

## CHAPTER 20

# Self-compassion in PTSD\*

Christine Braehler<sup>a</sup>, Kristin Neff<sup>b</sup>

<sup>a</sup>University of Glasgow, United Kingdom

<sup>b</sup>University of Texas at Austin, United States

*Compassion is the antitoxin of the soul:  
where there is compassion even the most poisonous impulses remain  
relatively harmless.*

*Eric Hoffer (1955)*

### Defining self-compassion

Self-compassion is formally defined and measured by Neff (Neff, 2003; Neff et al., 2018) as representing the balance between increased positive and decreased negative self-responding in times of personal struggle. Self-compassion entails being kinder and more supportive toward oneself and less harshly judgmental. It involves greater recognition of the shared human experience, understanding that all humans are imperfect and lead imperfect lives, and fewer feelings of being isolated by one's imperfection. It entails mindful awareness of personal suffering and ruminating less about negative aspects of oneself or one's life experience. The six components of self-compassion are conceptually distinct yet operate as a system, tapping into different ways that individuals emotionally respond to suffering (with kindness or judgment), cognitively understand their predicament (as part of the human experience or as isolating), and pay attention to pain (in a mindful or overidentified manner).

### Self-kindness versus self-judgment

Most of us try to be kind and considerate toward our friends and loved ones when they make a mistake, feel inadequate, or suffer some misfortune. We may offer words of support and understanding to let them know we care—perhaps even a physical gesture of affection such as a hug. We might

\*Note: Client's stories have been altered and blended to protect clients' identities. All clients were treated by Christine Braehler, Clinical Psychologist, DClInPsy, PhD.

ask them “what do you need right now?” and consider what we can do to help. Curiously, we often treat ourselves very differently. We say harsh and cruel things to ourselves that we would never say to a friend. In fact, we’re often tougher on ourselves than we are with people that we don’t like very much. The kindness inherent to self-compassion, however, puts an end to the constant self-judgment and disparaging internal commentary that most of us have come to see as normal. Our internal dialogues become benevolent and encouraging rather than punishing or belittling, reflecting a friendlier and more supportive attitude toward ourselves. We begin to understand our weaknesses and failures instead of condemning them. We acknowledge our shortcomings while accepting ourselves unconditionally as flawed, imperfect human beings. Most importantly, we recognize the extent to which we harm ourselves through relentless self-criticism and choose another way.

Self-kindness involves more than merely ending self-criticism, however. It involves actively opening up our hearts to ourselves and responding to our suffering as we would to a dear friend in need. Beyond accepting ourselves without judgment, we may also soothe and comfort ourselves in the midst of emotional turmoil. We are motivated to try to help ourselves, to ease our own pain if we can. Normally, even when we experience unavoidable problems like having an unforeseeable accident, we focus more on fixing the problem than caring for ourselves. We treat ourselves with cold stoicism rather than warmth or tender concern and move straight into problem-solving mode. With self-kindness, however, we learn to nurture ourselves when life is difficult, offering ourselves support and encouragement. We allow ourselves to be emotionally moved by our own pain, stopping to say, “This is really difficult right now. How can I care for myself in this moment?” If we are being threatened in some way, we actively try to protect ourselves from harm. We can’t be perfect, and our lives will always involve struggle. When we deny or resist our imperfections, we exacerbate our suffering in the form of stress, frustration, and self-criticism; however, when we respond to ourselves with benevolence and goodwill, we generate positive emotions of love and care that help.

### **Common humanity versus isolation**

Self-compassion is embedded within a sense of interconnection rather than separation. One of the biggest problems with harsh self-judgment is that it tends to make us feel isolated and cut off from others. When we fail or feel inadequate in some way, we irrationally feel like everyone else is just fine

and it's only me who is such a hopeless loser. This creates a frightening sense of disconnection and loneliness that greatly exacerbates our suffering.

With self-compassion, however, we recognize that life challenges and personal failures are part of being human, an experience we all share. In fact, our flaws and weaknesses are what make us card-carrying members of the human race. The element of common humanity also helps to distinguish self-compassion from mere self-acceptance or self-love. While self-acceptance and self-love are important, they are incomplete by themselves. They leave out an essential factor—other people. Compassion is, by definition, relational. It implies a basic mutuality in the experience of suffering and springs from the acknowledgement that the human experience is imperfect. Why else would we say “it's only human” to console someone who has made a mistake? Self-compassion honors the fact that all human beings are fallible and that taking wrong turns is an inevitable part of living. When we're in touch with our common humanity, we remember that everyone has feelings of inadequacy and disappointment. The pain I feel in difficult times is the same pain that you feel in difficult times. The triggers are different, the circumstances are different, the degree of pain is different, but the process is the same. With self-compassion, every moment of suffering is an opportunity to feel closer and more connected to others. It reminds us that we are not alone.

### **Mindfulness versus overidentification**

To have compassion for ourselves, we need to be willing to turn toward our own pain and to acknowledge it with mindfulness. Mindfulness is a type of balanced awareness that neither resists, avoids, nor exaggerates our moment-to-moment experience. In this receptive mind state, we become aware of our negative thoughts and feelings and are able to just be with them as they are, without fighting or denying them. We recognize when we're suffering, without immediately trying to fix our feelings and make them go away.

We might think that we don't need to become mindfully aware of our suffering. Suffering is blindingly obvious, isn't it? Not really. We certainly feel the pain of falling short of our ideals, but our mind tends to focus on the failure itself, rather than the pain caused by failure. This is a crucial difference. When our attention becomes completely absorbed by our perceived inadequacies, we can't step outside ourselves. We become overly identified with our negative thoughts or feelings and are swept away by our aversive reactions. This type of rumination narrows our focus and exaggerates implications for self-worth (Nolen-Hoeksema, 1991). Not

only did I fail, but also I am a failure. Not only am I disappointed, but also my life is disappointing. Overidentification means that we reify our moment-to-moment experience, perceiving transitory events as definitive and permanent.

With mindfulness, however, everything changes. Rather than confusing our negative self-concepts with our actual selves, we can recognize that our thoughts and feelings are just that—thoughts and feelings—which help us to drop our absorption in the storyline of our inadequate, worthless selves. Like a clear, still pool without ripples, mindfulness mirrors what's occurring without distortion so that we can take a more objective perspective on ourselves and our lives.

Mindfulness also provides the mental spaciousness and equanimity needed to see and do things differently. When we are mindful, we can also wisely determine the best course of action to help ourselves when in need, even if that means simply holding our experience in gentle, loving awareness. It takes courage to turn toward our pain and acknowledge it, but this act of courage is essential if our hearts are to open in response to suffering. We can't heal what we can't feel. For this reason, mindfulness is the pillar on which self-compassion rests.

Higher levels of self-compassion have repeatedly been associated with psychological well-being (MacBeth & Gumley, 2012; Zessin, Dickhäuser, & Garbade, 2015), while lower levels of self-compassion have been associated with increased symptoms of depression (Ehret, Joormann, & Berking, 2015; Krieger, Altenstein, Baettig, Doerig, & Holtforth, 2013), generalized anxiety disorder (Hoge et al., 2013), psychosis (Eicher, Davis, & Lysaker, 2013), eating disorders (Kelly & Tasca, 2016), bipolar disorder (Døssing et al., 2015), and PTSD (Hiraoka et al., 2015). Self-compassion therefore appears to increase emotional (Dahm et al., 2015; Zeller, Yuval, Nitzan-Assayag, & Bernstein, 2015) and physical resilience (Breines et al., 2014) by buffering against the pain we all inevitably experience. It would seem logical to conclude that individuals with psychological disorders—especially those affected by PTSD—may benefit from (1) becoming aware of their pain instead of avoiding it or being overidentified with it, (2) feeling more connected instead of isolated, and (3) caring for themselves instead of judging themselves.

Germer and Neff (Germer & Neff, 2019; Neff, 2018; Neff & Germer, 2018) note that there is both a yin and a yang aspect to self-compassion. Yin self-compassion involves “being with” pain by validating, soothing, and comforting the self. The three components of kindness, common humanity,

and mindfulness manifest in yin self-compassion as loving, connected presence. When individuals hold their pain in loving, connected presence, they begin to heal. Yang self-compassion involves acting in the world by protecting oneself, providing what is needed in the moment, and motivating change. The components of yang self-compassion can manifest as fierce, empowered truth (Neff, 2018). Self-kindness means we fiercely protect ourselves to prevent harm. Common humanity helps us to recognize that we are not alone and that we don't need to hang our heads in shame. We can stand together with others in the experience of being harmed and become empowered as a result. And mindfulness manifests as clearly seeing and speaking the truth.

Research indicates that both aspects of self-compassion lead to well-being. For instance, yin self-compassion reduces depression, anxiety, and shame (Johnson & O'Brien, 2013; MacBeth & Gumley, 2012) by replacing self-judgment with self-acceptance. When individuals take refuge in the safety of their own warmth and care, they become happier and more satisfied with their lives as a result (Neff, Kirkpatrick, & Rude, 2007). Yang self-compassion allows individuals to actively cope with life challenges. Whether it's combat (Hiraoka et al., 2015), divorce (Sbarra, Smith, & Mehl, 2012), cancer (Pinto-Gouveia, Duarte, Matos, & Fráguas, 2014), or parenting a special-needs child (Neff & Faso, 2015), self-compassion provides people with the resilience needed to stand strong without becoming overwhelmed. Yang self-compassion motivates individuals to keep going even after failure and setbacks, providing grit and perseverance in the face of adversity.

## Self-compassion and PTSD

What do we currently know about the relationship between self-compassion and PTSD? Although research on this topic is still new, the body of literature is growing. Thompson and Waltz found self-compassion to be negatively associated with the avoidance cluster of PTSD but unrelated to the hyperarousal and reexperiencing clusters in a student sample (Thompson & Waltz, 2008). Maheux and Price (2015) found self-compassion to be negatively associated with PTSD symptoms in two nonclinical samples when using both DSM-IV and DSM-5 definitions. Scoglio et al. (2018) found self-compassion to be negatively related to PTSD symptoms among women who were seeking treatment after experiencing interpersonal violence. Karatzias et al. (2017) examined the link between self-compassion and complex PTSD. According to the forthcoming 11th version of the

International Classification of Diseases (ICD-11), complex PTSD is defined as consisting of the existing PTSD criteria plus a set of symptoms referred to as “disturbances in self-organization,” which summarize the pervasive dysregulating effects of chronic victimization on affect, the sense of self, and relational functioning (Maercker et al., 2013) (Herman, 1992). Interestingly, self-compassion was found to be negatively associated with the “disturbance in self-organization” factor, but not with a general PTSD factor in this largely female sample referred to trauma therapy services (Karatzias et al., 2017). More specifically, low self-compassion was linked to negative self-concept, relationship difficulties, and affect dysregulation—particularly hypoactivation strategies. Hypoactivation of distress involves attempts to downregulate, numb, and turn the distress inward, which are in keeping with shame, defeat, dissociation, and feelings of depression, whereas hyperactivating strategies involve increasing arousal, expressing distress, and potentially becoming aggressive. Such an internalization of the abusive treatment by others is a common consequence of chronic interpersonal trauma, especially when it occurs early in life and in caregiving contexts (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). In contrast, increasing self-compassion among individuals with PTSD is hypothesized to help them to improve their affect regulation, self-concept, and relational functioning by reducing their feelings of shame, guilt, failure, and defeat (Lee, Scragg, & Turner, 2001).

### **Self-compassion, shame, and PTSD**

Self-compassion may be an effective antidote to the shame experienced by those with PTSD, where feelings of kindness, common humanity, and mindfulness can come to replace feelings of self-blame, isolation, and emotional avoidance. Although shame is known to exacerbate many types of psychological disorders, including PTSD, it is still frequently overlooked in treatment, which has historically prioritized anxiety, fear, and anger (Taylor, 2015).

What is shame? Shame is a universal emotion (Sznycer et al., 2018) characterized by a state of hypoarousal and submission that evolved to avert attack by members from one’s own group (Keltner & Harker, 1998). To escape the attack, shame activates submissive or aggressive defenses. If those are ineffective and the individual cannot find safety or support with another person or group, then primary consciousness shuts down leading to dissociation (Schore, 2015). Shame can have a paralyzing effect, and thus being shamed can be considered traumatic if it happens early in development

and if done by a caregiver (Matos & Pinto-Gouveia, 2010). Submissive strategies involve pleasing powerful others by adapting and giving up one's own will, internalizing their opinions about oneself, correcting or punishing oneself, suppressing anger and self-protective impulses in the body, losing any boundaries with powerful others, and becoming complacent. Aggressive strategies involve some form of counterattack such as blaming others overtly or covertly by talking negatively about people behind their backs or by using physical aggression.

Shame may help to maintain and exacerbate PTSD by increasing the severity and duration of illness (Brewin & Holmes, 2003) over and above the impact of exposure to trauma (DePrince, Chu, & Pineda, 2011). For example, intrusive memories of traumatic experiences were found to be accompanied more often by feelings of shame than by feelings of fear, horror, or helplessness (Holmes, Grey, & Young, 2005). Other recent research indicates that shame may mediate the relationship between PTSD symptom severity and suicidal ideation among veterans with PTSD (Cunningham, Davis, Wilson, & Resick, 2018). In contrast, self-compassion might help veterans to better adjust once back home by reducing their shame, as higher self-compassion has been linked to lower PTSD symptoms, general psychopathology, and better functioning among returning veterans, irrespective of trauma exposure (Dahm et al., 2015; Hiraoka et al., 2015).

Shame is often a result of childhood trauma, which is a risk factor for the later development of PTSD and other pathologies. Childhood maltreatment has been linked to higher shame and lower self-compassion and worse PTSD symptoms (Andrews, Brewin, Rose, & Kirk, 2000) via emotion dysregulation (Barlow, Goldsmith Turow, & Gerhart, 2017; Scoglio et al., 2018; Vettese, Dyer, Li, & Wekerle, 2011). Children may internalize their caregivers' contemptuous and hostile intentions by developing deeply shaming core beliefs such as "I am bad/evil/disgusting/unworthy," which resolves some of the cognitive dissonance (Briere, 1992). Not surprisingly, higher doses of early trauma are associated with lower levels of self-compassion (Játiva & Cerezo, 2014; Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011). For example, highly critical or otherwise dysfunctional family environments and emotional abuse have been linked to low self-compassion and insecure attachment (Neff & McGehee, 2010; Tanaka et al., 2011). In turn, low levels of self-compassion have been associated with depression and anxiety (Joeng et al., 2017), self-harming behavior (Jiang et al., 2016), anxiety (Berryhill, Hayes, & Lloyd, 2018), and PTSD symptoms (Bistricky et al., 2017).

Self-compassion has the potential to buffer against the impact of traumatic stress through the process of cognitive appraisal and emotion regulation (Barlow et al., 2017; Játiva & Cerezo, 2014; Zeller et al., 2015) and by helping individuals to make better use of social support (Maheux & Price, 2015). Much like attachment security, self-compassion offers an inner safe haven, where individuals can seek refuge and recover when distressed, and a secure base, from which they can explore the world and connect to others to feel energized again (Bowlby, 1988). Capacities for emotion regulation and mentalizing/psychological flexibility develop in early attachment contexts and are critical for later emotional and interpersonal functioning (Fonagy, Gergely, Jurist, & Target, 2002). Self-compassion involves both emotional regulation (self-kindness) and mentalizing (mindfulness and common humanity). Research demonstrates that attachment styles are, however, fluid across the lifespan and that a secure attachment style can be developed later in life through corrective experiences with another attachment figure, such as a teacher, a romantic partner, or a spiritual being—an “earned secure” style (Roisman, Padrón, Sroufe, & Egeland, 2002). It could be argued that self-compassion is the result of such a corrective experiences, which have been shown to buffer against the impact of dysfunctional family experiences (Berryhill et al., 2018; Homan, 2016; Jiang, You, Zheng, & Lin, 2017).

### **Self-compassion and the treatment of PTSD**

A number of psychotherapies have been found to be efficacious treatments for PTSD (Cusack et al., 2016). What is the role of self-compassion, if any, in standard treatments for PTSD? Two individual trauma-focused approaches recommended for PTSD sufferers with childhood trauma are DBT-PTSD (Bohus et al., 2013) and STAIR/MPI Training (Cloitre, Koenen, Cohen, & Han, 2002), which both include phases of alliance building and skills training, followed by exposure. STAIR/MPI invites patients to create narratives of shame but does not directly train in self-compassion. DBT-PTSD has more recently begun to include self-compassion modules to reduce shame.

Hoffart, Øktedalen, and Langkaas (2015) randomized 65 PTSD patients to either standard prolonged exposure, which includes imaginal exposure to the traumatic memory, or modified prolonged exposure, with imagery rescripting of the memory instead of imaginal exposure in a 10-week residential program. Improvements in self-kindness, self-judgment, isolation, and overidentification each had significant effects on risk for subsequent PTSD symptoms across therapies and most strongly in patients with higher initial self-judgment; however, what remains unclear is what helped the



patients to develop self-compassion? Was it a function of the patients' or the therapists' characteristics, the therapeutic setting, the therapeutic relationship, or other events in the patients' lives? [Kearney et al. \(2013\)](#) offered war veterans with PTSD group-based loving-kindness meditation (LKM) training. By the end of the training, self-compassion had increased, with a large effect size. At the 3-month follow-up, increases in self-compassion were associated with reduced PTSD and depressive symptoms. However, this study was limited by the fact that veterans received concurrent treatment making it difficult to assess any specific effect of LKM.

Compassion-focused therapy was developed to reduce shame and increase self-compassion in psychiatric groups as an adjunct to cognitive behavior therapy (CBT) ([Gilbert, 2010](#)). [Beaumont, Galpin, & Jenkins, 2012](#) compared individual CBT versus CBT plus 12 sessions of individual compassionate mind training (CMT) in 32 individuals referred following a traumatic incident. Both treatment groups experienced a comparable reduction in anxiety, depression, hyperarousal, reexperiencing, and avoidance symptoms. Both treatment groups also demonstrated an increase in self-compassion, which was statistically greater in the CBT plus CMT group but unrelated to symptoms.

The strongest evidence to date of the potential of CFT to reduce shame and to increase compassion comes from two pilot RCTs focusing on psychosis ([Braehler, Gumley, et al., 2013](#)) and eating disorders ([Kelly, Wisniewski, Martin-Wagar, & Hoffman, 2017](#)). Kelly had previously shown shame to trigger episodes of disordered eating and demonstrated that TAU (individual CBT with DBT elements) plus 12 sessions of group-based compassionate mind training adapted for eating disorders resulted in significantly greater improvements in self-compassion, shame, and pathology than TAU alone. [Braehler et al.](#) compared 16-session CFT group therapy adapted for psychosis ([Braehler, Harper, & Gilbert, 2013](#)) with TAU involving only nursing support but not therapy. Individuals in the CFT group showed significantly greater clinical improvements than TAU and greater increases in self-compassion and decreases in perceived sense of marginalization (external shame) and depressive symptoms ([Braehler, Gumley, et al., 2013](#)). Although these results do not directly translate to the treatment of PTSD, these studies suggest that clinical adaptations of group-based compassion-based trainings and group therapies are safe, acceptable, and beneficial if (1) delivered by clinicians who can determine the timing of the intervention to suit the individual's needs and capacities and (2) offered as part of routine mental health care with options to offer individual therapy ([Kirby, Tellegen, & Steindl, 2017](#)).

Although the research to date clearly suggests that self-compassion may protect against the toxic effects of shame in PTSD, the preliminary intervention data are limited. Nonetheless, Judith Herman, a pioneer of trauma research and therapy, summarizes the work of trauma recovery as involving “overcoming barriers to shame and secrecy, making intolerable feelings bearable through connection with others, grieving the past, and coming to a new perspective with a more compassionate view of oneself in the present” (Herman, 2015, p. 276), thus placing self-compassion at the heart of trauma recovery.

## Understanding fears and barriers to self-compassion

Asking a person who is more familiar with being in abusive than nonabusive relationships to “treat herself like a dear friend,” as is done in some self-compassion practices, may simply be impossible for the person to do, as she has no template to draw upon. The repair of the attachment system of this person must start by slowly developing a secure attachment to the therapist. How should a patient hold herself in a kind embrace when she has never been held unconditionally? Learning to trust and to receive kindness and care from another seems the logical first step in treatment. Unfortunately, individuals with attachment trauma are often deeply mistrustful and afraid of compassion and kindness from others, which is the real starting point of therapy.

Why are some people afraid of kindness and care? Such difficulties are often rooted in early experiences of receiving care and likewise may make it difficult to extend compassion. Our attachment system is shaped by our experience of how our caregivers responded to us when we were in distress. Consequently, our reactions to compassion and our obstacles to developing self-compassion will vary as a function of our early attachment experiences. If we experienced neglect or some form of emotional or physical abuse at times of distress, we will have formed emotional memories linking the experience of needing and/or receiving care with negative emotions of shame, anger, loneliness, fear, or vulnerability. Our ability to feel affiliative emotions such as love, compassion, longing, and grief toward others and ourselves can be severely compromised. Germer and Neff (Germer & Neff, 2019; Neff & Germer, 2018) summarize this paradoxical experience by saying, “When we give ourselves unconditional love, we uncover the conditions under which we have not been loved.”

Receiving kindness from a therapist may be a first step in helping patients to desensitize to the care that most longed for, but many clients experience receiving compassion from another as aversive. Why would

clients be rejecting of the very quality they need to alleviate their suffering? Whereas many people experience ease when imagining a compassionate friend, individuals with more insecure attachments experience it as subjectively and objectively stressful (Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008). Common metacognitive beliefs people hold are as follows: “I will become dependent on it.” “I do not deserve it.” “It will make me weak/lazy/selfish.” “I will be overwhelmed by distress.” “I will let myself off the hook.” “Others will take advantage of me” (Gilbert, McEwan, Matos, & Rivas, 2011). Such fears and resistance to receiving and giving compassion have been associated with greater anxiety and depression in the general population (Gilbert et al., 2012) and in clinical cohorts (Gilbert, McEwan, Catarino, Baião, & Palmeira, 2014).

Early memories of shame and fewer memories of warmth and safeness have been linked to being more afraid of receiving compassion from others and receiving compassion from oneself and to increased anxiety, depression, and paranoia (Matos, Duarte, & Pinto-Gouveia, 2017). In both nondepressed and clinically depressed samples, fear of receiving compassion from others has been strongly correlated with fear of receiving compassion from oneself. A combined fear of compassion factor predicted 53% of variance in depressive symptoms and correlated strongly with self-criticism, a known predictor of depression (Gilbert, McEwan, Catarino, & Baião, 2014a). Fear of compassion has also been associated with greater attachment insecurity in clinically depressed individuals (Gilbert, McEwan, Catarino, & Baião, 2014a; Gilbert, McEwan, Catarino, Baião, & Palmeira, 2014).

Although research refers to “fears of compassion,” the concept really taps into people’s fears about what reactions they may have to compassion. More in-depth research shows that fear of sadness, in particular, is associated with depression and that fear and avoidance of sadness and anger correlate with fears of compassion (Gilbert, McEwan, Catarino, & Baião, 2014b). This makes intuitive sense: if one has no early memories of safeness and warmth when being distressed to draw upon, then experiencing compassion might undermine one’s emotion regulation capacities. Thus the expression of difficult emotions can be threatening if we cannot build on representations of others lovingly validating and holding our emotions.

Another obstacle to receiving compassion from others can be related to mentalizing difficulties, such as a compromised ability to infer and reflect on the mental states of oneself and others and to take different perspectives (Fonagy et al., 2002), which is similar to psychological inflexibility (Miron, Seligowski, Boykin, & Orcutt, 2016). Gilbert found that individuals

with greater fears of compassion not only were more self-critical but also struggled to label their emotions and to talk about their feelings making it more difficult to notice and feel their pain (Gilbert et al., 2012). Fear of self-compassion and high psychological inflexibility have been shown to interact to predict PTSD symptom severity in students with trauma exposure (Boykin et al., 2018; Hiraoka et al., 2015). Clients with the highest levels of shame and self-criticism experience the lowest level of self-compassion and the greatest fears of receiving compassion from others including from oneself, which correlates with insecure attachment (Gilbert, McEwan, Catarino, Baião, & Palmeira, 2014), low mentalizing ability (Boykin et al., 2018), and worse outcomes (Kelly & Carter, 2013; Miron et al., 2016; Vettese et al., 2011). Therefore adding self-compassion to the clinical tool box requires, first and foremost, awareness and skills for overcoming these fears and barriers while taking into account their clients' mentalizing capacity. Compassion-based work is attachment-based work and taps directly into early experiences of attention, care, love, and appreciation or lack thereof. As with all trauma-based work, it requires clinicians to be sensitive, flexible, diligent, and willing to become a safe haven and secure base for their clients until they learn to become a safe haven and secure base for themselves.

### **Safely navigating uncharted attachment trauma territory**

Research shows that isolated self-compassion exercises can activate threat states in individuals with early attachment trauma instead of creating safety (Rockliff et al., 2008). Research also suggests that receiving compassion from others—including a therapist—may evoke fears in clients with childhood trauma and high shame. If clients fear the care they long for, then how can we safely integrate self-compassion into therapy? The main question to ask is as follows: “How can I, as a therapist, safely access the care system in this person without unnecessarily activating the threat system?”

If a person presents with complex PTSD, shame, and self-blame, it is important to gauge if they have any fears of compassion from others, for others, or for self. Self-report questionnaires might help to assess conscious fears (Gilbert et al., 2011); however, these fears of receiving kindness often show up relationally between client and therapist. The following variables are important in understanding how these fears might manifest between a therapist and a client.

- Attachment
- Emotion regulation
- Mentalization or psychological flexibility

## Attachment

If securely attached, clients are less likely to show such fears as they can draw on an inner working model that considers others and oneself as reliable sources of support at times of distress. The person considers herself worthy of care and is therefore open to accepting help from the therapist. The person also considers herself to be capable of supporting herself and therefore is likely to find it easier to offer herself compassion when in distress.

Anxious-preoccupied attachment tendencies might manifest as a sense of needing the therapist or other people in her life for support, guidance, reassurance, and comfort as the person does not trust her own ability of supporting herself. The idea of giving herself what she needs may evoke barriers such as not knowing what she needs and wants, not trusting her own feelings and needs, and fearing that if she did care for herself that she would lose the attachment bonds with significant others. The person may require the supportive encouragement from the therapist to gradually develop self-knowledge, trust in her own experiences and capacities to care, and self-efficacy. Therapists at first require compassion for the restlessness and clinging that stems from the lack of an inner safe haven to avoid being dismissive and to trust in the person's potential to develop such an inner safe haven to avoid staying in a parental role that would foster the sense of dependence on others. Adopting the role of a supportive, encouraging sports coach who often says "I trust that you can do it. Give it a try. I am here to catch you" is likely to support clients.

Dismissive-avoidant attachment tendencies are the opposite of the anxious-preoccupied ones. The person has come to exclusively rely on herself as other human beings could not be relied upon at times of need. Seeking help from others will evoke fears of being abandoned, let down, or disappointed and will likely evoke great shame because the person must acknowledge that her assumption that she can take care of all her needs has been undermined. Expressing respect for and genuinely honoring the strength that the person has shown to survive without others' help are important in beginning to engage clients with dismissive-avoidant attachment strategies. Treating the person with respect—including respecting their need for autonomy—will be critical throughout. Therapists can engage the person by giving sensitive and attuned care from a place of being an authentic human being who sometimes struggles, instead of a parent who is helping a child. Using focused self-disclosure can help to reduce shame in the client. For example, if a therapist feels the client hesitating to open up, the therapists may ask how they are feeling about coming to see them and

seeking help. The therapist may normalize that experience in different ways including sharing their own shame about seeking help or fears of being vulnerable at different times in their lives.

Fearful-avoidant attachment tendencies in adults result from a sense of being unable to trust neither themselves nor others to care for them at times of distress, creating confusion, dissociation, and intense despair. Such expectations are strongly associated with sexual, physical, or emotional abuse and neglect by caregivers during childhood (Van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). The attachment figure was a source of fear accounting for the intensely ambivalent and confusing behavior in relationships. Seeking help is likely to be a struggle for clients with this attachment conditioning as they touch on the fear of being abused again. Significant courage and motivation to help oneself are needed to overcome this fear. Expressions of care from the therapist are likely to be met with intense fear and reactivation of early relational trauma, such as flashbacks, dissociation, or numbing. Rage or anger might be another response to create distance again from the therapist who is seeking to come closer. Clients with such distressing early experiences require the utmost stability, attunement, flexibility, patience, and good will from the therapist. Any rigid expectations with regard to how the client should respond and behave or how therapy should unfold may be met with increased dysregulation and could potentially result in the client dropping out of therapy prematurely.

### **Emotion regulation**

Insecure and disorganized attachment styles are linked to emotion regulation difficulties. If caregivers did not sufficiently soothe the distress of the child, the child needed to develop alternative ways to regulate the distress, either by making it disappear or by increasing its display to get help. Hypoactivating emotion regulation strategies involve the downregulation of affect to hide it not only from others but also from oneself. These can include withdrawal from others, not speaking about feelings to others, experiential avoidance, or numbing feelings through substances or food. Hyperactivating emotion regulation strategies involve the upregulation of affect to elicit a care response from others. These can include worry, impulsiveness, high emotional expression, or frequent seeking of closeness including sexual intimacy.

### **Mentalization**

Attachment style partly predicts the ability to infer one's own and other mental states and to shift perspectives and hold different perspectives in

mind (i.e. mentalizing), which is an emotion regulation capacity as it helps to make sense of our relationships (Fonagy et al., 2002). Good mentalizing involves being able to make sense of one's own and others' behavior in terms of mental states, such as intentions, feelings, and thoughts. Low mentalizing ability shows up in different ways. When clients are stuck in self-blame, they tend to get overidentified with stories of suffering, which serves to maintain their distress instead of putting their heart to rest. Exaggerated self-blame distorts the actual attribution of responsibility in a given situation. Alternatively, low mentalizing may manifest as clients who struggle to shift perspectives and who might project their perception onto others or lack the ability to see the world in terms of mental states but rather in concrete behaviors.

### **Principles for selecting a starting point in treatment**

The following descriptions apply to complex PTSD clients with shame who have experienced childhood abuse from a caregiver and have not had any corrective interpersonal experiences. Hence it makes sense to enhance evidence-based treatments for complex PTSD by including self-compassion when dealing with shame (Lee et al., 2001). Following an assessment and formulation, including experiences of safeness, warmth, and care, the therapist might want to formulate some hypotheses about where roadblocks may occur. Despite the best analysis and preparation, many attachment traumas remain hidden until they are activated during therapy. The following three principles developed by me (CB) may help to prevent unnecessary activation of the threat system and help overcome fears of compassion safely.

### **Desensitization: Warming up slowly**

As the client with attachment trauma may experience a threat state at any time when opening the attachment system, the therapist needs to “warm up slowly.” First, this means that the therapist and client look for an easy and safe entry point to bring the care system “online” without evoking any distress. Therapists might want to normalize the paradoxical effect that the client may at first feel worse as the care system goes online before they start to feel better: “Imagine you have been out in the snow and cold without gloves on for a while. Your hands will start to feel ice cold. As you enter the warm house to warm your hands over the fire, you might feel some pain as your hands receive the warmth they so urgently needed. To titrate the pain, you approach the fire slowly so your hands can slowly absorb the warmth.

It is like a temporary pain of healing, that is, in and of itself, is not harmful. The warmth is what you need to survive in the long term. Starting with lukewarm is perfectly okay and wise.”

The care system is “online” when the person experiences any, some, or all of the following sensations and emotions: safeness, trust, ease, warmth, connection, calm, peace, openness, acceptance, love, joy, or compassion. By bringing to bear the principle of desensitization to the fear of care itself, we can help to avoid overwhelming the care system of the traumatized person and stay within the window of tolerance. To familiarize the person to the felt sense of care, therapists can ask clients to describe what sensations they notice in the body all the while ensuring that no distress arises. Therapist and client can then shift to a metalevel to address any fears of compassion that are present, by asking directly what it felt like and how that relate to their worry. For instance, if the fear is that receiving kindness or compassion makes one weak and vulnerable, the client might discover the quality of calm strength in the care state during the session. Clients can be invited to engage in behavioral experiments in between sessions to further test out the beliefs that compassion might have negative consequences. Once the care state can be brought online by the client without any distress, the person has discovered a wonderful resource that feels empowering.

### **Direction: Who is caring for whom?**

The principle of “warming up slowly” can further be implemented by considering in which direction the client can feel one or several qualities of care most easily. Care can only be experienced in relationship with another: other to other, self to other, other to self, and self to self. The client can choose how far away or how close to them they want to experience the care. Clients with intense mistrust or paranoia benefit from observing caring interactions between others from a distance as an initial exposure exercise to get themselves used to the feeling without their fears of being used or bullied or being triggered. For instance, a client might observe a friendly interaction between a shop assistant and a customer at a shop or between a mother and a child in a park (Braehler, Gumley, et al., 2013; Braehler, Harper, & Gilbert, 2013). She is likely to feel free from threat and can let herself feel some of the qualities of good will or kindness vicariously as she is not involved in this interaction. Imagining and feeling what it is like to give care to others (self to other) such as to a child, a pet, or a good friend (self to other)



moves the compassion closer in. Clients usually find this direction easy as memories typically evoke their strengths and less their vulnerability since the focus is on the pain of the other. Imagining or recalling receiving compassion from another (other to self) directly activates early memories of receiving care, including any moments of abuse or neglect or other traumatic events that may have occurred in the context of receiving care. Since this is likely to be the most challenging direction to train and to “detoxify,” we require the third principle of differentiation (see in the succeeding text). Giving oneself care (self to self) is effectively self-compassion. For clients with avoidant attachment tendencies, it can be a safe starting point to view themselves as the source of the care for oneself instead of risking disappointment or hurt from letting in a real or imaginary other. Giving yourself sensitive and attuned care that you would have hoped to have gotten from another is a goal that many therapies pursue. Ask yourself: “In which direction can the client feel trust, kindness, compassion, or happiness most easily while experiencing the least threat?”

### **Differentiation: Who needs what from whom?**

Over the course of therapy, clients become more aware of their emotions, sensations, thoughts, and links to earlier experiences. Some clients achieve a degree of differentiation that allows them to identify and distinguish an adult self with the capacity for compassion or extra helper selves with the compassion still “outsourced,” protector parts, and vulnerable exiled parts. The protector and exiled parts are connected to specific autobiographical memories. Clients with a good level of mentalizing, reasonable stability (no dissociation, no self-harm, or suicidality), and a reasonably compassionate adult self may therefore be able to work with parts-based psychotherapies to help integrate traumatic memories. These approaches allow the client to care for specific younger selves in a very individual and developmentally sensitive way; however, since the differentiation of parts usually involves contacting specific pain-laden autobiographical memories, individuals with lower mentalizing may not have the ability to switch perspectives and disidentify from the old pain so easily. Working with differentiated self-compassion practices such as the compassionate friend might evoke more distress. Thus, when working with individual with low mentalizing abilities, it is recommended that you make any intervention concrete, visible (interpersonal), and focused on the here and now instead of making it abstract and invisible (intrapersonal) and focusing it on distress in the there and then (Bateman, 2006).

The principle of blended versus differentiated can also be applied to the resource of self-compassion instead of the degree of differentiated awareness of the suffering. In interpersonal trauma, victims usually become mistrustful of others. Building up trust in other human beings is a critical part of thriving and building support network beyond therapy. The degree of human mindedness can slowly be increased with imagery (see “titrating the receiving of compassion” in the succeeding text) or in reality by simply giving the client time and space to return to the same practice and to build on it. Over time the mindedness of sources of care—real or imaginary—may increase, thus having a corrective effect on the attachment system.

Differentiation may also be applied to the quality of care. What is needed? The following are some qualities of care that are either more archetypically feminine (Yin) or masculine (Yang).

- Insecurity/encouragement (Yang)
- Abuse/protection (Yang)
- Neglect/providing (Yang)
- Grief/comfort (Yin)
- Fear/calming (Yin)
- Shame/validating and belonging (Yin)

Safeness and trust are the foundation of care. Physical affection reflects the earliest form of care when a parent soothes the undifferentiated distress of a preverbal infant who cannot yet express distress in a differentiated way. Soothing or supportive touch or a compassionate body scan may therefore be good blended practices for clients with low mentalizing capacities.

## **Integrating self-compassion into treatment of complex PTSD**

We now highlight how self-compassion can enhance working with shame during any phase-based treatment of complex PTSD (Judith Lewis [Herman, 1992](#)). Self-compassion for the therapist strengthens compassionate presence, which, in turn, strengthens the therapeutic relationship and lastly allows for sensitive direct interventions with the client.

### **Attuned presence helps to establish safety for shame and perpetrator parts**

Nora presented with outbursts of rage that she turned against herself and others that were interfering with her ability to relate to others.

*Engagement.* At our first meeting, it became apparent that having eye contact with me (CB) was difficult for her as she gazed down or to the

side beginning to shuffle restlessly in her chair and eventually having to walk around the room to relieve the obvious tension. I sensed the intense discomfort she was experiencing. Without yet knowing any of her history, I had to make sense of her behavior through what I saw and felt in that moment “neck down” in my body (resonance) and my previous clinical experience (perspective). Clearly, she felt unsafe, and it was my job to invite her to make herself feel as safe as possible in my office. Having worked with people with complex mental health issues, I was familiar with people struggling to engage with the therapist in this classic therapy setting and knew that having more casual arrangements like going for walk or sitting facing in the same direction and chatting helped as the person could avoid direct eye contact. I therefore suggested to her to change the seating arrangement so that she would feel as comfortable as possible involving us sitting more side by side, thus avoiding direct eye contact and her being free to get up, stand, and walk around whenever she wanted to. What was key here was to let her control the degree of contact. Nora’s window of tolerance was standing or sitting side by side and looking out of the window together and ending the session when she felt it was enough. Being attuned to her and my own body allowed me to tune into her and respond sensitively to her needs in the situation, which she did not dare to voice yet due to being in a submissive state. I then realized that the simple setup of being seen and having all the attention focused on her triggered shame.

Despite giving her control over the setting, her fearful-avoidant attachment tendencies and difficulties mentalizing led her to sometimes see me as the perpetrator leading to fear, anger, and then dissociation. My personal practice of mindfulness and compassion helped me to notice my slight anxiety at her getting worse, and I would breathe in for myself and out for her to calm my anxiety and to stay connected with Nora in good will and trust instead of worry and dread as if saying to her in my mind “I do not yet understand why this is happening but that’s okay. I trust and I will stay here and am willing to figure out together with you what you need now.” I was then able to ground her by inviting her to stand up and walk around, which she did, and by guiding her to talk about daily events at work that helped her to connect with her adult self that was less burdened.

What helped me not to get panicky was not just clinical experience but more importantly an informal practice called Compassion with Equanimity that I had learned in the mindful self-compassion (MSC) training program developed by Germer and Neff (Germer & Neff, 2019; Neff & Germer, 2018).

## **Self-reflection: Strengthening compassionate presence with high shame clients**

- Letting go of the script of how therapy should unfold that resides “neck up” and dropping “neck down” to feeling one’s body and emotions to resonate with the client. Resonance gives us cues for what to say and do next, and the feedback from our client gives us yet another cue, therefore allowing an interactive unfolding dance moment to moment. The guiding intention from the therapist is to support the person in an attuned way.
- Expecting self-consciousness or shame to arise in clients during engagement instead of being taken aback by it. Respecting shame without questioning it and flexibly adapting situation to ensure client feels safe.
- Taking responsibility for when one’s own difficult emotions or vulnerabilities get triggered. For instance, we may feel shamed by a client not engaging with ourselves. In return, we may shame the client by saying things such as “it does not seem like we will be able to work with each other.” Or “You do not seem to be ready yet to engage in therapy.” To name just one of many responses. Learning about shame in therapy starts with learning about our shame conditioning. Explore the following questions in peer supervision where you feel safe:
  - How do I know that I feel shame?
  - What triggers feelings of shame in me?
  - How do I compensate feelings of shame? Submissive or aggressive or both?
- Staying with not knowing.
- Connecting to good will.
- Trusting emergence.
- Committing to working together and being flexible.

## **Titration of the receiving of compassion from another**

Warmth, kindness, and wisdom are qualities we would hope to find in all therapists. What is important is that any warmth does not emerge from a script of how one should be as a therapist but emerges from resonance with the client and good will, which helps therapists to provide sensitive, attuned, and thus flexible care. Flexible means also toning down one’s expression of kindness if it is “too much of a good thing” for the client, as I learned with Nora.

Nora had started to feel safer in our sessions but still experienced direct eye contact as triggering an aversive body memory. She wanted to be able to look at me more often as she found it helped her to stay in her adult self

instead of dissociating. To help tolerate looking at me more often, she asked me “to not look in such a kind way, for instance, by not smiling so strongly.” That made a lot of sense. She wanted to connect with me as the source of care from other to self as a starting point of desensitizing to these qualities that were conditioned with fear and traumas. However, she needed to titrate the dose and asked me to tone down the dose of warmth and kindness to a level that she could tolerate without her threat system being activated.

Nora feared that kindness would make her vulnerable. She felt safe to begin with compassion for others. She could recall times when she effectively comforted a distressed toddler at the nursery she worked at. This memory provided her with a visceral experience of warmth, calm, and being soothed and tapped into her motivation to help others. Over time, she was able to let in more care from myself, other therapists, and her friends. Imagery exercises were too difficult as mentalizing broke down when the affect was too high. Here-and-now relationships were easier to work with as they were more concrete.

Another client, Lucy, had avoidant attachment tendencies and good enough mentalizing. Due to her high level of autonomy, her safe entry point into her care system was imagery (self to self), which became increasingly more differentiated and human. We worked with the compassionate friend practice (Germer & Neff, 2019; Neff & Germer, 2018) or ideal compassionate other (Gilbert, 2010) in stages and over several months during weekly sessions to allow her to gradually let in the care and love from another without getting distressed. As is often the case with interpersonal trauma, images were at first impersonal (a golden white light) and later became human (Phoebe from TV series “Friends”) and greater in number (different kind, wise, “clumsy,” and funny TV characters). These images elicited a strong visceral experience of relaxation, warmth around the heart, feeling safe, connected, sharing joy, and accepted as she is. She concluded that since she could trust these characters she may as well try to trust others in real life. The growth of her inner affiliative system seems to have acted as imaginary exposure to external affiliation. Drawing on these embodied experiences of feeling supported, accepted, joyous, and strong helped her to feel more self-confident and content and to start to take care of her body, of which she had previously been deeply ashamed.

### **Empowerment through fierce self-compassion**

Survivors of high betrayal traumas need to activate healthy anger (fierce self-compassion) to move from dissociation, shame, and self-attacking

into righteous outrage about the injustices suffered and eventually into self-protection and self-empowerment. If a therapist cannot tolerate a patient's anger well, then the therapist is likely to shame the client for being angry or to react with anger. As a consequence the patient is likely to feel invalidated or shamed, thus dropping out of therapy or returning to submissive relational patterns. A common misunderstanding among therapists is that compassion means only to be nurturing, calming, and soothing instead of also including assertiveness, protection, and encouragement. Compassion means being sensitive to suffering and alleviating it with a quality of care that is appropriate to the suffering. What is needed in the case of anger in high betrayal traumas is to validate the outrage, the injustice, the betrayal, and all the pain it caused and still causes fully and as long as the person needs to have this validated, not as long as I as the therapist think this should last. In fact, my role as a therapist is often to mirror and model healthy self-protective anger on the patient's behalf to let them realize that being raped, locked up, beaten, or having food or medical help withheld from them is not normal and not a sign of good will. Eventually, once clients believe themselves and have realized that what was done to them was wrong and in most cases a criminal offense, they grow in their ability to validate their own anger. This is the first component of yang self-compassion as described in the yang self-compassion break (Neff, 2019). Whenever the shame creeps back in, the person returns to feeling guilty for having been angry with the perpetrator and a submissive defeat state reactivates depressive mood (Catarino, Gilbert, McEwan, & Baião, 2014). Therapists require patience to explore the fear of anger that many such clients carry and help them slowly to teach clients to protect themselves to avoid retraumatization including body-based work and self-defense techniques.

### ***Informal practice for trauma survivors: Yang self-compassion break for protection***

Once clients are no longer in the grip of shame and guilt and have learned to seize the power of their anger to protect and to assert themselves, they might feel confident enough to practice fierce self-compassion when they feel like somebody is acting in unjust ways toward them or threatening to hurt or harm them in some way. The following self-compassion break was developed by Neff (2019) to help validate one's truth, to evoke courage, to empower oneself to connect with others and feel solidarity, and to connect with one's own wisdom and vow to protect oneself. Even though

the fierceness in this practice may seem strong or partly angry, it is never aggressive and never disconnecting. It is a stable, solid, calm, and strong stance of self-assertion.

1. Mindfulness of suffering
  - a. Validating the pain or hurt or injustice you are experiencing  
“This is my truth. I believe what I experienced. I trust myself despite what others might be saying to invalidate me!”
  - b. Courage  
“I dare speak my truth starting with myself.”
2. Common humanity
  - a. Empowering yourself to reach out to and to trust in others to share your truth.
  - b. Feeling connected in suffering to others who experience similar suffering and to feel solidarity in protecting yourself against future hurts.
3. Fierce self-kindness
  - a. What do I truly need to protect myself or to support myself or to stand up for myself? To say “no!” to draw my boundaries?
  - b. What is the wisest thing for me to do in this situation in the short term and in the longer term?

## **Mourning the life lost**

Once shame and guilt have abated and righteous anger has been transformed into assertiveness and self-protection, many trauma survivors experience grief about the horrors they had to endure and the negative impacts these experiences have had on their quality of life. Mourning the life lost is an important part of trauma recovery, and the quality of care needed is comfort. Therapists’ compassionate presence will allow clients to gradually grieve while feeling held by the therapist’s witnessing and being with the pain. Over time, when the fears of receiving compassion have reduced, clients might feel able to comfort themselves.

### ***Informal practice for trauma survivors: Yin self-compassion break for grief***

The self-compassion break developed by Neff and Germer ([Germer & Neff, 2019](#); [Neff & Germer, 2018](#)) for the MSC program might help a client to comfort themselves when grief about life lost emerges. The client requires an ability to feel their body without dissociating and to be able to name their emotions to themselves and to have found safe access to their

care system in therapy. This informal practice is well suited for when clients end therapy and need tools to help them maintain what they have learned.

1. **Mindfulness:** To notice, name, and validate the distress  
 “It is tragic that this happened to me. It is so painful to have missed out on happiness, joy, and ease. It is so understandable that I would feel like this at this point.”
2. **Common humanity:** To help you feel connected instead of isolated  
 “Even though it feels like I am all alone, I also feel some connection to my two friends from group therapy. They are people who really understand what it is like to have experienced these unspeakable things.”
3. **Soothing touch:** To bring the care physiology online  
 Client may place the hand on a part of the body where touch feels comforting or touches a warm blanket or warm mug of tea or strokes a pet.
4. **Self-kindness:** To offer yourself inner guidance and comfort  
 “I am here for you, my dear. Luckily the hurt is over. May you be extra gentle and kind with yourself as you go through this grief remembering that it will pass, too. I will take good care of you and allow you to feel whatever you are feeling.”

### **Allowing in happiness and play**

Just when the final phase of reconnecting is reached in trauma therapy, the final phase focuses on learning to thrive instead of merely surviving. Most survivors of complex PTSD have spent most of their lives in a threat state because their survival was threatened when they relaxed and were playful and carefree. Chronic tension and hyperarousal, sleep and digestive problems, restlessness, and hypervigilance constitute a familiar way of being. A set of specific fears may arise about what might happen when the client feels joy and happiness depending on early conditioning (Şar, Türk, & Öztürk, 2019). In addition to the general unease about relaxing and needing to slowly habituate to these new states, specific conditioned memories may manifest. For instance, if a client was humiliated through words and physically punished after happily singing along to a cheerful song and laughing when a child, the client quickly learns to suppress any expression of happiness and instead habituates to a hypoaroused defeat states. Fear of happiness shows similar relationships to attachment insecurity, alexithymia in clinically depressed groups as do fears of compassion (Joshani, 2018). Letting joy in when we are afraid of it or simply unfamiliar with it requires modeling from the therapist and reinforcement in other relationships, just as with compassion. Rejoicing with our clients and acknowledging their



strengths and resources as well as inviting humor and lightness are part of such modeling and counteract shame.

Natalie had been a naturally cheerful and happy child who had developed complex PTSD as an adult when early trauma was triggered by a sexual assault. The final phase of therapy focused on gradually building up more periods of rest and spontaneous play time with friends and her partner. The moment she sat down to rest instead of work, a defeat state set in accompanied by an urge to binge-eat. After spending several sessions integrating the old memories of being humiliated and punished for simply being a happy cheerful child playing, she was gradually able to better relax and to enjoy “doing nothing” for short periods of time on her own. As she had been rather isolated as a child during those states, we worked on her seeking out contact with others including from a distance such as lying in a park in the sun among other people and later on to spend time with friends to “play with.” Despite her happy child having been silenced in such cruel ways, she was able to reclaim her own voice by singing and literally playing music with her friends.

## Conclusion

We cannot change our clients’ painful past experiences, nor is it entirely within our power—no matter how effective the treatments are—to fully alleviate their suffering. Self-compassion can provide a resource for therapists to protect themselves against compassion fatigue, to increase therapists’ holding capacity to avoid shaming or retraumatizing their clients, and to offer a safe haven until client have developed safe havens within themselves. The suggested principles for integrating compassion into treatment for PTSD can help to strengthen clients’ attachment systems, improve their capacity for emotion regulation, and enhance their interpersonal functioning in a safe way and ultimately to improve the qualities of lives of people with complex PTSD.

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