to what they define as attuned care-giving.

**Present (Response to Intervention)**
Themes and subthemes discussed under the time-stamp “Present” refers to how participants experienced the self-compassion-based intervention consisting of a brief psychoeducational component as well as the Self-Compassion Break introductory activity.

**Theme 3. Increased Insight**

The theme *increased insight* reflects the expanded awareness that participants gained during the intervention. All of the participants described attaining novel understandings about the concept of self-compassion as well as themselves.

“Um because sometimes people make self-compassion look or feel like selfish towards yourself, but looking at it like this is what you would do for other people so why don’t you do it for yourself is a good way of putting it.”- Dani

“I would like to get more of that for myself but um having a solid concept would make it a lot easier to find avenues to create more self-compassion for myself.”- Alex

“Well I didn’t know what it was at first um like so your explanation of it made me have a realization that like myself like how I don’t necessarily have any well like I have self-compassion but like where I lack.”- Emily

“Nobody has ever really sat down and been like this is how you need to be nice to yourself you just see people do it like participating in this kind of like hearing how I talk to somebody else and realizing I don’t talk to myself like that putting myself in that situation and being able to like repeat like it’s okay other people are in this position being understanding of my own feelings validating my own thoughts is very comforting to me.”- Sonia

For Dani, re-conceptualizing their understanding of self-compassion as separate from selfishness allowed for more permission to engage in it. Alex reflected on how a more structured definition of self-compassion could lead to more accessible methods of practicing it. Emily
developed a more nuanced awareness of herself by moving from a more generalized self-awareness to being able to differentiate where she struggles more than others. Lastly, Sonia continuously remarked throughout the semi-structured interview on her astonishment that no one had ever communicated this information to her. At times, she appeared resentful of how “simple” the concept of self-compassion is, yet it had never explained to her.

**Theme 4. Discomfort when Confronting Avoidance**

The theme **discomfort when confronting avoidance** captures the sensations that participants described coming up for them while engaging in the Self-Compassion Break. The purpose of the Self-Compassion Break involved intentionally connecting to the discomfort prior to applying self-compassion. This invitation presents an experiential opportunity to “be with” discomfort mindfully, without dissociating or becoming overwhelmed. All of the participants described staying present with the discomfort.

“I mean I don’t really like sitting with myself focusing on myself and how I am feeling so that was like mindfulness is usually uncomfortable for me because I am very fidgety and anxious so like sitting still with my feelings is like uncomfortable but a good uncomfortable.” - Dani

“The issue isn’t really that big so it’s not something feeling like an overwhelming doom about it it’s just like not necessarily something I like to be thinking about.” - Alex

“During it I it was really hard for me because it was difficult for me to get through that block but I didn’t see myself like getting over it like it’s still a problem that I am facing but I think I am able to think about it in a way that not as scary to think about like I feel like I can look at the issue and not feel like I need to push it away.” - Emily

“I wouldn’t say overwhelming but I would say discomforting just not comfortable with it like I don’t want to be I don’t want to like sometimes put myself in situations that I’m
uncomfortable or have some sort of negative feelings towards so doing that activity like I almost wish I could just come to peace with that situation it’s almost like this allowed me to do that it allowed me to be like hey it’s okay don’t be so hard on yourself don’t be so angry at yourself it’s like a sense of relief.” - Sonia

A subtheme, benefits from self-compassionately confronting avoidance, speaks to the various ways in which participants felt that confronting their avoidance during the Self-Compassion break ultimately benefitted them. For Dani and Sonia, these benefits arose as positive physiological changes that indicated movement from a sympathetic nervous system response to a parasympathetic nervous system response. Alex shared that they were able to challenge their self-critical voice and connect with their compassionate-self in the form of validation. Emily resonated with the “common humanity” component of the Self-Compassion Break and stated that she feels more able to emotionally-regulate when confronting the same issue in the future.

“I think it helped me relax a little bit because I am very tense especially around the situation that I was thinking about so I think letting go of the judgment really helped me calm down.” - Dani

“It’s like reminding myself to have compassion for myself just like take a minute and it is fine to be existing in the way that I am existing and that I don’t need to apologize for that.” - Alex

“I feel like now that I’m now that I have had time and an opportunity to sit down and really just focus on what is the conflict and like you said other people have also gone through it it might just be easier for me to do it again and think about it.” - Emily
“I feel like in the beginning of it I felt like a very heavy chested like I needed to breathe really hard and once I was able to kind of do that I felt a sense of almost relief so yeah I felt good.” - Sonia

**Future (Impressions and Takeaways Post-Intervention)**

Themes and subthemes categorized under the time-stamp “Future” reflects the participants’ concluding impressions and future directions pertaining to self-compassion as they imagine their lives moving forward.

**Theme 5. Self-Compassion Perceived as Beneficial**

The theme, *self-compassion perceived as beneficial*, reflects the general consensus held by participants that self-compassion, in theory, is helpful.

“I feel like I would have a lot of tension lifted off um because being so hard on yourself really adds to the stress to like everyday life so being compassionate towards yourself like really taking care of yourself and like you’re not going to have that extra stress and tenseness.” - Dani

“I probably wouldn’t be in as much pain (laughs) physically but also mentally and like I feel like my mind would be more open I would be able to look at myself with a more positive view or like how other people see me.” - Dani describing imagined benefits from practicing self-compassion

“100% I think that could definitely help significantly um if I was struggling and I did show myself compassion I think that would definitely help a lot more than my existing strategies.” - Alex

“I think like it is important to have self-compassion like focus on yourself and treat yourself how you would a friend or a family member or someone that you cared about I think it’s important.” - Emily
“I like associate self-compassion with happiness and excitement so I guess the things that make me happy and excited I would like to do more maybe like if that means like going out with a friend or like going to dinner getting a drink or just even hanging out with people who make me happy.”- Sonia

A sub-theme, **increased sense of motivation to lessen suffering**, emerged from the superordinate theme to capture the shift in participant responses from feeling stuck in their current states to actively improving their lives. Dani, Alex, and Sonia identified that this shift would look like dedicating more time for themselves to engage in self-care activities. The unspoken prerequisite of such imaginings entails feeling deserving of prioritizing oneself as a pathway to lessen suffering. All three participants appeared more willing to start applying these changes going forward than they described prior to the intervention. Emily, who had previously spoken at length about her tendency to self-isolate, stated (with notable determination) her intention to tend to herself in these moments rather than dissociate.

“Working on doing little things for myself or really taking a moment for myself to recharge to like read a book or take some time for myself to just focus on myself and doing things that make me feel better about myself.”- Dani

“I feel like doing less drugs would be a great step and showing myself compassion by not allowing myself to fall into those struggles and just exist where I am and not be like oh I will wallow in it and instead bring myself out of it.”- Alex

“I think I need to confront what I push away and like when I choose to lock myself like push myself away from the world, I need to actually focus on why I am and not just I need time away just to have time away. Like if I want to use that space and time to escape what I am then I have to use it to channel it into helping myself instead of just letting it pass me.”- Emily
“I think one of the biggest things is making time for myself whether that be like doing things that I want to do or not doing anything at all. Sometimes I genuinely just like to sit down and do nothing for like an hour I think it’s important to allow my mind to just like wander and I don’t really give myself time to do that I almost try to keep myself busy so that I don’t have time to do what I want but I think I like to go to the gym making certain time for like not like physical things but getting my nails done or anything about nature like going for a run or just making more time for that kind of stuff.”- Sonia

**Theme 6. Persisting Barriers to Self-Compassion**

The theme **persisting barriers to self-compassion** reveals some of the blocks that the participants continued to endorse following the intervention. Dani underscored the inherent difficulty involved in changing well-established habits. Alex echoed their earlier sentiment regarding the struggle to apply theory into practice. Interestingly, Emily connected her history of feeling disappointed by mental health care professionals to her current negative perceptions and pervasive lack of trust in others. Despite self-compassion being an individual, internal process, Emily’s unresolved trauma symptoms appear to contribute to her reluctance to truly take in the content given its association with mental health. Sonia expressed concern of not being able to properly balance self-compassion with compassion for others. Her response suggests that she might be conflating self-compassion with a narcissistic self-focus and could benefit from continued psychoeducation on what self-compassion is and is not.

“I have been working on self-compassion but it’s still like when you have been engaged in behavior for so long that it is so ingrained in you it’s very hard to change so it is still a working progress.”- Dani

“It makes sense as a concept to me, but I mean, in practice it feels more difficult.”- Alex
“I think that mental health is important and stuff but I think that like sometimes I think it’s like a weak approach to it like I’ve tried reaching out when I was really struggling with my mental health I tried reaching out to the school therapist and I always felt like it was just like okay I’m doing my job and that’s it I didn’t feel very cared about and I learned how to deal with my issues myself and how to resolve them independently. So, I feel like the whole mental-health stuff I guess I have a self-stigma about it yeah just like personally I don’t think mental health or seeking therapy is like going to help me at all.” - Emily

“I don’t think this would happen because I’m at such like a low self-compassion right now but sometimes I feel like giving yourself too much you’re not again maybe like you’re too focused on yourself and you’re not focused on others.” - Sonia

A subtheme, societal barriers to self-compassion, arose from the various times participants indicated barriers not just stemming from themselves, but from their social environments as well.

“I feel like we don’t learn enough about self-care growing up and were so like we are told to be focused on other things and like other people. I think a lot of other people have the same judgments about self-compassion as I do and that’s something that us as a society like we need to work on like, especially with kids growing up in this day and age, they need to learn how to care for themselves like give themselves that kindness and compassion.” - Dani

“Society is just very it just moves very, very quickly and I was talking about this yesterday in my creating meaning class we were talking about like capitalism and how like a capitalist society forces you to like move quickly throughout life and doesn’t really allow time to just live slowly. And I feel like at least for me, showing myself compassion would be to slow
down a little and just listen to myself more slowly which is not what I feel like the path that society’s pushing me towards.” - Alex

“Like at school that’s hard because I’m living in a very tightly packed dorm where like most people that I’m friends with live in my building. They are always texting me asking me for help, advice, stuff like that. Like sure but I’m also trying to distance myself from things right now so I can focus on myself.” - Emily

“I think a lot of people view self-compassion as like I don’t want to say Feminine but like weak which sounds so bad because it’s not but I think the way that it’s almost portrayed or people talk about it. And there’s misconceptions it’s almost like you’re playing telephone and the words get mixed up down the line and you wind up with something that doesn’t even make sense I don’t think people really know what soft compassionate is and how to almost do it so I think that’s where society fails us.” - Sonia

Three out of the four participants described how, by design, societal systems undermine the value of self-compassion. Dani reflected on her experiences growing up without being taught the importance of self-care. Her choice to name children in particular in her response suggests she believes society holds a responsibility to deliver these messages during impressionable ages in development. Alex acknowledged how a capitalist system values profit and productivity over an individual’s inherent worth, which subsequently contributes to the pressure to “keep moving” without slowing down. Sonia expressed frustration that society maintains a distorted interpretation of self-compassion. Lastly, Emily identified the impact of one’s proximal environment on how accessible practicing self-compassion feels. To her, maintaining her boundaries feels more difficult when immersed in an area with individuals that constantly request her help.
Chapter 5: Discussion

This study sought to better understand the subjective experiences of individuals with complex trauma symptomology and low rates of self-compassion with the hope of incorporating the gathered information into the designs of more effective trauma treatment and delivery. Given the current empirical evidence suggesting CBIs as being beneficial for alleviating the symptomology associated with complex trauma in particular (Au, 2016; Kearny et al, 2013; Lang et al., 2017; Muller-Engelmann et al., 2018), I chose to focus my study on how these individuals responded to a brief self-compassion-based intervention derived from the MSC eight-week treatment program (Germer & Neff, 2019). This study utilized a qualitative reflexive thematic analysis (Braun & Clarke, 2013) to analyze the participants’ responses during a follow-up semi-structured interview. The findings that emerged showed six themes across three timestamps categorized by how the participants experienced themselves in the past, present, and hypothetical future. The superordinate themes from the past included avoidance perceived as realistic coping skill and inner conflict creates discrepancy. The themes from the present were increased insight and discomfort when confronting avoidance. The future-related themes that emerged were self-compassion perceived as beneficial and persisting barriers to self-compassion.

Avoidance Perceived as Realistic Coping Skill

When speaking with each of the four participants regarding how they tend to cope when life gets difficult, avoidance arose as the most frequently cited method. Throughout this portion of the interviews, participants described general tendencies to move away from their current issues as opposed to taking steps toward resolving them. Their depictions of avoidance are more aligned with the diagnostic criteria listed under ICD-11 CPTSD rather than DSM-5 PTSD as they
describe avoidance as a byproduct of characterological affect dysregulation rather than a response to specific trauma-related reminders (*DSM-5*; APA, 2013; WHO, 2018). To elaborate, participants spoke of avoidance as a reaction to distress across multiple contexts and relationships, regardless of proximity to an identified trauma (Cloitre et al., 2013). The consistent and pervasive nature of the avoidance indicates that the core issue confronting participants resides in the inability to tolerate painful affect enough to begin regulating it. This observation parallels findings from published literature on traumatized individuals that describe the phenomenon of emotional flooding, which is understood as a nervous system response to an overwhelming surge of stress hormones in reaction to unbearable emotions (Germer & Neff, 2015). These responses interfere with one’s capacity to both think and feel rationally, resulting in ensuing outbursts or dissociation.

The reported characterological affect dysregulation helps to account for the observed contradictions in how participants described partaking in avoidance behaviors. On one hand, participants openly shared their propensity to avoid stressors, while on the other hand, they also acknowledged how avoidance perpetuates suffering. One might fairly wonder why a person would knowingly continue to engage in a behavior that carries such negative consequences. Befitting of qualitative research, this question was proposed to the participants themselves to gain insight into how they make sense of this conundrum. Overall, participants expressed how avoidance might not be ideal, but it is realistic. There seemed an implied positioning of avoidance as a “lesser of two evils” option. Current trauma research helps to contextualize this response through its understanding of how humans respond to perceived threats to survival. If an individual has, overtime and through repetition, learned to associate painful affect with threat to survival, they will respond based on their capacity to fight, flee, or freeze (Gilbert, 2009a). In the
case of the participants, avoidance could be conceptualized a protective response against the internal threat-to-self posed by the painful affect. Additionally, more recent research has found that individuals diagnosed with CPTSD are often unable to recognize their emotional reactions to present-day situations as being connected to their past trauma, which may help to explain why participants struggle to completely formulate their reasons for avoiding (Out of The Storm, 2021).

Participants also reported concerns of externalizing their suffering onto other people, which presents the threat of an interpersonal rupture. Self-isolating until the painful affect has somewhat subsided may be perceived as a safer option to “protect” the relationship, even if this approach fails to resolve the initial issue. Bowlby (1969) posited that attachment is a primary, biological, and absolute need, which helps to explain why participants endorsed such reluctance to reach out to others for support, since doing so could risk exposing others to a version of themselves they deem harmful. In this case, participants appear willing to subject themselves to their own “badness” as long as their relationships ultimately prevail. This speculation coincides with research into individuals with trauma histories who accept self-deprivation as punishment for their “misdeeds” out of fear of breaking bonds with their primary caregivers (Gilbert & Proctor, 2006). Relatedly, research in developmental neuroscience explains how chronically charged dyadic interactions with primary care-givers during early development can interfere with normative brain plasticity by “hard-wiring” the right-brain to respond to relational intimacy with fear, leading to the adoption of insecure attachment styles (Schore, 2001). In other words, when in distress, the participants may also be unconsciously seeking to protect themselves from the perceived threats posed by others.
Inner Conflict Creates Discrepancy

Located throughout each participant’s responses to the semi-structured interview questions lie various discrepancies. Some of these discrepancies were detectible by the participants while others remained separated from conscious awareness. Examples of instances where participants exhibited awareness included reported differences between how they provide care for others compared to themselves during times of hardship. Previous self-compassion based research has noted the omnipresence of this discrepancy by discovering that many people, especially in Western countries, extend compassion to others more readily than to themselves (Knox, Neff, & Davidson, 2016). Thus, the findings in this study come as not particularly surprising since this phenomenon appears, in part, culturally influenced. However, what may distinguish the participants in this study from the “general” population is the former’s remarkable propensity to engage in harsh self-critical dialogue when met with distress. This observation reflects a manifestation of the negative self-concept domain listed under the ICD-11 CPTSD symptom cluster (WHO, 2018) that centers around a chronic sense of shame, guilt and worthlessness.

The four participants were also aware of the discrepancies in their treatment towards themselves that appeared to vary depending on how subjectively stressful a situation felt to each one. The participants reflected on the presence of a self-deprecating and punishing voice that, after being invited to visualize, took on the forms of people in their lives who had previously hurt them. Common expressions of this self-critical voice encompassed an array of invalidating and berating statements, which hit on worthlessness and defectiveness schemas. These findings corroborate previous research conducted on individuals diagnosed with CPTSD who demonstrated an over-identification with their perpetrators (Williams & Poijula, 2002). The
researchers discovered that individuals with CPTSD experienced great difficulty separating both mentally and emotionally from their abusers due to unconscious defensive processes. Similar to the participants in this study, these individuals unconsciously adopted their perpetrators introjects as “truth” to protect themselves from genuinely accepting that the people responsible for their care failed them, which might lead to unbearable grief (Williams & Poijula, 2002).

In addition to the unconscious influence of introjections on their self-concept, participants also unknowingly engaged in projection when establishing themselves as particularly well-equipped care-givers to others. According to Kernberg (2018), projection occurs when an individual encounters an intolerable experience and subsequently projects this experience onto another in an effort to create distance and fortify the ego’s defenses. This defensive process resulted in discrepancies between the participants’ intentions and self-appraisals in comparison to their impacts on others. Participants confidently reported being able to “attune” to the needs of the other in the form of the following: advice-giving, “tough love”, and making themselves smaller (both physically and metaphorically). Based off their reports, one can surmise that the participants experienced their own distress when confronted with their friend’s distress. As previously discussed, participants also reported difficulty with emotion regulation. Taking all accounts into consideration results in the likelihood that participants may be unconsciously attempting to get their own needs met rather than actually meeting the needs of those they are providing care to. In other words, they may be trying to care for others so that they themselves can feel okay, yet are unknowingly limited by their own understandings of what empathetically attuned care both looks and feels like.

Overall, the sheer amount of discrepancies found in how participants formulated their understandings of themselves signified an ongoing internal conflict between different self-states.
According to the relational psychoanalyst Bromberg (2011), self-states are defined as “highly individualized modules of being, each configured by its own organization of cognitions, beliefs, dominant affect, and mood” (p. 72). In relatively healthy individuals, self-states become increasingly integrated into a greater whole as identity development progresses (Bromberg, 1996). In the case of repeated exposure to interpersonal trauma (i.e., complex trauma), self-states that hold onto the experiences of trauma become dissociated from the psyche and only emerge when life stressors erode the psychological defensives typically containing them (Bromberg, 2011). In this study, participants expressed persistent conflicts between the part of themselves that wants to feel deserving of self-compassion and the part of themselves that opposes that idea. It is likely that the latter part of themselves holds onto the unresolved trauma and serves to confound the participants about why they cannot “simply” be kinder to themselves.

**Increased Insight**

Throughout the course of the intervention, participants often remarked on their newfound knowledge of both self-compassion and of themselves. During the psychoeducational portion of the intervention, they described an increased sense of clarity concerning what self-compassion actually is. In particular, participants resonated with the concept of self-compassion defined as “the opposite of the golden rule” (i.e., do unto yourself as you would do unto others) (Neff, 2018). One explanation for this collective reaction could be that they appreciated the nod of acknowledgement to the “good” parts of themselves that are, in fact, capable of extending compassion. The reminder that they are able to offer care when witnessing the suffering of others connects them to the common humanity sub-component of self-compassion, which recognizes that all beings suffer (Neff, 2003). Therefore, the participants may have been more inclined to
perceive themselves as deserving of care when first prompted to consider that all suffering individuals deserve care.

Another possible, though not necessarily opposing, explanation could be the way in which the specific phrasing serves to challenge the perceived “badness” that individuals with complex trauma may associate with self-care. This notion is supported by developmental trauma research showing that traumatized individuals often conflate self-indulgence with self-compassion due to internalized messages that “others have it worse” (Germer & Neff, 2015). The study goes on to report that individuals with these associations likely experienced their basic needs failing to be met by those responsible for them and subsequently began to view their basic needs as “forbidden indulgences.” Given the number and frequency of participants referencing their previous conception of self-compassion as selfish indicates that a trauma history could impact how the delivery of information gets metabolized.

Following the Self-Compassion Break, participants reported an increased awareness of themselves and the issues they are currently facing. They described attaining clarity on their emotional states in particular, which implies willingness and capacity to connect with the mindfulness component of self-compassion (Neff, 2003). In fact, many of the participants described coming into closer contact with negative emotions that they were previously unaware of holding. Mindfulness-based research demonstrates that individuals who experience emotional pain stemming from self-criticism are, ironically, often unaware of the full extent of it (Neff & Knox, 2016). The published research in this area offers an explanation to this phenomenon by describing the tendency for individuals to quickly move into “fix it mode” without first recognizing the importance of providing themselves comfort for the experience (Neff, 2003b). Relatedly, mindfulness also offers individuals the opportunity to connect with thoughts and
feelings without automatically incorporating them into their self-concept (Neff & Knox, 2016). This approach could explain how the participants were able to engage with material previously deemed too threatening to hold since their self-concept was no longer at risk from attack. This speculation is backed by research revealing that incorporating self-compassion into mindfulness practice can soothe “ego threats” (Johnson & O’Brien, 2013).

**Discomfort from Confronting Avoidance**

As intended in the design of the study, all of the participants commented on their discomfort during the Self-Compassion Break. Accounting for the explicitly stated invitation to bring to mind an ongoing issue in their lives, it is not unexpected that discomfort arose. On the contrary, the participants’ abilities to feel their pain could signify an increased sense of safety that allowed for regulated contact with the discomfort. This conjecture aligns with the aim of the Self-Compassion Break, which entails choosing an issue located within one’s “window of tolerance” so that emotional processing can take place (Neff, 2018). The Window of Tolerance model purports that between the extremes of a sympathetic hyperarousal and parasympathetic hypoarousal response is an optimal range where emotions can be tolerated and integrated (Siegel, 1999). Although confronting avoidance is a hallmark to many manualized, exposure-based treatments for PTSD, such as prolonged-exposure therapy (PE), many do not adequately adjust for a significantly reduced window of tolerance that often hinders the accessing of painful emotions on command (Gleiser, Ford, & Fosha, 2008). By providing participants direction and agency to choose what issue gets brought to mind during the activity, the Self-Compassion Break offered the opportunity for confronting avoidance at a more self-determined pace (Neff & Germer, 2019; Watkins, Sprang & Rothbaum, 2018; Williams & Poijula, 2016). This structural
aspect likely influenced the notable absence of any participants expressing either overwhelm or dissociation during the activity.

Beyond the participants’ ability to mindfully connect with their feelings of discomfort were the reported benefits experienced as a result of self-compassionately confronting avoidance. Many participants replied to interview questions regarding their experiences following the Self-Compassion Break with statements conveying a sense of relief and release of tension. These reports indicate that the incorporation of self-compassion to the mindfully-held discomfort worked to soothe an activated nervous system response. According to Germer and Neff, accompanying mindful awareness with self-compassion invites in care in the midst of a painful experience (2013). Psychobiological research in self-compassion supports this theory through its findings showing decreased stress hormones and increased heart-rate variability in participants following a brief self-compassion exercise (Rockcliff et al., 2008). These biomarkers are associated with a greater ability to self-soothe when stressed (Porges, 2007). Importantly, participants in this study subjectively reported being able to both take in the self-compassion messages and offer them back to themselves in the midst of the discomfort. Considering how all of the participants previously disclosed their heightened propensity towards self-criticism when in distress, their shift towards care during the exercise suggests how self-compassion can be cultivated during any developmental stage, regardless of trauma history.

**Self-Compassion Perceived as Beneficial**

Participants unanimously reported self-compassion as a theoretically beneficial construct. When queried about their impressions of self-compassion, all of the participants claimed that an increase in self-compassion would lead to an increase in positive changes in their lives. For many, these changes looked like a reduction in overall stress levels since the additive stress that
is often associated with a self-critical stance would be alleviated. Importantly, participants did not anticipate always circumventing stressful situations, but rather they anticipated responding to these situations with more effective coping skills. This outlook deserves underscoring considering how avoidance-based strategies previously monopolized their approach to stress management. The participants’ impressions parallel findings from self-compassion research demonstrating its potential in promoting psychological resiliency (Neff, 2011). Deconstructing this finding highlights the processes that self-compassion uniquely offers. Instead of predating the resolution of stress on either avoiding or replacing negative emotions with positive ones, which is presumably especially difficult for individuals with complex trauma symptomology, self-compassion entails embracing negative feelings (Neff, 2003a). The implications of this approach permit care in the midst of suffering, *because one is suffering*, which insinuates that care does not have to be earned by being “good” to deserve it. This message stands in sharp contrast to the introjected messages that the participants reportedly carry with them from their upbringing.

While perceiving self-compassion as beneficial begins the process of cultivating it, perception alone is not sufficient for actually experiencing its evident benefits. Participants initially vocalized this point early on within their responses that expressed feelings of “stuck” in regards to how to transform theory into practice. This noted confusion, at times pessimism, about their potential for increasing self-compassion coincides with research findings demonstrating that individuals with histories of childhood maltreatment can readily identify and restructure maladaptive thoughts about the self; however, they do not find this process emotionally reassuring (Gilbert, 2010). In other words, this sub-population may cognitively connect with the ideological premise of self-compassion, but will likely experience difficulty emotionally
connecting to the material. This finding matters because it indicates that self-compassion interventions may not be absorbed if delivered exclusively within an intellectual framework. Consequently, the psychoeducational component of the intervention may have provided a theoretical foundation for self-compassion, but it was the experiential nature of the Self-Compassion Break that participants reported resonating the most with.

Following the Self-Compassion Break even the participant who reported the most initial hesitancy displayed heightened motivation to apply self-compassion more in their life. By the end of the interview, participants responded to questions with increased confidence and determination to enact changes that would improve quality of life. Previously published research largely supports the notion that self-compassion is not only associated with greater motivation, but that it directly enhances it (Brienes & Chen, 2012). In four separate experimental studies, participants were randomly assigned to one of three mood induction conditions: 1) Self-compassion, 2) Self-Esteem, or 3) Positive Mood. Compared to the other conditions, participants in the Self-compassion Condition group exhibited significantly more motivation to change for the better, repair past harms, and not repeat past mistakes (Brienes & Chen, 2012).

**Persisting Barriers to Self-Compassion**

To fully appreciate how individuals with complex trauma symptomology respond to self-compassion, questions attending to potential misgivings were incorporated as part of the interview segment in this study. Participant responses shed light on the persistent nature of certain barriers, compelling the need for continued addressment. A commonly referenced barrier consisted of the misconception that self-compassion equates to selfishness. The concern of neglecting their loved ones by becoming “too self-compassionate” suggests that participants retain the fear that attending to their own needs threatens relational ties. Underneath this fear lies
the assumption that care operates as a zero-sum game, with only one party able to receive care at a time.

Accumulated research in self-compassion illustrates a different story. One study found that self-compassionate people were rated by their romantic partners as more caring and giving in relationships (Neff & Beretvas, 2013). Another study found that self-compassionate college students were more likely to set compassionate relationship goals that promoted interpersonal trust and support (West & Craddock, 2016). Conversely, individuals low in self-compassion were found to be more likely to subordinate their needs during relationship conflict (Yarnell & Neff, 2013). Perhaps the most strikingly relevant finding found that self-compassionate individuals were less likely to engage in “pathological concern” for others, which was defined as an overinvestment in others’ needs while simultaneously denying one’s own (Gerber, Tolmacz, & Doron, 2015). It is this form of concern that all participants both endorsed and identified with as a character strength. Therefore, participant misconception of self-compassion might actually be rooted in misconception of what genuine care looks and feels like.

Participants also spoke on their association to self-compassion as a weak approach to navigating life. One participant continued to subscribe to this belief through the end of the interview while the others asserted that even though the association exists in their minds, they do not agree with it. Emily maintained her position while offering it from a place of unresolved pain. It became evident by her inclusion of a previous negative experience in her response that she felt let down by individuals who were supposed to care for her but failed to adequately meet her needs. One way of conceptualizing this reaction is by framing it as a manifestation of defended “backdraft,” which, as previously mentioned in Chapter Two, is the distress that can accompany feeling cared for in the present as it resurfaces times from the past when care was
needed but not received (Germer & Neff, 2018). Experiencing backdraft is more likely to occur in individuals with histories of childhood abuse because there are numerous painful memories waiting to be evoked (Gilbert et al., 2011). Although Emily attributed weakness to self-compassion and not herself, it is likely truer that she fears feeling weak as it threatens her already unstable sense-of-stability. Research supports this speculation through its findings that fear of self-compassion is prevalent amongst individuals with trauma histories (Gilbert et al., 2011).

Some of the identified barriers reportedly originated from sources outside of participants themselves. Participants attributed these barriers to various influences spanning across multiple levels of their surrounding environments. According to Bronfenbrenner’s bioecological theory, development occurs through bidirectional interactions between a person and the layered, yet interconnected systems that comprise the ecological environment (Bronfenbrenner, 1979). This theory provides a framework for understanding how external factors contribute to participants feeling barred from their desire to apply more self-compassion in their lives. Participants expressed a felt sense of pressure to sacrifice time for themselves in order to maintain expectations set by a fast-paced, capitalist society. This recognition of macrosystemic influences on the perceived accessibility of self-compassion suggests that participants grapple with the question of what is and is not within their locus of control. Individuals with histories of extensive trauma may be more likely to underestimate their agency in navigating these systems as adults if they repeatedly experienced their agency taken from them as children. Recent research in this area supports this notion through its findings that childhood trauma was negatively associated with internal locus-of-control (Türk-Kurtça & Kocatürk, 2020).
Post Reflexive Analysis

During the multitude of years spent working on my dissertation as a student-researcher, I was simultaneously working on developing my skills and professional identity as a student-clinician. Over this period of time, both the psychology field as a whole as well as my own understanding of complex trauma became increasingly enhanced compared to when CPTSD was first formally recognized as a diagnosis in 2018. I dedicated much of my time and energy over these years learning about the etiology, symptom manifestations, and course of treatment for complex trauma both within an academic lens and also in my own therapeutic practice. The past three years I spent practicing as a therapist within a college counseling center at a small, private liberal arts college that provides long-term, psychodynamic therapy to its student body. The privilege of working with individuals navigating their complex trauma on a long-term basis shaped my purview in ways that presumably co-exist within and outside my conscious awareness.

That being said, there were certainly times when my theorizing about the participants in this study extended beyond the scope of what had been directly stated in their responses. For example, participants did not report on their family history, yet my discussion section included comments about the potential effects of attachment trauma and ongoing attachment-related difficulties. Additionally, I spoke to various ideas that therapists could consider in their work (see Implications section) despite participants not endorsing such statements in their responses. In these instances, my voice as the researcher moved to the forefront. These speculations likely stem from my understandings gathered outside the confines of this study, which presents itself as a dual strength and weakness of this paper. Ultimately, the decision to preserve these
speculations in the final paper emanated from a place of offering. While it is clearly unadvisable to interpret the speculations as “truth”, they offer ideas worthy of contemplation.

**Implications**

The findings from this study contribute to the literature by providing insight into how individuals with low self-compassion and complex trauma symptomology respond to a brief introduction and application of a Mindful Self-Compassion (MSC) intervention. The aim of this study sought to better understand the lived experiences of this group to expand upon and inform the empirically-supported trauma treatments currently offered. This study revealed the potential benefits and barriers to self-compassion from the perspectives of therapy clients themselves rather than relying on findings derived from quantitative outcome data alone. More specifically, this study portrayed how these individuals are simultaneously both drawn to and discouraged by the concept of self-compassion. This ambivalence is predicated upon the ongoing conflict between the parts of themselves that still hold trauma and the parts that seek healing. As such, it is imperative that clinicians working with this population attune to the ways that self-compassion can serve as both a trigger and solution to unresolved trauma.

**The Therapeutic Presence.**

The quality of the therapeutic alliance has consistently been recognized as the main factor in determining successful psychotherapy outcomes across all orientations, and it is especially the case when working with trauma (Gleiser et al., 2008; Lynch, 2012; Luborsky 1994). It is understood that individuals with complex trauma symptomology experienced most of their emotional pain within the context of relationships, thus, it is through relationships that reparative healing can occur. Research has even shown that just being in the presence of a compassionate person can change the brain through experience-based neuroplasticity (Cozolino, 2017). Because
human beings are biologically “hardwired” to feel the emotional states of other people, sitting with a compassionate therapist can cultivate a client’s own level of self-compassion (Bernhardt & Singer, 2012). To establish the conditions conducive for this work to occur, the clinician must first connect to their own therapeutic presence (Germer & Neff, 2019). The term therapeutic presence has been previously defined as a way of conducting therapy in which the therapist is a) open and receptive to the client’s experience, b) attuned inwardly to the countertransference evoked by the client’s moment-to-moment experience, and c) uses this countertransference as a guide to promote connection (Geller, 2017).

Despite the importance of the therapeutic presence in developing a strong therapeutic alliance, clinicians working with complex trauma may find maintaining this position especially difficult (Germer & Neff, 2019). Clients with complex trauma symptomology are more likely to elicit provocative countertransference reactions that can overwhelm a clinician’s own internal resources (Kernberg, 2018). Even more subtle processes, such as striving to “fix” a client’s emotional state (thereby colluding in maladaptive avoidance), can distract clinicians from their connection to their therapeutic presence (Germer & Neff, 2019). Research demonstrates that practicing self-compassion can help clinicians return to their therapeutic presence by soothing the threat response evoked by unwanted countertransference reactions. Without an activated threat response, clinicians, in a parallel process to the participants in this study, are more able and motivated to fully take in the present moment (Bibeau, Dionne, & Leblanc, 2016).

**Therapeutically Relating to Clients.**

One of the biggest takeaways from this study is the importance of establishing a subjectively felt sense-of-safety for clients with complex trauma symptomology. Participants demonstrated increased capacity to confront avoided material when remaining within the
parameters of their window of tolerance. This recommendation aligns with currently established guidelines for clinical work involving the presence of complex trauma symptomology.

According to Herman, who first proposed the identification of CPTSD as a distinct diagnosis, treatment intervention should occur in stages. The first stage centers on developing emotion regulation skills so that, in later phases, clients can more effectively tolerate the distress entailed in directly processing trauma (1992). Therefore, clinicians should provide psychoeducation on the different tolerance zones as well as collaborate with clients on how to move towards more challenging affect without experiencing emotional flooding.

One self-compassion-based method for facilitating this development involves explicitly permitting clients to disengage from distressing material on their terms (Germer & Neff, 2019). This stance stands in direct contrast to Prolonged Exposure’s (PE) treatment protocol for PTSD, which asserts that shifting attention away from the traumatic material during a session amounts to collusion (Hembree et al., 2003). Although empirical evidence supports PE for alleviating PTSD symptoms, the behavioral-based intervention neglects to account for attachment disruptions found to be highly associated with complex trauma (Gleiser, Ford, & Fosha, 2008). These attachment disruptions manifest as subconscious defensives processes, which were observed across all four participants within their intra-and interpersonal relationships. By not allowing space for client agency in determining treatment pace, the risk for inadvertently reenacting past traumatic experiences increases. For example, clients with complex trauma may respond to a PE approach by passively complying with the more powerful “other,” thereby replicating experiences of coercion and loss of control. Clients may also respond to this intervention by “suffering in silence” while holding onto unformulated shame and aloneness, which would bring forth experiences of abandonment and betrayal. Finally, clients with
dissociative tendencies may internalize their response to the intervention as a “failure” on their part and further proof that they are “bad” (Gleiser, Ford, & Fosha, 2008). Altogether, inviting clients to self-compassionately honor their limits when co-creating the pace of treatment is essential when considering how the best meet the needs of individuals with complex trauma symptomology.

Another way that self-compassion-based interventions can be beneficially integrated into complex trauma treatment is through the targeted alleviation of shame. All participants endorsed a pervasive sense of shame that coincides with the *negative self-concept* domain listed under the *ICD-11* description of CPTSD (WHO, 2018). Understandably, participants felt shame during the self-compassion intervention as they realized their propensity for harsh self-treatment (i.e., they felt shame for feeling shame). Individuals with the combination of low self-compassion and complex trauma symptomology would benefit from psychoeducation dedicated to “de-shaming shame.” In the clinical realm, this psychoeducation might look like the clinician first acknowledging the presence of shame with the client. Subsequently, the clinician could re-frame the concept of shame from a blameworthy emotion to an innocent one. In other words, recognizing with the client that shame is constituted by ruptures in relationships, which ultimately stem from a wish for loving connections that is necessary for physical survival since infancy. When clients can acknowledge their innocent desire for loving connections, they can begin addressing what actually happened (Germer & Neff, 2019).

Similarly, self-compassion-based approaches can also be utilized to attend to all the parts-of-self that clients present with. As previously stated, the participants in this study exemplified on-going struggles with the different parts of themselves that were activated by the self-compassion intervention. Working with parts-of-self is not new to the psychotherapy field;
therapy models such as internal family systems (IFS) focus on attending to these different parts in the effort towards eventual integration (Schwartz, 1994). IFS works to understand each part of self by categorizing them by their role as either “protector” or “exile.” The exile-part is often connected to childhood trauma and stays locked away while holding onto the burdens of shame. The protector-self strives to keep the exile safe from harm and prevent the individual from accessing the pain held by the exile. One of the commonly identified ways that protector-self manifests is as a strong inner critic that functions to make the individual “behave properly.” This conceptual frame can be aptly applied to individuals with complex trauma symptomology learning self-compassion since the prominent protector-self may resist engaging in self-compassion in a misguided, yet well-intentioned, effort to keep the individual safe.

Undoubtedly, it is important for clinicians to be informed of the ways that self-compassion can initially threaten the protector-self (i.e., inner critic). Self-compassion inherently challenges the ways that individuals with complex trauma symptomology have subconsciously relied upon for safety; therefore, clinicians should hold and extend compassion for all parts that present during treatment (Germer & Neff, 2019). This approach entails seeking a better understanding of the protector-self while explicitly validating its intentionality. As the protector-self begins to soften, the exile-part is likely to come forward. At this time, it is imperative that the clinician (connecting to their therapeutic presence) provides a good-enough holding environment so that the burdens held by the exile-part for so long can finally be shared and compassionately attended to.

It is recommended that clinicians working alongside individuals with complex trauma symptomology stay cognizant for the probability that the exile-part appears somatically following a self-compassion exercise. In other words, backdraft engendered from receiving
Compassion can manifest physiologically. Although participants in this study did not report somatic reactions post-self-compassion break, research demonstrates that unprocessed trauma often becomes stored in the body (Mulloy, 2019; Van der Kolk, 2017). For example, a client may notice a lingering lump in the throat after completing a self-compassion exercise. A clinician could invite the client to gently place a hand on the particular spot as an expression of care for the struggle happening within. If the discomfort persists, a clinician may follow-up by inviting the client to speak compassionately to the lump as if it was a part of herself, and if it feels okay, to listen to what that part might say. To uphold the philosophy supporting the window-of-tolerance model, it is recommended that this interaction remain contained within a 10-20 second duration (Germer & Neff, 2019). This example serves as just one instance of how self-compassion-based interventions can activate trauma and consequently soothe it.

As previously illustrated, the window of tolerance model should not only apply when facilitating client movement towards avoided material, but also to their self-compassion practice. Participants in this study were intentionally guided through an introductory exercise in self-compassion to mitigate against unhelpful levels of backdraft, yet subtle indicators suggested that one participant felt internally prompted to defend against it. The results from this study combined with previous research implore clinicians to “warm clients up slowly” to self-compassion so that the experience of backdraft does not overwhelm them (Germer & Neff, 2015; Gilbert et al., 2011). Despite this precaution, the emergence of backdraft over the course of a compassion-based trauma treatment proves both inevitable and necessary for healing (Germer & Neff, 2015). Successfully managing backdraft can be considered a method of “re-parenting” by providing reparative emotional experiences (Mikulincer & Shaver, 2017). To elaborate, self-compassion can lay old attachment wounds bare, which can be soothed by meeting these wounds
with the kind of care that had been previously hoped for, but not received. This study demonstrated that individuals with a complex trauma history struggling with self-compassion would likely need to experience receiving compassion before being able to genuinely internalize it. Research supports this impression and adds that the overall process may span years (Cloitre, Cohen, & Koenen, 2011). However, behavioral practices in self-compassion can augment this process by supplying individuals resources for cultivating self-compassion without the presence of a therapist (Germer & Neff, 2019).

**Clients Relating to Themselves through Home Practice.**

This study demonstrated that individuals with complex trauma symptomology are likely interested in developing more self-compassion, but may feel stuck in regards to how to go about it. Clinicians can scaffold this process by framing the work as happening both inside and outside the therapy space. The overarching question clinicians should recommend their trauma clients to keep in mind when incorporating self-compassion into their home practice is “What do I need right now?” (Germer & Neff, 2019). Posing this question may be too difficult for clients to answer initially as individuals with histories of complex trauma rarely experienced their needs being met (Herman, 1992). This question can be adapted to meet the client’s current developmental position by suggesting they reflect on the question “How do I care for myself already?” (Germer & Neff, 2019). By broadening the practice of self-compassion as engagement in activities that feel familiar- and perhaps ordinary- clients can feel self-efficacious in meeting their suffering with compassion even when they feel stuck. Clients who desire a more formalized self-compassion practice should be advised to titrate their practice by starting with shorter practices and gradually working up to longer meditations, per the window of tolerance theory (Germer & Neff, 2015). Additionally, a recently published study investigating mechanisms of
change within a group-formatted self-compassion-based intervention for individuals with complex trauma demonstrated reported improvements in self-worth, relationships, and symptom reduction (Ashfield, Chan, & Leff, 2020). Although preliminary evidence is currently sparse, this adjunctive therapy option may present beneficially fruitful.

It is important for both clinician and client to keep in mind whether a supposedly self-compassionate practice is actually self-compassionate (Germer & Neff, 2019). This evaluation can be determined by how a practice “lands”, in other words, how it felt for the client during and post-engagement. Due to the heterogeneous nature of trauma, what might be experienced as soothing by one individual might be experienced as triggering by another (Cloitre, 2015). For example, three participants in this study endorsed feeling comforted by the physiological act of putting their hands on their hearts. On the other hand, the fourth participant disengaged from reflecting on the body during the interview portion of the study, indicating that bodily contact could likely be triggering. Because trauma is often dissociated from conscious awareness (i.e., exile-self), predicting in advance which activities are triggering or soothing can be unreliable. It is advisable that clinicians hold this awareness when exploring behavioral self-compassion activities with clients and defer to them as the experts of their experiences. Relatedly, due to the pervasive nature of shame, clients with complex trauma symptomology may be more likely to emotionally withdraw if experiencing adverse effects from a self-compassion exercise rather than inform their clinician. It is recommended that clinicians regularly check-in with their clients about all of their experiences—both positive and negative ones (Germer & Neff, 2019).

Limitations

This study utilized qualitative thematic analysis to provide rich and in-depth first-person accounts that helps bridge the gap in understanding how to meet the needs of an understudied
population. Despite this study generating nuanced information from the perspectives of individuals who, historically, may have been excluded from other trauma-research studies, limitations in this study did exist. It could be argued that the small number of participants limits the generalizability of the findings. However, this argument depends on which philosophical definition of generalizability gets applied. According to Carminati, positivist traditions previously dominated the social sciences, which led to the adoption of quantitative-based definitions of generalizability. Instead of defining generalizability by statistical generalizations, qualitative research aims to define generalizability by its analytical or theoretical generalizations (Carminati, 2018).

Limitations regarding participant demographics existed. All of the participants identified as either cis-gender women or non-binary, which meant that perspectives from cis-gender men were not heard, and therefore, not integrated into the development of themes. While the initial hope was to collect a gender-diverse pool of participants, the ultimate goal focused on recruiting individuals with low rates of self-compassion and complex trauma symptomology. Therefore, an underrepresentation of individuals identifying as men in this study may reflect the findings from a meta-analysis of self-compassion research showing that women, on average, score significantly lower on self-compassion measures than men (Yarnell et al., 2015). It may be the case that the men who completed the Qualtrics screening survey did not meet the inclusionary criteria as often as individuals with other gender-identities. The social science field would benefit from future research exploring the experiences of men with low scores of self-compassion and complex trauma symptomology.

Relatedly, all of the participants racially identified as White. The transcribed interviews were devoid of responses from individuals with racially-marginalized identities, who may have
contributed essential viewpoints distinct from those reported by the four recruited participants. Recent self-compassion research demonstrates that the relation between self-criticism and self-compassion is moderated by ethnicity. Interestingly, the researchers found a positive correlation between self-criticism and self-compassion among Asian Americans, which counters the negative association commonly found between these two constructs among European Americans (Boyraz, Legros & Berger, 2021). This finding necessitates further exploration as it calls attention to the limits of this study’s generalizability across racial and ethnic groups. Future qualitative research dedicated to better understanding the nuances of how cultural differences influence the relation to self-compassion would provide important information moving forward.

Lastly, all of the participants’ ages ranged from 18 years-old to 21-years old, thereby placing them within a developmental position some researchers refer to as “emerging adulthood” (Arnett, 2007). According to Arnett, this period in a life cycle is marked by identity exploration, instability, feeling “in-between”, self-focus, and the potential for many possibilities (p. 69). The presence of conflicting self-states and the openness to alternative ways of relating to themselves that were observed in the participant responses may have been, in part, connected to their current developmental position. Future research could benefit from exploring how implementing self-compassion based interventions to individuals at differing developmental stages effects results.

It is important to consider the recruitment procedure when reflecting on limitations. This study recruited participants on a voluntary basis, which potentiates the possibility for selection bias effects. It is not known how this bias may have impacted the end results, but certain outcomes can be speculated. For example, participants experiencing financial burdens may have been more inclined to participate in this study due to the provided $20.00 compensation. Socioeconomic status as a demographic variable was not collected, so no evidence can support
nor challenge this notion. Additionally, participants who were not able or comfortable discussing vulnerable material with a new person likely did not choose to sign up for the second phase of the study. Therefore, degree of functioning and level of baseline trust may have determined whose perspective was heard and whose was not.

Finally, the effects that the study’s atmosphere may have had on the results deserves consideration. Each participant partook in the self-compassion intervention on one agreed-upon day with the preemptive understanding that it would span around an hour. Time-constraints may have impacted how thorough participants felt they could be in their responses to the semi-structured interview questions. Similarly, participants may have responded differently to the questions if more reflection time had been allotted or if they were given an opportunity for follow-up clarification post-intervention. Follow-up questions may have also elucidated how participants continued to relate, or not relate, to self-compassion after a period of time. Lastly, the power differential evoked by the presence of the principle investigator as the interviewer could have impacted the degree of honesty participants felt comfortable conveying within their responses. Certain measures, such as guaranteeing payment at any time and acknowledging the absence of “right” and “wrong” answers, were taken to promote safety in the space as well to mitigate the aforementioned effects.
Chapter 6: Future Directions and Conclusions

Future Directions

Considering the growing amount of accumulated research in self-compassion demonstrating its effectiveness in alleviating symptoms associated with trauma, especially complex trauma, interest in its clinical potential is sure to continue. There are several areas of interest that warrant further investigation. As previously touched upon in the Limitations section, continued research should emphasize the recruitment of a broader range of demographic diversity to increase understanding of a wider population. Similarly, exploring the nuanced experiences of individuals with differing intersecting identities would help the field better understand how the phenomenology of self-compassion exists within cultural contexts. Qualitative research investigating the experiences of individuals holding marginalized identities (such as minoritized ethnic groups or LGBTQIA+ individuals) may be especially pertinent given the ongoing preponderance of racism, transphobia, and ethnoviolence in the United States (Stout & Slevin, 2022).

Future research should continue empirical investigation into the developmental trajectory of compassion towards self and other. Although it is understood that early attachment relationships impact a person’s level of compassion in adulthood (Wei et al., 2011), there is a dearth of information regarding developmental changes in the ability to engage in compassion. Identifying the developmental skills, such as perspective-taking, that may serve as a prerequisite for compassionate relating could elucidate further barriers that deserve addressing. Additionally, all participants in this study indicated frustration surrounding the lack of education on this topic in the education system. Researching how self-compassion can be more expansively implemented during early developmental stages could offer insight into protective factors. One
research study conducted a twelve-week compassion-based Kindness Curriculum for preschoolers. Results demonstrated that children taking the program portrayed greater improvements in social competence and socio-emotional development compared to the children in the waitlist (Burke, 2010). Continued research into how and when compassion should be taught across different systems could help to construct more conducive environments for compassion to grow (Bronfenbrenner, 1979).

As previously mentioned in the Implications section, furthering research in assessing the potential of group-formatted self-compassion-based interventions for complex trauma could elucidate novel therapeutic benefits. The research study that conducted this type of intervention concluded that the group format proved essential for the change process that observably occurred (Ashfield, Chan, & Leff, 2021). A group context offers ample opportunity to practice giving and receiving compassion amongst peers with similar difficulties, which calls forth the common humanity subcomponent of self-compassion in real-time. Future research exploring this approach through randomized-controlled trials (RCTs) is needed to establish efficacy. In particular, comparing self-compassion-based group interventions to an active control condition would help determine which processes account for the outcome results. Relatedly, tracking change through longer-term follow-up measures post-intervention would aid in capturing the prevalence of sustained outcomes. Previous studies highlight that measures of interest include those assessing for shame, emotion regulation, and relationships (Ashfield, Chan, & Leff, 2021).

Conclusions

The objective of this study was to illuminate the internal experiences of individuals with low levels of self-compassion and complex trauma symptomology during an introductory self-compassion-based intervention. The qualitative design served to fill a methodological gap in the
research that has previously relied upon quantitively-derived outcome data to inform trauma
treatment. The findings from this study suggest that cultivating self-compassion can provide
benefits that specifically address the symptom domains uniquely associated with complex
trauma, namely: affect dysregulation, negative self-concept, and interpersonal difficulties. The
results also indicate that the prevalence of accumulated trauma can negatively impact the
cultivation of self-compassion, thereby hindering individuals from reaping these benefits.
Individuals with extensive trauma histories are likely to exhibit reliance on protective, albeit
maladaptive defenses that arose as a result of developmental needs not being adequality met.
However, these barriers are not insurmountable. Thematic analysis demonstrated that
participants subjectively experienced decreased avoidance along with increased esteem and
motivation following the brief self-compassion intervention. Altogether the combined findings
from this study and previous literature suggest that attending to the impacts of trauma through
establishing safety and extending compassion for all parts-of-self can enhance the delivery of
self-compassion for individuals with complex trauma symptomology.
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Appendix A

Dear therapist and supervisor:

My name is Brooke Roseman and I am currently in my 3rd year of the WCU clinical Psy.D. program working on collecting data for my dissertation. For my dissertation, I will be conducting a qualitative-based study that will explore initial reactions/perceptions to a brief psychoeducation/application of self-compassion within individuals currently experiencing symptoms associated with Complex Post-Traumatic Stress Disorder (CPTSD). At this time, I am in the process of recruiting a total of four individuals, which I am hoping you will be able to assist me with.

The individuals I am hoping to recruit as participants in my study meet the following inclusionary criteria:

- At least 18 years-old
- Fluent in English
- Low reported rates of self-compassion
- Exposure to at least one traumatic event during their lifetime
- CPTSD symptom criteria (participants must endorse at least one symptom within each of the following six domains: 1) avoidance, 2) hypervigilance, 3) re-experiencing, 4) affective dysregulation, 5) negative self-concept, 6) interpersonal difficulties)

Given you and your supervisor’s direct therapeutic experience with your clients, I ask that you incorporate use of clinical judgment when determining if a potential client will be an appropriate match for the study. Clients meeting all of the aforementioned inclusionary criteria will be asked to complete a Qualtrics survey as a further screening protocol for the study.

Out of all the individuals who are referred (by you and your supervisor) to complete the Qualtrics survey, the first four individuals who complete the survey and meet all necessary criteria will be invited to participate in the research study. These participants will be asked to complete the following procedure:

1. Schedule a time to meet with me in my graduate assistantship lab for approximately one hour.
2. During this hour, I will provide them a brief overview of the concept of self-compassion as is it defined by Kristen Neff in her Mindful Self-Compassion (MSC) manual.
3. Immediately following, I will guide participants through an MSC activity called the “Self-Compassion Break”, which is an approximately ten minute practice on applying the concepts of self-compassion in “everyday” life.
4. Afterwards, I will conduct a semi-structured interview to gather information related to each participant’s unique reactions and perceptions to the concept of self-compassion.

5. Each participant will be provided a $20.00 VISA gift card as an incentive for participation.

Thank you, your assistance is greatly appreciated. If you have any questions or would like further information, you can contact either myself at br895204@wcupa.edu or my dissertation chair Dr. Lia O’Brien at lobrien@wcupa.edu.
Appendix B

Have people ever told you...

- "you’re too hard on yourself?"
- "you should be kinder to yourself?"

If you are experiencing any difficulties in life, including major life stressors, and would like to learn more about Self-compassion… this study may be of interest to you!

Upon completing two brief questionnaires, you may be selected to participate in an interview that would take approximately one hour.
If selected for the interview, you will receive a $20 Visa gift card for your time.

For more information please contact:
Brooke Roseman, M.S. at br895204@wcupa.edu or
Lia O’Brien, Ph.D. at lobrien@wcupa.edu
Appendix C

Apr 13, 2022 8:18:53 AM EDT

To: Brooke Roseman
Psychology, University College

Re: Modification - IRB-FY2021-241 Exploring Perceptions of Self-Compassion in Individuals with Complex Trauma Symptomology: A Qualitative Approach

Dear Brooke Roseman:

Thank you for your submitted modification to your WCUPA Institutional Review Board approved project Exploring Perceptions of Self-Compassion in Individuals with Complex Trauma Symptomology: A Qualitative Approach. We have had the opportunity to review your modification and have rendered the decision below effective April 13, 2022.

Decision: Approved

Sincerely,
WCUPA Human Subjects Review Board

IORG#: IORG00004242
IRB#: IRB000005030
FWA#: FWA00014155
Appendix D

Informed Consent

Project Title: Exploring Perceptions of Self-Compassion: A Qualitative Approach

Investigator(s): Brooke Roseman, M.S.; Lia O'Brien, Ph.D.

Project Overview:

Participation in this research project is voluntary and is being done by Brooke Roseman as part of her doctoral dissertation to examine how individuals experience applying self-compassion in their lives. Your participation will take up to an hour to complete a self-compassion-based activity and follow-up interview. There is minimal risk involved with engaging in the self-compassion-based activity as participants will be invited to bring to mind a mild-moderately stressful life event as they are guided through applying skills of self-compassion. There are some potential benefits to participating in this study. The self-compassion-based activity may help alleviate current and future discomfort during moments of distress. In addition, participants will also be provided a $20.00 VISA gift card upon completion of the interview.

If you would like to take part, West Chester University requires that you agree and sign this consent form.

You may ask Brooke Roseman any questions to help you understand this study. If you don't want to be a part of this study, it won't affect any services from West Chester University. If you choose to be a part of this study, you have the right to change your mind and stop being a part of the study at any time.

1. **What is the purpose of this study?**
   - Examine how individuals experience applying self-compassion in their lives.

2. **If you decide to be a part of this study, you will be asked to do the following:**
   - Receive a brief introduction to the concept of self-compassion
   - Engage in a five-minute self-compassion-based activity
   - Answer interview questions about your experience
   - This study will take up to an hour of your time.

3. **Are there any experimental medical treatments?**
   - No

4. **Is there any risk to me?**
   - Possible risks or sources of discomfort include: There is minimal risk involved with engaging in the self-compassion-based activity as participants will be invited to bring to mind a mild-moderately stressful life event as they are guided through applying skills of self-compassion.
   - If you become upset and wish to speak with someone, you may speak with Brooke Roseman at br895204@wcupa.edu
   - If you experience discomfort, you have the right to withdraw at any time.

5. **Is there any benefit to me?**
Benefits to you may include: Participants will learn and apply a self-compassion-based technique that may help alleviate discomfort during moments of distress. In addition, participants will also be provided a $20.00 VISA gift card upon completion of the interview.

Other benefits may include: The field of psychology will better understand the experiences of individuals who historically have been under-represented in treatment research studies. Relatedly, this study will also provide more information about the association between experiencing trauma and levels of self-compassion. Clinically, therapists may use this information to better adapt standardized self-compassion-based/trauma interventions to more effectively meet the needs of individuals who may not respond to typical treatment interventions.

6. **How will you protect my privacy?**
   - The session will be recorded.
   - Audio recordings of the interview portion of the study will be temporarily stored on both a password protected phone and laptop.
   - Your records will be private. Only Brooke Roseman, Lia O’Brien, and the IRB will have access to your name and responses.
   - Your name will **not** be used in any reports.
   - Records will be stored:
     - Password Protected File/Computer
   - Participants’ names will never be connected to their data. Email addresses will be deleted upon study completion.
   - Records will be destroyed after manuscript development, but no less than three years.
   - There are two exceptions to complete confidentiality. As a mandated reporter, the researcher is required to report to appropriate personnel in the case that there is reasonable evidence for immediate harm to self or an identifiable other. In addition, if the researcher has cause to believe that there is current abuse to a minor, only the relevant information will be reported to appropriate personnel to ensure the safety of all parties.

7. **Do I get paid to take part in this study?**
   - Yes; $20.00 VISA gift card.

8. **Who do I contact in case of research related injury?**
   - For any questions with this study, contact:
     - **Primary Investigator:** Brooke Roseman at 610-500-1763 or br895204@wcupa.edu
     - **Faculty Sponsor:** Lia O’Brien at 610-436-2081 or LOBrien@wcupa.edu

9. **What will you do with my Identifiable Information?**
   - Your information will not be used or distributed for future research studies.

For any questions about your rights in this research study, contact the ORSP at 610-436-3557.

I, _________________________________ (your name), have read this form and I understand the statements in this form. I know that if I am uncomfortable with this study, I can stop at any time. I know that it is not possible to know all possible risks in a study, and I think that reasonable safety measures have been taken to decrease any risk.

_________________________________
Subject/Participant Signature       Date:________________

_________________________________
Witness Signature                   Date:________________
Appendix E
Demographic Questionnaire

1) Please indicate in the space below your preferred gender identity and preferred pronouns.

2) Provide your age in the space provided.

3) Are you of Hispanic/Latinx/Spanish origin?
   - Yes
   - No

4) How would you describe yourself from the following options?
   - American Indian/Alaskan Native
   - Asian
   - Black or African American
   - Native Hawaiian or Other Specific Islander
   - White/Caucasian
   - If none of the above, use the space below to provide your identified race/ethnicity

5) Select your current level of education:
   - Less than a high school degree
   - High school graduate
   - Some college
• Bachelor’s degree

• Master’s degree

• Doctoral degree

6) Are you comfortable with both understanding and speaking English?
   • Yes

   • No
Appendix F

International Trauma Questionnaire

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience _______________________________________________________

When did the experience occur? (circle one)

1. less than 6 months ago
2. 6 to 12 months ago
3. 1 to 5 years ago
4. 5 to 10 years ago
5. 10 to 20 years ago
6. more than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.
Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1. Having upsetting dreams that replay part of the experience or are clearly related to the experience?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>P2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>P3. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>P4. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>P5. Being “super-alert”, watchful, or on guard?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>P6. Feeling jumpy or easily startled?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

In the past month have the above problems:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>A little bit</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>P7. Affected your relationships or social life?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>P8. Affected your work or ability to work?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>P9. Affected any other important part of your life such as parenting, or school or college work, or other important activities?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

### 1. Diagnostic scoring for PTSD and CPTSD

#### PTSD

If P1 or P2 > 2 criteria for Re-experiencing in the here and now (Re_dx) met
If P3 or P4 > 2 criteria for Avoidance (Av_dx) met
If P5 or P6 > 2 criteria for Sense of current threat (Th_dx) met
AND
At least one of P7, P8, or P9 > 2 meets criteria for PTSD functional impairment (PTSDFI)
If criteria for ‘Re_dx’ AND ‘Av_dx’ AND ‘Th_dx’ AND ‘PTSDFI’ are met, the criteria for PTSD are met.

#### CPTSD

If C1 or C2 > 2 criteria for Affective dysregulation (AD_dx) met
If C3 or C4 > 2 criteria for Negative self-concept (NSC_dx) met
If C5 or C6 > 2 criteria for Disturbances in relationships (DR_dx) met
AND
At least one of C7, C8, or C9 > 2 meets criteria for DSO functional impairment (DSOFI)
If criteria for ‘AD_dx’ AND ‘NSC_dx’ AND ‘DR_dx’, and ‘DSOFI’ are met, the criteria for DSO are met.
PTSD is diagnosed if the criteria for PTSD are met but NOT for DSO.
CPTSD is diagnosed if the criteria for PTSD are met AND criteria for DSO are met.
Not meeting the criteria for PTSD or meeting only the criteria for DSO results in no diagnosis.

2. Dimensional scoring for PTSD and CPTSD.

Scores can be calculated for each PTSD and DSO symptom cluster and summed to produce PTSD and DSO scores.

**PTSD**

Sum of Likert scores for P1 and P2 = Re-experiencing in the here and now score (Re)  
Sum of Likert scores for P3 and P4 = Avoidance score (Av)  
Sum of Likert scores for P5 and P6 = Sense of current threat (Th)  
PTSD score = Sum of Re, Av, and Th

**DSO**

Sum of Likert scores for C1 and C2 = Affective dysregulation (AD)  
Sum of Likert scores for C3 and C4 = Negative self-concept (NSC)  
Sum of Likert scores for C5 and C6 = Disturbances in relationships (DR)  
DSO score = Sum of AD, NSC, and DR
Appendix G

Self-Compassion Questionnaire

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Almost always</th>
<th>5</th>
</tr>
</thead>
</table>

1. I’m disapproving and judgmental about my own flaws and inadequacies. 
2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong. 
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through. 
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world. 
5. I try to be loving towards myself when I’m feeling emotional pain. 
6. When I fail at something important to me I become consumed by feelings of inadequacy. 
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am. 
8. When times are really difficult, I tend to be tough on myself. 
9. When something upsets me I try to keep my emotions in balance. 
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people. 
11. I’m intolerant and impatient towards those aspects of my personality I don't like. 
12. When I’m going through a very hard time, I give myself the caring and tenderness I need. 
13. When I’m feeling down, I tend to feel like most other people are probably happier than I am. 
14. When something painful happens I try to take a balanced view of the situation. 
15. I try to see my failings as part of the human condition. 
16. When I see aspects of myself that I don’t like, I get down on myself. 
17. When I fail at something important to me I try to keep things in perspective.
Coding Key:
Self-Kindness Items: 5, 12, 19, 23, 26
Self-Judgment Items: 1, 8, 11, 16, 21
Common Humanity Items: 3, 7, 10, 15
Isolation Items: 4, 13, 18, 25
Mindfulness Items: 9, 14, 17, 22
Over-identified Items: 2, 6, 20, 24

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items before calculating subscale means - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1) - then compute a grand mean of all six subscale means. Researchers can choose to analyze their data either by using individual sub-scale scores or by using a total score.
Appendix H

Debrief Form

We thank you for your time and effort in taking the survey.

Please contact the study’s principle investigator, Brooke Roseman, at BR895204@wcupa.edu if you have any questions or concerns.

In case of a psychological emergency, contact Public Safety at 610-436-3311, call the National Suicide Prevention Lifeline: 1-800-273-TALK (1-800-273-8255), dial 911, or go to your closest emergency room.
Appendix I

Invitation to Participate in Phase Two

Some participants may be selected to participate in the second phase of this study, which will consist of a brief self-compassion based activity and follow-up interview. Participants will be provided a $20.00 VISA gift card for their time and efforts. If you are interested in participating, please provide your preferred email address in the space below to receive more information.
Appendix J

What is Self-Compassion?

Self-Compassion is treating ourselves with the same kindness and understanding as we would treat a friend when things go wrong (It is the reverse of the Golden Rule: Do unto yourself as you would do onto others).

Self-Compassion is treating ourselves as we would like others- family and friends- to treat us.

Self-Compassion can be understood as encompassing three components. The three components include 1) Self-kindness versus Self-Judgement, 2) Common Humanity versus Isolation, and 3) Mindfulness versus Over-identification.

The first component- self kindness- is treating ourselves with kindness, care, understanding, and support, just as we would treat a good friend. Most people treat themselves more harshly, saying cruel things to themselves that they would never say to others. Compassion includes the wish and effort to alleviate suffering. There is an action component of self-compassion. It involves actively comforting, protecting, and supporting ourselves when we’re in pain.

The second component- common humanity- is seeing our imperfections as part of the larger human experiences. Also, recognizing that everyone suffers. When we struggle or fail, we often feel that something has gone wrong- that this shouldn’t be happening. This creates a feeling of abnormality (I am wrong), leading to shame and isolation. This process can be referred to as over-identification.

The third component- mindfulness- is knowing that we are suffering, while we suffer. This is a pre-requisite for compassion to arise. Mindfulness allows us to turn towards painful feelings and “be with them” as they are. Mindfulness is a balanced state of awareness. We do not suppress or avoid what we’re feeling; nor are we carried away by the dramatic storyline of what’s happening.
Appendix K

Self-Compassionate Break

Taking the posture you prefer for meditation sitting or lying down. Feeling your connection to gravity feeling the weight of the body. Settling into your posture. Allowing yourself to be held, perhaps centering yourself by making the breath the focus of your attention. Feeling the breath moving in the body, aware of the breath in the body sitting or lying down.

“Thinking of a situation if your life that is difficult, that is causing you stress right now, such as a health problem, a problem with an important relationship, a work problem, or perhaps someone crossed your boundary or disrespected you. Please choose a problem in the mild-moderate range, not a big problem. (pause). We do not want to overwhelm ourselves as were first learning the skills of self-compassion.”

“Allow yourself to see, hear, and feel your way into the problem, to the extent that you experience some uneasiness in the body. Where do you feel it the most? Make contact with the discomfort that you feel in your body.”

“Then say to yourself, slowly and clearly, ‘This is a moment of suffering.’ That’s mindfulness. Other options include ‘This hurts,’ or ‘This does not feel good.’ (Pause)

“Next, say to yourself, again slowly and clearly, ‘Suffering is a part of living.’ That’s common humanity. Other options include ‘Others would feel just like me,’ ‘I am not alone,’ or ‘Me too.’ (Pause)

“Now put your hands over your heart, or where it feels supportive, feeling the warmth of your hands. Say to yourself, ‘May I be kind to myself.’ ‘May I give myself what I need.’ That’s self-kindness. Perhaps asking yourself what quality of self-compassion you need right now, whether it be tenderness or protection. Tenderness language might be ‘May I accept myself just as I am’ or ‘May I care for myself tenderly in this moment.’ Protection language might be ‘No, I will not allow myself to be harmed in this way,’ or ‘May I have the courage and strength to make a change.’ (Pause)

“If you are having difficulty finding the right words, imagine that a dear friend or loved one is having the same problem as you. What would you say to this person, heart to heart, without giving advice? If your friend were to hold just a few of your words in her mind, what would you like them to be? What messages would you like to deliver? (Pause) Now, can you offer the same message to yourself?” How does that feel to receive these messages for yourself? Being mindful of the quality or qualities that are arising in this moment and Letting go of judgment. (Pause)

When you’re ready bringing your attention back to the breath moving in the body, sensing the body here, being held by gravity, Sensing the body breathing in this moment, noticing thoughts
and feelings and allowing yourself to be exactly as you are, which in and of itself is an act of self-compassion.

Appendix L

Self-Compassion Interview Questions

1. What was your reaction upon learning about self-compassion?
2. What is your definition of self-compassion?
   a. Has that definition changed since this introduction to the concept? How so?
3. What was completing the “Compassionate Break” exercise like for you?
   a. What feelings did completing this exercise arise in you?
   b. Was any part of completing this exercise uncomfortable to you in any way?
4. Think about various times when you’ve had a close friend who was struggling in some way and you were feeling pretty good about yourself. How do you typically respond to your friends in such situations?
   a. What do you say? What tone of voice do you use? How is your posture?
5. When life gets difficult, describe how you typically cope.
   a. How do you typically respond to yourself in these situations? What do you say?
      What tone of voice do you use?
6. Consider the differences between how you treat your close friends when they are struggling and how you treat yourself?
   a. Can you describe any differences you noticed?
   b. Do you notice any patterns?
7. What part of this introduction to self-compassion resonated the most with you?
   a. Which parts feel the most challenging to either understand or implement in your life?
8. Do you have any misgivings that you personally have about self-compassion?
   a. Any fears or concerns you have about its possible downsides?
9. If any, what are some of the misgivings you believe other people or society at large have about self-compassion?
10. Are there times when you find it easier or harder to be compassionate towards yourself?
11. Can you think of any positives to being able to forgive/be kinder to yourself when life gets difficult?
12. How would you apply self-compassion more in your life?
13. On a scale from 1-10, how interested are you in continuing to learn and practice incorporating self-compassion into your life?
14. Is there any other information you think would be important for me to have?