Can being kind to ourselves make a difference?  
The relationship between self-compassion and post traumatic stress disorder

Submitted by Lisa Gilmour, to the University of Exeter
as a thesis for the degree of Doctor of Clinical Psychology
May 2014

This thesis is available for Library use on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature.................................................................
Table of Contents

1.0 Abstract ................................................................................................................................. 7
2.0 Introduction .............................................................................................................................. 8
3.0 Aims and objectives ................................................................................................................. 10
4.0 Methodology .......................................................................................................................... 10
  4.1 Eligibility criteria of studies ................................................................................................. 10
    4.1.1 Study design .................................................................................................................... 11
    4.1.2 Treatment interventions ................................................................................................. 11
  4.2 Search strategy ...................................................................................................................... 11
    4.2.1 Study selection ................................................................................................................ 12
    4.2.2 Data extraction ................................................................................................................ 12
    4.2.3 Data synthesis .................................................................................................................. 12
5.0 Results ..................................................................................................................................... 14
  5.1 Study characteristics ............................................................................................................. 15
  5.2 Study methodology .............................................................................................................. 17
    5.2.1 Design and measures ..................................................................................................... 17
    5.2.2 Change in self-compassion ............................................................................................ 18
    5.2.3 Treatment intervention ................................................................................................. 19
    5.2.4 Self-compassion and psychiatric symptom reduction ..................................................... 20
    5.2.5 Mechanisms .................................................................................................................... 22
6.0 Discussion ............................................................................................................................... 23
  6.1 Change in self-compassion .................................................................................................... 23
  6.2 Self-compassion and psychiatric symptom reduction ............................................................ 24
  6.3 Limitations ............................................................................................................................ 25
  6.4 Future Implications ............................................................................................................... 26
7.0 Conclusion ............................................................................................................................... 27

References ...................................................................................................................................... 28

Appendices ................................................................................................................................... 32

Appendix A: Summary of treatment interventions ........................................................................ 32
Research Paper

8.0 Abstract...............................................................................................................40

8.0 Context and Background.........................................................................................41
8.1 Self-compassion........................................................................................................41
8.2 The malleability of self-compassion.........................................................................41
8.3 Self-compassion and mental health...........................................................................42
8.4 Self-compassion and PTSD.......................................................................................42

9.0 Aims and Research Questions..................................................................................44

10.0 Methods................................................................................................................45
10.1 Design....................................................................................................................45
10.2 Sample and participants.........................................................................................45
10.3 Measures and materials........................................................................................46
10.3.1 Phase 1: Qualitative material.............................................................................46
10.3.2 Phase 2: Quantitative measures.........................................................................47
10.4 Procedure.................................................................................................................49
10.4.1 Phase 1: Qualitative procedure...........................................................................49
10.4.2 Phase 2: Quantitative procedure.......................................................................50
10.5 Data Analysis Strategy............................................................................................51
10.5.1 Phase 1: Qualitative analysis.............................................................................51
10.5.2 Phase 2: Quantitative analysis..........................................................................52

11.0 Results....................................................................................................................54
11.1 Phase 1: Qualitative results.......................................................................................54
11.1.1 Self-compassion.................................................................................................55
11.1.2 Self-kindness versus self-criticism......................................................................56
11.1.3 Common humanity versus isolation....................................................................58
11.1.4 Mindfulness versus over-identification...............................................................59
11.1.5 Hierarchy of components...................................................................................61
11.1.6 PTSD recovery....................................................................................................63
11.2 Phase 2: Quantitative results.................................................................64
  11.2.1 Clinical outcomes (RCI).................................................................65
  11.2.2 Time course of responses...............................................................67
11.3 Summary of phase 1 and phase 2 findings........................................69

12.0 Discussion. ..........................................................................................70
  12.1 The meaning of self-compassion for PTSD recovery............................71
  12.2 Change in PTSD symptoms and self-compassion................................74
  12.3 Limitations.........................................................................................75
  12.4 Future directions................................................................................77

13.0 Conclusion ..........................................................................................77

References ..................................................................................................79

Appendices ...............................................................................................86
  Appendix D: Treatment intervention session overview............................86
  Appendix E: Participant interview schedule............................................90
  Appendix F: Therapist interview schedule.............................................92
  Appendix G: Treatment data: Tape recorded therapy sessions...............94
  Appendix H: Self-compassion summary..................................................101
  Appendix I: Participant information sheet.............................................102
  Appendix J: Therapist information sheet...............................................105
  Appendix K: Participant consent form....................................................108
  Appendix L: Participant de-brief form.....................................................109
  Appendix M: Statistical improvement rates.............................................111
  Appendix N: Reflexivity statement.........................................................112
  Appendix O: Dissemination statement.....................................................113
  Appendix P: Journal of Traumatic Stress: Author guidelines...............114
  Appendix Q: NHS National Research Ethics Service ethics approval........118
  Appendix R: University of Exeter’s ethics approval...............................122
LIST OF FIGURES

FIGURE 1: Flow diagram of study inclusion/exclusion process..........................13
FIGURE 2: Plot for CAPS data for the RCI.......................................................66
FIGURE 3: Plot for SCS data for the RCI .........................................................67
FIGURE 4: Regression slopes for PTSD symptoms..........................................68
FIGURE 5: Regression slopes for Self-compassion............................................69
FIGURE 6: Summary model of change ..........................................................70

LIST OF TABLES

TABLE 1: Summary of the articles under review.............................................14
TABLE 2: Study methodology and key findings.............................................16
TABLE 3: Demographic details of patients....................................................46
TABLE 4: Participant completion rates........................................................53
TABLE 5: Key themes and sub-themes........................................................54
Being kind to ourselves: Changes in self-compassion and the implications of treatment within mental health

TRAINEE: Lisa Gilmour

SUPERVISORS:
Primary: Dr Anke Karl
Secondary: Dr Janet Smithson

DATE: May 2014

ASSIGNMENT: Literature Review

TARGET JOURNAL: Clinical Psychology Review

THE WORK HAS BEEN SUBMITTED IN PARTIAL FULFILMENT OF REQUIREMENTS FOR THE DOCTORATE IN CLINICAL AND COMMUNITY PSYCHOLOGY DEGREE

WORD COUNT: 4000
Abstract

There is a plethora of evidence to support a relationship between self-compassion and adaptive functioning, yet there is currently a deficit in studies addressing the malleability of self-compassion, and its impact on psychiatric functioning. This psychological review aimed to examine whether treatment interventions can induce change in self-compassion for clinical populations and if so, what implications this holds for psychiatric morbidity. Twelve peer reviewed journal articles were included in the review that fully met the inclusion criteria: consideration of self-compassion, implementation of a treatment intervention and an adult clinical population. Due to their diverse methodologies and samples, a narrative data synthesis method was adopted for presenting the results. The review provides evidence to show that self-compassion can be raised within clinical populations, through various interventions such as compassionate mind training, and also highlights the potential influence of self-compassion on psychiatric symptom reduction. The review is limited by the current deficit in large scale clinical trials within self-compassion and provides evidence for the necessity of further large scale experimental studies to examine the underlying mechanisms of self-compassion, treatment interventions and their combined impact on psychiatric symptom reduction within the clinical population.
In light of the increasing interest in adaptive functioning in psychological health, the last decade has seen a growth in research examining such constructs as mindfulness (Brown & Ryan, 2003), self-esteem (Baumeister, Tice & Hutton, 1989) and self-compassion (Neff, 2004). Self-compassion, in particular, is fast emerging as an influential construct and to date has been linked to psychological well being (Gilbert, 2005), life satisfaction and emotional intelligence (Neff, Hseih & Dejitthirat, 2005). According to Neff (2003a), self-compassion consists of three main components: self-kindness, common humanity and mindfulness. Self-kindness is the ability to be caring and sympathetic to ourselves, particularly when we are suffering or feeling inadequate. Common humanity refers to the recognition that as human beings, we all suffer, make mistakes and feel inadequate at times. Mindfulness is the ability to acknowledge negative emotions in a balanced way, neither over-exaggerating them nor suppressing them, whilst paying purposeful attention to the present moment.

As self-compassion is a relatively new construct, studies are limited into the causal impact of self-compassion on maladaptive functioning, tending to focus more on correlational research and the relationship between self-compassion and mental health. Some authors perceive and assess self-compassion as a stable trait (Sbarra, Smith, & Mehl, 2012). However, as interest grows more studies are attempting to induce self-compassion to examine its malleability. For example, Adams and Leary (2007) showed that encouraging self-compassion in college students with restrictive diets can raise their compassion levels, influencing their affect and behaviour. Although useful, this study reflects the typical focus on non-
clinical populations within the self-compassion literature and is limited in terms of its benefits to the clinical population, who often struggle with low self-compassion, and can therefore be more problematic (Barnard & Curry, 2011).

Self-compassion based interventions are starting to emerge within mental health practices, however, there remains a requirement for studies to examine their influence on clinical symptoms. For example, Compassionate Mind Training (CMT) is perceived as producing change in self-compassion, through development of patients’ compassionate understanding of their distress and toleration of thoughts and feelings (Barnard & Curry, 2011), yet studies to evidence this are rare. This limited evidence base reinforces the need for clearly controlled clinical trials, with larger samples, to determine whether specific interventions, such as CMT, increase compassion more than others and can account for a reduction in psychiatric symptoms.

It has been suggested that self-compassion enhances psychological well being as it enables the capacity for closeness and endorses emotional regulation and successful coping skills (Gilbert, 2005). Self-compassion has also been shown to be negatively associated with mechanisms such as rumination and thought suppression (Neff, Hseih & Dejithirat, 2005), avoidance (Neff, 2008) and threat appraisals (Akin, 2010). Despite an abundance of similar research, there remains a deficit of experimental research examining the mechanisms underlying self-compassion and their impact on mental health conditions. In addition, there are currently no psychological reviews within this area to synthesise study findings and potentially guide the focus of future research.
Aims and objectives

There is a plethora of evidence to support a relationship between self-compassion & adaptive functioning (Neff, Kirkpatrick, & Rude, 2007), yet there is currently a deficit in studies addressing the malleability of self-compassion, and its impact on psychiatric functioning. In particular, research on the effects of self-compassion induction within clinical populations is sparse, resulting in a lack of clarity of self-compassion mechanisms and their impact on psychiatric recovery. This review consequently aims to examine the few studies that have investigated self-compassion, treatment interventions and psychiatric morbidity for clinical populations by considering the following questions; can treatment interventions induce change in self-compassion for clinical populations and do changes in self-compassion effect psychiatric symptoms?

Methodology

Eligibility Criteria of Studies

This review considered all studies published on self-compassion before February 2014. The definition of self-compassion varied according to study design and content, however, this was not limited to prevent bias in study selection. Specific inclusion criteria was as follows:

Study design.

All studies published in peer review journals were included that considered change in self-compassion through quantitative or qualitative measures. Studies included randomised controlled trials, quasi-experimental designs and case
studies. Correlational studies were excluded, due to their cross-sectional focus and lack of treatment intervention. Adults with a clinical diagnosis of a mental health condition were included in the review. Student samples, children and older adults were excluded.

**Treatment interventions.**

Any psychological treatment intervention, including psychodynamic, counselling, cognitive behavioural therapy (CBT), CMT and mindfulness based cognitive therapy (MBCT) were considered. A measure of change in self-compassion was required and included self-report measures and qualitative methods such as interviews and diaries. Psychiatric measures were dependant on the clinical sample and included measures of mood, trauma, distress, anxiety and cognitive functioning.

**Search Strategy**

Electronic databases were examined to identify all relevant studies based on the inclusion criteria. The databases included The Cochrane Library database (1984-2012), PsychINFO (1884-2012) and PsychARTICLES (1946-2012). Key search terms were utilised, in accordance with the objectives of the review. These were “self-compassion”, “treatment” and “intervention”. Different combinations using ‘or’ and ‘and’ were used with truncation to allow for all possible combinations of terms (self-compassion*, treat* and interven*). The search was limited due to the small number of experimental studies on self-compassion within the clinical population, therefore, additional studies that met the criteria were also obtained from Kristen Neff’s website: self-compassion, A Healthier Way of Relating to Yourself.
Study selection.

From the initial search, 338 articles were identified following the removal of 18 duplicates. The abstracts of these articles were then screened for relevance against the inclusion criteria, resulting in the exclusion of 310 studies. Full text articles were retrieved for the remaining 28 articles and these references were screened for additional cited references. No new articles met the inclusion criteria. Following reading the 28 full-text articles, only 12 articles fully met the inclusion criteria, potentially reflecting the only recent interest in self-compassion. These 12 studies were subsequently included in the review. See Figure 1 for the full selection process.

Data extraction.

For all 12 studies, details relating to the participants and treatment interventions were summarised (Table 1). Further details relating to the methodology of the studies, including the study design, measures and key findings, were also extracted (Table 2).

Data synthesis.

A narrative data synthesis method was adopted for presenting the results of this review (Centre for Reviews and Dissemination, 2009), due to the diverse methodologies and samples contained in the studies. The aim was to explore any patterns identified across the results and discuss the possible factors that might explain similarities or variations in study findings.
Identification

Total records identified through initial data base searching (n=356)

Screening

Total records after duplicates removed (n=338)

Abstracts screened (n=338) → Records excluded (n=310)

Eligibility

Full text articles assessed for eligibility (n=28) → Full text articles excluded (n=16)

Included studies

Studies included in review (n=12)

Reasons for exclusion include:
- Dissertations (n=83. 2 met the full criteria but were excluded as they were under-graduate projects without a rigorous peer review process)
- Book chapters/reviews (n=78)
- Sample characteristics (n=17)
- Un-related (n=132) (Including religion, morality & physical health)

Reasons for exclusion include:
- Non clinical sample (n=9)
- No treatment intervention (n=7) (correlational research)

Figure 1: Flow diagram of study inclusion/exclusion process
## Results

**Summary of the articles under review**

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>No of Participants</th>
<th>Diagnosis</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kelly, Carter, Zuroff &amp; Borairi (2013)</td>
<td>Canada</td>
<td>74</td>
<td>Eating disorder (DSM-IV)</td>
<td>CBT, group psychotherapy, medical stabilization, nutritional rehabilitation (12 weeks)</td>
</tr>
<tr>
<td>Najavits et al. (2013)</td>
<td>USA</td>
<td>7</td>
<td>Gambling &amp; PTSD (DSM-IV)</td>
<td>Seeking Safety Therapy, weekly and individually (six months)</td>
</tr>
<tr>
<td>Kearney et al. (2013)</td>
<td>USA</td>
<td>42</td>
<td>PTSD</td>
<td>Loving-kindness meditation (LKM; 12 class sessions)</td>
</tr>
<tr>
<td>Germer &amp; Neff (2013)</td>
<td>USA</td>
<td>1</td>
<td>Depression &amp; anxiety</td>
<td>Mindful self-compassion (MSC), 8 weeks, 2.5 hrs per week</td>
</tr>
<tr>
<td>Jazaieri, Goldin, Werner, Ziv &amp; Gross (2012)</td>
<td>USA</td>
<td>56</td>
<td>Social anxiety disorder (DSM-IV)</td>
<td>Mindfulness based stress reduction (MSBR) or aerobic exercise (8 weeks)</td>
</tr>
<tr>
<td>Beaumont, Galpin &amp; Jenkins (2012)</td>
<td>UK</td>
<td>32</td>
<td>Trauma</td>
<td>CBT coupled with CMT or CBT intervention only</td>
</tr>
<tr>
<td>Brooks, Kay-Lambkin, Bowman &amp; Childs (2012)</td>
<td>Australia</td>
<td>77</td>
<td>Alcohol dependence (DSM-IV)</td>
<td>Counselling, detoxification, needle and syringe programmes, a diversional programme, pharmacotherapy, cannabis clinic &amp; general practitioner medical management programmes</td>
</tr>
<tr>
<td>Eisendrath, Chartier &amp; McLane (2011)</td>
<td>USA</td>
<td>1</td>
<td>Treatment resistant depression (TRD).</td>
<td>8 week group based Mindfulness-based cognitive therapy (MBCT)</td>
</tr>
<tr>
<td>Kuyken et al. (2010)</td>
<td>UK</td>
<td>123</td>
<td>Depression (DSM-IV)</td>
<td>RCT comparing MBCT with maintenance antidepressants (mADM)</td>
</tr>
<tr>
<td>Mayhew &amp; Gilbert (2008)</td>
<td>UK</td>
<td>3</td>
<td>Schizophrenia &amp; hostile auditory hallucinations</td>
<td>Compassionate mind training (CMT) over 12 1-hour sessions</td>
</tr>
<tr>
<td>Gilbert &amp; Proctor (2006)</td>
<td>UK</td>
<td>6</td>
<td>Personality disorders/ chronic mood</td>
<td>12 two-hour sessions in compassionate mind training (CMT)</td>
</tr>
</tbody>
</table>

*See Appendix A for summary list of interventions*
Study Characteristics

Table 1 displays summary information on each study, including the country, sample size, clinical diagnosis and treatment intervention. The clinical diagnosis of participants varied and included eating disorders, gambling, PTSD, depression, anxiety, personality disorders, alcohol dependency and schizophrenia. Specific referral to a diagnostic classification system was limited, with only six studies referring to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Sample sizes ranged from 1-123 participants depending on the research design, which were randomised control trials (RCTs), quasi-experiments and case studies/series.

Treatment interventions were predominantly short-term, approximating between eight to sixteen weeks, with one exception involving a six month intervention (Najavits et al., 2013). The studies commonly included some form of mindfulness/compassionate based intervention, however CBT, psychodynamic, seeking safety therapy and counselling interventions were also used (see Appendix A for full details of interventions). Descriptions relating to the content of interventions were all generally well structured and reference was made to research literature across all studies, particularly in relation to psychiatric functioning. Consideration to self-compassion varied according to study design, with those studies specifically addressing self-compassion tending to refer to Neff’s (2003) definition and making good links between self-compassion and the evidence base.
<table>
<thead>
<tr>
<th>Study</th>
<th>Study Design</th>
<th>Key measures</th>
<th>Main Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Najavits et al. (2013)</td>
<td>Quasi-experimental Repeated measures (pre/post)</td>
<td>SCS, MINI</td>
<td>Positive change in self-compassion and PTSD symptoms</td>
</tr>
<tr>
<td>Kearney et al. (2013)</td>
<td>Quasi-experimental Repeated measures (pre/post)</td>
<td>SCS, PSS-I, PROMIS</td>
<td>Evidence of reduction in PTSD symptoms and depression by enhanced self-compassion</td>
</tr>
<tr>
<td>Germer &amp; Neff (2013)</td>
<td>Case study (qualitative)</td>
<td>Qualitative interview</td>
<td>Improvement in psychological wellbeing through increase in mindful self-compassion</td>
</tr>
<tr>
<td>Jazaieri, Goldin, Werner, Ziv &amp; Gross (2012)</td>
<td>RCT Control group Repeated measures (pre/post &amp; 3 month follow-up)</td>
<td>SCS, LSAS-SR</td>
<td>Significant improvement in self-compassion and a significant reduction in social anxiety for the exercise treatment group compared to the untreated group. No significant change in self-compassion for the MSBR group</td>
</tr>
<tr>
<td>Beaumont, Galpin &amp; Jenkins (2012)</td>
<td>Quasi-experimental Control group Repeated measures (pre/post)</td>
<td>SCS, HADS, IES</td>
<td>Participants in the CBT/CMT condition developed statistically significant higher self-compassion scores post-therapy than the CBT-only group</td>
</tr>
<tr>
<td>Brooks, Kay-Lambkin, Bowman &amp; Childs (2012)</td>
<td>Quasi-experimental Control group Repeated measures (pre/post)</td>
<td>SCS, OTI, DASS-21</td>
<td>Significant increase in self-compassion, mindfulness, common humanity &amp; self-kindness, and significant decrease in self-judgement, isolation and over-identification</td>
</tr>
<tr>
<td>Eisendrath, Chartier &amp; McLane (2011)</td>
<td>Quasi-experimental Design (pre/post)</td>
<td>BDI, qualitative participant feedback</td>
<td>BDI score decreased from 28 to 9 without any change in medication. Improvement in mindfulness and self-care (self-compassion)</td>
</tr>
<tr>
<td>Schanche, Stiles, McCullough, Svartberg &amp; Nielsen (2011)</td>
<td>RCT Control group Repeated measures (pre/post)</td>
<td>ATOS, SCL-90-R, IIP, MCMI</td>
<td>An increase in self-compassion significantly predicted a decrease in psychiatric symptoms, interpersonal problems, and personality pathology. Decrease in levels of inhibitory affects and increase in levels of activating affects were significantly associated with higher self-compassion</td>
</tr>
<tr>
<td>Kuyken et al. (2010)</td>
<td>RCT Control group Repeated measures (pre/post &amp; 15-month follow-up)</td>
<td>SCS, HRSD, KIMS, cognitive reactivity</td>
<td>MBCT’s effects were mediated by enhancement of mindfulness and self-compassion across treatment. MBCT changed the relationship between post-treatment cognitive reactivity and outcome</td>
</tr>
</tbody>
</table>
Table 2

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Design</th>
<th>Key measures</th>
<th>Main Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gilbert &amp; Proctor (2006)</td>
<td>Quasi-experimental Repeated measures (pre/post)</td>
<td>HADS, FSCS, FSCR, diary of self-soothing</td>
<td>Significant reductions in depression, anxiety, self-criticism, shame, inferiority and submissive behaviour. There was also a significant increase in the participants' ability to self-sooth.</td>
</tr>
</tbody>
</table>

See Appendix B for a full list of all measures and references

Study Methodology

Design and measures.

The methodological quality of studies varied significantly according to the study design. The RCT’s and experimental designs predominantly used more robust measures and provided stronger evidence in terms of statistical analysis. The three RCT’s used randomised allocation of participants, however, details of each study procedure were unclear. The RCT’s and the more recent studies considered effect sizes, however, consideration to power was generally overlooked. Only four studies included a control group and each study relied heavily on self-report measures to determine outcomes, generally referring to them in detail, with the exception of two studies (Beaumont et al., 2012; Eisendrath et al., 2011) which omitted any specific information.

The Self-Compassion Scale (SCS; Neff, 2003) was the most commonly cited measure of self-compassion particularly in the more recent studies. However, the Forms of the Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS:...
Gilbert Clark, Hempel, Miles & Irons, 2004) and the Achievement of Therapeutic Objectives Scale (ATOS: McCullough et al., 2003b) were also used alongside more qualitative measures such as interviews and diaries. The diary data, however, should be taken with caution as the information was dependent on the participants recording accurate data, and was therefore open to retrospective bias and insensitive measure bias (Hartman, Forsen, Wallace & Neely, 2002).

Measures used to record psychiatric morbidity varied significantly according to the sample client group and their psychiatric diagnosis (Appendix B).

All of the studies identified changes in self-compassion over the course of the treatment intervention, however, this change varied considerably in terms of measurement and analysis, and two studies lacked any formal measure (Germer & Neff, 2013; Eisendrath et al., 2011). In addition, each of the studies maintained some form of reduction in psychiatric symptoms as a result of the intervention. However, the explicit impact of self-compassion on this change was ambiguous across the majority of studies.

**Change in self-compassion.**

All studies referred to changes in self-compassion brought about by the intervention. The quality of these findings, however, varied significantly as a result of design quality and methodology. The most rigorous methods were adopted by the three RCT studies (Jazaieri et al., 2012; Kuyken et al., 2010; Schanche et al., 2011), using self-compassion measures that were shown to have good reliability and validity; the SCS and ATOS, and having much higher sample sizes than many of the other studies. The RCTs identified significant improvements in self-compassion and strong effect sizes, following intervention, providing good support
for the inducement of self-compassion within clinical populations. Similarly, three other studies, (Najavits et al., 2013; Beaumont et al., 2012; Brooks et al., 2012), showed a significant difference in self-compassion, pre and post intervention, supporting the findings from the RCT’s. Despite omittance of any information on effect sizes and power in two of the studies and low participant numbers in one study (Najavits et al., 2013), they provide further evidence in support of self-compassion malleability.

The studies with lower participant numbers ranging from one to seven (Germer & Neff; 2013; Najavits et al., 2013, Eisendrath et al., 2011; Gilbert & Proctor, 2006; Mayhew & Gilbert, 2008), had limited potential for robust quantitative analysis. Despite this, however, they all contained some reflection of a change in self-compassion, including use of the SCS, diary reports and qualitative interpretations/interviews. Whilst these findings should be taken with some caution, they are consistent with the conclusions from the more robust experimental designs.

**Treatment intervention.**

The majority of studies adopted an intervention which included an explicit component of self-compassion. However only four had control groups, creating some difficulty in attributing change in self-compassion to the intervention alone. The four studies with control groups were the studies with the more robust designs and higher participant numbers, however, they presented surprisingly varying results. Two studies identified significantly greater improvements in self-compassion for the interventions including a compassion based component: Kuyken et al. (2010) showed a significant difference in self-compassion and
mindfulness for the group receiving MBCT treatment in comparison to the group receiving anti-depressants. Similarly Beaumont et al. (2012) showed that Participants in the CBT/CMT condition developed significantly higher self-compassion post-therapy than the CBT-only group. In contrast, however, Schanche et al., (2011) showed no significant differences in self-compassion for the two interventions: psychotherapy (affect phobia treatment to develop self-compassion) and cognitive therapy, and Jazaieri et al. (2012) showed that the aerobic exercise was actually more efficacious in raising self-compassion than MSBR. Whilst the first studies support the effectiveness of self-compassion based interventions in raising self-compassion, the latter studies imply that interventions without explicit compassion components can be equally effective in raising self-compassion, perhaps through more implicit techniques. For example, both cognitive therapy and exercising could assist in decreasing negative judgements about one-self; thus facilitating greater self-kindness in a much more subtle way (Jazaieri et al., 2012).

One further study (Brooks et al., 2012) supports this latter argument in its study of alcohol dependency. The treatment programme for this client group was unspecific and included a range of potential interventions, including counselling, detoxification and pharmacotherapy, according to individual needs. There were no explicit components of self-compassion, yet the 15 week post intervention analysis identified a significant increase in self-compassion following intervention.

**Self-compassion and psychiatric symptom reduction.**

Two RCTs report on the relationship between self-compassion and psychiatric functioning: Kuyken et al. (2010) identified a significant interaction
between self-compassion change and cognitive reactivity in the prediction of depression scores and Schanche et al. (2011) showed that adaptive change in self-compassion predicts a decrease in symptom distress, interpersonal problems, and personality pathology. Similarly, two studies with less robust designs but high participant numbers also consider this relationship, although the findings should be interpreted with some caution due to a lack of control group: Kelly et al. (2013) identified, through multilevel modelling, that low self-compassion and high fear of self-compassion interact to prevent eating disorder clients responding to treatment and Kerney et al. (2003), provide evidence for a reduction in PTSD symptoms and depression by enhanced self-compassion. Whilst the remaining studies did not look explicitly at the relationship between self-compassion and psychiatric functioning, they discuss a potential association between the rise in self-compassion and a decrease in psychiatric symptom severity, post treatment. This lack of statistical analysis can partially be accounted for by the study designs, however, it may also be indicative of a lack of statistical significance in the findings and potential reporting bias.

Interestingly, however, in contrast to the above findings Brooks et al. (2012) report associations between the subcomponents of self-compassion and depression post intervention, showing that improvements in depression were significantly associated with reductions in self-kindness, self-judgement and mindfulness. Similar results were also found for anxiety and stress. These results appear unusual in terms of the research literature, and are potentially indicative of the importance of considering the clinical sample. The participants in this study were individuals with alcoholism and it is suggested that results may be impacted
due to the patients’ relationship with alcohol and their propensity to cope through self-medication (Brooks, Lambkin Bowman & Childs, 2012). This suggests that for alcohol dependency, there may be alternative underlying mechanisms at play, in comparison to other psychiatric disorders.

**Mechanisms.**

Interpretations of the underlying mechanisms involved in self-compassion vary according to the methodology of the studies. Only one RCT study (Kuyken et al., 2010) specifically looks at the interaction between self-compassion and cognitive reactivity (change in depressive thinking during a laboratory mood induction). The remaining quantitative studies simply imply a relationship between changes in self-compassion and underlying mechanisms, through pre-post therapy reductions in symptoms of avoidance (Beaumont et al., 2012) and inhibitory effects (Schanche et al., 2011) and increases pre-post therapy in mindfulness (Kearney et al., 2013), improvements in physical health (Jazaieri et al., 2012) and defence recognition and activating effects (Schanche et al., 2011).

The case study designs explore self-compassion mechanisms from a more qualitative angle, and although less robust than the quantitative data, their consideration is useful in understanding self-compassion. For example Eisendrath et al., (2011) explores avoidance and acceptance through a case illustration, identifying how changes in such mechanisms can be achieved through MBCT, potentially influencing the client’s reduction in depressive symptoms post-intervention. Additionally, Gilbert & Proctor (2006) explore the impact of self-soothing as a component of self-compassion showing, through self-monitoring diaries, how self-soothing thoughts become more powerful and accessible, and
self-attacking/critical thoughts become less frequent and intrusive, following a CMT intervention.

Only three studies examined the individual components of self-compassion (self-kindness, common humanity and mindfulness) as operationalised by Neff (2003a). Findings were variable and although one study showed a significant reduction in self-criticism, isolation and over-identification; the components' opposite domains (Najavits et al., 2013), the other two studies showed conflicting results with no clear patterns of change (Brooks et al., 2012; Mayhew & Gilbert, 2008). Two additional studies considered change in mindfulness only, alongside self-compassion, identifying positive change through MBCT (Kuyken et al., 2010) and MSC (Germer & Neff, 2013).

Discussion

Change in Self-compassion

Despite great diversity in study design, validity and reliability, overall, this review provides support for the malleability of self-compassion within clinical populations. As individuals with mental health difficulties tend to be lower in self-compassion (Neff, 2003), and there is a plethora of evidence to support a relationship between self-compassion and adaptive functioning (Neff, Kirkpatrick & 2007), these findings suggest that the inducement of self-compassion within clinical populations could be beneficial to psychiatric recovery.

As interest in self-compassion rises, treatment interventions incorporating compassion based components are developing and evidence is growing in support of their efficacy (Mayhew & Gilbert, 2008). Whilst this review provides strong
support for the inducement of self-compassion as a result of such interventions, the
effectiveness of compassionate guided interventions in raising self-compassion,
over other interventions, is more ambiguous and difficult to determine due to
contrasting study findings and a lack of adequate control measures. Certainly one
RCT, provides support for MBCT over anti-depressants in raising self-compassion,
however, the advantages over alternative therapeutic interventions are less clear.
Whilst one study supported CMT/CBT over CBT-alone in raising self-compassion,
another more powerful RCT showed no difference in self-compassion change
between psychotherapy (affect phobia treatment to develop self-compassion) and
cognitive therapy. In addition, one study showed that aerobic exercise was actually
more efficacious in raising self-compassion than MSBR. These findings potentially
challenge the requirement of an explicit self-compassion component within therapy
and demonstrate that interventions, regardless of approach, can impact on self-
compassion without overtly intending to, perhaps through more implicit methods
and techniques.

Self-compassion and Psychiatric Symptom Reduction

Whilst all the studies identified a decrease in psychiatric symptoms, the
actual relationship between this and self-compassion remains unclear. One of the
more robust studies demonstrated that adaptive change in self-compassion
predicts a decrease in psychiatric symptoms. However, the bulk of the studies
simply imply a link between the rise in self-compassion and symptom reduction
with limited statistical evidence to support this. In addition, the disparity in findings
between client groups, also suggests that for some clinical populations, such as
individuals with alcoholism, self-compassion based interventions may not positively
impact on symptom severity, perhaps due to the mechanisms at play. This highlights the requirement for further research into the effects of self-compassion within specific clinical presentations, such as alcoholism (Rendon, 2007).

Finally, whilst the underlying mechanisms of self-compassion were alluded to in several of the studies, overall, there was a shortfall in statistical analysis of their fundamental connection with self-compassion. The findings generally highlighted the importance of such mechanisms as mindfulness, self-soothing, self-attacking, avoidance and defence recognition (Neff, 2008; Akin, 2010) within psychiatric functioning, yet the studies predominantly make inferences to their relationship with self-compassion, rather than providing grounded evidence. This is partially due to the study designs and methodology, which prevented more in-depth statistical analysis. There is also a shortfall in examination of the key components of self-compassion (self-kindness, common humanity and mindfulness) as defined by Neff (2003a), which would be useful to address in future research.

Limitations

It should be considered that, despite attempting a thorough search of the literature, some studies meeting the inclusion criteria may have been missed, for example through search definitions, causing some possible bias in the findings. Alternatively, the limited studies may simply reflect the scarce body of research in this area. The review also only contains information presented by the articles alluding to useful results, potentially resulting in some reporting and publication bias. In addition, greater reflection and comparison of client groups was beyond the scope of this review. Consideration to this in future reviews, would add to our understanding of self-compassion within specific clinical populations.
At study level, the variation in definition, measurement and analysis of self-compassion caused some difficulties in synthesising the findings, reflecting the limitations of a developing evidence base. Whilst Neff’s (2003) definition was the most commonly cited, and the SCS the most widely measure, other alternative self-compassion descriptions and measurement, such as diaries, were also used. Similarly, the variation in study designs and lack of robust experimental research, made synthesis of the statistical results challenging and power analysis unfeasible.

Within self-compassion research there is a heavy reliance on self-report measures, despite some evidence to show variability according to understanding. For example, Mayhew and Gilbert (2008) revealed that participant scores on the SCS (Neff, 2003), did not reflect their diary sheet scores and there were problems with participants over-rating due to a lack of understanding of self-compassion. This has considerable implications for the self-compassion research literature and suggests that additional experimental measures of self-compassion would be useful, alongside self-report measures, to endorse validity and reliability.

**Future Implications**

In highlighting the malleability of self-compassion and the psychiatric symptom reductions brought about through compassion based interventions, this review provides evidence for the efficacy of such treatment programmes within the health service. This could potentially influence intervention guidelines, although more substantial empirical support is required. As self-compassion is a relatively new construct the literature is still growing and this review has highlighted some key areas for future research development. In particular, consideration to the individual components and underlying mechanisms of self-compassion is critical to
our understanding of the relationship between self-compassion and psychological well being and distress.

More specific research attention should be given to the varying treatment interventions adopted within the health service, including compassionate based interventions, to enable comparisons in self-compassion inducement and psychiatric symptom reduction, whilst also considering the diversity between different clinical populations. In order to achieve this, there is a requirement for more robust study designs, including large scale clinical trials and experimental studies, with strong methodological standards, control groups and perhaps less reliance on self-report measures (Barnard & Curry, 2011).

**Conclusion**

This review strengthens the growing body of research in support of the relationship between self-compassion and psychological health (Neff, Kirkpatrick & Rude, 2007). It provides evidence to show that self-compassion can be raised within clinical populations through various interventions such as CMT, and also highlights the potential influence of self-compassion on psychiatric symptom reduction (Raes, 2011). The review also reinforces the current deficit in large scale clinical trials and experimental studies within self-compassion and provides evidence for the requirement of research examining the underlying mechanisms of self-compassion, treatment interventions and their combined impact on psychiatric symptom reduction. In the future, consideration also needs to be given to the
diversity between clinical populations, to ensure the best possible treatment is provided according to clinical diagnosis and individual presentation.

“Learning to be kind to myself is the greatest gift I have ever treated myself to”

(Beamont, Galpin & Jenkins, 2012).
References


Centre for Reviews and Dissemination. (2009). *Systematic reviews. CRD’s guidance for undertaking reviews in healthcare*. Retrieved from
http://www.york.ac.uk/inst/crd/index_guidance.htm.


and coping with academic failure. *Self and Identity, 4*, 263-287.


## Appendix A

### Summary of Treatment Interventions

<table>
<thead>
<tr>
<th>Authors</th>
<th>Intervention Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Najavits et al. (2013)</td>
<td>Seeking Safety Therapy</td>
<td>Established model for PTSD &amp; addiction. CBT based approach that provides psycho-education and coping skills. Group or individual format. 25 topics to address cognitive, behavioural, interpersonal and case management domains.</td>
</tr>
<tr>
<td>Kearney et al. (2013)</td>
<td>Loving-kindness meditation (LKM)</td>
<td>Group intervention to cultivate positive emotions through loving-kindness meditation</td>
</tr>
<tr>
<td>Germer &amp; Neff (2013)</td>
<td>Mindful self-compassion (MSC)</td>
<td>The programme teaches a variety of meditations (eg loving-kindness, affectionate breathing) and informal practices for use in daily life (eg soothing touch, compassionate letter writing). Self-compassion is evoked through experiential exercises and homework practices.</td>
</tr>
</tbody>
</table>
**Aerobic exercise**  
2 month gym membership, with 2 individual sessions and 1 group session per week. Intensity of exercise & heart-rate were monitored. |
**CBT with Compassionate Mind Training (CMT)**  
All of the above, plus exploration of self-critical rumination, compassionate self and self-monitoring, compassionate letter writing, relaxation techniques, mindfulness, self-compassion diary, use of compassionate imagery. |
| Brooks, Kay-Lambkin, Bowman & Childs (2012) | Counselling, detoxification, needle and syringe programmes, a diversional programme, pharmacotherapy, cannabis clinic & general practitioner medical management programmes |
| Eisendrath, Chartier & McLane (2011) | Mindfulness-Based Cognitive Therapy (MBCT) | Group based intervention specifically to prevent relapse of individuals with recurrent depression. It includes formal teaching (body scan and sitting meditations) mixed with informal mindfulness practices and activities. |
| Schanche, Stiles, McCullough, Svarberg & Nielsen (2011) | Affect Phobia Treatment (short-term dynamic psychotherapy) | Helps patients develop self-compassion. It is guided by the Triangle of Conflict to enable exploration of avoided affects, anxiety, shame, guilt or pain together with defensive behaviours. |
**Cognitive Treatment**
Helping the patient to see critical or devaluing core beliefs and assumptions about the self and to transform critical core belief structures or schemas into more adaptive forms.

<table>
<thead>
<tr>
<th>Kuyken et al. (2010)</th>
<th>Mindfulness based cognitive therapy (MBCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group based intervention specifically to prevent relapse of individuals with recurrent depression. It includes formal teaching (body scan and sitting meditations) mixed with informal mindfulness practices and activities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mayhew &amp; Gilbert (2008)</th>
<th>Compassionate Mind Training (CMT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploration of self-critical rumination, compassionate self and self-monitoring, compassionate letter writing, relaxation techniques, mindfulness, self-compassion diary, use of compassionate imagery.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gilbert &amp; Proctor (2006)</th>
<th>Compassionate Mind Training (CMT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploration of self-critical rumination, compassionate self and self-monitoring, compassionate letter writing, relaxation techniques, mindfulness, self-compassion diary, use of compassionate imagery.</td>
</tr>
</tbody>
</table>
Appendix B

References for key self-compassion and psychiatric measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test/Scale Name</td>
<td>Reference</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
</tr>
</tbody>
</table>
Appendix C
Clinical Psychology Review
Author Guidelines

Use of word processing software
Article structure
Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered. Manuscripts should ordinarily not exceed 50 pages, including references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the online version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text. It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least through the prior calendar year) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (http://www.prisma-statement.org/statement.htm) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field. Appendices If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information
AUTHOR INFORMATION PACK 27 Apr 2014 www.elsevier.com/locate/clinpsychrev 6 Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information. Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author within the cover letter. Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.
Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address" (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.
Abstract
A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

Abbreviations
Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements
Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Footnotes
Footnotes should be used sparingly. Number them consecutively throughout the article, using superscript Arabic numbers. Many wordprocessors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

Tables
Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.

References
Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 1-4338-0559-6, copies of which may be ordered from http://books.apa.org/books.cfm?id=4200067 or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK. Details concerning this referencing style can also be found at http://humanities.byu.edu/linguistics/Henrichsen/APA/APA01.html

Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.
References in a special issue

Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference management software

This journal has standard templates available in key reference management packages EndNote (http://www.endnote.com/support/enstyles.asp) and Reference Manager (http://refman.com/support/rmstyles.asp). Using plug-ins to wordprocessing packages, authors only need to select the appropriate journal template when preparing their article and the list of references and citations to these will be formatted according to the journal style which is described below.

Reference style

References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. References should be formatted with a hanging indent (i.e., the first line of each reference is flush left while the subsequent lines are indented).

Can being kind to ourselves make a difference?
The relationship between self-compassion and post traumatic stress disorder (PTSD)

TRAINEE: Lisa Gilmour
SUPERVISORS:
   Primary: Dr Anke Karl
   Secondary: Dr Janet Smithson

TARGET JOURNAL: Journal of Traumatic Stress
RESEARCH SETTING: Mood Disorder Centre, Exeter University
DATE: May 2014
ASSIGNMENT: Research Paper

THE WORK HAS BEEN SUBMITTED IN PARTIAL FULFILMENT OF REQUIREMENTS FOR THE DOCTORATE IN CLINICAL AND COMMUNITY PSYCHOLOGY DEGREE

WORD COUNT: 8000
Abstract

There is a growing body of research in support of the relationship between self-compassion and psychological health (Neff, Kirkpatrick & Rude, 2007). However, studies are limited on the malleability of self-compassion specifically within clinical populations, and its influence on psychiatric symptom reduction (Raes, 2011). This study therefore aimed to explore self-compassion, through examination of the underlying components (self-kindness, common humanity and mindfulness), and their impact on maladaptive functioning, specifically for participants diagnosed with PTSD. The study used an exploratory mixed methods design, with eight participants recruited by their attendance at two PTSD CBT/IPT (with self-compassion) group treatment interventions. Participants were adults, with a diagnosis of PTSD and a history of recurrent or current depression. Participants attended a group interview and two therapists who facilitated each treatment group were also interviewed. Participants completed quantitative measures pre and post intervention; Self-Compassion Scale (Neff, 2003a) and Clinician-Administered PTSD Scale (Blake et al., 1995), and session data was recorded using the PTSD checklist (PCL-C; Weathers, Litz, Huska & Keane, 1994) and the Session Feedback Form (AccEPT Primary Care Psychological Therapies Service). The findings demonstrate the importance that individuals place on self-compassion in their PTSD recovery, particularly in relation to self-kindness and the generation of positive self-belief and a compassionate inner-voice. The study also indicates that a clinically significant change in self-compassion is possible for individuals with PTSD, supporting the malleability of self-compassion within clinical populations.
Context and Background

Self-Compassion

Self-compassion is fast emerging as an influential construct with increasing evidence to support a link to psychological well being (Gilbert, 2005). According to Neff (2003a), self-compassion consists of three main components: self-kindness, common humanity and mindfulness. Self-kindness is the ability to be caring towards ourselves, particularly when we are suffering or feeling inadequate. Common humanity refers to the recognition that as human beings, we all suffer, make mistakes and feel inadequate at times. Mindfulness is the ability to acknowledge negative emotions in a balanced way, neither over-exaggerating them nor suppressing them, whilst paying purposeful attention to the present moment.

The Malleability of Self-Compassion

Whilst some authors perceive and assess self-compassion as a stable trait (Sbarra, Smith, & Mehl, 2012), as interest grows more studies are attempting to induce self-compassion to examine its malleability. For example, Adams and Leary (2007) showed that encouraging self-compassion in participants with restrictive diets can raise their compassion levels, influencing their affect and subsequent behaviour. Although useful, this study reflects the typical focus on non-clinical populations within the self-compassion literature which is limited in terms of its benefits to the clinical population, who often struggle with low self-compassion, and can therefore be more problematic (Barnard & Curry, 2011). With the development of interventions such as Compassionate Mind Training (CMT; Gilbert & Proctor,
2006), evidence is slowly increasing to support the malleability of self-compassion with clinical populations, however, there remains a need for clearly controlled clinical trials, with larger samples, to determine whether specific interventions, such as CMT, increase compassion more than others and can account for positive psychiatric symptom change (Barnard & Curry, 2011).

Self-Compassion and Mental Health

Studies are limited into the direct impact of self-compassion on maladaptive functioning. It has been suggested that self-compassion enhances psychological well being as it enables the capacity for closeness and endorses emotional regulation and successful coping skills (Gilbert, 2005). Self-compassion has also been shown to be negatively associated with insecure attachment styles (Neff & McGeehee, 2010), childhood emotional abuse (Tanaka, Wekerle, Schmuck & Paglia-Boak, 2011) and mechanisms such as rumination and thought suppression (Neff, Hseih & Dejitthirat, 2005), avoidance (Neff, 2008) and threat appraisals (Akin, 2010). Despite an abundance of similar correlational research, there remains a deficit of experimental research examining the causal relationship between self-compassion and mental well-being.

Self-Compassion and PTSD

Studies looking at the relationship between self-compassion and PTSD are limited and although it has been suggested that self-compassion can benefit individuals whom have experienced a trauma (Thompson & Waltz, 2008), the evidence to support this relationship remains unclear. To date, cognitive models have been popularly applied to PTSD, with one particularly relevant model (due to its reference to the self) developed by Ehlers and Clark (2000). They explain PTSD
as resulting from the processing of a traumatic event which leads to a sense of serious and current threat. Two key processes lead to this threat development; excessive negative appraisals of the trauma/self and a disturbance of autobiographical memory. Negative appraisals have been found to generate situational and generalised fear, causing avoidant behaviour and a propensity to self-blame (Ehlers and Clark, 2000). These mechanisms are critical to the maintenance of PTSD and, as self-compassion has been highly associated with less self-critical behavior (Neff, 2003a) and less avoidant behavior (Thompson & Waltz, 2008), it would be expected that increases in self-compassion could potentially reduce self-blame and avoidance, thus decreasing the symptoms of PTSD.

According to Lee (2006), self-compassion is essential to PTSD recovery to counteract the shame and self-attacking/critical thinking associated with PTSD, which can make standard interventions such as cognitive behavioural therapy (CBT) challenging (Lee, Scragg, Turner, 2001). Compassion focused therapy (CFT) describes three distinct innate systems; the threat, self-soothing and drive systems, referring to the importance of threat processing in the development of negative self-evaluation and shame based self-critical dialogues. Evidence suggests that people who have experienced early histories of abuse and neglect have highly activated threat systems and difficulties in accessing their soothing systems, due to limited experience of feeling safe and soothed by others which deters their ability to self-sooth (Gilbert & Procter, 2006). Research shows that self-compassion deactivates the threat system and activates the soothing system. For example, Rockcliff, Gilbert, McEwan, Lightman, and Glover (2008), found that
a brief self-compassion exercise lowered participant levels of the stress hormone cortisol (threat system), whilst increasing heart-rate variability and the ability to self-soothe. Likewise, Gilbert and Procter (2006) found that the development of a compassionate mind, through CMT, facilitated significant reductions in self-criticism, shame, inferiority and submissive behavior and an increase in self-soothing behaviours.

Currently, the NICE guidelines (2005) stipulate a trauma focused CBT approach and eye movement desensitization and reprocessing (EMDR) treatment for PTSD, however, clinicians are starting to integrate self-compassion techniques within this framework, partially due to the findings of such studies as Lee (2006) and Gilbert and Procter (2006). Despite this, however, there remains a need for further evidence addressing the malleability and meaning of self-compassion within clinical populations, for individuals with conditions such as PTSD. In particular, there is currently a deficit of examination of the key components of self-compassion, as defined by Neff (2003a), and their influence on mental well-being. A mixed-method approach could help facilitate this research through examination of clients' experience of self-kindness, common humanity and mindfulness, whilst also considering clinically significant changes in self-compassion and PTSD symptoms brought about through treatment intervention.
Aims and Research Questions

Studies are limited on the malleability of self-compassion specifically within clinical populations, and its influence on psychiatric symptom reduction (Raes, 2011). This study therefore aims to explore self-compassion through examination of its impact on participants diagnosed with PTSD and undergoing a trauma focused intervention. The study specifically seeks to address the following questions: what meaning does self-compassion (self-kindness, common humanity and mindfulness) hold for individuals in relation to PTSD recovery and is there a clinically significant change in PTSD symptoms and self-compassion for individuals attending a PTSD trauma focused intervention?

**Hypothesis 1**

Positive change in understanding and practicing the components of self-compassion (self-kindness, common humanity and mindfulness) can benefit PTSD recovery.

**Hypothesis 2**

There will be a clinically significant change in PTSD symptoms and self-compassion for participants attending a PTSD trauma focused intervention.

**Methods**

**Design**

The study is an exploratory mixed methods design. Phase 1 consisted of qualitative analyses to explore participant understanding of self-compassion and its impact on their PTSD recovery. Phase 2 involved quantitative analysis of treatment
data to examine any change in PTSD symptoms and self-compassion that occurred during the treatment intervention.

**Sample and Participants**

Participants were recruited by their attendance at a trauma focused CBT/IPT (with self-compassion) treatment intervention held at the Mood Disorder Centre (MDC) at Exeter University (Appendix D). The criteria were; participants over 18 years of age, with a diagnosis of PTSD and a history of recurrent or current depression. As the research was specifically examining changes in self-compassion brought about by the intervention, research participants were required to have completed treatment. Any individuals who dropped out during the early stages were therefore excluded from the research. This amounted to five participants in total; one withdrew before treatment started and the remaining four left during the first five sessions due to personal difficulties unrelated to their trauma. The treatment intervention consisted of a group format of 18 sessions in total, with two separate groups held nine months apart. Five participants from the first group and three participants from the second group completed treatment. Two therapists who facilitated each group were also interviewed and there were subsequently ten individuals (eight participants and two therapists) involved in the study. The demographic details of the participants are presented in Table 3.
Table 3
*Demographic details of patients (N=8)*

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age (SD)</td>
<td>39 years (9.9)</td>
</tr>
<tr>
<td>Female: male ratio</td>
<td>7:1</td>
</tr>
<tr>
<td>Percentage White British</td>
<td>88 %</td>
</tr>
<tr>
<td>PTSD diagnosis</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of trauma</th>
<th>No of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood sexual abuse</td>
<td>4</td>
</tr>
<tr>
<td>Rape and physical violence</td>
<td>1</td>
</tr>
<tr>
<td>Physical violence</td>
<td>1</td>
</tr>
<tr>
<td>Difficult experiences in police role</td>
<td>1</td>
</tr>
<tr>
<td>Road traffic accident</td>
<td>1</td>
</tr>
</tbody>
</table>

**Measures and Materials**

**Phase 1: Qualitative material.**

*Participant interview schedule (Appendix E).*

As self-kindness, common humanity and mindfulness have been operationalised as the critical components for developing a self-compassionate frame of mind (Neff, 2003b) an interview schedule was developed to explore each of these in detail. The participants were already familiar with the key concepts as they were addressed within the treatment intervention, however, care was taken to format the questions in as neutral a way as possible to minimise any question bias between the self-compassion components and their opposites (self-criticism, isolation and over-identification). Specific examples were sought to help participants clarify and discuss any potential changes in self-compassion, brought about by the treatment intervention.
Therapist interview schedule (Appendix F).

The same interview schedule was followed to that of the participants', however, the questions were tailored slightly to elicit the therapist's understanding of participant response to self-compassion, and its impact on their PTSD recovery.

Tape recorded therapy sessions (Appendix G).

Initial participant response to self-compassion interventions within treatment were assessed through analysis of recorded therapy sessions. The treatment data (for both groups) included a session on self-compassion psycho-education and exploration, critical and compassionate inner voice exercises, visualisation exercises, safe-place/being exercises, loving kindness meditation and feedback on all processes including homework exercises. This amounted to approximately five hours of data in total.

Phase 2: Quantitative measures.

(i) Two key measures were used to record PTSD symptoms and self-compassion, pre and post intervention:

Clinician-Administered PTSD Scale (CAPS).

The CAPS (Blake et al., 1995) is a widely used PTSD assessment that provides a categorical diagnosis of PTSD, as defined by the DSM-IV. Findings from a psychometric study of the CAPS-1 provide good evidence of reliability and validity with kappa coefficients higher than .63 and a Cronbach’s alpha coefficient of .97 for all CAPS items (Pupo et al., 2011).

Self-Compassion Scale (SCS).

The SCS was developed by Neff (2003a). It is a 26 item questionnaire which calculates an overall score for self-compassion, and a score for each component
(self-kindness, common humanity and mindfulness) and their opposite domain
(self-criticism, isolation and over-identification). The scale has been shown to have
good validity and reliability; test-retest reliability .93, construct validity with the self-
criticism sub-scale \( r = -.65 \), and discriminant validity with scales such as the Berger’s
Self-Acceptance Scale \( r = .62 \) (Neff, 2003a).

(ii) Two additional measures were used to record session data for PTSD
symptoms and self-compassion:

**The PTSD checklist (PCL-C; Weathers, Litz, Huska & Keane, 1994).**

The PCL-C is a self-report measure of the 17 DSM-IV symptoms of PTSD.
It is shown to have strong internal consistency with Cronbach’s alpha estimates of
.97 (Weathers et al., 1993), and good test-retest reliability .88 (Ruggiero, Del Ben,
Scotti & Rabalais, 2003). The PCL-C also correlates positively with the Mississippi
PTSD Scale with convergent validity of between \( r = .85 \) and .93 (Weathers et al.,
1993).

**Session Feedback (MDC, AccEPT Primary Care Psychological Therapies Service).**

This form was developed by the MDC as a brief measure of some key
processes hypothesised to facilitate recovery, such as state self-compassion, state
attachment, group fit and mood, consisting of nine items. The item “right now I feel
like being very kind and understanding towards myself” refers to self-compassion
and was adapted from the SCS (Neff, 2003).

**Procedure**

**Phase 1: Qualitative procedure.**

The qualitative research was conducted first to prevent any potential
researcher bias brought about by the quantitative findings. For phase 1 of the study, ethical approval was obtained from the NHS National Research Ethics Service, Greater Manchester South (Appendix Q), and the University of Exeter’s school of Psychology Ethics Committee (Appendix R).

As the participants were already working within a group and were familiar with communicating openly with each other, the group format was continued within the research to provide stability, encourage participation and establish similarities and differences in participant understanding and experiences, not easily established by statistics (Morgan & Krueger, 1993). Information about the research was distributed to all participants on completion of their treatment intervention (Appendix I), which was followed-up by telephone to establish their interest and discuss any concerns. Following confirmation of attendance, all participants were invited to attend a one hour group interview with members allocated according to their treatment intervention groups; five participants in group one and three participants in group two.

Interviews were conducted in October 2013 (group two), December 2013 (group one) and January 2014 (therapists). On arrival, participants were asked to complete a participant consent form (Appendix K) and were given a summary of self-compassion to read, taken from the self-compassion treatment intervention (Appendix H). A definition of self-compassion, and each component of self-compassion, was written up on a flip-chart & referred to during the relevant question. Confidentiality was emphasised during the group and all participants received a debriefing statement (Appendix L). There was time at the end of each group for participants to speak to the facilitator if they required it. Contact numbers
for support services were also provided.

Unfortunately, one participant from group two was unable to attend on the day, therefore they were interviewed by telephone shortly after, with the same interview schedule followed. The two therapists from each group were interviewed individually, following the participant interviews. All interviews were audibly recorded and fully transcribed anonymously. After collection of all interview data, the video tapes of the treatment intervention were watched for each group, and the self-compassion sections fully transcribed anonymously. All data was stored electronically and password protected.

**Phase 2: Quantitative procedure.**

As the treatment intervention had commenced for both groups, approval for phase 2 of the study had already been obtained by the MDC, from the AccEPT clinic as part of their service evaluation procedures. The two treatment groups were held consecutively from May-September 2012, with a booster session in January 2013, and January–May 2013, with a booster session in August 2013. They were facilitated by two therapists with no contact from the researcher during this time. All participants attending the treatment interventions completed the phase 2 measures detailed above and consented to access to their data.

**Data Analysis Strategy**

**Phase 1: Qualitative analysis.**

The aim of the qualitative analysis was to examine the meaning that self-compassion has for individuals in relation to PTSD recovery, using an explorative approach. Thematic Analysis was used to analyse all interview transcripts (participants and therapists) and the treatment data, as it is a well evidenced
method that emphasises the similarities and differences between participants, according to dominant themes (Breakwell, Hammond, Fife-Shaw & Smith, 2006). Data analysis commenced with analysis of all participant data, starting with the group interviews and single participant interview (retrospective) followed by the treatment data (immediate), with particular consideration given to any differences between groups or in the timing of the data collection (retrospective versus immediate). Analysis of the therapist transcripts followed, with close attention paid to any similarities and differences between the therapist and participant data.

The process for data coding involved six distinct phases to establish meaningful patterns; familiarisation with data, generating codes, searching for themes among codes, reviewing themes, defining and naming themes, and producing the final report (Braun & Clark, 2006). Themes were generated using a deductive approach to explore self-kindness, common humanity and mindfulness, as evidence demonstrates these as critical components for developing a self-compassionate frame of mind (Neff, 2003b). Further sub-themes and codes were developed from the data using a more inductive approach, to help identify any additional important factors. To increase the reliability of the findings three researchers were invited to code the data simultaneously (Guest, 2012). This resulted in the revision of several sub-themes and the development of one additional theme.

**Phase 2: Quantitative analysis.**

To further investigate the findings from the qualitative data, a repeated measures and single-case visual analysis design was used to examine participant change in self-compassion and PTSD symptoms during the treatment intervention.
(i) The Reliable Change Index (RCI; Jacobson, Follette & Revenstorf, 1984) is an approach that preserves the individual identity of each case in the data presentation, whilst incorporating the basic baseline-intervention phase structure of all single-case designs. The RCI is a statistic that determines whether a change in an individual’s score is reliable or not, thus addressing any concerns about small sample sizes. RCI analysis also calculates whether an individual has made a clinically significant change according to specified clinical criteria or diagnostic cut-offs (Morley, 2013) and allows for multiple treatment groups within its calculations (Blampied, 2010), identifying individuals by group membership and highlighting possible group differences.

The RCI was used to determine whether any change in PTSD symptom severity (CAPS) and self-compassion (SCS; pre and post measures) was reliable and not due to measurement error or chance variation, with the criteria for each measure taken from previously published information (Griffin, Uhlmansiek, Resick & Mechanic, 2004; Lee et al., 2013). A scatter-plot analysis was used to visually present the data, with an overall effect indicated if the data moves away from the diagonal line of no effect.

(ii) For the session data, individual regression slopes were calculated using the data from the PCL-C (Weathers et al., 1994) and the session feedback measure of self-compassion. Calculating individual regression slopes is a widely used practice in determining the time course of behavioural or physiological responses (LaRowe, Patrick, Curtin & Kline, 2006). This enabled visual display of the session data time-course for each participant and allowed examination of the variability between participants. Where session data was missing then the last
value was carried forward in order to allow determination of response slopes (McKnight, McKnight, Sidani, & Figueredo, 2007). The response slope was calculated, using the regression equation $Y = bX + a$, for sessions one to eighteen, where $Y$ is the PTSD or self-compassion score, and $X$ is the session number. The rates of data completion for all measures are in Table 4.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPS score pre</td>
<td>100</td>
</tr>
<tr>
<td>CAPS score post</td>
<td>88</td>
</tr>
<tr>
<td>SCS score pre</td>
<td>100</td>
</tr>
<tr>
<td>SCS score post</td>
<td>100</td>
</tr>
<tr>
<td>PTSD session data</td>
<td>72</td>
</tr>
<tr>
<td>Self-compassion session data</td>
<td>62</td>
</tr>
</tbody>
</table>

**Results**

**Phase 1: Qualitative Results**

Hypothesis 1: Positive change in understanding and practicing the components of self-compassion (self-kindness, common humanity and mindfulness) can benefit PTSD recovery.

Six themes, with sub-themes, were identified from analysis of the qualitative data, including the two group participant interviews, single participant interview, treatment data and the therapist interviews (Table 5). There were no obvious differences identified between treatment groups, or between the participant retrospective data (group/single interviews) and the immediate data (treatment data), therefore all participant findings were amalgamated within the analysis. There were, however, some key differences identified between the participant and therapist data therefore these were analysed separately and summarised.
accordingly.

Table 5

<table>
<thead>
<tr>
<th>Key themes and sub-themes</th>
<th>Mindfulness versus over-identification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-compassion</strong></td>
<td></td>
</tr>
<tr>
<td>Understanding of self-compassion</td>
<td>Engagement</td>
</tr>
<tr>
<td>Facilitation of self-compassion</td>
<td>Use of mindfulness</td>
</tr>
<tr>
<td><strong>Self-kindness versus self-criticism</strong></td>
<td><strong>Hierarchy of self-compassion components</strong></td>
</tr>
<tr>
<td>Self-talk</td>
<td>(i) Self-kindness</td>
</tr>
<tr>
<td>Benefits of self-kindness</td>
<td>(ii) Mindfulness</td>
</tr>
<tr>
<td><strong>Common humanity versus isolation</strong></td>
<td><strong>PTSD recovery</strong></td>
</tr>
<tr>
<td>Shame and vulnerability</td>
<td>Symptoms of PTSD</td>
</tr>
<tr>
<td>Power of the group</td>
<td>PTSD related behaviours</td>
</tr>
</tbody>
</table>

Self-compassion.

**Understanding of self-compassion.**

All participants described themselves as struggling with self-compassion at the start of treatment. For some it presented as an alien concept as they were so caught up in self-judgement, self-blame, and self-criticism, key terms that came up repeatedly. There was a definite perception that the trauma was their fault and they did not deserve compassion.

"Because you have been so down on yourself for so many years, you don't believe you deserve it (self-compassion)...You don't believe you deserve to look after yourself."

Some participants described having no understanding, prior to treatment, of what self-compassion meant or how to apply it.

"People say be kind to your-self and actually I didn't really know what that
meant”.

“As far as I am concerned that part of me isn’t there, that part that gives empathy and reassurance, it feels totally alien to me.”

Whilst most participants referred to self-criticism in a negative sense, there was one participant who reflected that sometimes it can be helpful.

“Sometimes I probably think I need to be judgemental of whatever I have done”.

Facilitation of self-compassion.

All participants talked of their self-compassion changing during treatment in relation to their understanding, which they described as being kinder to themselves, more mindful, empathising, reassuring, comfortable and deserving, but also through changing behaviours and thinking differently.

“Trying to reward yourself and tell yourself that it’s not your fault what you went through and just try and be more open with yourself...I’m going through something awful, you know, so be nice to yourself and go and watch a nice film or have something to eat”.

To achieve this, participants described the importance of the therapists reiterating self-compassion throughout the intervention.

“It became something that you were compelled to think about, you know on a regular basis, which is why it began to make sense, having even just one session on it wouldn’t have been sufficient”.

Therapists.

The therapists described similar definitions of self-compassion and also reinforced the process of self-compassion as challenging for vulnerable and
isolated individuals. There was a consensus that it can be grasped relatively easily and put into practice.

“It always surprises me to the extent which people do get it, pick it up, find it acceptable, use it. And it’s just easy. It’s really easy to understand. It’s really easy to teach”

**Self-kindness versus self-criticism.**

**Self-talk.**

The participants all described themselves as self-critical at the start of treatment, tending to be hard on themselves, judgemental and self-blaming. Following treatment they all described shifting towards a kinder position, and whilst for many of them their first response to a difficult situation continued to be to self-judge, they were now able to recognise this and subsequently adopt a more empathetic approach. Participants discussed their critical voice as loud, harsh and an ingrained way of being. They talked of having to proactively source and tune into the kinder, gentler voice, which also required belief in themselves and a sense of deservedness.

“It’s quite hard to rein in that critical voice. I actually wanted to take all the blame for everything that went wrong”.

“I think the self-kindness is believing that you deserve it. That’s the thing that changes you”.

**Benefits of self-kindness.**

Participants described the benefits of self-kindness as a reduction in self-blame, gaining a healthier perspective, being more confident with people and being
able to ask for help. They also discussed being less internally focused and therefore having more time for others.

“In being kinder to myself I have got more capacity now to see what’s happening with them. There’s part of me that’s available now to take them on. Whereas when you have got a critical voice, your thoughts are full”.

**Therapists.**

Similarly, both therapists reinforced the benefits and simplicity of the compassionate inner voice. They also referred to the love and kindness exercise, which they felt was more challenging for individuals to engage with.

“The one thing I think about is when you talk about the tone of the voice, and you say, “how would you talk to a pet or a baby?” And people go, “Oh.” You can always see ding! “Oh yeah, I wouldn’t talk to a baby or a pet, or some vulnerable innocent thing, why do I talk to myself like that?” That’s really easy for people. The meditative exercise is more difficult, more time consuming. Worthwhile probably, but just more difficult”.

**Common Humanity versus Isolation.**

**Shame and vulnerability.**

The majority of participants talked of feeling isolated and alone in their experiences prior to treatment. They discussed feelings of failure, shame and vulnerability, and the fear of exposing themselves to other people.

“...it was incest and that makes you feel that you are all alone and that there’s no one you can turn to, you cannot share, you cannot tell anyone, it’s the shame that keeps you there”.

Although most participants acknowledged an awareness pre- treatment that
they were not the only ones to suffer, several participants also stated that this did not change how they felt in themselves or their sense of isolation.

“My feeling would be, I’m not the only one feeling like this and I’d understand that completely but that wouldn’t make me feel any better”.

**Power of the group.**

The majority of participants talked positively about the group experience, and the relief of being able to show their vulnerability in a safe setting. They discussed a sense of comradeship with other group members, describing learning from each other’s experiences and gaining feelings of normality in recognising similar suffering in others.

“I had one of my most profound healing experiences in terms of shared suffering was when... we found out, both of us, that we woke up in the morning very depressed, feeling that there was no sense to life and wishing life would end”.

In addition, one participant also described how the presence of others helped her work harder in her recovery, particularly when faced with something difficult.

“Because the session is not just about you, it made me work harder because there was a few of us there”.

The only critique of the group was around the presence of less compassionate individuals, which some participants found difficult to manage. One participant also talked about how isolated he felt after treatment due to the loss of support from the group.

**Therapists.**

Both therapists discussed the participants as initially feeling alone in their
experiences. They described the benefits of the group as reducing isolation by helping individuals to share their experiences, whilst acknowledging similar suffering in others and modelling compassion. The group helped to normalise experiences and also challenge beliefs about self-blame.

“It was remarkable some of the processes that were going on there. People that we wouldn’t have expected to have, kind of, paired their experiences together, walking in different places along that path but having very similar experiences and talking about that back and forth”

Mindfulness versus over-identification.

Engagement.

The participants described themselves at the start of treatment as over-identifying with their emotions, finding it difficult to engage with mindfulness due to being “absorbed in negative thoughts and feelings” and anxiety related symptoms such as tenseness, panic and an inability to relax. For some, as treatment progressed, they were able to engage with the exercises which seemed to get easier with practice.

“You have to sort of ground yourself, where you are, at least taking something pleasant from your surroundings and then breathe in the fog. And it does help. But it’s quite a hard. It’s not an easy process to train yourself to do it, but once you do start doing it, it becomes more automatic”.

For others, they described finding the mindfulness exercises hard as they highlighted the difficult things they were avoiding, causing discomfort and a desire to avoid engaging in this way.

“I just wanted to leave to be honest, that was my instinct, I just wanted to get
up and go, that’s how I felt, I found it un-enjoyable”.

**Use of mindfulness.**

Reference was made to a range of different mindfulness techniques including a meditation CD, breathing techniques, muscle relaxation exercises, focus on surroundings/objects and tuning into senses. The use of mindfulness varied among participants, with some using it in their everyday lives, and others acknowledging that they should use it more. There was only one participant who felt it was completely unhelpful. For those that found mindfulness helpful, they described being able to balance their critical voice more, pay greater attention to what’s happening in the moment (sensory factors), taking time out from situations to calm themselves and just letting things pass.

“It happens now naturally when something upsets me. I was walking the dog, breathing, taking my break and thinking “right so how am I feeling? How does that feel?” the feelings in my body, you know about what reactions I am having. All the mindfulness which we learnt about last year in the group was kicking in when it mattered and that happens regularly which is good”.

“Ah, that’s a panic attack starting. Just that thought going through and just letting it pass through. It’s unbelievable. And I have never had a panic attack again”.

**Therapists.**

The therapists reinforced the variation in response to mindfulness, describing the meditative exercises as particularly hard due to participant fixation on their emotions. They described those most benefitting as the individuals who worked hard at it. The therapists discussed using a similar range of techniques,
however, one therapist talked of the real change coming from an understanding of
the process of mindfulness, which was facilitated through group discussions.

“If changes in mindfulness happened, I think it was through other
processes, though. It was through the discussions that we had in the group, maybe
augmented by the practice, but the practices themselves weren’t enough. I think it
was something to say, experientially, here’s something for you to have, to be
aware of, but we are going to talk and do”.

Hierarchy of components.

Self-compassion, common humanity and mindfulness.

The final interview question asked the participants to rate the components of
self-compassion in order of benefit to their recovery. Interestingly seven of the
participants rated self-kindness first, followed by mindfulness and then common
humanity. Overall, there was a general consensus that self-kindness appeared to
be an easy concept for participants to engage with, and although mindfulness
appeared a little mixed in its benefits, final feedback referred to a commonality
between self-kindness and mindfulness with participants discussing an interaction
between the two mechanisms.

“They’re mixed, I feel like I was learning about the kindness bit through
some of the mindfulness exercises”.

Common humanity was generally described by participants as least
beneficial, although there was one exception, who referred to common humanity as
the most important component in her recovery.

“The common humanity thing, I think for me what has changed in my life is
that I know I’m part of a community of the abused and none of us is alone even
though we’ve been made to feel that we are alone”.

**Therapists.**

Similarly, both therapists defined self-kindness as the most vital component to client recovery, with one therapist referring specifically to the importance of generating awareness of the critical voice to facilitate change. In contrast, however, common humanity was also perceived as important, and facilitated by the group through a safe place to share suffering, whilst supporting and connecting with others. Both therapists were uncertain of the impact of mindfulness due to the variability in engagement with the mindfulness exercises/techniques.

“The self-kindness piece wouldn’t have worked as well without the common humanity piece... So here are people who are trying to practise a new skill. It’s really hard...and to come back into a place where they felt really safe with other people and to hear affirmations, and to connect with other people in that way, I think really reinforced that for them.”

**PTSD Recovery.**

**Symptoms of PTSD.**

There was a frequent reference to PTSD symptoms with participants describing persistent states of fear/panic, agitation and tenseness. One participant spoke of the specific difficulties they experienced with nightmares and flashbacks and the challenges in managing these pre-treatment. Participants described a reduction in these symptoms during treatment facilitated by helpful techniques such as talking to themselves differently, sharing, self-soothing and breathing exercises.

“I had severe panic attacks. And I used to have to talk myself through that.”
They were horrific...now, if I feel that panic coming on, I can talk myself back into, it’s okay, you are not going to die, it’s a panic attack. It’s brilliant. And if I am feeling even more worse after that, then I’ll put my dressing gown on and chill out and watch a nice movie or something”.

There was also reference to a lowering of standards/expectations of themselves and others, and a reduction in self-blame.

“I have been having the most horrendous dreams about my past...but in a way it’s sort of, kind of, not coming from the perspective that it’s my fault”.

**PTSD related behaviours.**

Avoidance was something that came up consistently and appeared a predominant way for participants to cope pre-treatment. They discussed avoiding anything that would evoke a negative feeling including attending the group, participating in exercises, thinking/talking about their experiences and watching the news.

“I have had problem, which is why I missed a couple of sessions, and for me I couldn’t actually bring myself to come here”.

Participants generally discussed their avoidance as reducing during the intervention, describing being more willing and able to sit with and manage difficult thoughts and feelings. Stigma and perception were also commonly referred to, with the need to project a particular image of being strong and coping to others.

“It’s a bit like the duck in the water with the legs going, it’s like trying to maintain an image of everything’s fine”.

**Therapists.**
The therapists referred to the chronic trauma that participants had experienced, and the high level of shame associated with it, causing them to separate from the rest of the world. They described severe self-blame and preoccupation with the trauma and emotions, alongside anxiety related symptoms. They also talked of the importance of re-connecting with the world, which was facilitated by the group.

“But you can’t belong if you are a wounded creature separate of others. So perhaps that’s the key healing process there, is to find it within yourself to be somebody who can connect again in a meaningful way in the world”.

**Phase 2: Quantitative results**

Hypothesis 2: There will be a clinically significant change in PTSD symptoms and self-compassion for participants attending a trauma focused treatment intervention.

**Clinical Outcomes.**

Clinical outcome scores were calculated using the CAPS pre/post scores for PTSD and the SCS pre/post scores for self-compassion. Although data analysis considered the use of effect sizes (Appendix M), these have been omitted due to the limited sample size and recommendations for feasibility, precision about the mean and variance, and regulatory considerations (Julious, 2005). A reliable change in PTSD symptoms, as determined by the RCI, was shown for seven of the participants, with four of the participants also showing a reliable change in self-compassion. The three participants who showed no reliable change in self-compassion had higher scores in self-compassion than the other participants at the start of the intervention and whilst their results revealed small improvements, it was
not enough to meet the criteria for reliable change. Interestingly, the only participant who showed no change in PTSD symptoms also showed deterioration in self-compassion.

Plots were used to visually present the data with the pre/post treatment scores for the CAPS or SCS, plotted on the x-axis and y-axis. For the CAPS data (Figure 2), the plots show that seven of the participants meet the criteria for reliable change, with six also meeting the criteria for clinically significant change according to the PTSD diagnostic cut-off score. Comparison of group differences indicate that four out of five participants in group one meet the criteria for reliable change and three for clinically significant change. All three participants in group two meet the criteria for reliable change and clinically significant change.

Figure 2. Plot for CAPS data for the RCI.
For the SCS data (Figure 3), four of the participants meet the criteria for reliable change, with three also meeting the criteria for clinically significant change. One participant shows deterioration in self-compassion, and three show no change (two of these showed an improvement, however, not enough to meet the criteria for reliable change). Interestingly, there appears to be big group differences in the SCS data, with only one of the participants in group one showing a reliable change in self-compassion compared to all of the participants in group two. Overall, findings show that group two participants have a greater clinical change in both PTSD and self-compassion, than group one participants.

Figure 3. Plot for SCS data for the RCI.
Time course of responses.

Individual regression slopes were calculated using the session data from the PTSD checklist and self-compassion feedback form. A visual analysis of the individual response slopes for PTSD symptoms (Figure 4) is as predicted that PTSD symptoms tended to decrease over the intervention period, however the trajectories differed for each participant. It is interesting that the participants from the second group show the steepest reduction in PTSD symptoms, which could be related to their higher scores pre-intervention. These are the same participants that met the criteria for clinically significant change in both PTSD and self-compassion in the RCI data.

Figure 4. Regression slopes for PTSD symptoms
The self-compassion regression slopes (Figure 5) are more variable than the PTSD slopes, suggesting greater variance in response to treatment for self-compassion than PTSD symptoms. However, they generally reflect what would be expected that most participants show some improvement in self-compassion over time.

*Figure 5. Regression slopes for self-compassion*

**Summary of Phase 1 and Phase 2 Findings**

To synthesise the results a model was produced incorporating the key findings from the qualitative and quantitative data (Figure 6). The model shows the changes that occurred during the treatment intervention, according to participants...
and therapists, with the qualities above the treatment arrow increasing alongside self-compassion, and the qualities below the treatment arrow decreasing, in conjunction with PTSD symptoms. Specific treatment techniques that were referred to as key to facilitating this change are indicated within the treatment arrow.

*Figure 6. Summary Model of Change*
Discussion

This mixed method study aimed to explore the meaning that self-compassion (self-kindness, common humanity and mindfulness) has for individuals in relation to PTSD recovery, and whether there is a clinically significant change in PTSD symptoms and self-compassion for individuals attending a trauma focused treatment intervention. Group/single participant interviews and treatment data revealed that the participants perceive self-compassion as important to PTSD recovery, particularly in relation to self-kindness and the generation of positive self-belief and a compassionate inner-voice. The therapists reiterated this finding, however, they also placed common humanity as a critical component to PTSD recovery, referring to the importance of the group process in normalisation of suffering. The RCI data showed a clinically significant reduction in PTSD symptoms for most participants and a clinically significant improvement in self-compassion for some participants, particularly in group two. Session treatment data showed that PTSD symptoms decreased during the intervention period, whilst self-compassion generally increased, although the self-compassion data was more variable.

The Meaning of Self-compassion for PTSD Recovery

Participants generally described the most critical component of self-compassion as self-kindness and the concept of a compassionate inner voice, which helps reduce self-blame/criticism and an internal focus, enabling greater capacity for interaction with others. Whilst mindfulness appeared a little mixed in its effectiveness, feedback referred to a commonality between self-kindness and
mindfulness, with participants describing an important interaction between the two mechanisms, which is reflected within the evidence base (Germer and Neff, 2013). A range of mindfulness techniques were discussed as helpful, however, the therapists also described the importance of explicitly addressing the mindfulness process within treatment, to facilitate change.

Common humanity was generally described by participants as the least beneficial component to PTSD recovery. However, this contradicts the participant data somewhat which contained frequent reference to the group process in helping to reduce isolation and facilitate shared suffering, which was also reflected in the therapist feedback. This disparity could be indicative of some participant confusion around the meaning of common humanity, which was less explicitly addressed within the treatment intervention in comparison to self-kindness and mindfulness. It could also reflect more implicit group processes at work, that the participants were perhaps less aware of due to their preoccupation with their trauma and tendency to be “internally focused”.

Both participants and therapists reported a high level of participant shame and self-blame prior to treatment. For many participants they had no understanding of self-compassion and were so caught up in negative self-appraisals, thinking in kinder ways was a real challenge. This supports the cognitive model of PTSD (Ehlers & Clark, 2000) and the impact that negative appraisals can have in reinforcing patterns of thinking and behaviour caused by trauma. Participants described their self-criticism as reducing during the intervention, however, essential to this was the concept of the kinder inner-voice and the need to feel/believe they were deserving of self-kindness in the first instance. Trauma-focused CBT has
been shown to have good efficacy within PTSD (Bisson, 2007), however, highly self-critical clients have also been found to struggle with it, due to its focus at a cognitive level, and a difficulty in believing positive concepts about themselves (Gilbert, 2005). This certainly appears to be reflected in the study findings and potentially supports the evidence for an explicit experiential component of self-compassion within interventions (Neff and Garmer, 2013), to help overcome the shame/self-blame associated with trauma (Lee, 2006).

The physical symptoms of PTSD were reiterated throughout the interviews, with participants describing a persistent state of fear/panic, agitation and tenseness. The findings support the CFT model of trauma and are suggestive of a highly activated threat system, and the autonomic arousal associated with it (Gilbert & Procter, 2006). For most individuals this altered during the intervention, with participants referring to a reduction in their symptoms facilitated by talking to themselves differently, sharing their suffering with others, self-soothing behaviours and relaxation exercises. This is indicative of a deactivation of the threat system, and activation of the soothing system associated with safeness, calmness and social connectedness within the CFT approach (Rockcliff et al, 2008).

There is a general assumption within the literature that self-compassion is a healthy characteristic which enhances psychological well being (Gilbert, 2005). This is reiterated within therapeutic practice, with self-criticism generally presented as detrimental and unhelpful. Whilst the study findings generally support this concept, one participant described self-criticism as sometimes favorable, for example when having done something wrong. This disparity is potentially indicative of the different emotions that can be triggered by self-criticism, which can produce
very different responses. For example, Gilbert (2009) distinguishes between shame and guilt reactions to self-criticism, presenting shame as punishment focused and threat activating, and guilt as helping to facilitate compassion through recognition of potential harm to others and acknowledgment of their pain. For clients with PTSD who are often stuck in highly self-critical patterns of thinking (Ehlers and Clark, 2000) and shame based dialogues (Lee, 2006), this distinction between shame and guilt feelings could be an important consideration within therapy, to help individuals develop more healthy mechanisms/responses to self-criticism, rather than attempting to eradicate it entirely. Complete suppression of their critical voice, was certainly something that all participants described struggling with throughout treatment.

**Change in PTSD Symptoms and Self-compassion**

As predicted, the RCI results indicate a clinically significant reduction in PTSD symptoms for most participants, supporting the use of a CBT/IPT (with self-compassion) treatment intervention with this client group (NICE, 2005). Although the PTSD regression data varied slightly (with all participants showing a reduction in PTSD symptoms), the findings also reflect a positive response to treatment in terms of symptom reduction. Within the literature, there is currently some ambiguity around the malleability of self-compassion and its benefits to clinical populations (Barnard & Curry, 2011). The study findings indicate that a clinically significant change in self-compassion is possible for individuals with PTSD, particularly for those with more severe levels of PTSD and lower levels of self-compassion at the start of treatment. Findings from the RCI showed the only participant with no change in PTSD symptoms, was also the only individual to have a reduction in self-
compassion post-intervention. This is potentially suggestive of an underlying relationship between PTSD and self-compassion, and whilst no firm conclusions can be made, it certainly highlights the requirement for further exploration.

The RCI data revealed some interesting group differences and although any disparity is difficult to clarify due to the limited sample size, group two appeared to benefit from the treatment intervention more than group one, particularly in relation to self-compassion. These group differences could be due to factors such as smaller participant numbers in group two and more individual focus, or greater experience in running the intervention by the second group. The variation could also be accounted for by individual differences within the groups, as the participants in group two presented with higher levels of PTSD and lower levels of self-compassion pre-intervention, potentially reflecting a greater capacity for change. Interestingly, these participants all experienced sexual abuse, mostly during childhood, reflecting a possible association between long-term traumatic experiences and low self-compassion (Tanaka et al., 2011), and indicating the potential for augmenting self-compassion with this client group. For those in group one with higher levels of self-compassion pre-intervention (and less severe PTSD), although some improvements were identified, these did not all meet the criteria for reliable change, which could be indicative of less need for change due to pre-existing self-compassionate behaviours. Certainly, for two of these participants, their trauma was linked to a one off experience, which may reflect healthier mechanisms in place pre-trauma, such as positive attachments, functional families and better emotional regulation, all of which have been positively associated with self-compassion within the evidence base (Neff & McGeehee, 2010).
Limitations

Limitations of the research include a small sample size which means caution needs to be taken in generalising the results. Dropouts were also not considered which may mean the participants completing the study were potentially less representative of the population (Hoerger, 2004). It would be interesting in future research to explore the relationship between self-compassion and participant withdrawal from treatment in more detail. The small number of participants, and therapists, also means that the themes generated by the qualitative research may not be exhaustive and there could be the potential for the emergence of new themes with greater participant numbers (Rebar, Gersch, Macnee & McCabe, 2011).

Although due to the chronic nature of participant PTSD diagnosis it is unlikely that there were passage of time effects or spontaneous recovery (Kessler et al., 1995), any firm conclusions on the relationship between self-compassion and PTSD symptom reduction, are not possible due to the study design and limited sample size. In future research it would be beneficial to have a purely CBT/IPT treatment intervention as a control group, to examine any differences in PTSD recovery specifically in relation to the self-compassion component of the treatment, although this would require considerable logistical considerations.

Within self-compassion research there is a heavy reliance on self-report measures, which could have implications for the quality of the literature in this area (Adams, Soumerai, Lomas & Ross-Degnan, 1999). This study has highlighted some differences in findings between the key quantitative measures used, which although minimal and potentially exacerbated by missing data, could also reflect
some possible response bias due to social desirability and demand characteristics (Barker, 2013). It could be beneficial in future research to consider the use of experimental measures of psychophysiological responses such as cortisol estimations (threat system) and heart-rate variability (soothing system; Rockcliff et al., 2008), alongside self-report measures such as the SCS, to help endorse the validity and reliability of studies.

A further limitation is in the wide range of methods used during data collection including self-report measures, group interviews, individual interviews (participants and therapists) and treatment session data. Whilst a thematic analysis approach was adopted to help draw out any similarities and differences in the data (Breakwell et al., 2006), it should be noted that there may remain some inherent bias within the data, brought about by the variation in methods used to elicit viewpoints and understanding (Totten, 2012). The group interview data may also be limited by time constraints and the participants' willingness to share their experiences openly (Liamputtong, 2011). However studies of group data suggest that the group interview can also be a forum for contrasting opinions to emerge (Smithson, 2000). In addition, despite a consistent additional therapist in both groups, a manualised treatment guideline and regular external supervision of the therapist teams by an accredited practitioner, no formal treatment fidelity checks by external raters were performed. Possible variation between therapist styles and effects of non-specific psychotherapy factors such as therapist-patients relationships and relationships between group members, may therefore also have contributed to the quantitative differences between the two groups.
Future Directions

This study provides evidence that individuals consider self-compassion helpful in their PTSD recovery, something which could potentially inform the development of PTSD interventions in the future. Comparative examination of compassionate guided interventions versus non-compassionate interventions could help reinforce the importance of augmenting self-compassion within PTSD, whilst also considering other clinical populations. Although more substantial empirical support is currently required, ultimately the findings could help influence the treatment of other mental health conditions with similar underlying distress mechanisms, such as anxiety and depression.

It is hoped that in adding to the body of growing literature in this area, this study could help guide future research towards more empirical examination of the underlying mechanisms of self-compassion and their impact on psychological wellbeing. Within the self-compassion evidence base, there is certainly a requirement for more robust study designs, including large scale clinical trials and experimental studies, with strong methodological standards and perhaps less reliance on self-report measures (Barnard & Curry, 2011).

Conclusion

This study adds to the increasing evidence examining the concept of self-compassion within clinical populations, demonstrating the importance that individuals place on self-compassion in their PTSD recovery, particularly in relation to self-kindness and the generation of positive self-belief and a compassionate
inner-voice. The study findings indicate that a clinically significant change in self-compassion is possible for individuals with PTSD, supporting the malleability of self-compassion within clinical populations. The study also highlights the requirement for more robust study designs to examine the underlying mechanisms of self-compassion and their impact on psychiatric symptom reduction in more detail. The more evidence that can be found in favour of such positive constructs, the greater the chance of developing effective interventions within a world where unmet mental health needs is a growing problem (World Health Organisation 2013).
References


## Appendix D

### Treatment Intervention Session Overview

<table>
<thead>
<tr>
<th>Session number</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Assessment session (individual) Establish symptom status and eligibility/tx motivation</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Orientation session (individual) 1. Individual feedback about the assessment 2. Psychoeducation and initial individual formulation 3. Tx rationale and tx motivation 4. Brief information about the treatment and signing the treatment contract 5. Relaxation exercise (PMR)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Psychoeducation, group building and introduction of self-monitoring  Introduction to the therapy group Group norms and rules Refresh overview of treatment Review relaxation rationale and homework from orientation session Do Relaxation exercise together and review experiences Introduce self-monitoring (situation, thoughts, feelings, body, response)</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Group session 2 - Discussion of avoidance and continued group building 4. Memories and avoidance; preparation for individual session 1 5. Moment to moment awareness: psychoeducation 6. Moment-to-moment exercise</td>
</tr>
<tr>
<td>3</td>
<td>Individual session 1 – Identifying hotspots for imaginal exposure 1. Quick review of how tx went so far and what patient has taken away 2. Review if patient has understood the exposure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>rationale discussed in previous sessions</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Review trauma story</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Develop a hierarchy of hot spots</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Prepare first IE session</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Review homework on mindfulness/moment-to-moment exercise</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Introduce safe place</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Group session 3 – Tackling avoidance and managing emotions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Review of memory work</td>
</tr>
<tr>
<td></td>
<td>Review of awareness practice</td>
</tr>
<tr>
<td></td>
<td>Managing emotions: psychoeducation &amp; exercise</td>
</tr>
<tr>
<td></td>
<td>Wise mind exercise</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Individual session 2 – Imaginal exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discuss updated trauma story and revisit hot spot hierarchy</td>
</tr>
<tr>
<td></td>
<td>Remind/introduce SUDS, conduct IE, 3. Explain homework/exposure diary</td>
</tr>
<tr>
<td></td>
<td>4. Self soothing PE and exercise</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Individual session 3 – Imaginal exposure continued</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Discuss IE homework</td>
</tr>
<tr>
<td></td>
<td>Continue/update IE with CR elements/record new tape</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Group session 4 – Tackling avoidance continued: stimulus discrimination technique</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revisit avoidance/exposure rationale for in-vivo exposure; give example for avoided situations</td>
</tr>
<tr>
<td></td>
<td>Developing a hierarchy of avoided situation and places (in pairs)</td>
</tr>
<tr>
<td></td>
<td>Introduce positive/healthy self talk for IVE and discuss possible social support</td>
</tr>
<tr>
<td></td>
<td>Concrete planning of exercise</td>
</tr>
</tbody>
</table>

|   | Group session 5 – Tackling behavioural avoidance continued: role of unhelpful thoughts |


<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Psychoeducation CT, Identifying and challenging unhelpful cognitions</td>
</tr>
</tbody>
</table>
| 9 |   | **Group session 6 – Taking care of and being kind to yourself**  
Taking care of and being kind to yourself: psychoeducation, linking it with IVE positive selftalk  
self-compassion exercises (safe place and safe being; comp body scan) |
| 0 | **Mid- Tx Assessment**  
Expected: PTSD and depression symptom reduction  
Reduced dysf neg cognitions/rum/avoid  
Improved emotion regulation |   |
| 10 |   | **Group session 7 – The importance of social support: Compassion for self and others**  
Brief review/ Discussion of IVE and other homework  
Give intro to the second part of the treatment  
Give psychoeducation on the role of trauma, social support and coping  
Review close relationships and their importance |
| 11 |   | **Group session 8 – Role transitions**  
3. Role transitions – old role/wished for role |
| 12 |   | **Group session 9 – Role transitions continued**  
Role transitions – Identifying the challenges of the new role  
Merging the old role and new role |
| 13 |   | **Group session 10 – Interpersonal disputes**  
Identify dispute and expectations  
Brainstorm solutions  
Try out new communication  
Compassion exercise (LKM) |
<p>| 14 |   | <strong>Group session 11 – Interpersonal disputes continued</strong> |</p>
<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
</tr>
</thead>
</table>
| 15 | **Group session 12 – Interpersonal disputes continued & Patterns in relationships**  
Understanding patterns across relationships  
Exploring patterns in relationships (Handout) |
| 16 | **Group session 13 – Patterns in relationships continued** |
| 17 | **Group session 14 – Tying it all together and Consolidating progress** |
| 18 | **Group session 15 – Building resilience and awareness of warning signs** |
| 0 | **Post-tx Assessment**  
Further improvement in PTSD and depression symptoms and emo reg  
Improved social functioning (ability to ask competently for social support, being able to provide social support, compassion for self and others) |
| 4 months later | **Follow-up assessment**  
Expected: further improvement in symptoms reduction, social functioning and resilience |
| 4 months later | **Booster session/reunion**  
Review of progress of the group members  
Sharing of helpful strategies  
Refreshing of recovery and resilience plan  
Compassion exercise |
Appendix E

Participant Interview Schedule

Participants arrive:
1. They are asked to complete all consent documentation.
2. They are given a summary of self-compassion to read, taken from the self-compassion session (session 6), held within the CBT group.

A definition of self-compassion & each component of self-compassion (self kindness, common humanity & mindfulness) will be written up on a flip-chart & referred to during the relevant question.

Focus group statement and questions

Q 1. Initial questions around self-compassion: What is your understanding of self compassion? Has this changed since the CBT group intervention, if so how?

Preamble:
Think about something you have found difficult in the past few weeks (eg making a decision, attending a social event, getting something wrong), try to remember what was going through your mind and what your ‘inner voice’ was saying. Discuss….

Keeping this situation in mind, please discuss the following:

Additional prompt questions (to be asked after each question) to illicit any changes:
Have you noticed any changes in this since attending the CBT group? If yes, was anything in the intervention particularly helpful with this?

Self kindness versus self judgement:
Q 2: When going through a hard time:
   a) I give myself the caring I need.
   b) I am judgemental of my own flaws and inadequacies.

Discuss….

Common humanity versus isolation:
Q 3: When I feel inadequate in some way,
   a) I try to remind myself that feelings of inadequacy are shared by most people.
   b) I tend to feel that I am the only person that ever fails at anything, or gets anything wrong.

Discuss….
Mindfulness versus over-identification:
Q 4: When something upsets me,
   a) I try to keep my emotions in balance.
   b) I tend to obsess and fixate on everything that’s wrong.

Discussion:

Closure:
Was there any component (self kindness, common humanity, mindfulness) that was more critical to your experience/recovery than the others? Has receiving group therapy (rather than individual) helped facilitate change in self-compassion? Is there anything anyone would like to add?
1. Therapists asked to complete consent documentation.
2. Therapists are given a summary of self-compassion to read, taken from the self-compassion session (session 6), held within the CBT group.

A definition of self-compassion & each component of self-compassion (self kindness, common humanity & mindfulness) will be referred to during the relevant question.

**Q 1. Self-compassion:**
What is your understanding of self compassion?
Did you notice any specific changes in self-compassion for clients, during or after the CBT group intervention?
What was the most helpful method/tool used within the group to facilitate change in self-compassion?

**Q 2. Self kindness versus self judgement:**
At the start of therapy, when going through a hard time would you say the clients tended to:
- c) Give themselves the caring they need.
- d) Be judgemental of their own flaws and inadequacies.
Did you notice any changes in this during the group intervention?
If yes, was anything in the intervention particularly helpful with this?

**Q 3. Common humanity versus isolation:**
At the start of therapy, when feeling inadequate in some way, would you say the clients tended to:
- c) Remind themselves that feelings of inadequacy are shared by most people.
- d) Feel that they were the only person that ever fails at anything, or gets anything wrong.
Did you notice any changes in this during the group intervention?
If yes, was anything in the intervention particularly helpful with this?
Q 4. Mindfulness versus over-identification:
At the start of therapy, when something upset them, would you say the clients tended to:
   c) Try to keep their emotions in balance.
   d) Obsess and fixate on everything that’s wrong.
Did you notice any changes in this during the group intervention?
If yes, was anything in the intervention particularly helpful with this?

Q.5 Closure:
Was there any component (self kindness, common humanity, mindfulness) that was more critical to the clients’ experience/recovery than the others?
Does receiving group therapy (rather than individual) help facilitate change in self-compassion?
Why is change in self-compassion important to PTSD recovery?
Is there anything else you would like to add?
Appendix G

Treatment Data: Tape Recorded Therapy Sessions

**Group session 6**
*Conducted by:* 2 group facilitators  
*Duration:* 120 minutes

**Agenda:**
1. Review of IVE homework  
2. Challenging sense of danger: stimulus discrimination  
3. Self compassion  
4. Wind down & home work

**Therapist checklist for materials to bring:**
- Flipchart and pens  
- Chart and handouts (now/then work sheet, more expo and monitoring sheets, self compassion handout)

<table>
<thead>
<tr>
<th>1. <strong>Group grounding exercise</strong> minutes</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• brief exercise for grounding and orienting group to session</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. <strong>Review of IVE homework</strong> minutes</th>
<th>20</th>
</tr>
</thead>
</table>
| • In pairs  
  - What worked well,  
  - what will try next time  
  - Does anxiety go down?  
  - If not: what happens, what makes it difficult,  
  - Bring back to group and feedback  
    - Facilitator: Beware sense of danger and identify safety behaviours  
    - How did encouraging statements work? |

**BREAK**

<table>
<thead>
<tr>
<th>3. <strong>Self-compassion</strong> minutes</th>
<th>60</th>
</tr>
</thead>
</table>

*Note, this is ambitious for 60 minutes; worst case is that only the first bit may be possible in session in which case we can do the visualization of safe being in their safe place.*

**Review compassionate body scan homework**
- in group, 5 minutes

**Self-compassion (30 minutes)**
• **Individual:** Think about how you speak to yourself. Think about times when you have been doing something difficult (could be a trigger situation from your monitoring sheet, could be from your exposure homework) – identify a time with a bad outcome.
  - Now remember what was going through your mind: what was your inner voice saying?
  - What was the tone of the voice like?
  - What stands out most about your inner voice on each occasion?
  - What was the consequence of hearing that inner voice?
  - Distribute worksheet 1 and ask individuals to write down

• **Bring back to group and discuss:**
  - What are the consequences of negative self-talk?
  - Why do it? (where does it come from).
  - Is it useful? If not, why not? (and even when it is, what are the limits to its usefulness?)

• **Individual:** think of someone you care about.
  - Think about a difficulty he or she is facing at the moment, and imagine that he or she comes to speak to you about it.
    - He / she is trying really hard to work it out, but not succeeding.
    - He or she tells you “I feel like a total mess, a total failure”.
    - Now imagine what you would say to support your friend.
    - Think of the sorts of things you would say.
    - Notice how your voice sounds: is it soft or hard, loud or quiet?
      Imagine how your words would affect your friend.

• **Bring back to group and discuss:**
  - What did you notice about your voice (DRAW LIST ON BOARD) – tone, volume, pace, content?
  - friend?
  - Do you think he / she will go away feeling more or less able to sort the problem out?
  - What are the advantages of compassionate self-talk? (Idea that compassionate self-talk might be associated with being more effective and with feeling better).
  - When is it helpful / unhelpful?
  - what does / could your compassionate self-talk sound like?
  - What are some key phrases that help you be compassionate to yourself or others (WRITE suggestions on board and encourage group to write down their own or those of others on the worksheet 1).

**Visualisation exercise : safe place and safe being (15 minutes).**

Note to facilitator: patients have already been practicing the safe place exercise; so all that needs be added is the safe and wise being/protector

- **In group**
  
  “Imagine your safe place where you feel warm, at peace, and safe. Just take a moment to get an image in your mind of this place. (then walk through visualisation of what the place looks, sounds, feels, like – etc).

  Now, as you’re imagining this safe place, I’d like you to imagine a wise and safe being – a being you feel utterly safe with. This being can take any form, but should be something or someone you trust with every piece of you, someone whom you feel accepted and loved by. Imagine being in your safe place with this being. What does it feel like to be with this being? …. Pause…. Give them time to think of this. What does the being say to you? Imagine how the being speaks to you – the tone of voice, the pitch of voice, how loudly or
MAJOR RESEARCH PROJECT

softly the being speaks – etc) the point is to get the individual to imagine a being that is trustworthy and safe and to think of what and how that being speaks to the individual and then to later draw on this image.

- Individuals:
  o write down what your safe being was like (use worksheet 2)

Prepare using self-compassion in exposure or difficult situation (20 minutes)

- Pairs Exercise:
  o one person – select a difficult situation or task you are likely to face in the coming week (exposure or other).
  o Discuss this with your partner. Talk to your partner about some of the words and ways you would typically speak.
  o Imagine your partner was facing it, and speak to them as you would a friend, encouraging them in it.
  o Now, keeping an image of the safe person in mind, imagine speaking to yourself in the same way. Then swap roles and repeat.

- bring back to group for discussion of potential barriers:
  o not sure what to say
  o fears about what would happen if was compassionate to self: will be less effective, less motivated
  o feels uncomfortable

- Problem-solve these barriers, e.g.
  o specific techniques you could adopt: Are there a couple of key phrases you can use, keeping the gentle tone?
  o weigh up against how effective it has been to talk to self in a critical way: pros and cons of each, what is the smallest bit of compassion you would be prepared to try? Plan experiment to see if this makes you more or less effective.
  o Feeling uncomfortable: graded hierarchy
  o Can note down plan for tackling these barriers on worksheet 3.

- Homework: put into action your plan to speak to yourself compassionately in the upcoming difficult situation. Evaluate outcome (external outcome, mood outcome) and note down on worksheet 3.

Note to facilitators:
1. Idea that self-compassion can be threatening. Can create a hierarchy of objects of compassion, ending in self.
2. Use other terms as well as compassion e.g. supportive, encouraging.
3. compassion is leaving the safety you’ve set up for yourself – but that safety is lonely and self-derogatory and not allowing you to move towards a valued life.

4. Wind down & home work

- Continue IE/IVE,
- monitor and challenge NATs and self-criticism,
- continue compassionate body scan

5 minutes
Critical and compassionate inner voice

Think about something difficult you often have to do. Identify a time when you did it, and it had a bad outcome. Now remember what was going through your mind as it was going badly: what was your inner voice saying? What was the tone of the voice like? What was the consequence of hearing that inner voice?

Based on what you notice, what are the features of your own negative self talk? Think about tone of voice, and the sort of things it says.

Tone: _______________________________________________________________

Pace: _______________________________________________________________

Volume: _____________________________________________________________

Consequences: _______________________________________________________

Key phrases:
1. ___________________________________________________________________
2. _________________________________________________________________
3. ___________________________________________________________________
4. ___________________________________________________________________
5. ___________________________________________________________________

What would a more compassionate voice sound like?

Note down tone of voice, pace, and some key phrases you might say to be supportive to yourself.
Tone: _______________________________________________________________

Pace: _______________________________________________________________

Volume: _______________________________________________________________

Consequences: _________________________________________________________

Key phrases:
1. _________________________________________________________________
2. ___________________________________________________________________
3. ___________________________________________________________________
4. ___________________________________________________________________
5. ___________________________________________________________________
Safe place and safe being

Go back to your safe place. Take your time to get there and feel the warmth and safety. As you’re imagining this safe place, bring to mind a wise and safe being; this can be your wise inner adviser or a mentor-like figure that may resemble somebody you know. Or they can be entirely in your imagination – a being you feel utterly safe with, where you can be you and with whom you feel entirely safe and protected. This being can take any form, but should be something or someone you trust with every piece of you, someone whom you feel accepted and loved by. Imagine being in your safe place with this being.

What does it feel like to be with this being?

__________________________________________________________________________

__________________________________________________________________________

What does the being say to you?

__________________________________________________________________________

__________________________________________________________________________

Imagine how the being speaks to you – the tone of voice, the pitch of voice, how loudly or softly the being speaks.

__________________________________________________________________________

__________________________________________________________________________
Using self-compassion to support exposure work

Think of your next exposure homework or difficult situation you face. Practice speaking to yourself about it in a compassionate way.

How can you make it as compassionate as possible?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What you can do to tackle any barriers to being able to talk to yourself compassionately when this situation arises in real life?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are there any key phrases that it would be helpful to say to yourself?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What can you do to make it easier to speak to yourself in a compassionate way?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
What is self-compassion?

There may be times we might experience a more compassionate inner voice that feels supportive, helpful and is encouraging us to better things. For example, we may say to ourselves, “It is ok, I have given my best, next time I may try x but now it is time for some rest”. “Perhaps I should take a break now and recharge my batteries.” “This is stressful but I can manage when I take good care of myself”. Self-compassion is being kind to ourselves when things get tough. Instead of beating ourselves up we take a step back, acknowledge that this is a hard and painful time and choose to tolerate this. Self-compassion is choosing to respect ourselves and our bodies and deciding to engage in self-soothing behaviours when we need to be soothed and comforted. Self-compassion is accepting that we are not perfect and acknowledging that gentle reminders and positive encouragement and self-challenge can be more helpful than harsh inner critique.

Think about something difficult you have recently had to do. Now remember what was going through your mind: what was your inner voice saying? What was the tone of the voice like? What was the consequence of hearing that inner voice?
Appendix I

Participant Information Sheet

Self-Compassion and Post Traumatic Stress Disorder (PTSD)

My name is Lisa Gilmour. I am a Trainee Clinical Psychologist currently conducting some research on self-compassion and Post Traumatic Stress Disorder (PTSD). I would like to invite you to take part in this, however, before you make a decision please read this information sheet carefully. If you have any questions after reading this, please feel free to contact me directly (details below).

Summary of the research
This study aims to look at the impact of self-compassion on trauma recovery. Should you agree to participate, you will be involved in discussing some questions with the same people you attended your recent CBT group treatment programme (focus group) with, or individually with me (interview). This will be dependent on how many of you wish to take part in the study. The focus group or interview will take around one hour of your time and will involve meeting myself and possibly your fellow group attendees at Exeter University. The study has been reviewed and passed by an NHS Research Ethics Committee.

Aim of the study
The aim of this study is to investigate the relationship between self-compassion
and PTSD. You have recently attended a cognitive behavioural therapy group intervention and the research aims to explore your response to this in more detail. In particular, we will be looking at the meaning that self-compassion holds for you, whether you feel that this has changed since receiving treatment, and the impact that this has had on your recovery.

**Why have I been chosen?**
You have been chosen because you attended a CBT group intervention for PTSD and everyone in your group has been invited to give some feedback on your experiences.

**Do I have to take part?**
This is entirely up to you. If you decide to take part you are still free to end your participation at any time and without giving a reason. A decision to stop at any time, or a decision not to take part, will not affect the standard of care you receive. Taking part in the study will have no effect on any treatment you currently receive.

**What will happen to me if I take part? What do I have to do?**
Taking part in this study involves either meeting with the same people that you received your treatment with, or meeting with me individually, to discuss some questions about self-compassion, your treatment experience and your trauma recovery. All your personal details will remain confidential and secure and the reported results of the research will only include information about the range of participants who took part, such as average age and sex. Your identity will not be revealed in any report or publication.

**What are the possible disadvantages and risks of taking part?**
Being part of this research will simply involve you giving up your time to answer some questions. You will be given the opportunity at the end of the task to discuss any difficulties or upsetting feelings and further support contact details will be provided, should you require them.

**What are the possible benefits of taking part?**
Your contribution is invaluable and will help improve PTSD treatment programmes in the future.

**What if there is a problem?**
It is extremely unlikely that any part of this study will cause you harm. If, however, the way you have been approached or treated in the course of the study causes you concern, please write to the project supervisor Dr. Anke Karl at the School of Psychology, College of Life and Environmental Sciences, University of Exeter, Washington Singer Laboratories, Perry Road, Exeter, EX4 4QG. If you remain
unhappy and wish to complain formally, you can do this through the Chair of the University Ethics Committee, Department of Psychology, University of Exeter, Perry Road, Exeter, EX4 4QG.

What will happen to the results of the study?
I am aiming to publish the work in an academic journal and upon request I can provide you with a summary of the results. Our research is also often reported on the Mood Disorders Centre website at http://www.centres.ex.ac.uk/mood.

Contact for further information
If you would like any advice about participating in research you can contact your local Patient Advice and Liaison Services (PALS) at: Exeter Primary Care Trust, Jenny Bowers, Exeter PALS, NHS Walk-in Centre, Bedford Street, Exeter, Tel: 01392 208640, Email: jenny.bowers@exeter-pct.nhs.uk, Web: www.devon.gov.uk.

To thank you for your time taking part in this study you will receive a £5 gift voucher of your choice. Your travel expenses will also be reimbursed.

If you have any further questions please feel free to contact me at the following address:

Lisa Gilmour
Clinical Psychology Department
School of Psychology
University of Exeter
Exeter EX4 4QG
Email: lg296@exeter.ac.uk
Appendix J

Therapist Information Sheet

Self-Compassion and Post Traumatic Stress Disorder (PTSD)

My name is Lisa Gilmour. I am a Trainee Clinical Psychologist currently conducting some research on self-compassion and Post Traumatic Stress Disorder (PTSD). I would like to invite you to take part in this, however, before you make a decision please read this information sheet carefully. If you have any questions after reading this, please feel free to contact me directly (details below).

Thank you for taking the time to read this.

Summary of the research
This study aims to look at the impact of self-compassion on trauma recovery. Should you agree to participate, you will be involved in discussing some questions about the group treatment programme you recently ran for clients with PTSD. The interview should take about 30 minutes and will involve meeting with myself, somewhere suitable for you. The study has been reviewed and passed by an NHS Research Ethics Committee and the Exeter University ethics committee.

Aim of the study
The aim of this study is to investigate the relationship between self-compassion and PTSD. You have recently ran a cognitive behavioural therapy (CBT) group intervention and the research aims to explore your interpretation of the client response to this in more detail. In particular, we will be looking at the meaning that
self-compassion holds for clients and whether you feel that this has changed for them since receiving treatment, and the overall impact that self-compassion has had on their recovery.

**Why have I been chosen?**
You have been chosen because you ran the PTSD group intervention and each therapist has been invited to give some feedback on their experiences of this.

**Do I have to take part?**
This is entirely up to you. If you decide to take part you are still free to end your participation at any time and without giving a reason.

**What will happen to me if I take part? What do I have to do?**
Taking part in this study involves meeting with me individually to discuss some questions about self-compassion, including your interpretation of the clients’ treatment experience and their trauma recovery. All your personal details will remain confidential and secure and the reported results of the research will only include information about the range of participants who took part, such as average age and sex. Your identity will not be revealed in any report or publication.

**What are the possible disadvantages and risks of taking part?**
Being part of this research will simply involve you giving up your time to answer some questions. You will be given the opportunity at the end of the task to discuss any difficulties or upsetting feelings and further support contact details will be provided, should you require them.

**What are the possible benefits of taking part?**
Your contribution is invaluable and could help improve PTSD treatment programmes in the future.

**What if there is a problem?**
It is extremely unlikely that any part of this study will cause you harm. If, however, the way you have been approached or treated in the course of the study causes you concern, please write to the project supervisor Dr. Anke Karl at the School of Psychology, College of Life and Environmental Sciences, University of Exeter, Washington Singer Laboratories, Perry Road, Exeter, EX4 4QG. If you remain unhappy and wish to complain formally, you can do this through the Chair of the University Ethics Committee, Department of Psychology, University of Exeter, Perry Road, Exeter, EX4 4QG.

**What will happen to the results of the study?**
I am aiming to publish the work in an academic journal and upon request I can provide you with a summary of the results. Our research is also often reported on the Mood Disorders Centre website at http://www.centres.ex.ac.uk/mood.

Contact for further information
If you would like any advice about participating in research you can contact your local Patient Advice and Liaison Services (PALS) at: Exeter Primary Care Trust, Jenny Bowers, Exeter PALS, NHS Walk-in Centre, Bedford Street, Exeter, Tel: 01392 208640, Email: jenny.bowers@exeter-pct.nhs.uk, Web: www.devon.gov.uk.

If you have any further questions please feel free to contact me at the following address:

Lisa Gilmour
Clinical Psychology Department
School of Psychology
University of Exeter
Exeter EX4 4QG
Email: lg296@exeter.ac.uk
Title of Project: Self-Compassion and Post Traumatic Stress Disorder (PTSD)
Name of Researcher: Lisa Gilmour

1. I confirm that I have read and understand the information sheet dated 18th April 2013, Version 3, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant data collected during the study, may be looked at by individuals from Exeter University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I agree to the audio-recording of the discussion/interview.

5. I agree to take part in the study.

6. I agree that my anonymised demographic information and clinical assessment data can be included in the research dissertation and scientific publications resulting from the research.

7. I have received a £5 voucher as a thank-you for participating in the study.

Name of Participant:  
Date:  
Signature:  

Name of Person taking consent:  
Date:  
Signature:  
The aim of this study was to investigate the relationship between self-compassion and PTSD. You recently attended a cognitive behavioural therapy group intervention for PTSD, and this research aimed to explore your response to this in more detail. In particular, we were examining your understanding of self-compassion, whether you feel this has changed since receiving treatment, and the impact that self-compassion has had on your recovery.

You were presented with a list of questions on self-compassion to discuss, either individually or with other members of your group. Whilst it was important to establish your personal experience and understanding of self-compassion, the similarities and differences you shared with other group members was equally valuable. At the end of the discussion/interview you were provided with the opportunity to ask questions, if you found anything distressing.

The results of this study will not include your name or any other identifying characteristics and a summary of the findings can be sent to you, if you so wish. To receive this, please leave your name and contact details with the facilitator, who will forward it to you on completion of the study.

I would like to take this opportunity to thank you for your assistance with this study. Your contribution has been invaluable and will help improve PTSD treatment.
programmes in the future. As a sign of our gratitude you will receive a £5 gift voucher and reimbursement of your travel expenses.

If you have any further comments about your experiences of the study or questions you would like to ask, please contact me at the address below.

Here are some additional sources of support should you require them:

**Helplines:**
Samaritans (24 hours a day). Telephone: 08457 909090. Website: [www.samaritans.org](http://www.samaritans.org).

Lisa Gilmour  
Clinical Psychology Department  
School of Psychology  
University of Exeter  
Exeter EX4 4QG  
Email: lg296@exeter.ac.uk
### Statistical Improvement Rates

#### Table 3

*Statistical improvement rates (N=8)*

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD symptoms (CAPS):</strong></td>
<td></td>
</tr>
<tr>
<td>Pre treatment mean (SD)</td>
<td>73.13 (14.37)</td>
</tr>
<tr>
<td>Post treatment mean (SD)</td>
<td>31.44 (26.86)</td>
</tr>
<tr>
<td>Pre-post effect size</td>
<td>2.9</td>
</tr>
<tr>
<td>Standard error</td>
<td>4.06</td>
</tr>
<tr>
<td>RCI value</td>
<td>11.26</td>
</tr>
<tr>
<td>Number &quot;No change&quot;</td>
<td>1 (14%)</td>
</tr>
<tr>
<td>Number &quot;Deteriorate&quot;</td>
<td>0</td>
</tr>
<tr>
<td>Number &quot;Improved&quot;</td>
<td>7 (88%)</td>
</tr>
<tr>
<td>Number meeting CSC criteria</td>
<td>6 (75%)</td>
</tr>
<tr>
<td><strong>Self-compassion (SCS):</strong></td>
<td></td>
</tr>
<tr>
<td>Pre treatment mean (SD)</td>
<td>2.29 (.64)</td>
</tr>
<tr>
<td>Post treatment mean (SD)</td>
<td>2.77 (.67)</td>
</tr>
<tr>
<td>Pre-post effect size</td>
<td>.75</td>
</tr>
<tr>
<td>Standard error</td>
<td>.18</td>
</tr>
<tr>
<td>RCI value</td>
<td>.50</td>
</tr>
<tr>
<td>Number &quot;No change&quot;</td>
<td>3 (38%)</td>
</tr>
<tr>
<td>Number &quot;Deteriorate&quot;</td>
<td>1 (14%)</td>
</tr>
<tr>
<td>Number &quot;Improved&quot;</td>
<td>4 (50%)</td>
</tr>
<tr>
<td>Number meeting CSC criteria</td>
<td>3 (37.5%)</td>
</tr>
</tbody>
</table>
I have a background working within mental health and experience of augmenting self-compassion during individual therapy. Although my experience of working with PTSD is limited, I have witnessed the explicit benefits that self-compassion can have on clients with depression and anxiety, particularly for those who are struggling to respond to therapy at a cognitive level.

It was subsequently important to consider my position on self-compassion during the research process, whilst also acknowledging how awareness of the theoretical models underpinning PTSD, could potentially prejudice the research. I therefore attempted to set my understanding aside, by noting my potential subjectivities during the research process and carrying out ongoing reflection of these throughout the course of the study. This helped to genuinely consider participant responses, facilitating the development of the model from the raw data rather than pre-existing experience and theory. Alternative perspectives, from supervisors and colleagues, were also obtained during the design process and data analysis to help further minimise the impact of researcher bias on the overall findings.
Appendix O

Dissemination Statement

Participants

All participants have been given the opportunity to request a summary of the research findings, which will be distributed accordingly.

Lived Experience Group (LEG), Therapists and other health professionals associated with the Mood Disorder Centre (MDC)

The research paper will be forwarded to the LEG member who contributed to the design of the qualitative research. Copies of the paper will also be distributed to the therapists that were involved in the study, and other key MDC members, to help influence the design of future PTSD interventions.

Academia and wider audiences

The research findings will be presented to all final year trainees and supervisors at the University of Exeter and thought will be given to presenting the findings at relevant conferences, as and when appropriate. It is also intended for the research paper to be submitted to the Journal of Traumatic Stress for consideration for publication.
1. The *Journal of Traumatic Stress* accepts submission of manuscripts online.

2. Three paper formats are accepted. All word counts should include references, tables, and figures. *Regular articles* (no longer than 6,000 words) are theoretical articles, full research studies, and reviews. Purely descriptive articles are rarely accepted. In special circumstances, the editors will consider longer manuscripts (up to 7,500 words) that describe complex studies. Authors are requested to seek special consideration prior to submitting manuscripts longer than 6,000 words. *Brief reports* (2,500 words) are for pilot studies or uncontrolled trials of an intervention, case studies that cover a new area, preliminary data on a new problem or population, condensed findings from a study that does not merit a full article, or methodologically oriented papers that replicate findings in new populations or report preliminary data on new instruments. *Commentaries* (1,000 words or less) cover responses to previously published articles or, occasionally, essays on a professional or scientific topic of general interest. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries.

3. The *Journal* follows the style recommendations of the 2010 *Publication Manual of the American Psychological Association* (APA; 6th). Manuscripts should use non-sexist language. Files must be formatted using letter or A4 page size, 1 inch (2.54 cm) margins on all sides, Times New Roman 12 point font, and double-spacing for text, tables, figures, and references.

4. The title page should include the title of the article, the running head (maximum 50 characters) in uppercase flush left, author(s) byline and institutional affiliation, and author note (see pp. 23-25 of the APA manual).

5. An abstract no longer than 200 words follows the title page on a separate page.

6. Format the reference list using APA style: (a) begin on a new page following the text, (b) double-space, (c) use hanging indent format, (d) italicize the journal name or book title, and (e) list alphabetically by last name of first author. If a reference
has a Digital Object Identifier (DOI), it must be included as the last element of the reference.

**Journal Article**


**Book**


**Book Chapter**


7. Tables and figures should be formatted in APA style. **Count each full-page table or figure as 200 words and each half-page table or figure as 100 words.** Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table and figure should begin on a separate page. Only black and white tables and figures will be accepted (no color). Figures (photographs, drawings, and charts) should be numbered (with Arabic numerals) and referred to by number in the text. Place figures captions at the bottom of the figure itself, not on a separate page. Include a separate legend to explain symbols if needed. Figures should be in Word, TIFF, or EPS format.

8. Footnotes should be avoided. When their use is absolutely necessary, footnotes should be formatted in APA style and placed on a separate page after the reference list and before any tables.

9. The *Journal* uses a policy of **unmasked review**. Author identities are known to reviewers; reviewer identities are not known to authors. During the submission process, authors may request that specific individuals not be selected as reviewers; the names of preferred reviewers also may be provided. Authors may request blind review by contacting jots@ucsf.edu prior to submission in order to provide justification and obtain further instructions.

10. Statement of ethical standards: All work submitted to the *Journal of Traumatic Stress* must conform to applicable governmental regulations and discipline-
appropriate ethical standards. Responsibility for meeting these requirements rests with all authors. Human and animal research studies typically require approval by an institutional research committee that has been established to protect the welfare of human or animal subjects. Data collection as part of clinical services or for program evaluation purposes generally does not require approval by an institutional research committee. However, analysis and presentation of such data outside the program setting may qualify as research (i.e., an effort to produce generalizable knowledge) and require approval by an institutional committee. Those who submit manuscripts to the *Journal of Traumatic Stress* based on data from these sources are encouraged to consult with a representative of the applicable institutional committee to determine if approval is needed. Presentations that report on a particular person (e.g., a clinical case) also usually require written permission from that person to allow public disclosure for educational purposes, and involve alteration or withholding of information that might directly or indirectly reveal identity and breach confidentiality.

11. Reports of randomized clinical trials should include a flow diagram and a completed CONSORT checklist (available at [http://consort-statement.org/resources/downloads](http://consort-statement.org/resources/downloads)). The checklist should be designated as a "Supplementary file not for review" during the online submission process. As of 2007, the *Journal of Traumatic Stress* now follows CONSORT Guidelines for the reporting of randomized clinical trials. Please visit [http://consort-statement.org](http://consort-statement.org) for information about the consort standards and to download necessary forms.

12. Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to the International Society for Traumatic Stress Studies will be required before the manuscript can be accepted for publication. Click on the Copyright Transfer Agreement link above for the form. Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

13. Pre-Submission English-Language Editing: Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. Japanese authors can find a list of local English improvement services at [http://www.wiley.co.jp/journals/editcontribute.html](http://www.wiley.co.jp/journals/editcontribute.html). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.
14. The author(s) are required to adhere to the "Ethical Principles of Psychologists and Code of Conduct" of the American Psychological Association (visit apastyle.org) or equivalent guidelines in the study's country of origin. If the author(s) were unable to comply, an explanation is requested.

15. The journal makes no page charges. Author Services – Online production tracking is now available for your article through Wiley-Blackwell’s Author Services. Author Services enables authors to track their article - once it has been accepted - through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated emails at key stages of production. The author will receive an email with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete email address is provided when submitting the manuscript. Visit http://authorServices.wiley.com/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission, and more. Corresponding authors: In lieu of a complimentary copy free access to the final PDF offprint of your article will be available via Author Services only. Please therefore sign up for Author Services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers. Should you wish to purchase reprints of your article, please click on the link and follow the instructions provided: https://caesar.sheridan.com/reprints/redir.php?pub=10089&acro=JTS