

Running head: GROUP MINDFULNESS PROGRAM FOR TRAUMA SURVIVORS

DEVELOPMENT AND PROPOSED EVALUATION OF A MINDFULNESS BASED THERAPY

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Abstract

While effective in a number of contexts, exposure therapies for PTSD have significant limitations. Treatments such as Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) produce high dropout rates, struggle to treat the full sequelae of PTSD and may be inappropriate for more complex or severe manifestations of the disorder (Najavits, 2015; Talkovsky & Lang, 2017; Vujanovic et al., 2011). In response to these issues, there is considerable research interest in alternative or adjunctive mindfulness-based interventions (MBIs) that are more tolerable than exposure therapy, prepare clients for more intensive trauma treatment, and treat the residual symptoms exposure often struggles to address (e.g. guilt/shame, depression, and attachment disturbances). The nascent literature on this topic does not yet include more contemporary MBIs, which more explicitly emphasize how mindfulness helps cultivate self-compassion, positive affective experiences and interpersonal connections. This is a non-trivial gap in the literature, as these features of more contemporary MBIs may be uniquely well suited for trauma survivors with more complex and severe manifestations of PTSD who most need alternatives to exposure therapy. With the needs of this population in mind, this dissertation offers a novel MBI for trauma survivors which will integrate Compassion Focused Therapy (CFT), a third-wave behavior therapy, and the Mindful Self-Compassion (MSC) program, a contemporary MBI. This is a relatively novel contribution to the literature as the vast majority of MBIs adapted for PTSD and other clinical disorders integrate first and second wave behavioral principles to form their theoretical basis. There will be a discussion on the way the principles of CFT encourage a more holistic treatment philosophy to trauma when compared to the ‘front-line’ or ‘gold-standard’ exposure therapies that dominate the literature today. This dissertation will also suggest an alternative class of trauma treatments to be used alongside the proposed curriculum including compassionately augmented exposure therapy. Concerns regarding the dissemination and implementation of this package of treatments into

an integrated care setting will be discussed as well. Lastly, this dissertation will offer quantitative and qualitative research methods for a hypothetical pilot study of the proposed curriculum.

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Chapter I: Introduction

In 2017 the APA released guidelines for the treatment of PTSD much to the dismay of members of the psychoanalytic community and practitioners espousing critical elements of that tradition's core theories (APA, 2017). The guidelines emphasized behaviorally oriented treatments that underscore the critical importance of exposure and overlooked a number of different psychodynamic approaches that have a clear trauma focus. This decision excited tensions between behavioral and psychodynamic communities and led to polarized debates in various online resources our professional community uses to communicate.

The guidelines also illuminated far more important issues than our own intellectual disputes. In a controversial piece addressing the guidelines, Johnathan Shedler, a leading figure in psychotherapy research and advocate for psychodynamic treatments, alluded to exposure-based treatments as 'bad therapy' and suggested that these approaches were responsible for large dropout rates in the treatment of PTSD (Shedler, 2017). While Shedler cited a random control trial that demonstrated a dropout rate of 40% to help substantiate his point, he was really just scratching at the surface of the problem (Schnurr, Friedman & Engel, 2007). Dropout from trauma treatment is a clinical phenomenon significantly more pervasive in real-world clinical settings. In one of the most comprehensive reviews on the topic, Najavatis's (2015) revealed startling statistics in the VA hospital system, with some treatment programs having combined dropout and non-compliance rates as high as 98% percent.

This issue of clinical dropout has attracted considerable attention in the literature and some researchers now turn to mindfulness for a potential solution (Vujanovic, et al., 2011). There is hope mindfulness can be integrated into treatment in order to help patients more easily participate in exposure treatment. As of now, the literature has almost exclusively studied the use of First-Generation Mindfulness Based Interventions (FG-MBIs) for PTSD. Unlike FG-MBIs, Second Generation Mindfulness Based Interventions (SG-MBIs) explicitly emphasize self-compassion in

mindfulness practice, and this may make them better suited for the more severe or complex presentations of PTSD where the individual experiences trauma related guilt/shame. As such, this dissertation attempts to fill this gap in the literature by presenting a SG-MBI curriculum for the treatment of PTSD in an integrated care setting, such as a hospital or community mental health center.

While mindfulness programing may hold promise for a brighter future, we are currently facing a sobering reality as many trauma survivors likely receive inadequate treatment. It is equally disturbing that our scientific and professional community focuses so much of its attention on political tensions when we face serious problems that likely require our increased collaboration in order to solve them. Accepted by most clinicians, and eliciting minimal controversy, mindfulness may provide our field some sort of a middle way. Perhaps the unassuming and simple practice of mindfulness can help ground our patients as they prepare for the challenges of trauma treatment. Perhaps mindfulness may even ground our professional community as we prepare to take on such an enormous issue.

Chapter II: Review of the Literature

The controversy that surrounds exposure treatments for PTSD has brought critical attention to the clinical phenomenon of treatment dropout. The issue of dropout has always been a concern with exposure as many clinicians have wondered if the anxiety producing nature of the intervention may be too difficult for some clients. While behaviorists take the brunt of the criticism for dropout, exposure alone may not be the issue, but rather faulty implementation of the entire class of past-focused interventions to which exposure treatments belong. Past-focused trauma treatments challenge the client to explore their past trauma in detail and include both psychodynamic therapies as well behavioral approaches emphasizing exposure. Present-focused interventions, however, focus on skill development and improving the client's functioning.

A number of meta-analyses of outcome research for PTSD suggest that there are significant increases in dropout when clients choose a past-focused intervention (Bisson et al., 2007; Hembree et al., 2003; Imel et al., 2013; Swift & Greenberg, 2012). Meta-analysis of efficacy research suggests that using a past vs. present focused treatment is the critical factor in premature dropout (Imel et al., 2013). Furthermore, this research suggested that there is not any significant variability in dropout among past-focused trauma treatments. The efficacy research these meta-analyses are based on also suggests that dropout has always been an issue even as these treatments were being developed in research laboratories. Per Hodge et al. (2014) psychotherapy treatments for PTSD in RCTs average 70-80% recovery rates for those who complete treatment, but because of large dropout rates the real recovery rates across these studies is closer to 40%. Perhaps something clinicians might have in common is that regardless of their theoretical orientation they are vulnerable to contributing to premature dropout when using a past-focused trauma treatment.

The issue of dropout, however, becomes more troubling and complex when we look at this clinical phenomenon in real-world clinical settings. What follows is only a brief review of the data on

this issue, of which we have plenty. Researchers have been collecting excellent data on dropout in the largest health care system in the United States ever since the VA decided to roll out two past-focused treatments, Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) (Karlin et al. 2010). After years of collecting data, scientists can now evaluate the real-world value of the past few decades of trauma research largely conducted in research laboratories.

In a revealing review, Najavitis (2015) identifies a number of research studies sampling from thousands of cases in the VA that indicate 'first line' or 'gold-standard' treatments such as PE and CPT are producing significantly higher rates of dropout and non-compliance than they did in random control trials. In a sample of roughly 2000 veterans, Watts et al. (2015) concluded that 98% of veterans either failed to comply with treatment or dropped out before they received the adequate 'dose', which was defined as a minimum of 8 sessions. In another sample of nearly 800 veterans with a PTSD diagnosis who sought treatment from a provider trained in PE or CPT, only 11% of them began a course of exposure treatment, and roughly 8% actually completed treatment (Mott et al., 2014). Najavitis (2015) suggests that this data is consistent with other research studies that corroborate her final conclusion that on average less than 10% of veterans at a VA hospital seeking treatment for PTSD will end up being successful in either a PE or CPT treatment (Mott et al., 2014; Seal et al., 2010). Additional concern lies in the possibility that a large subset of veterans who try one of these treatments may have to go through the added obstacle of treatment failure, which may limit future engagement in clinical services. This is especially troubling because many of these veterans failed in treatment either because they were clinically inappropriate for PE and CPT, or there were systemic obstacles to implementation that the field did not adequately consider when rolling out these new treatments.

This last concern related to systemic issues is highlighted by an effectiveness study that took place in a VA hospital that the authors believe reflected real-world conditions (Eftekhar et al., 2013). Najavitis (2015), however, suggests that this description of 'real-world' conditions is inappropriate

because of a few critical features of the study. Eftekhari et al (2013) reported outcomes on 1931 veterans and found that 72% completed treatment of PE, an impressive and encouraging statistic for the viability of exposure treatments in the VA. These treatments, however were provided in the context of an intensive roll out agenda that included four-day trainings for practitioners in PE, weekly consultation, and audio-taped supervision that tracked treatment fidelity. It was also a highly selective clinician sample of almost entirely doctoral level practitioners. Initially, one might interpret this data as indicating that exposure in fact meets the needs of this client population and it is just a matter of improving the quality of the intervention. A closer look, however, reveals that the treatment sample in this study only included clients deemed 'suitable' for treatment, although suitability was not operationalized. This suggests exposure works for a certain subset of clients, and alternative treatments may be needed for clients who might be unsuitable for the intervention.

Najavits (2014) identifies a number of potential contra-indicators for successful completion of exposure, which include more severe PTSD symptoms, complex PTSD, and co-morbid personality and substance use disorders. Broadly speaking, she suggests that the more severe the trauma survivor's clinical presentation, the less able they are to complete exposure. Additionally, Glesier, Ford and Foshua (2008) identify a variety of clinical phenomena consistent with more complex presentations of PTSD that may also be contra-indicators for successful exposure treatment including emotional dysregulation, disorganized/insecure attachment, disorders of selfhood (i.e. compartmentalization, derealization, depersonalization and structural dissociation), alienation/self-defeat, and toxic-shame. Accordingly, addressing the issue of dropout may require expanding treatment options beyond the cluster of behaviorally oriented exposure treatments initially rolled out. Furthermore, these treatment options may also need to be suitable to a subset of veterans with more complex and severe trauma presentations.

Mindfulness Based Interventions for PTSD

Considering the limitations of exposure-based treatments, many now look to mindfulness to function as a complimentary, alternative or adjunctive treatment option. In particular, researchers have developed an interest in using mindfulness to reduce core symptom clusters (e.g. hyper vigilance, avoidance, intrusion etc.), increase emotion regulation skills that may facilitate exposure, and to treat the ‘residual’ symptoms (e.g. depression, negative affect, self-blame/guilt) of PTSD that exposure often struggles to address (Talkovsky & Lang, 2017; Vujanovic et al., 2011). Boyd, Lanious, & Mckinnon (2017) identify an encouraging body of research that contains 17 studies documenting the efficacy of mindfulness based treatments for PTSD. The review contains a number of different MBIs including Mindfulness Based Stress Reduction (MBSR), Mindfulness Based Cognitive Therapy (MBCT), Mindfulness Based Exposure Therapy for PTSD (MBET), Loving Kindness Meditation (LKM), and Mantram Repetition Practice (MRP). The findings of this review are summarized below. Additionally, other relevant literature and studies are integrated into the summary as appropriate.

Mindfulness-based stress reduction (MBSR).

To date, standard and trauma-adapted MBSR has been the most studied of the mindfulness based-programs including 2 pilot studies, 3 larger uncontrolled studies and 5 randomized controlled trials (Boyd, Lanious, & Mckinnon, 2017). The two pilot studies provided standardized MBSR to veterans with PTSD and women with a history of interpersonal violence and high rates of perceived stress (Cole et al., 2015; Galleos et al., 2012). In the first pilot study, veterans showed significant decreases in self-reported PTSD symptoms and these decreases were maintained at a three-month follow-up (Cole et al., 2015). In the next study, women with a history of interpersonal violence showed significant decreases in self-reported PTSD and depression as well as favorable increases in emotion regulation immediately after treatment and in a one-month follow-up (Galleos et al., 2012).

The three larger uncontrolled studies included a trauma adapted MBSR curriculum for women survivors of childhood sexual abuse and two standardized MBSR programs for veterans and another sample of trauma survivors with a mixed etiology of PTSD (Kimbrough et al., 2010; Goldsmith et al., 2014; Kearney et al., 2011). The sample of female survivors of childhood sexual abuse showed significant decreases in self-reported PTSD avoidance/numbing symptoms, re-experiencing, hyperarousal, depression and anxiety (Kimbrough et al., 2010). In the sample of participants with mixed etiology, Goldsmith and colleagues (2014) reported significant decreases on self-reported depression, PTSD symptoms, and shame-based trauma appraisals at mid-treatment and post-treatment. The sample of veterans also demonstrated favorable changes in PTSD symptoms (i.e. re-experiencing, avoidance, emotional numbing and hyperarousal), depression, experiential avoidance and mental health-related quality of life (HRQOL) at post-treatment and two and four-month follow-up (Kearney et al., 2011).

Of the four RCTs identified by Boyd and colleagues (2017), two demonstrated between group differences on symptoms of PTSD (Kearney et al., 2014; Possemato et al., 2016; Niles et al., 2012; Polusny et al., 2015). The largest of these four studies compared a group of 116 traumatized veterans receiving standard MBSR with a control group provided present-centered therapy (Polusny et al., 2015). There were significantly greater reductions in clinician rated PTSD symptoms and a significant increase in quality of life in the MBSR group compared to the control group. These differences were not present immediately post-treatment, but rather during the two-month follow-up, suggesting that MBSR may provide enduring change. Niles and colleagues (2012) compared a tele-health based MBSR (two 45-minute in-person sessions and six 20-minute weekly phone calls with weekly individual practice) to Telehealth psychoeducation program and found significant between-group differences in PTSD symptoms on both self-report and clinician administered assessments. It is important to note, however, that the sample was significantly smaller in this second study with only 33 veterans, a limitation acknowledge by the study's authors.

Possemato and colleagues (2016) failed to produce significant between group differences when comparing a group of 62 veterans receiving an abbreviated MBSR curriculum (four weekly 90 min sessions) to a TAU control. However, the authors found significant differences across groups in PTSD severity when a complete analysis was conducted. Kearney and colleagues (2012) also failed to produce significant decreases in PTSD symptoms when comparing a group of 47 veterans receiving a standardized MBSR to a TAU control. There were, however, significant differences in mindfulness and quality of life immediately following the intervention, but these were not maintained during follow up.

Across studies of these MBSR interventions, all dropout rates fell within a range of 10%-22% with the exception of one study that reported a 43% rate of dropout. This is a very encouraging finding and suggests that MBSR and similar mindfulness-based interventions may be a strong alternative for clients more vulnerable to drop-out.

Mindfulness-based cognitive therapy (MBCT)

To date there is one pilot study on the use MBCT for PTSD (King, Erickson, Giardino, et al., 2013). MBCT is based on MBSR, but integrates basic behavioral principles consistent with cognitive behavioral therapy into its curriculum. Furthermore, the authors adapted MBCT specifically for PTSD by including psychoeducation on PTSD and providing more attention to working with trauma related memories and other PTSD specific symptoms. Mindfulness exercises were also abbreviated to accommodate the unique sensitivities trauma survivors may have to the practice. The investigators assigned 20 subjects to four separate MBCT groups and 17 subjects to three separate control group which included a PTSD psycho-education & skills group and two Imagery rehearsal therapy groups. The dropout rate for the MBCT groups was 25% and 27% for the other control groups. These rates are also encouraging for the suitability of mindfulness for traumatized populations.

The pilot study showed significant decreases in overall PTSD symptoms as captured by the clinician-administered PTSD scale (CAPS). Additionally, there were significant decreases on the avoidance subscale of this measure. The MBCT group outperformed the TAU group as there were no such

reductions on the CAPS in this control. In the MBCT group, 73% of participants demonstrated significant decreases in PTSD through this scale, but only 33% demonstrated such changes in the three control groups. Completer's of the MBCT group also showed significant decreases on self-report of overall PTSD symptoms on a numbing subscale. Additionally, there were significant reductions on self-reported self-blame within the MBCT group.

Mindfulness-based cognitive behavioral conjoint therapy (MB-CBCT)

Developed by Davis & Luedtke (2013), MB-CBCT integrates mindfulness practice with first and second wave behavioral principles. Unlike standard MBCT, MB-CBCT emphasizes the interpersonal difficulties common to PTSD through the inclusion of a weekend couples' retreat and nine subsequent couples' sessions. Currently, the literature on this approach is restricted to one case study, which demonstrated significant reductions in core PTSD symptom clusters as well as increased relationship satisfaction (Luedtke et al., 2015). The authors are currently completing an RCT study on this intervention as well.

Mindfulness-based exposure therapy (MBET)

In addition to studies on MBCT for PTSD, King and colleagues (2016) have also produced a pilot study on a novel mindfulness based program called MBET. Like MBCT, this approach also integrates cognitive behavioral principles for its theoretical foundation. MBET is distinct from MBCT as it includes non-trauma related in-vivo exposures in its curriculum. There is also an added focus on body sensations, emotions and a module in self-compassion training. Pre vs post test scores on clinical administered PTSD symptoms revealed significant decreases in symptoms for both MBET and the control group, which received present centered group therapy, a therapeutic approach developed for research purposes without a trauma focus.

Mantrum repetition practice (MRP)

Mantrum repetition practice is the silent repetition of a word or phrase. While MRP has spread to the west primarily through the transcendental meditation movement, it is a practice found in a variety of different Eastern Wisdom traditions. Bormann and colleagues (2014) completed a large RCT with a sample of 146 veterans comparing a six-week MRP course with TAU. Data at post-test found that the MRP group significantly outperformed TAU on a variety of measures. There were significantly greater reductions on client and clinician reported symptoms of PTSD. In particular, there were greater reductions on self-reported symptom clusters of PTSD such as hyperarousal and numbing. Additionally, there were significantly greater increases in the MRP group on measures of general psychological well-being. Furthermore, the authors found that increased scores on mindful attention and frequency of mantrum meditation practice mediated these favorable changes in scores. Finally, and of particular note, was the unusually low rate of dropout; 5%. Intuitively, this finding makes sense considering the anchoring effect that word repetition in MRP plays in meditation practice. Returning to a familiar word, rather than sitting in mindful awareness may be more reassuring to some practitioners.

Rosenthal and colleagues (2011) completed similar research on MRP, but in a significantly smaller pilot study. They provided transcendental meditation, a specific form of MRP, to a group of seven veterans. Among the five who completed treatment, there were significant decreases in clinician assessed PTSD and significant increases in measures on quality of life.

Loving-kindness meditation (LKM)

Loving Kindness Meditation (LKM) or *Metta* originates from the Theravada branch of Buddhism. It encourages the practitioner to cultivate an intention to direct love, kindness, and well-being to themselves and others. There is considerable interest in using such an intervention to treat the residual symptoms of PTSD that exposure often struggles to address. Currently the literature includes one pilot study for LKM interventions for veterans with PTSD (Kearney et al., 2013). In a sample of 41 participants provided a standardized 12-week LKM protocol, the authors found significant increases in self-

compassion, mindfulness skills and reductions in both PTSD symptoms (large effect size) and depressive symptoms (medium effect size). Furthermore, the authors found that self-compassion positively influenced treatment outcome. Such findings suggest that MBIs may work via self-compassion as a mechanism of change.

The body of literature for mindfulness-based interventions is promising. These studies demonstrate the acceptability of mindfulness for traumatized individuals as dropout rates were quite low across many different MBIs. Additionally, many of these interventions appear capable of treating a wide range of clinical issues including many of the residual symptoms common among trauma presentations (e.g. depression, numbness). As such, mindfulness appears to be a viable, relatively low risk treatment of PTSD and its full sequelae.

Second generation mindfulness

There is a noticeable gap in this literature as the mindfulness curricula studied are restricted to First Generation Mindfulness Based Interventions (FG-MBIs) while a number of the more contemporary, Second-Generation Mindfulness Based Interventions (SG-MBIs) are excluded. Van Gordon and colleagues (2015) describe how FG-MBIs are consistent with Kabat Zinn's original definition of mindfulness; "[paying] attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994:4). This definition coincides with earlier frameworks that conceptualized mindfulness as consisting of two elements: 1) self-regulation of attention and 2) orientation of experience (Bishop et al., 2004). The former translates to the capacity to bring attention to specific aspects of one's psychological experience. The latter refers to the individual's ability to accept experience as it is with curiosity and openness. Together, these two components offer an eliminative account of mindfulness where the practice reduces or neutralizes distress through acceptance rather than resistance. In this widely cited paper, it is important to note that the authors explicitly separated the following components from their definition; patience, trust, calmness, wisdom and compassion. Instead they described

these constructs as correlates or outcomes of mindfulness practice and not a component of the practice itself.

Unlike FG-MBIs, Second Generation-Mindfulness Based Interventions (SG-MBIs) advocate for a more active rather than passive form of mindful awareness. In other words, mindfulness does not function to passively accept experience non-judgmentally, but rather mobilize action in response to experience; “The participating observer notion is intended to help mindfulness practitioners understand that it is possible (and indeed essential) to observe and let-go of present moment experiences, while concurrently discerning how to respond in an adaptive manner” (Vangordon et al., 2015: p. 592). This shift towards second generation mindfulness has also coincided with the development of new conceptual frameworks for the practice as well. Garland and colleagues (2015) offer the *mindfulness to meaning theory* which states:

Mindfulness evokes a metacognitive state that transforms how one attends to experience, thereby promoting positive reappraisals that facilitate positive affect and adaptive behavior...the process of positive reappraisal that flows from mindfulness involves broadening the scope of appraisal to appreciate that even aversive experiences are potential vehicles for personal transformation and growth. Through this reorienting to aversive experience, positive reappraisal provides meaningful experiences in the face of stress that complement and sustain the extinction of maladaptive cognitive habits. (p. 295)

As one can see, the *mindfulness to meaning theory* advocates for a transformative rather than eliminative account of the practice. Distress is reduced or eliminated, while positive life enhancing psychological states are simultaneously generated. A number of second-generation mindfulness based interventions, Mindful Self Compassion (MSC), Compassion Cultivation Training (CCT), and Mindfulness Based Compassionate Living (MBCL), have evolved through various pilot studies to become more consistent with this understanding of mindfulness by explicitly integrating self-compassion into their curricula (Neff & Germer, 2013; Jazajeri et. al., 2013; Reddy et al., 2013). Additionally, Compassion Focused Therapy (CFT), a contemporary third wave behavior therapy, has integrated a more transformation account of mindfulness into its theoretical framework as well (Gilbert,

2009). Unfortunately, the literature for the use of such programs with trauma survivors is not well developed. This is unfortunate considering the value of self-compassion in the context of mental health and trauma.

The benefits of self-compassion

Research publications on self-compassion and its impact on mental health have seen exponential growth over the past decade (Neff, 2016). In a comprehensive review on the topic, Germer & Neff (2019) identified the positive impact of self-compassion on a variety of factors, including emotional well-being, motivation, physical health, stress, body image, disordered eating, relationships, altruism, caregiving, attachment, and psychopathology. In a meta-analysis of 79 studies, Zessin and colleagues (2015) established a clinically significant relationship between self-compassion and well-being. Another meta-analysis of 14 research studies revealed an inverse relationship between self-compassion and a wide variety of psychopathology (MacBeth & Gumley, 2012). Furthermore, the results indicated a large effect size in this finding. A full review of this literature is too vast to cover at this time. Interested readers may wish to consult Germer & Neff's (2019) *Teaching the Mindful Self-Compassion Program* for greater detail.

Self-compassion also appears to have a significant relationship to and impact on trauma. A number of studies have found significant negative correlations between self-compassion and poor mental health outcomes among trauma survivors (Dahm et al., 2015; Hiraoka et al., 2015; Scoglio et al., 2018; Thompson & Waltz, 2008; Zeller et al., 2015). In a particularly revealing study, self-compassion was a stronger predictor of positive mental health outcomes than the amount of combat experienced by veterans returning home from war (Hiraoka et al., 2015). This research suggests, that compassion may function as a buffer against the development of trauma related symptoms. Additionally, there may be a tipping point at which one's own capacity for self-compassion outweighs the stress of traumatic experiences, that may otherwise lead to PTSD.

In addition to holding a robust relationship with mental health and well-being, a number of theorists have suggested that self-compassion may function as a critical mechanism of change in therapeutic processes (Baer, 2010; Germer & Neff 2013; Gilbert, 2009). The empirical literature has demonstrated that this may in fact be true. In a random control trial comparing cognitive therapy and short-term dynamic therapy (i.e. affect phobia therapy), increases in self-compassion during treatment in both conditions significantly predicted pre-to-post therapy reductions in psychiatric symptoms, interpersonal problems and personality pathology. Additional research has also evaluated the session to session impact of self-compassion on outcome. One study completed at a university-based clinic using only short-term dynamic psychotherapy found that self-compassion predicted pre-to-post therapy improvements as well as improvements in general functioning on a session-to-session level (Galili-Weinstock et al., 2018). Similar research using cross-lagged time analysis has further suggested the causal role self-compassion may play on depression among individuals receiving brief cognitive therapy (Krieger et al., 2016). The results of this study showed that increases in self-compassion predicted lower levels of depression, and that depression did not predict levels of self-compassion. Self-compassion also appears to be a mechanism of change in exposure therapy for PTSD (Hoffart et al., 2015). In a randomized control trial, standard PE and a compassionately augmented version of PE were both equally effective in treating symptoms of PTSD. Interestingly enough, both groups demonstrated significant increases in self-compassion and higher levels of self-compassion predicted better outcomes in both conditions. Such findings suggest the compassionate nature of treatment, rather than treatment type, may be a more robust predictor of outcome. Furthermore, compassion may be an implicit mechanism of change in effective behavior therapies (e.g. cognitive therapy & exposure therapy).

Self-compassion also appears to play a significant role in not just traditional psychotherapy, but in mindfulness-based interventions as well. In a research study comparing MBCT to maintenance antidepressants, self-compassion mediated the reduction of depressive symptoms in the MBCT group at 15-month follow up (Kuyken et al., 2010). Self-compassion cultivated through mindfulness programs

has also been implied as a mechanism of change in the treatment of PTSD. Kearny and colleagues (2013) found that veterans who received an 8-week loving kindness meditation intervention demonstrated significant decreases in both PTSD and depression, and that these effects were mediated by increased levels of self-compassion. Considering compassion's positive impact on PTSD, as well as a whole host of other factors of mental health, it may be wise to develop the literature on MBIs that have an explicit compassionate focus. At the same time, however, the literature suggests MBIs without an explicit compassionate emphasis do appear to still be effective and also improve levels of self-compassion among participants (Germer & Neff, 2019). As such, the importance of developing this literature on compassionately oriented mindfulness programs and other interventions for PTSD may be to make these implicit dimensions of clinical care more explicit. This might have important effects on the development of theory, training, supervision and the pedagogy that surrounds the treatment of mental health disorders as well as trauma and PTSD. As such, a trauma adapted SG-MBI with a compassionate focus may be welcome addition to the literature.

Mindful Self-Compassion

Mindful Self-Compassion (MSC) is an example of a SG-MBI, which has received considerable attention in the research literature. To date, there are two random control trials in non-clinical populations that demonstrate MSC not only enhances levels of self-compassion and well-being, but reduces levels of stress, depression, anxiety and emotional avoidance (Friis et al., 2016; Neff & Germer, 2013). The program, however, has yet to be researched for person's suffering from mental illnesses. Other research on MSC has focused on adolescents, health care workers, cancer survivors as well as college aged students (Germer & Neff, 2019).

MSC contains eight weekly sessions approximately two hours long and it is typically co-facilitated by two therapists. It is loosely based on earlier mindfulness programs like MBSR and MBCT to help form its structure, but expands the range of practices. Germer & Neff (2019) define self-

compassion as understanding one's own suffering coupled with an intentional act to alleviate that suffering. Self-compassion includes three components. They are mindfulness, self-kindness and common humanity. Mindfulness is the ability to focus on painful experiences with nonreactive, balanced awareness. Self-kindness includes being warm and caring toward ourselves when we encounter suffering, and common humanity is the acknowledgment that not only do all people suffer, but that we are not alone in our suffering. MSC has adapted a number of earlier meditations and exercises from MBSR and MBCT to help elicit positive, warming affective states. For example, instead of the standard mindfulness or concentration meditation found in MBSR, MSC offers an affectionate breathing meditation designed to encourage additional positive or warming affects during the exercise. Because there is no research for SG-MBIs that include an emphasis on compassion, we do not yet know if they add any additional value to the treatment of PTSD, particularly in complex presentations of the disorder that are influenced by shame. As such, there is a need in the literature for an adapted program and research to support its viability.

Compassion Focused Therapy

Compassion focused therapy (CFT) may be a useful resource in adapting an existing MSC curriculum for use with traumatized populations. In fact, CFT has already been used to help adapt more contemporary, compassionately focused, mindfulness curricula (Cullen & Brito-Pons, 2015). The model was first developed as a trans-diagnostic, multi-modal therapy for psychological problems that were primarily rooted in shame, self-criticism, and poor attachment. Accordingly, the therapy is considered process- rather than disorder-focused (Gilbert, 2010). There is a considerable and growing body of literature that supports CFT's effectiveness for a wide range of problems, including a number of difficult to treat clinical issues such as complex PTSD, personality disorders, psychosis and eating disorders (Craig et al., 2020). CFT has influences from both CBT and Jungian psychology. Additionally, it

integrates elements of social psychology, evolutionary emotion theory, attachment theory, neurophysiology and the science of compassion to help form its theoretical basis. Unlike earlier FG-MBIs (e.g. MBSR, MBCT), which draw on the Theravada branch of Buddhism, CFT draws from the Mahayana branch (Gilbert, 2010). This is critical in distinguishing CFT from earlier mindfulness-based programs as Mahayana Buddhism places a significantly greater emphasis on the interpersonal nature of meditation practice as well as the central role compassion for self and other plays in personal transformation.

CFT was developed, in part, to address the disconnection between intellectual and emotional learning that more troubled clients, often afflicted with shame and poor attachment histories, experienced when participating in standard CBT (Gilbert, 2010). While certain individuals might come to identify and restructure their illogical, negative thoughts, they may struggle to believe those newer beliefs if they have internalized self-critical attitudes from previous attachment figures. CFT developed a conceptual framework to better describe the emotional tone of one's psychological experience in order to address this issue (Gilbert, 2009). In the CFT model, there are three distinct emotion regulation systems, including the threat system, the drive system and the soothing-affiliative system. The threat system is associated with protective behaviors (e.g. fight, flight, freeze and submit) and related negative affects (e.g. anger, anxiety, fear, shame). The drive system is associated with the pursuit of resources (e.g. food, shelter, sexual opportunities) and related positive feelings (e.g. excitement, pride, mastery). Like the drive system, the soothing system is also associated with positive feelings, but these feelings are distinct in that they are de-activating. The feelings of the soothing system are associated with a sense of calmness and reassurance. Additionally, the soothing system, also called the affiliative system, is rooted in the more evolved, mammalian portions of the human brain that help foster the development of securely attached relationships. Mental health issues are the product of an imbalance in these three emotion regulation systems and a critical focus in CFT is increasing the individual's capacity to access the soothing system in an attempt to better regulate the other two.

Compassion focused therapy and trauma.

Due to its sensitivity to issues regarding shame, structural dissociation and attachment disturbances, CFT may provide a very useful framework for understanding trauma and augmenting an existing mindfulness program. CFT conceptualizes PTSD as a shame-based disorder, a departure from earlier exposure-based therapies that has seen it primarily as a fear-based disorder (Iorns & Lad, 2017; Lee & James, 2012). Germer & Neff (2014) suggest that feelings such as shame and guilt alter the expression of the threat response (i.e. fight, flight, freeze) as well as the classic PTSD symptom clusters with which they are associated (i.e. arousal, avoidance, intrusions). Due to co-occurring shame, the threat response and related trauma symptoms become more self-focused (Germer & Neff, 2014). For example, a more self-focused expression of anger and the fight response may include self-criticism. In such unique manifestations of PTSD, self-compassion may be particularly useful.

An additional appeal of CFT includes its implicit sensitivity to issues of structural dissociation, a clinical issue considered as a poor prognostic indicator for successful exposure treatment (Gleiser et al., 2008). Furthermore, experts on this model suggest that exposure treatment may be more useful in a phase-based approach where this clinical issue is addressed first (Steele et al., 2005). Described as a schism in the personality, the theory suggests that after a severe trauma, an individual's psyche may split into separate personalities or selves in an attempt to cope with overwhelming difficulties (van der Hart et al., 2006). Furthermore, these protective and fragmented parts of personality cohere around evolutionarily primed action systems (e.g. fight, flight, freeze, submit). CFT draws on evolutionary psychology, social psychology and Jungian archetypal theory to offer a remarkably similar understanding of the psyche where individuals personalities cohere around different selves or social mentalities (Gilbert, 2010). Like the theory of structural dissociation, trauma adapted CFT also acknowledges how these selves or social mentalities can cohere around evolutionary primed action systems (Lee & James, 2012). The therapeutic focus of CFT includes identifying maladaptive self-states originating in the

threat system and meeting them with alternative, more compassionate self-states (i.e. the compassionate self) to regulate difficult emotions and self-soothe.

Lastly, CFT suggests that cultivating self-compassion helps treat psychological distress by increasing the individual's capacity to better use helping relationships for their benefit (Gilbert, 2010). Correlational research provides preliminary evidence to support this claim (Bistrick et al., 2017). In a sample of survivors of relational trauma low levels of self-compassion were associated with higher levels of insecure attachment. Additional factor analysis found that the combined effect of low self-compassion and insecure attachment was associated with lower interpersonal competence, which correlated with greater posttraumatic stress symptoms. The link between self-compassion and attachment has not gone unnoticed; a number of theorists developed Attachment Based Compassion Focused Therapy (ABCT) in order to leverage the effect compassion appears to have on developing a secure attachment style (Garcia-Campayo et al., 2016). In a non-randomized control trial of ABCT, individuals receiving the treatment demonstrated significantly greater increases in attachment and these changes were mediated by increases in self-compassion (Navaro-Gil et al., 2018). Such analysis suggests that CFT may to be a viable approach to helping individuals develop the relational resources needed to participate in later trauma therapy.

Due to these features of CFT, it is not surprising that it has now been adapted to fit the needs of trauma survivors (Lee & James, 2011; Lee & James, 2012). There is a growing literature on this topic with one random control trial supporting the use of CFT for PTSD (Daneshvar et al., 2020). In this study, 42 Iranian female survivors of intimate partner violence were randomly assigned to group CFT or a control. Results indicated that CFT predicted clinically significant increases in meaning of life and decreases in avoidance symptoms of PTSD. Beyond this study, however, the research is largely restricted to small pilot studies and case studies (Au et al., 2017; Beaumont et al., 2012; Beaumont et. al., 2016; Bowyer et al., 2014). As such, CFT was not included in the APA guidelines for PTSD as it did not exceed the minimum requirement of two RCTs.

It's important to note, however, that the literature has also framed CFT's use in PTSD as an augmentation to exposure-based therapies for trauma (Beaumont et al., 2012; Bowyer et al., 2014). Kolts (2016) explains that "CFT...can be used both as a motivator to engage with exposure and as a means to make it more palatable to clients and therapists alike (p. 201)". Through CFT, the individual can build the psychosocial resources needed to meet the distress of an exposure with self-kindness and self-compassion. Consistent with this thinking, Ashfield and colleagues (2020) developed a phase-based CFT group for complex PTSD that emphasizes the development of compassionate resilience prior to engaging in an exposure-based therapy. In addition to making the exposure more palatable, CFT has been used to fundamentally reconceptualizes how the exposure process operates. Compassionately augmented exposure draws on new research in memory reconciliation, which suggests that exposure, in addition to promoting extinction and new learning, can lead to the permanent alteration and reconciliation of traumatic memories when they are accessed with other calming and non-fearful psychological experiences (Monfils et al., 2009; Schiller et al., 2010). In CFT, this is accomplished by actively integrating mindfulness and self-compassion techniques into the exposure itself (Kolts, 2016). This often includes compassionate imagery, where the individual is asked to visualize a compassionate version of themselves or a compassionate other reassuring the individuals traumatized self, the part of the part of the individual carrying the emotional burdens of the trauma. Case study research on this novel approach has also demonstrate significant reductions in PTSD symptoms (Hoffart et al., 2015). Kolts (as cited in Kolts et al., 2013) suggests that clients have responded favorably to compassionately augmented exposure by making comments such as "The memory is still there, but instead of the fear that used to be there, there is an experience of being supported-of not being alone". From this comment, it appears that compassion may play a critical role in undoing the sense of aloneness and alienation that may be rooted in trauma related feelings of guilt and shame.

In sum, CFT offers a unique way of approaching trauma and its full sequelae that is distinct from earlier behavioral approaches that may prove useful. CFT suggests the use of an integrative, multimodal and phase-based approach to treatment that is uniquely sensitive to the needs of clients who do not neatly fit into diagnostic categories due to complex clinical presentations. This model, along with relevant research, suggests that self-compassion is a core mechanism of change and transformation. This runs in stark contrast to first and second wave behavior therapies that emphasize the importance of self-efficacy and mastery over traumatic experiences while identifying extinction of the fear response as the primary mechanism of change. Unlike these approaches, CFT has also made explicit how the therapy relationship is intrinsically healing as compassion is embedded in and learnt through participation in securely attached relationships (Gilbert, 2010). As such, CFT challenges many of the assumptions of our current RCT paradigm and the cluster of behavioral trauma therapies it endorses. Moving forward it may be useful to develop this literature as it might provide opportunities for newer, more appropriate treatment options for trauma survivors. In particular, CFT may offer an alternative conceptual framework to the first and second wave behavioral principles that have grounded mindfulness-based programs in the past (i.e. MBCT). An approach such as MBCT, may limit mindfulness practice to an emotion regulation technique used to reduce distress and better tolerate exposure-based treatments that focus on the extinction of the fear response. A SG-MBI grounded in CFT principles might offer richer psychoeducation and clinical techniques for working with shame-based trauma, structural dissociation and attachment disturbances. Additionally, such a program may also better prepare clients for a compassionately augmented versions of exposure that may offer a more transformational model of change through memory reconciliation. If patients or therapists prefer to use other approaches, the proposed mindfulness program might also be useful in preparing patients for other therapies with an explicit compassion focus such as, Emotion Focused Therapy (EFT; Greenberg, 2006), and Internal Family Systems (IFS; Schwartz, 1995).

Dissemination and Implementation of Mindfulness and Compassion Programming

Compassionately oriented treatment options subtly challenge the way in which we have approached the dissemination and implementation of clinical programs in real world settings. Considering the vital role compassion appears to play in therapeutic progress, we may need to consider the extent to which treatments are delivered compassionately. Doing so might encourage us to see how the dissemination of evidence-based practices also includes a larger organizational process. Youngson (2011) suggests that the disease focused and reductionistic model of health care has encouraged a less humane approach to medical practice, in turn reducing the quality of care. According to the author, this issue is further exacerbated by the inability of training and working environments that adequately address the critical role that personal qualities such as non-judgment, empathy and compassion play in the provision of medical services. In response to these concerns, Sinclair and colleagues (2016) have developed the compassion model; an empirically supported framework developed through qualitative research that interviewed the experience of cancer survivors and their medical providers. The model suggests that compassion is not only a feature of good care, but in some cases is what may drive positive treatment outcome. It defines compassion as a “virtuous response that seeks to address the suffering and needs of a person through relational understanding and action” (p. 195). Accordingly, the quality of trauma treatment in medical settings such as a hospital, may ultimately come down to the organization’s capacity to help cultivate virtue and compassion among its members and express these qualities in a relational context with their patients. Mindfulness programming, in particular, has been considered as a viable tool for such kinds of organizational change (Leonard, 2016; Senge et al., 2005). Research conducted in medical settings has even demonstrated how a workplace adapted mindfulness program can significantly reduce burnout and promote job satisfaction, both strong predictors of workplace effectiveness (Krusche et al., 2020). While this dissertation restricts itself to the development of a mindful-

ness-based curriculum for trauma survivors, it does suggest that the curriculum, along with other compassionately based psychotherapies, would likely be more effective if it were introduced with additional organizational programming and a sensitivity to larger systems issues.

Chapter II: Methodology

This dissertation offers a mindfulness curriculum designed for the unique needs of trauma survivors, especially those who present with more complex clinical presentations and are not yet ready to participate in a past-focused treatment. It draws on trauma adapted CFT to provide psychoeducation on trauma as well as a theoretical framework to ground the practices found in a typical MSC program (Germer & Neff, 2019; Lee & James, 2012). While this curriculum could be applied in any setting, it is designed for an integrated care setting such as a community mental health center or hospital. For the focus of the present study, we assume that this program will function as both an alternative and adjunct to past focused treatments that often include exposure. This intervention will be incorporated into a hypothetical study of the efficacy of the program when compared to a control group.

Participants

Participants eligible to be considered for the study include any patient who has gone through the standard intake process and is now waiting to begin treatment. Intake clinicians identify patients who meet the necessary criteria, and then refer them to the group therapist for a second interview to ensure eligibility and begin relationship building. Initial exclusion criteria include a primary diagnosis of another disorder (e.g. depression, anxiety, features of personality disorder). This still means, however, that persons with another disorder will be considered eligible as long as PTSD was the primary presenting issue. Participants will be ruled out if they have significant safety risks (e.g. self-harm, history of suicide, substance use), serious psychotic disturbances, cognitive impairment that might interfere with treatment and current traumatic social environment (e.g. abusive relationship). Additionally, participants will be ruled out if they have started and are receiving any other treatment for trauma or any other mental health disorder. This includes both psychotherapy and psychiatric interventions.

Following the standard intake, participants who appear suitable for the group will be invited to meet the group therapist of the mindfulness intervention to further determine eligibility. The interview will follow a semi-structured protocol that is included in Appendix B. Additionally, participants will fill out three self-report measures and a brief questionnaire about their treatment history. During the interview, they will receive information on the voluntary nature of the group, its goals and relevant risks. The group therapist will explain the limited risks of practicing mindfulness with a trauma history and how the group is designed to manage those risks as best as possible. The therapist will make clear that patients can stop participation with any exercise in the curriculum if they experience distress and that they should let the group leader know if any issues arise. Participants will also be provided basic information about the study and the importance of not only attending the group, but also later interviews related to the research following the group. This information will be provided to them in the consent form. Participants who communicate interest in the group will be invited for an additional individual session with the group therapist to prepare for the mindfulness group. The details for how to conduct the session are in the subsequent chapter.

Therapists should be aware of additional exclusion criteria that they might be able to identify in this more in-depth interview as well. Participants who may have more severe social anxiety or any other psychological barriers to speaking in the group should be considered for exclusion. If a potential group member has a personality disorder or other significant interpersonal difficulties, the group facilitator will consult with the referring clinician to determine if the client can participate in the group. If information gathered from the referring clinician and the clinical interview suggests that the individual can participate in the group without undermining group cohesion or the boundaries of the group, then that individual would be considered eligible.

Outcome Measures

All participants referred to the study will complete a screening interview including self-report measures designed to assess each individual's PTSD symptomatology, general functioning and skills developed throughout the program. PTSD will be measured with the PCL-5, a 17 item self-report measure that reflects all aspects of a DSM-5 PTSD diagnosis. The OQ-45 is a 45 question self-report measure designed to assess general functioning and mental health outside of PTSD symptomatology. This measure is included because we assume many group members will likely have other mental health issues outside of PTSD symptoms. Lastly, the Self-Compassion Scale (SCS) will be used to assess three components of self-compassion that are captured on the measure's three sub-scales (i.e. Self-Kindness vs. Self-Judgment, Common Humanity vs. Isolation, Mindfulness vs. Over-identification). The SCS will help identify increases in psychological resources that might make a client a better candidate for later post-focus treatments. At the end of the 12-week program, members of the mindfulness group will complete the same assessment battery.

As mentioned above, the participant will complete a qualitative interview at the beginning and end of the treatment. Prior to being assigned to the mindfulness group, participants in the study will meet with the group therapist to complete the initial interview. We include the group therapist in this process in order to facilitate the development of rapport with the group leader and promote the participant's engagement with the treatment. Exit interviews, however, will be conducted by another mental health practitioner or research professional in order to prevent the group facilitator's bias from influencing the results. The exit interview will look to identify the elements of mindfulness practice that were most helpful to the patient. Special attention will be paid to increases in emotion regulation, mindful self-awareness, positive affective experiences and self-compassion. Additionally, participants will be asked about any desires to drop out of the treatment as well as their interest in completing a

later trauma treatment. The instructions for this semi-structured interview are included in Appendix B. There will be no additional follow-up after the exit interview.

Group Description

The mindfulness program consists of six to eight participants and includes twelve 90-120-minute group sessions and one individual session. The group would be most easily conceptualized as having four distinct parts taking 15-30 minutes each. The group opens with a meditation followed by a reflection on the meditation practice. Second, the meditation will be followed by a group discussion reviewing last week's home practice. A break will be provided, and then then the third part of the group will begin; psychoeducation on a particular topic related to trauma, mindfulness or self-compassion. Lastly, the fourth part of the program will include a workshop that is thematically linked to the psycho-educational component. This might include some brief meditation exercises, worksheets to be completed together, or a group discussion. At this time, home practice will also be assigned, often an exercise or meditation practice thematically linked to the earlier workshop. Facilitators will conclude the group at which point they will make themselves available for participants' questions or concerns.

As previously mentioned, the basis of the program is the integration of trauma adapted CFT and a standard MSC program. The CFT program is primarily used for the development of psychoeducational material, while the MSC curriculum is used as a resource for meditations and other exercises. There are a number of other less significant influences. Principles of trauma sensitive mindfulness are integrated into the curriculum, particularly in the first two sessions (Treleaven, 2018). Briere & Spinazola's (2005) framework for trauma assessment, particularly their work on cognitive distortions, is drawn on to further develop the psycho-education module on shame. Psychoeducation on forgiveness and related meditation exercises from the Mindfulness-Based Emotional Balance (MBEB) curriculum are used as well (Cullen & Brito-Pons, 2015). Fredrickson's (2009; 2013) work on the broaden and build theory is used for psychoeducation and exercises related to positive emotions, in particular love

and compassion. Attachment Based Compassion Focused Therapy (ABCFT) is used for the psycho-educational module on attachment (Garcia-Campayo et al., 2016). Lastly, Tara Brach's (2020) RAIN (Recognize, Allow, Investigate, Nurture) skill is embedded throughout the program. The following is a tentative outline of the focus and key activities in each session:

Group Outline

Group 1 – Introduction: Defining trauma and compassion

Topic: Boundaries, safety and the window of tolerance

Core/opening Meditation: Well meditation

Workshop: RAIN, soothing/supportive touch, mindfulness of breathing

Topic: Defining trauma and compassionate resilience

Homework: RAIN: recognizing our psychological experience

Group 2 –The threat system

Core/opening Meditation: Affectionate breathing

Homework Review: Reading, soothing touch, RAIN

Topic: The fight, flight, freeze, submit and dissociate responses to trauma

Workshop: RAIN: recognizing our threat response, mindfulness in daily life

Homework: Reading, Affectionate Breathing, RAIN, Mindfulness in daily life

Group 3 – Intrusions

Core/opening Meditation: Affectionate breathing

Homework Review: RAIN: Recognizing/mindfulness of our threat response

Topic: Re-experiencing, intrusions/flashbacks and shame

Workshop: Managing flashbacks, self-compassion in daily life

Homework: Affectionate Breathing, self-compassion in daily life, Managing Flashback worksheet, RAIN

Group 4 – Meeting our protectors

Core/opening Meditation: Affectionate breathing

Homework Review: Managing flashbacks, self-compassion in daily life

Topic: Protector selves and negative emotions

Workshop: RAIN, Investigating our protectors

Homework: Affectionate Breathing, RAIN, Meeting our Protectors Worksheet

Group 5 – Shame

Core/opening Meditation: Affectionate breathing

Homework Review: Affectionate Breathing, RAIN, Meeting our Protectors Worksheet

Topic: Shame

Workshop: Being with Shame

Homework: Affectionate Breathing, Meeting our Inner Critic Worksheet, RAIN

Group 6 – Self-empathy and Forgiveness

Core/opening Meditation: RAIN Meditation: Meeting our Protectors

Homework review: Affectionate Breathing, Meeting our Inner Critic Worksheet, RAIN

Topic: Self-empathy and forgiveness

Workshop: Forgiveness Meditation

Homework: Forgiveness Meditation, RAIN

Group 7 – Self-Love and Loving-Kindness

Core/opening Meditation: Loving Kindness Meditation

Homework Review: Forgiveness Meditation, RAIN

Topic: Self-love and loving-kindness

Workshop: Developing Loving Kindness Statements

Home Practice: Reading, Loving Kindness Meditation, RAIN

Group 8 – Finding our Compassionate Voice

Core/opening Meditation: Loving Kindness for Ourselves

Home Practice Review: Reading, Loving Kindness Meditation, RAIN

Topic: Review

Workshop: Compassionate Letter, Developing Self-Compassionate Phrases

Home Practice: Loving Kindness for Ourselves, RAIN

Group 9 – Finding Our True Selves**Core/opening Meditation:** Giving and Receiving Compassion**Home Practice Review:****Topic:** Positive Emotions and Human Flourishing**Workshop:** Finding our True Selves**Home Practice:** Reading, Giving and Receiving Compassion, Finding our True Selves Worksheet, RAIN**Group 10 – The Traumatized Self****Core/opening Meditation:** Giving and Receiving Compassion**Home Practice Review:** Reading, Giving and Receiving Compassion, Finding our True Selves Worksheet, RAIN**Topic:** Attachment Styles**Workshop:** Meeting Difficult Emotions**Home Practice:** Reading, Giving and Receiving Compassion, Compassionate Letter (optional)**Group 11 - Attachment****Core/opening Meditation:** Compassionate Friend**Homework Review:** Reading, Giving and Receiving Compassion, Compassionate Letter (optional)**Topic:** Interpersonal Love and Attachment**Workshop:** Meeting Unmet Needs**Home Practice:** Reading, Compassionate Friend, RAIN**Group 12 – Gratitude and Self-Appreciation****Core/opening Meditation:** Compassion for Self and Others**Home Practice Review:** Reading, Compassionate Friend, RAIN**Topic:** Gratitude and Self-Appreciation**Workshop:** What Would I like to Remember?**Closing**

Research methodology

The quantitative data gathered through the three self-report measures in this study (i.e. PCL-5, OQ-45 & SCS) will be analyzed through a series of matched paired t-tests. In addition to the composite scores of each measure, this study will analyze the data gathered from the various subscales on each measure (see table below).

Table 1: Research variables

Outcome	Pre-test M (SD)	Post-test M (SD)
SCS composite		
SCS mindfulness		
SCS common humanity		
SCS loving kindness		
OQ-45 composite		
OQ-45 symptom distress		
OQ-45 interpersonal relations		
OQ-45 social role		
PCL-5 composite		
PCL-5 re-experiencing		
PCL-5 avoidance		

Table 1 - Continued

PCL-5 hyper-arousal		
PCL- negative cognition/mood		

Such analyses will provide preliminary data regarding the feasibility of such a program. Assuming the clinical usefulness of the interventions, we should expect decreases in clinical measures (i.e. OQ-45, PCL-5) and increases in levels of self-compassion as captured by the SCS. While the program focuses on all the different clusters of PTSD symptoms, it does place a special emphasis on shame and negative alterations in cognition/mood. As such, significant reductions in this symptom cluster would provide preliminary evidence that compassionately oriented MBIs may have a special contribution to dealing with this clinical issue. Considering the experimental design of the proposed study, these quantitative analyses would have to be considered as preliminary evidence. As such, significant changes pre-to-post intervention would be used to support the viability of the proposed intervention and inspire future study, one with a more rigorous research design that may either include random assignment or a control group.

As mentioned before, participants complete an interview pre- and post-intervention to collect quantitative data regarding the client's experience of the intervention. This will include a special focus on emotion regulation, mindful self-awareness, positive affective experiences, self-compassion and interpersonal relationships. The purpose of these interviews is to gather the patient's subjective experience of whether or not any meaningful therapeutic change occurred through the program. Additionally, the interview is designed to specifically capture what each patient believes helped contribute to that change.

CHAPTER IV: Teaching the Program

The structure and framework of the proposed curriculum closely resembles that of MBCT. Like MBCT, the proposed program follows the following sequence; an opening meditation, home practice review, a break, psycho-education and then a workshop often including further meditation and other related exercises. The psycho-educational module and the subsequent workshop are thematically linked, in that the information covered usually prepares the individual to more fully participate in the exercises of the workshop. After the workshop, each session ends with a review of the assigned home practices for the week. The assigned home practices are typically related to exercises covered in the workshop.

Thematically, the program contains three separate stages or phases. The goal of the first is building self-empathy accomplished through mindful awareness training combined with psycho-education. The goal of the second phase is developing compassion for the self, through more advanced self-compassion practices and the final phase expands the practice of self-compassion into interpersonal relationships. A participant going through these phases would expect to gain a better understanding and awareness of their trauma related difficulties, learn to self-soothe their distress through self-compassion, and then develop skills to more fully participate in securely attached relationships that facilitate the participants recovery moving forward.

The first phase includes five sessions and meditation practice is restricted to basic awareness training exercises. There is also an emphasis on psychoeducation that describes the specific difficulties associated with trauma. The program assumes a synergistic effect with awareness training and psychoeducation, whereby the individual can use greater mindfulness skills to help name specific reactions to trauma that they have learned through psychoeducation. Ultimately, the goal of this phase is to gather one's psychological experience to the point where they can identify an aspect of one's self that is experiencing distress. This includes the ability to specifically identify a self-state or social

mentality and regulate any associated negative affects through mindful awareness. Furthermore, limiting practice to awareness training functions as a feature of trauma sensitive mindfulness. Doing so prevents better prepares individuals for more advanced, compassion focused meditation practices that may have a greater likelihood of eliciting adverse effects among trauma survivors (Germer & Neff, 2014).

The second phase of the program builds on the capacity of self-empathy developed in the first phase. The transition into the second phase of the program starts with an individual session, where the therapist and patient collaboratively identify a self or social mentality on which they would like to focus future compassionate meditations. In the following four group sessions, the focus will be on developing forgiveness for this aspect of self-hood and learning how to gift it self-kindness and self-love. Accordingly, a new set of meditations are introduced that focus exclusively on developing compassion on an intra-relational basis. There is also psychoeducation on forgiveness and positive affects, in particular self-love and other feeling states that produce human flourishing and well-being.

In the third and final phase of the group, the emphasis transitions away from self-compassion towards a more interpersonally driven version of compassion. At this point, psychoeducation begins to emphasize the relational nature and bonding effects of positive feeling states, in particular loving and compassionate states of being. Participants are also exposed to more advanced meditation exercises that include visualizations of giving and receiving compassion with other people. Therapists also adopt a slightly more relational tone to their interventions, encouraging more feedback among participants, provided it fits within the necessary norms of the group. This more relational sharing is best exemplified in the final closing exercise. Participants are asked to express appreciation for other group members and their hopes for them in the recovery. They are also asked to share any moments during the program where they felt particularly connected to another person's practice.

Individual sessions

The initial session occurs after the group therapist has conducted the screening for the study. The focus of this session includes continuing to develop an alliance with the therapist, framing therapeutic goals, establishing boundaries of the group and instilling hope. Relationship building is particularly important for trauma survivors or any other psychologically vulnerable person, as they may have greater emotional obstacles to fully participating in treatment, including a desire to prematurely drop out. Seeing the therapist as a safe and trusted person may help them better transition into the group. Therapists should approach this encounter with radical non-judgment and, as best they can, a kind and embodied presence. If done well, the exchange should offer the prospective participant a deep sense of empathy and safety. Consistent with this focus, therapists should seek to normalize and validate the suffering of the individual. How the therapist chooses to do this should be left to their own discretion and therapeutic style. Ideally, this approach should influence the way in which the initial screening is done as well.

The therapist should ask any follow-up questions about the individual's clinical history and encourage any elaboration that might elicit a richer clinical picture of the individual. When enough information has been gathered, the therapist should offer the individual a brief and simple working conceptualization of their problem and briefly explain how the group might help. For example, a therapist might offer the following to a trauma survivor who appears to have issues with an avoidant attachment style and hypervigilance ; "It sounds like you've learned to survive the many difficulties in your life through an impressive ability to rely on yourself, I wonder if this group might give you an opportunity to learn how to allow others to help you in your recovery." The point of such a statement is to provide a sense of understanding of the person's problem while also instilling a sense of hope. In addition, this comment is intended to initiate a dialogue where the patient can start to identify a particular problem area. This is one of the principle goals of the initial phase of the program where

participants are asked to identify a self-state or social mentality on which they'd like to place their focus. Therapists should not expect patients to be easily identify a focus at this point. Instead, therapists should conceptualize this dialogue as a work in progress that continues through the initial stage of the group. Lastly, therapists should let patients know about the individual session that occurs midway through the program and how the therapist and patient will revisit the patients progress on this particular focus.

This conversation should conclude with a brief review of the norms outlined in the initial session. While this may seem redundant, it's critical that group members are keenly aware of the norms, as their impact on safety may be uniquely important for trauma survivors. In particular, patients should clearly understand norms that protect the individual's agency in sharing about their trauma as well as rules that discourage criticism or invalidation of other people's experiences, particularly those related to their trauma history. Therapists should also inquire about any potential difficulties related to the expectations of the group and explore ways to accommodate any unique needs that may surface. Therapists should also address any potential concerns that may surface for the patient during meditation practice or speaking in a group of six to eight people.

In between the fifth and sixth session, therapists should schedule time to meet individually with each participant. The purpose of this session is to check in regarding the client's attitude towards treatment thus far, identify the focus for future self-compassion exercises, and review safety needs before more advanced meditations are introduced. Therapists should initiate this conversation by asking patients about their feelings and attitudes towards their progress and the focus developed in the initial interview. Therapists should be inviting and accepting of all responses, particularly those that express cynicism, frustration or disillusionment with the program. Consistent with the aims of the program, in particular the first phase of the group, therapists should continue to offer a deeply empathic response to the client's suffering. Additionally, therapists should normalize and validate barriers to

“successful” practice. Therapist’s may also seek to leverage the group as a means of normalizing the patient’s perceived limitations. For example, “You know, you might not be the only one in the group experiencing this, there might be other people who as full as doubt as you seem to be, but they’ve yet to be as open about it in the group as you’ve been with me. I wonder if this might be easier for you if we can talk about it in the next group.”

Next, therapists should collaboratively identify an area of focus, a self-state or social mentality, that the participant would like to work on. This should be a feature of the patient’s clinical presentation that is among the easiest with which to work. It should include a common enough problem that the individual will have opportunities to work on it in daily life, but not produce too much distress that it will overwhelm the individual. Lastly, the focus should be an issue of enough significance that working on it should coincide with meaningful therapeutic gains. Therapists and patients may identify together a distinct threat response (e.g. fight, flight, freeze, submit) or a more general, vague sense of shame and self-criticism, often referred to as the inner critic throughout the program. This process should include an attempt to name this self-state, as a part of one’s personality or psyche. For example, “Angry Joe” or “Down on myself Jane”. Therapists should conclude the session reviewing with the patient the additional risks associated with upcoming meditations that have a greater focus on self-compassion. Therapists should explain that these exercises may be more likely to produce resistance or discomfort and review relevant psychoeducation on trauma sensitive mindfulness.

Facilitating group process

Compared to earlier MBIs this program more actively leverages interpersonal and group processes to facilitate the development of mindfulness and self-compassion skills. The group should not be confused, however, with an interpersonal process group as interpersonal feedback will be limited. Accordingly, working through conflict among members is strongly discouraged as participants will be encouraged to bring personal grievances to the therapist if they appear through the group. It is

the responsibility of the therapist to carefully guide opportunities for more interpersonally driven learning while ensuring that the norms are interpersonal sharing are maintained. It is critical, especially considering the predisposition to shame and self-criticism many trauma survivors have, that therapists ensure that interpersonal sharing is non-judgment and non-critical among members. In the few instances when interpersonal feedback is encouraged, participants are asked to focus on their internal reactions as opposed to their external judgments of others. Additionally, therapists should largely restrict group-based interventions in the first phase to ones that facilitate shared identification (e.g. “Who else has experienced something similar that?”). As the group progresses into the second and third phase, interventions may shift more towards the ways in which other people have positively impacted or inspired their practice. Therapists should place a special emphasis on the way positive affects resonate between and among group members. For example, a therapist might make the following intervention; “I felt really uplifted when you shared your practice with us, did anyone else feel that way too?”. Negative affects that may be difficult for individuals and groups should not be worked through on a group level. This is to prevent conflict among and between group members that may reinforce self-criticism and related feelings of guilt and shame. When participants do encounter stuck points, therapists should approach them in a more one to one basis.

Inquiry

Following meditation exercises, therapists should allow a few minutes to process the experience. The amount of total time allocated to inquiry is up to the discretion of the therapist, and it may need to vary depending on the time constraints of each group. As a rule of thumb, therapists should aim for no more than ten minutes of total time and focus on two to three group members at most. Therapists should do their best to approach inquiry with radical acceptance and non-judgment. This might be best achieved by avoiding overly interpretive, invasive, or goal focused questions or remarks that may impose, even implicitly, certain expectations onto the individual’s practice. Therapists

should also aim to approach inquiry with, as best they can, a warm and embodied presence that emotionally resonates with the individual's felt experience. This requires the therapist to attune to the participant's moment to moment affective experience and respond accordingly. For example, this may include encouraging participants to share more about a particular aspect of practice that elicits a positive affective response. Alternatively, this might include responding to shame and self-criticism with a non-judgmental and warmly encouraging tone or relational presence. This approach should coincide with the understanding that the therapist is demonstrating in-vivo a mindful and compassionate presence.

The therapist should also reflect, affirm and validate the skillful use of mindfulness and self-compassion within exercises. When patients struggle with a practice, however, therapists should not attempt to fix, but rather validate challenges to practice. When appropriate, therapists may wish to assist in applying mindfulness and self-compassion when stuck points are identified in practice. For example, this might include asking a participant to simply hold and allow for negative feelings that surfaced during the practice. "As you struggle with this exercise, can we first slow down and just try to allow whatever is coming up right now to just be, as it is? Perhaps we can start just by acknowledging together what your distress feels like in your body at this moment."

Home practice review

Patients are asked to read a handout each week, which is composed of the talking points from the previous week's psycho-educational material. At the beginning of the home practice review, therapists should review and clarify any questions concerning this material from last week's psychoeducation. Next, therapists should review use of formal meditation practices. Consistent with the approach of the inquiry process, therapists should be affirming and privilege positive moves towards more regular meditation practice. Therapists should also validate and normalize obstacles to consistent practice. While it is important to emphasize the importance of using the meditation practices in the

prescribed order, therapists should expect that patients will likely exert greater autonomy over their practice as time goes on, often picking the meditations they like most. In instances such as these, therapists should veer in the direction of encouraging any and all practice, rather than insisting on a particular sequence of meditation. Next, therapists should initiate a review of the applied mindfulness and self-compassion skills. This may include the use of worksheets over the week or informal self-compassion practices (e.g. self-compassion break). Therapists may invite interested participants to share their personal experience of their practice at this time. Consistent with group norms, this process should largely be limited to an individual or one-to-one discussion with the therapist. This is to avoid any advice giving, or fixing behaviors that could potentially come off as critical or judgmental. At times, the therapist may need to be slightly more instructive in order to provide necessary information related to a particular skill, if it appears the participant could benefit from such knowledge.

Use of the RAIN meditation and RAIN skill

Developed by Tara Brach (2020), RAIN (Recognizing Allowing Investigating Nurture) is both a meditation and behavioral skill designed to evoke self-compassion in daily life. As a meditation, RAIN asks the individual to visualize a distressing event and then practice self-soothing through self-compassion. As a skill, RAIN is used to approach distress as it appears in daily life. RAIN is used as the central skill and meditation of the curriculum, but it has been adapted to fit the unique needs of trauma survivors by integrating elements of the CFT. CFT identifies a number of different dimensions to psychological experience that comprise a particular self, or social mentality. They include body sensations, emotions, attentional patterns, thinking/reasoning, motivation, behavior and imagery/fantasy. The center of experience is emotion. Furthermore, threat-based emotions (e.g. anger, anxiety, fear, shame) coincide with evolutionarily primed action tendencies (e.g. fight, flight, submit). In the adapted RAIN skill, participants are asked to recognize the separate pieces of their psychological experience (e.g. thoughts/reasoning, motivation, body sensations) when a distressing event occurs. In

the next step, allowing includes accepting the potentially unpleasant aspects of this experience, rather than resisting it. Next, investigating includes organizing the separate pieces of psychological experience into one coherent self-concept rooted in the individual's trauma response. For example, a patient might find that they are fantasizing about failing in a particular task, feel a pit in their stomach, have the motivation to withdraw from others, and remain stuck thinking about their worthlessness. Through investigating, the individual organizes their experience as being related to a core feeling of shame and the submit response. Investigation will often entail naming this self or social mentality. In this particular instance, the participant might choose "down on myself-Joe".

The last feature of RAIN, nurturance, includes any self-soothing activity that can help regulate the negative feeling state associated with this self, and transition the individual into the soothing/affiliative system. This can include compassionate phrases to one's self, behavioral forms of self compassion or even soothing touch. Nurturance should answer the quintessential question of self-compassion practice, as outlined in the MSC program. That is, "What do I need?". As one can see from this question, the skill encourages a variety of different compassionate responses to self.

In the adapted RAIN meditation, the participant is asked to imagine a mildly, to moderately difficult situation. Over the course of a ten-minute, guided mediation, the participant is asked to slowly go through the four steps of RAIN in an attempt to deal with whatever distress was elicited through the practice. A critical adaption to the meditation includes specifically asking the participant to identify the distinct aspects of their psychological experience as outlined by the CFT framework (e.g. thoughts, body sensation, images/fantasies) and if they would like to name which social mentality is surfacing. As one can see, the meditation facilitates the use of the skill. One can prepare for distressing events that may surface in daily life and learn to approach them compassionately. Furthermore, the RAIN meditation might better prepare individuals for past-focused trauma treatments as it builds capacities for self-compassion and self-soothing in the face of distressing emotions.

Readers familiar with MBCT, may see overlaps between the RAIN skill and skills in the MBCT curriculum such as *sitting with difficulty* and *the three-minute breathing space* (Sears & Chard, 2016). There are critical differences between these skills, however, and highlighting them illuminates the distinct flavor of a more compassionately oriented mindfulness for trauma. As such, the subsequent explanation may help the reader and prospective practitioners using this adapted version of the RAIN skill to better understand the spirit with which it should be used.

The RAIN meditation and *sitting with difficulty* exercise are analogous in that both function, to some degree, as an imaginal exposure. Like RAIN, sitting with difficulty includes bringing to mind and visualizing a distressing situation. Both exercises encourage the participant to approach their distress with a spirit of acceptance, rather than resistance. The sitting with difficulty exercise, however, is different as it emphasizes the development of distress tolerance. Sears & Chard (2016) explain that “participants will say that the experience was not as bad as they thought it would be” (p. 89). This process is also associated with gaining a sense of mastery or control over the experience.

RAIN is distinct, in that it extends beyond accepting and tolerating negative experiences by encouraging self-nurturance. First, RAIN encourages the individual to gather their experience more fully through the investigation step, even naming their experience as a self if need be. Next, the nurturance step encourages the individual to practice love and kindness towards the part of themselves that is in need of soothing. As such, RAIN more explicitly emphasizes developing a compassionate self-to-self relationship. Through its emphasis on compassion there is also a greater sensitivity to the transformative potential of meditation practice and the positive affects that are produced through compassionate responding to distress. Taken together, the individual develops resources that extend beyond distress tolerance, but also self-love and self-compassion.

The breathing space technique also shows a critical overlap with RAIN as both skills are used to address issues as they surface in daily life. Like sitting with difficulty, the breathing space exercise focuses primarily on sitting with discomfort. Next, there is no focus on gathering experience as in

identifying a self-state or meeting such an experience with kindness or warmth. As such, positive affects are not identified as playing any explicit role in this technique. Lastly, the action step taken in this exercise, which overlaps with self-nurturance in the RAIN skill, emphasizes actions that produce mastery, pleasure or mindful distraction. Additionally, there appears to be a greater outward focus that is paired with physical action as a form of coping.

While these differences may seem subtle, they imply significant differences in the tone and spirit with which the interventions should be delivered. RAIN appears to be based on a transformational account of mindfulness practice, where the goal is to transition out of the threat system and into the soothing system where the individual can craft a more compassionate relationship with their own suffering. Alternatively, interventions in MBCT offer an eliminative account of the practice, whereby the goal appears to be distress tolerance, and positive coping grounded in either distraction or mastery. They appear to ultimately be driven by two separate principles, self-efficacy vs. self-compassion. If MBCT includes an emphasis on compassion, however, it is likely done implicitly and through the discretion of the therapist. The purpose of including compassionately oriented programming such as the proposed curriculum, may support practitioners in making these implicit dimensions of transformative meditation practices more explicit and easier to share with their patients.

CHAPTER V: Program Curriculum

The following chapter provides the curriculum with accompanying guidelines for how to provide the intervention. Therapists should approach the curriculum with enough flexibility to bring their own style to the intervention. For example, this might include the therapist introducing relevant videos, poems, and real-life examples to help communicate the principles of the program. Additionally, therapists may want to amend certain aspects of the guided meditations so that they more accurately reflect the style and approach of the clinician. The use of such flexibility, however, should not compromise the core structure of the program as outlined in the previous chapter. Additionally, the psycho-educational material should remain largely consistent with manual, and if therapist do elect to introduce any new information it should be philosophically consistent with the program and CFT.

Session I: Defining trauma and compassion

Topic: Welcome, practical details, boundaries/group norms

Core/opening mediation: Welcome meditation

Break

Topic: What is trauma and how can self-compassion help?

Workshop: Soothing and supportive touch, RAIN

Home practice: RAIN, soothing and supportive touch

Topic: Welcome

The therapist should engage and welcome members as they arrive. Depending on the context, therapists may want to encourage casual conversations with group members. Next, they should address the group as a whole and acknowledge having met each person individually during the preparation phase of the group. As the therapist does this, they should say how we have all found ourselves coming to this group because we acknowledge that we have survived a hardship or trauma and we are looking to learn self-compassion to help us recover.

Topic: Practical details

Next, the therapist will review the practical information of the program. This may depend on the unique context of the group, but should include details such as the group schedule, the mid-session break time, the use of printouts/handouts for the program, as well as expectations surrounding home practice. Therapists should emphasize their availability outside of group including time immediately after the group. Participants are encouraged to bring any challenges that might arise in their practice or any other general questions.

Topic: How to approach this program

Therapists should initiate a new conversation about how to get the most out of the program. They should discuss the following talking points and ask the group relevant questions to spark an interactive dialogue:

An adventure: “What is the difference between a journey and an adventure?” An adventure takes us into uncharted territory, while a journey does not. This is an inner adventure where we might learn new things about ourselves and how our past has shaped us. This can be scary, but the facilitators and the group are here to help you along the way.

An experiment: This is an experiment of self-discovery and self-transformation. We'll be working in the laboratory of our own experience to test out what helps us recover and what doesn't. Therapists might ask the following question; "What are the qualities of a good scientist?"

Becoming one's own therapist/coach: You will learn a number of mindfulness and self-compassion exercises in this program. You will learn the rationale behind each practice so you can understand and tailor the practice to meet your own individual needs-to become your own best therapist.

Becoming part of a team: Learning self-compassion is not a solitary adventure. It requires learning from and with other people. For example, we may learn compassion by internalizing it from others based on how they treat us. Some may teach us self-compassion by being an example of it. Others may give us feedback or teach us skills to help us cultivate self-compassion more deeply. "What are the qualities of a good team player? How might a good teammate bring the best out of a peer?"

Window of tolerance: Compassion is a positive emotion associated with happiness and well-being. However, there is an expression, "Love reveals everything unlike itself." This means that experiencing positive feelings may contrast with and reveal other negative feelings. In some cases, these could be feelings we have avoided for some time. To help us better anticipate, understand and compassionately respond to those emotions let's review what we call the window of tolerance.

Window of tolerance (cont.): The negative emotions that come up during meditation fall into either one of two categories or zones. These include the **hyper-arousal zone** and the **hypo-arousal zone**. Hyper-arousal is being overwhelmed or "keyed-up". Hypo-arousal is being under-stimulated or "checked-out". "What might be some examples of a person experiencing hyper-arousal (e.g. anxiety, scary memories, and self-criticism) and hypo-arousal (e.g., numbness, sleepiness, depression)?"

Between hyper-arousal and hypo-arousal is the optimal arousal zone or the window of tolerance. It is

when we feel safe, calm and secure. We are at our best in the window of tolerance. “What might be some examples of you as your true self in the window of tolerance?”

Beginners’ mind: Self-criticism is a very common form of hyper-arousal that comes up in meditation and self-compassion practice. When we are trying to calm our mind and do one of the practices, we might notice that we are struggling to do it “right”. There is no such thing as a perfect mindfulness student and the practice is not about getting things “right”. In fact, one of the most crucial parts of mindfulness and self-compassion practice is creating moments where we get off track so we can learn to non-judgmentally and warmly bring ourselves back.

Beginners’ mind (cont.): Every time we do this, we strengthen our capacity for self-compassion. The more we strengthen our capacity for mindfulness and self-compassion our circle of tolerance expands and the zones for hyper- and hypo-arousal get smaller. Practicing mindfulness and self-compassion, however, requires pushing on the boundaries of both the hyper and hyper arousal zone. Therefore, it is critical that we do our best to never completely leave the window of tolerance.

Example: Practicing in the hyper- and hypo- arousal zone would be like swimming in a deep ocean where you were not tall enough to touch the bottom. If the tide gets too strong you could risk drowning. Practicing on the edge of the window of tolerance requires going out into that same ocean, but you are swimming in shallower waters. If the tide comes, you may get knocked down, but your feet will always be able to touch the ground and keep your head above water.

Preparation for later trauma work: The purpose of this group is not about working through our old wounds or prior traumas. It is about expanding our window of tolerance through mindfulness and self-compassion practices. This is primarily a resource building therapy. There may be times, however, where people might want to share their old wounds and we welcome that. We just ask that you do so

carefully, as not to trigger/overwhelm others or even yourself. We ask that you consult with the therapist first, or if it naturally comes up in the group that you ask for permission before your share.

Meditation: This program is not designed to make everyone a meditator, but rather teach people to recognize their suffering and respond in a kind and non-judgmental way. Meditation can take many forms including formal mindfulness meditation to mindfully cleaning dishes. What is important is that you give your best effort to find what works for you.

Practice-focused comments: After each exercise we will have a review discussion. This is an opportunity for each individual to process their personal experience of the exercise. We want to keep the sharing at this time to our personal experience. In other words, try to avoid crosstalk and “keep it on the I”. There will be opportunities to share your reactions to other people’s sharing as the group progresses, but these opportunities will be provided by the facilitator

Personal needs: If at any time during a break or in between sessions you want to personally talk about your work please let us know. If there is anything you might need to help you feel safe or comfortable, please let us know as well. You’re also welcome to leave at any time during an exercise, or topic weather it is just for a break or to gather yourself. Lastly, please try and let the therapist know if you plan on missing a session.

Topic: Guiding principles

- Please take a moment and look around. We are a community. Over the next twelve weeks, we will be creating a culture together. How often do you get to write the rules of your own culture? Let’s do that together. Please take out a piece of paper and write down your thoughts, or simply reflect, on these questions:
 - How would *I* like to be treated so I feel safe and comfortable in this program? (Pause)
 - How would I like to treat *others* so they feel comfortable and safe with me? (Pause)

- In other words, what *guiding principles* should we keep in mind as we go through the program together?
- Comments can be written on a white board or flipchart as the group discusses/reflects on their answers together. If any of the following guidelines from the standard curriculum are not mentioned, therapists can add them to the discussion:
 - Protecting confidentiality
 - Letting go of fixing
 - Not needing to save others
 - Avoiding advice giving
 - Practicing non-judgment
 - Respecting differences
 - Honoring diversity
 - Supporting inclusion
 - Giving space
 - Respecting physical boundaries
 - Being mindful of romantic attraction
 - Protecting your own safety and comfort
 - Asking for permission before sharing old wounds/traumas

Topic: Diversity inclusion and belonging (DIB)

Therapists should transition into a discussion that acknowledges diversity and the role it may play in the group. The purpose of this topic is to help each participant feel as welcome as possible even if they look or feel different from others.

Talking points:

Respect for differences: One of the guidelines that was just mentioned is respect. Respect often means respect for *differences*. In this program we want to acknowledge and honor our differences, especially differences in our identity or identities:

- There are differences in identity that we may be able to see and those that are less visible. What are some examples of differences that we may be able to see?
- What are some differences in identity that may be less visible?

Identity as a source of strength: Our identities are important to us because they can often be a source of strength, resilience and a healthy sense of pride. Often times our identities may be closely tied to skills, qualities or characteristics about ourselves that help us in our recovery. As such, it's critical we do the best that we can to give everybody a chance to harness the power of whatever identity/identities they feel may help them in their recovery. Participants are asked to write out their responses privately to the following questions:

- What identity/identities may be a source of strength/resilience? What identities may help you in your recovery and get the most out of this group? (Pause)

Identity as a source of pain: Our identities can also be what carries our pains, burdens or even traumas. Some individuals may have experienced oppression, discrimination and bias due to their differences. We call this cultural identity pain. For some, addressing the hardships or traumas that might have brought them to this group may overlap with their cultural identity pain/s. It is important that we acknowledge the pains our identities may carry. For some of us, this might be critical before we do any work together as to prevent hurting or re-traumatizing a part of ourself. Therapists should ask group members to privately write out the response to the following question and ask permission for group members to share afterwards.

- Which of your identities have not received the respect, understanding, safety or compassion they deserve? (Pause)
- Maybe an identity of yours has been a source of pain and strength. If so, take a moment and try if you can to explain how this came to be? (Pause)

Working through differences: Developing a culture where we learn to respect differences is not always easy. Many groups and societies have failed to do this, and we acknowledge that many people, perhaps some in this room, have identities that may have not been respected. In this group, however, we ask that all members work towards respecting differences. This begins with trying to understand someone else's uniqueness without invalidating or attacking it in some way. It means, first do no harm. This requires suspending your own views for a moment and creating a space for someone else's perspective that might be different than your own. We might call this process empathy, and it is the foundation of compassion. If you feel you have spent the time necessary to really empathize with someone else, you might be ready to offer help. We ask that you be careful with this second part. Before you try to help or encourage someone else, we encourage you to ask for their permission to be helped first.

Respecting differences as an ideal: Learning to respect differences is an ideal that we hope to work towards. At times, we may reach that ideal. At other times, we might try our best and fail. No group is perfect, and neither is this one. What makes a strong and resilient group, however, is the ability to work through our failures. If you feel that someone did not respect one of the differences you brought to the group, feel free to bring it to the attention of one of group facilitators. As therapists, we want to be available to help everyone feel safe, and also use a failure as a potential opportunity to learn, and practice forgiveness when possible.

Safety measures: Pumping the breaks

Prior to beginning the meditation, the therapist should explicitly acknowledge how creating safety and comfort before any meditation helps us get the most out of the practice by giving ourselves some assurances. Part of creating safety or comfort includes a plan if you feel like you're entering into hyper-arousal or hypo-arousal. There are a few strategies that have been identified as helpful that the therapist may offer (Trelevan, 2018). The therapist may consider writing these strategies on a flip chart, so they are available for participants to look at and try later:

- Keeping one's eyes open during meditation
- Taking a break, and walking around
- Distracting yourself through comforting touch
- Stopping the practice to take a few slow, deep breaths to anchor yourself
- Adjusting one's seat position in the room (for persons with hyper-vigilance)

Core/opening meditation: Welcoming meditation**Instructions: (10 min)**

- Taking the time now to pause and direct your attention inward, allowing your eyes to close or your gaze to soften.
- And then, imagining you are standing beside a deep wishing well. Picture yourself beside this deep well of your own life experience and this question is like a tiny pebble that you are dropping into this deep well of your life. Consider this simple but deep question: "Why am I here?" (Pause) "Why am I at this course at this particular time?" (Pause) "Why am I here?"
- The first thoughts may be of things that are somewhat superficial or unreflective, but taking some time to hold the question in awareness. (Pause)

- And as this pebble continues to drop deeper into the well, perhaps considering an even deeper question, the question of “Why am I REALLY here?” Letting the response come from a deeper place inside you. Letting go of needing the answer to completely make sense or to be logical, let it arise spontaneously from an open heart. (Pause)
- And when you are ready, as the pebble falls still deeper into the deep, deep well of your own experience, following another, still deeper question to see where it leads: ‘Why are you REALLY, REALLY here? (Pause) Allowing yourself to be surprised or inspired or curious about what comes up. There aren’t any right answers here, just what seems right to you at this moment.
- As you’re ready, allowing your eyes to open and your attention to return to the room.
- When you are ready, take a moment to write down your reaction to this question, of “Why am I here?” (Pause)

The therapist should transition to a group conversation where they now invite each participant to briefly introduce themselves and share a little bit about what has brought them to the program. The therapist should make clear, however, that participants are only encouraged to share what they are comfortable sharing about what has brought them to the group.

Break

Psychoeducation I: What is Trauma and PTSD and how can Self-Compassion Help?

Stress is a normal part of life: We all experience triggers, both internal and external, that elicit a stressful response. Stress is a normal part of life and it isn’t necessarily a bad thing. If we have the resilience to deal with stress, it can actually provide us with opportunities to grow.

Self-compassion and stress: Self-compassion is a powerful form of resilience; It is often described as our ability meet our own suffering. It includes two critical components; self-empathy and self-

love/kindness. Self-empathy is understanding with depth why we are suffering and what we need to feel better. Self-love/kindness is associated with giving ourselves what we need to feel better. This last part can come in many different forms depending upon the individual.

Example: When we work out, we put physical stress on a muscle that results in what physical trainers call micro-tears or micro-traumas. These micro-tears or micro-traumas trigger the body to heal the muscle after the workout by sending blood full of just what it needs to recover (i.e. oxygen and amino acids). As a result, the muscle heals as the tears in the muscle transform into new muscle fibers creating a bigger, stronger muscle. The oxygen and amino acids in your blood would be like your body naturally giving your torn muscles self-compassion.

Yin and yang of self-compassion: Self compassion comes in many forms, sometimes being compassionate to yourself involves a tenderness and warmth, where we give ourselves comfort, reassurance and validation. Other times self-compassion might require the yang components of self-compassion by accessing our power to protect, provide or motivate ourselves.

Self-compassion is not invulnerability: Self-compassion is not pushing our suffering away so we can get by or tough it out. In fact, it is the opposite. It is working through our stressors so we can learn from them and live a richer life as a result. Self-compassion requires courage, because we have to look at, accept and work through our suffering rather than push that suffering away.

Example: Toughing it out might be denying that your muscle aches, refusing to take the necessary rest during the recovery phase and pushing through the pain as you continue to work out more. Self-compassion, however, would include being honest with your limits, and resting enough to let your body naturally heal itself.

Definition of trauma: Trauma is the result of stress that overwhelms a person's capacity for resilience; it occurs when the intensity of the trauma outweighs the person's resilience, including their capacity for

self-compassion. Trauma can be caused by one event, or the accumulation of many traumatic events over time. If we don't have the resilience to respond to the stress of the trauma, we can be left experiencing a variety of unpleasant things; anger, fear, flashbacks, survivor guilt and shame, just to name a few. It is possible, however, for people to experience stressful events and not be traumatized if they had the resilience to deal with the event at the time.

Example: A workout leads to an injury when the tear or trauma to the muscle is too great. The body does not have the capacity to heal the tear immediately after the workout, so the injury persists over time. The injury could be the result of one incident, or the accumulation of many small stresses on the muscle over time.

Responding to trauma: Trauma comes in different forms (e.g. combat, accidents, abuse) and all people respond differently to it. Some people who have experienced trauma(s) will go on to develop Post Traumatic Stress Disorder (PTSD), while others will not. Generally speaking, the severity of one's trauma response is the interaction of the stress they were experiencing during the trauma, prior experience with trauma and their capacity for resilience while they were experiencing the trauma.

Self-compassion and healing trauma: We all have an innate capacity for self-compassion. In fact, we are all biologically hard wired for compassion and its part of what makes us human. We can also cultivate our ability for self-compassion through practice. When the strength of our self-compassion starts to outweigh the initial stress of the trauma, we are then able to start to heal and transform our suffering into post-traumatic growth. The focus of this group is not opening old wounds, rather it is giving you the resources to heal by increasing your ability for self-compassion.

Research on self-compassion and trauma: Researchers assessed the mental health functioning of veterans who returned from tours in Iraq and Afghanistan and found that veterans with higher rates of self-compassion functioned better in daily life and had fewer symptoms of PTSD (Dahm et al., 2015).

Additional research shows that veterans with low levels of self-compassion were at a greater risk of developing PTSD than veterans with more combat related stress (Hiraoka et al., 2015). In other words, psychological health had more to do with how much self-compassion you had, than how much combat trauma you went through.

Researchers have also found that a group of veterans who completed a 12- week meditation training improved their levels of self-compassion. Furthermore, the more each veteran increased their levels of self-compassion, the less they experienced symptoms of depression and PTSD (Kearney et al., 2013). In sum, growing our capacity for self-compassion can help alleviate symptoms of trauma and PTSD.

Workshop: The RAIN of Self-Compassion

Instructions (12 min):

- Please close your eyes, partially or fully.
- Think of a situation in your life that is difficult, that is causing you stress right now, such as a health problem, a problem in a relationship, a work problem or perhaps someone disrespected you because of your age, your ability or another identity. Please choose a problem in the mild range, not a big problem. We don't want to overwhelm ourselves as we're first learning the skill of self-compassion.
- Now allow yourself to feel your way into the problem, to the extent that you feel some uneasiness. Now **recognize** that discomfort by bringing awareness to all of what is in your awareness. What thoughts, body sensations, images/fantasies, motivations/urges and feelings do you notice?
- As you recognize all parts of your experience, say to yourself, slowly and clearly, "This is a moment of suffering." Other options include "This hurts" "Ouch!" Or "This does not feel good."

- Next allow yourself to **accept** rather than resist that discomfort. Allow yourself to sit with it. Ask yourself “Can I accept this moment exactly as it is, can I accept that this moment couldn’t be any other way given everything that has led up to it.”
- Can I accept that suffering is a part of life, and that we all suffer and none of us are alone in our moment of suffering?
- Now try and **investigate** what's behind that discomfort. Can I take a moment and piece together my experience? The thoughts, feelings, body sensations, mental images that are causing me suffering, where did they come from? What part of me may be hurting right now?
- Now put your hands over your heart, or wherever it feels supportive, feeling the warmth of your hands. Say to yourself, “May I be kind to myself” “May I give myself what I need.” That’s **nurturance**. Perhaps asking yourself “May I accept myself just as I am” or “May I care for myself tenderly in this moment.” Or perhaps you need something different. Maybe you need to say “No, I will not allow myself to be harmed in this way” or “May I have the courage and strength to make a change.”
- If you’re having difficulty finding the right words, imagine that a dear friend or loved one is having the same problem as you. What would you say to this person, heart to heart, without giving advice? If your friend were to hold just a few of your words in their mind, what would you like them to be? What message would you like to deliver? (Pause) Now, can you offer the same message to yourself?
- Slowly come back to the room.

Inquiry: Participants are then asked to take out the RAIN home practice worksheet and fill it in based on their experience of just completing the RAIN of self-compassion exercise in the group. Therapists should allow two to three minutes for patients to do so. Therapists should then ask the group follow-up

questions to facilitate an inquiry. During this conversation, therapists should emphasize and further explain the four components of self-compassion; recognizing, accepting, investigating, nurturing.

Workshop: Soothing and supportive touch

The therapist may invite participants to stand up to try a simple and easy exercise to demonstrate self-compassion. They should go on to explain how touch is a key signal for compassion and can be used to comfort themselves. It might be useful to acknowledge the initial resistance to the exercise, whether it's due to participants finding it silly or perhaps even uncomfortable to touch their bodies. Therapists should encourage students to give their best try none the less. The following options can be provided:

- Palms gently pressed against one another
- One hand cupped in the other
- Two hands over the heart
- Cupping one hand over a fist over the heart
- One hand over the heart
- Gently stroking one's chest, back and forth in small circle
- One hand over the heart and one over the belly
- Two hands on the belly
- One hand on a cheek
- Cradling one's face in the hands
- Crossing one's arms and giving a gentle hug
- Gently stroking one's arms

Home practice: RAIN, Soothing and supportive touch

Therapists should then ask the group to read and reflect on the RAIN psychoeducational handout and be prepared to talk about it next week. Additionally, group members should do their best to use the RAIN home practice worksheet over the course of the week when something difficult/troubling triggers them. Therapists should encourage participants to select something in the mild to moderate range, so they can first practice the skill with a less troubling event. Therapists should

also emphasize how RAIN will be a skill developed over the course of the program, so it's not essential to get all aspects of it right. In the following week all that will be reviewed is the R or recognizing aspect of RAIN that emphasizes mindfulness.

RAIN Home Practice Worksheet

RAIN is an easy to remember tool to teach self-compassion. The four components of RAIN overlap with the definition of self-compassion.

Recognizing what is going on

Allowing the experience to be there, just as it is

Investigating with interest and care

Nurture with love/kindness

R- Recognize what's going on

Recognizing what is going on essentially means **mindfulness**. It is about bringing attention to our current experience. It is our ability to take a step back and acknowledge that we are having a moment of suffering. This includes bringing attention to all aspects of psychological experience including our thoughts, body sensations, images/fantasies, motivations/urges, behavior and feelings.

A- Allow the experience to be there, just as it is

Allowing means letting our experience of suffering to exist as it is and without trying to fix, avoid or push it away. Allowing is not wallowing in your suffering. Rather, it's simply accepting that suffering happens, and that we all go through it. The idea that we all suffer is *Common humanity*. For some, knowing we are not alone in our suffering helps us better accept it.

I- Investigate with interest and care

Once we have agreed to allow our suffering to be, just as it is, we can begin to look at it with an open mind. We are not stuck in thoughts of resistance (e.g. Why me? This shouldn't be happening! It isn't fair that I'm the only one who has to go through this!). Instead, we can start to piece together how

we stumbled into our suffering and did so through no fault of our own. We examine our psychological experience; our thoughts, feelings, motivations, behaviors, images, fantasies, and body sensations. When we are ready to piece it together, we can see our suffering with greater clarity. This process is called **empathy**, but you are gifting it to yourself. When we have **self-empathy**, we can see the true nature or personality of our suffering.

N- **Nurture** with self-kindness

If empathy is what comes from approaching your suffering with an open mind, then nurturance and self-kindness is what flows from an open heart. We naturally and intuitively know how to be kind and nurturing to ourselves once we have seen the nature and personality of our suffering. We are able to give ourselves exactly what we need to start feeling better. We may need to be with our suffering in a soft/tender way by comforting, reassuring or validating ourselves (The Yin of Compassion). Or we may need to access our power by protecting, providing or motivating ourselves (The Yang of Compassion).

Now that you have some background with RAIN, give it a try in your everyday life.

R- Recognize: Bring mindful awareness to what triggered you and write it out. What are the thoughts, feelings, body sensations, motivations, images/fantasies and behaviors that came up?

A- Allow: Accept your experience as it is. If it helps write out a phrase of common humanity (e.g. we all suffer, it's okay)

I- Investigate: Now examine your psychological experience (e.g. thoughts, feelings, behavior) and try to piece them together and identify how and why you might be suffering. Provide yourself with empathy and understanding and try and identify what you need in this moment to feel better.

N- Nurture: Write out a phrase of self-kindness that speaks to what you need to hear. Or if you need action, brainstorm a kind thing you can do for yourself.

Self-Empathy + Self-Love = Self-Compassion

R- Recognize: Recognizing your psychological experience (i.e. thoughts, fantasies, body sensations) with mindfulness.

A- Allow: Allowing, rather than resisting the distress of your psychological experience.

I- Investigate: Investigating your psychological experience. Piecing your experience together to better understand your suffering and what you need.

N- Nurture: Meeting your suffering with feelings of self-love, and action to care for oneself.

R-A-I + N = Self-Compassion

Window of Tolerance

Hyperarousal

Window of Tolerance

Hypoarousal

Hyperarousal, Hypoarousal and Optimal Arousal

Optimal arousal: Sits within our window of tolerance. It is the ideal state where we feel safe and calm. We also experience a greater sense of connection with people and the world around us.

Hyper-arousal: Is characterized by excessive activation and energy often in the form of anxiety, panic, fear and hyper-vigilance. This impacts our ability to relax, often making it difficult to sleep and manage our emotions.

Hypo-arousal: Is a process of shutting down or checking out from our experience. It is characterized by exhaustion, depression, flat affect, numbness, disconnection and dissociation. This limits our ability to meaningful engage with the world around us.

Session II: Trauma and the threat response

Core mediation: Affectionate breathing

Homework review: RAIN, recognizing our psychological experience

Break

Psychoeducation: Trauma and the threat response

Workshop: Identifying our threat response, mindfulness in daily life

Home practice: RAIN – Recognizing the threat response, affectionate breathing meditation, mindfulness in daily life

Core (opening) meditation: Affectionate breathing**Instructions (20 min):**

- Please find a posture in which your body is comfortable and will feel supported for the length of the meditation. Then let your eyes gently close, partially or fully. Taking a few slow, easy breaths, releasing any unnecessary tension in your body.
- If you like, offering yourself soothing or supportive touch as a reminder that we're bringing not only awareness, but affectionate awareness, to our experience and to ourselves. You can leave your hand there or let it rest anytime.
- In this meditation, we will be feeling the breath in our bodies. However, focusing on the breath is uncomfortable for some people. If you feel that way, it's perfectly fine to simply return your attention to the sensation of soothing or supportive touch, or rather than focusing on the breath, just feel your entire body swaying gently back and forth as you breathe.
- Only if it feels right, please begin now to notice the sensation within your body, feeling the body breathe in and feeling the body breathe out. (Pause)
- Perhaps noticing how your body is nourished on the in-breath and relaxes with the out-breath. (Pause)
- Just letting your body breathe you. There is nothing you need to do.
- Now noticing the rhythm of your breathing as you might toward a beloved child or a dear friend.
- Feeling your whole body subtly moving with the breath, like the movement of the sea.
- Your mind will naturally wander like a curious child or a little puppy. When that happens, just gently returning to the rhythm of your breathing.

- If you notice there's a sense of watching your breath, see if you can let that go and just be with your breath, feeling it.
- Allowing your whole body to be gently rocked and caressed - internally caressed by your breathing.
- If you like, even giving yourself over to your breathing.
- Just breathing. *Being* breathing. (Long pause)
- And now, gently releasing your attention to your breathing, sitting quietly in your own experience, and allowing yourself to feel whatever you're feeling and to be just as you are.
- When you are ready, return to the group.

Inquiry

Homework Review: Soothing touch, RAIN skill

Break

Psychoeducation on trauma II: Trauma and the threat response

The old brain: Our brains have evolved into two systems to help our species survive. The first system (i.e. the drive system) seeks out resources (e.g. food, shelter, sex, warmth) and the second system (i.e. the threat system) helps us avoid threats that might compromise our survival (e.g. fleeing a predator). These survival qualities of our brain are consistent with the brains of all other animals, including the earliest and most primitive animal species (e.g. lizard).

The mammalian brain: The brains of animals on the planet started to change when mammals evolved. As mammals, we have a third and more evolved part of our brain (i.e. the safety system). This part of our brain encourages us to collaborate for survival. It allows us to feel connected to others, build friendships, care for our children/family and feel compassion for ourselves and others. This part of the

brain is where we experience enduring positive feelings related to our wellbeing (e.g. compassion, joy, contentment, closeness, awe).

The new brain: This is the part of our brain that is unique to humans. It gives us the ability to think, reason and plan. It is also the part of our brain that gives rise to our identities and the ability to self-reflect. The new brain is a double-edged sword. Critical self-reflection can lead to shame/guilt and make our problems even worse. Compassionate self-reflection, however, helps us better understand our difficulties and respond in a kind way.

The brain's response to threat: When an individual experiences a stressful event they enter the threat system and automatically choose one of several coping mechanisms. This happens outside of one's conscious awareness. Unlike resilience, which promotes long term recovery from overwhelming pain, hardship or trauma, coping focuses on short term survival. The following are examples of different coping strategies:

- a. **Fight:** In the window of tolerance, the fight response would be characterized as hyper-arousal. It typically draws on emotions related to anger, which motivate us towards behaviors that help us control or overcome threats. People with PTSD may experience hyper-vigilance and difficulties with anger as symptoms of the fight response.
- b. **Flight:** The flight response would be characterized as hyper-arousal in the window of tolerance. It typically draws on emotions related to fear and anxiety. Additionally, these feelings motivate us towards behaviors that help us avoid threats. People with PTSD may have avoidance symptoms or anxious arousal symptoms.
- c. **Attach:** Attach would be considered hyper-arousal. It is associated with fears and anxieties triggered by the threat of loss. These feelings motivate us towards behaviors to seek out relationships for help/support (e.g. a cry for help).

- d. **Freeze/dissociate:** Unlike fight and flight, freeze and dissociate protectors are characterized as hypo-arousal. These are responses people often use when fight or flight are no longer an option. The freeze response is an evolutionary survival skill, similar to how an animal may play dead. People who use freeze might also dissociate as a way of distancing themselves from the pain they are feeling. This is similar to checking out of one's body as not to feel pain.
- e. **Submit:** The submit response creates safety by complying with the attacker. It is often a very common reaction after experiencing chronic relational abuse. The submit response is often associated with a variety of negative feelings such as guilt, shame, self-loathing, depression and feelings of emptiness. These feelings motivate continued compliance with the attacker. People who make use of the submissive protector may have complex PTSD.

Overlap with flight and the drive system: Often times the flight response can overlap with the drive system. We flee negative experiences, by seeking out something pleasurable (e.g. alcohol).

Choosing the wrong coping skill: When we are overwhelmed by a trauma or hardship we unconsciously choose a coping strategy (e.g. fight, flight, freeze). It's not uncommon to select the wrong strategy, for example submitting when you should have fought.

Choosing the wrong coping skill results in an overactive threat system: When people use the wrong coping skill, they often leave the experience feeling stuck, trying to use the same coping mechanism over and over again in the future. Oftentimes, this results in the use of coping skills being used in inappropriate contexts that are not adaptive. As a result, the person remains stuck in the threat system and is unable to experience the benefits of the safety system and drive system.

Getting unstuck through compassionate resilience: Compassionate resilience is the capacity to transition out of the threat system and then compassionately address our suffering from the safety system. This includes understanding how we got stuck (i.e. self-empathy), and warmly giving ourselves what we need to feel better (i.e. self-kindness/self-love).

Workshop: Identifying our threat response

Therapists may want to use an example, perhaps a very brief case example, to demonstrate the concepts. They might consider handing out or reading aloud the case example provided. If they want, therapists may develop their own case example to share with the group that better fits the population served. Before distributing or reading a case example, therapists should encourage the group to practice listening non-judgmentally and practice common humanity to see if they can identify with any part of the person's experience. This is a deliberate strategy to help create norms around sharing that can continue to be developed through the course of the group. Therapists should invite participants to share which aspects of the psychoeducational material they identify with most.

Workshop: Mindfulness in daily life

Facilitators should now introduce the mindfulness in daily life activity by explaining how mindfulness can be practiced informally at any moment of the day. They should go on to explain how one might practice mindfulness in this way by encouraging participants to 1) Pick an ordinary activity 2) Choose one sensory experience (e.g. touch, taste, smell) 3) immerse yourself in that experience 4) gently return attention to the task when the mind wanders off.

Home practice: RAIN, affectionate breathing meditation, mindfulness in daily life

Facilitators should then ask participants to complete another RAIN home practice worksheet over the course of the week. Participants should identify three to five events that triggered their threat response. They should have at least one that they would consider sharing in the following group.

Participants are also encouraged to start a daily practice of affectionate breathing and incorporate mindfulness in daily life.

Case example I: “Black-Hole” Jane

Jane entered therapy hoping to work on relationship issues. She was seeing a man who was emotionally distant from her, but also very demanding and at times emotionally abusive. Jane was unhappy being mistreated but stayed in the relationship because she believed that by supporting him, he might change and start to treat her better.

As therapy went on, Jane realized that her relationship issues had a lot to do with her history of trauma. Through psychoeducation Jane learned that she got stuck using the submit response because of a previous trauma and it was now surfacing in her relationship. To help her talk about her submit response in therapy, she came up with the term “black-hole” Jane, a needy, shy and people pleasing part of herself. During an argument with her partner, Jane started to blame herself for something, even though she was not at fault. Mindfulness allowed her to **R-ecognize** her experience and acknowledge that this was a moment of suffering. She could slow down and look at her thoughts, feelings, behavior and body sensations. Instead of criticizing herself or feeling overwhelmed by her experience, she could **A-cccept** the reality of her difficulties as they are. This allowed her to look more deeply and **I-nvestigate** what was going on. Using self-empathy, she could now see that this was “black-hole” Jane surfacing in an attempt to protect her. She could acknowledge that this part of her was not helping her in the long term, but rather just keeping her stuck in a cycle of suffering.

Jane realized that the most **N-urturing** thing she could do was to remind herself that what she wanted was important too. She also realized it was nurturing to give herself permission to access her anger to assert her needs. When she confronted her partner days later, she accessed what she later described as her “brave-self”. Expressing her anger was a moment of **compassionate resilience**; she was accessing a different part of herself that could address her issue in a more adaptive way. She also left the experience feeling positive emotions that she had previously struggled to feel, such as pride and a sense of empowerment.

Window of Tolerance

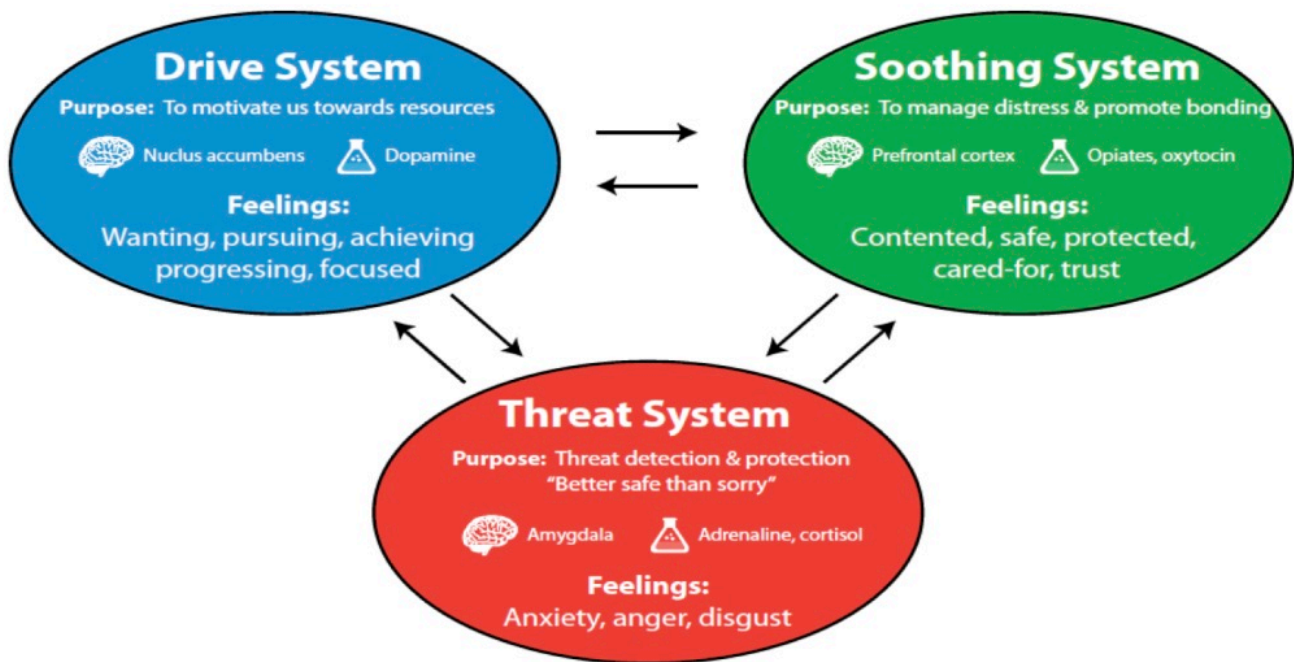
Hyperarousal: Fight, Flight, Attach

Window of Tolerance: Safety system

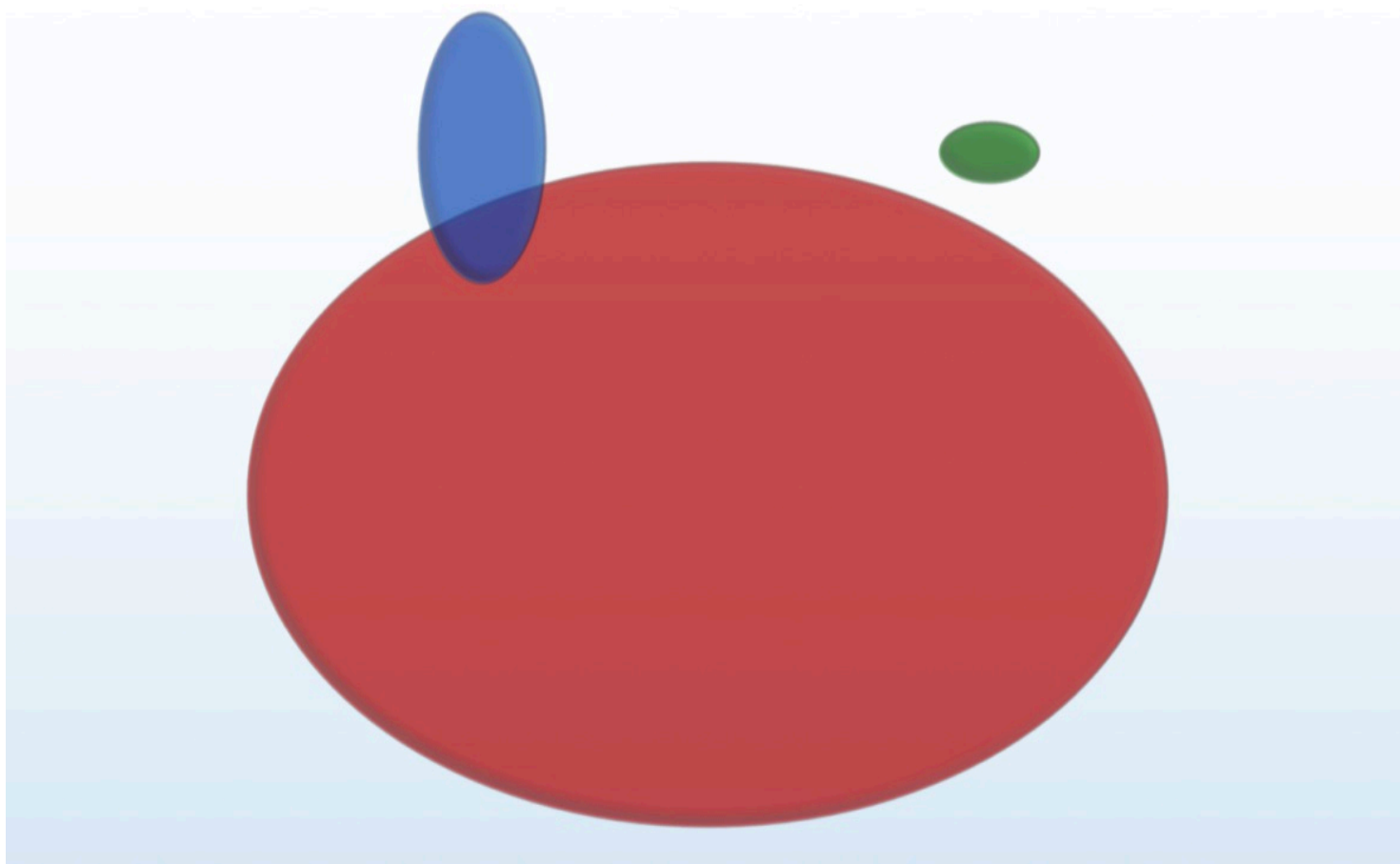
Hypoarousal: Freeze/Dissociate, Submit

Regulating affect

Emotional Regulation Systems



Them Mind after trauma: An over-active threat system



Session III: Re-experiencing symptoms

Core mediation: Affectionate breathing

Homework review: RAIN, mindfulness in daily life, affectionate breathing meditation

Break

Psycho-Education VI: Re-experiencing symptoms

Workshop: RAIN, self-compassion in daily life, here and now stone

Home practice: RAIN, managing flashbacks, self-compassion in daily life, here and now stone

Core (opening) meditation: Affectionate breathing**Instructions (20 min):**

- Please see instructions for the meditation and reflection in session II

Homework Review: RAIN: recognizing our threat response, mindfulness in daily life, affectionate breathing

Break**Psycho-education III: Re-experiencing symptoms**

Flashbacks are normal: Flashbacks are normal following an overwhelming or traumatic event. If we have enough access to our resilience as well as support from others, we can safely process our flashbacks and move on. If the memories of the event are too overwhelming, however, we may develop symptoms of PTSD called re-experiencing. These include nightmares, flashbacks and intrusive thoughts that are accompanied by overwhelming feelings/body sensations that make the individual feel as though they are in the traumatic event all over again.

Traumatic memories vs normal memories: Memories of prior traumas or hardship are stored in the amygdala, while normal memories are stored in the hippocampus. As a result, normal memories and traumatic memories are experienced differently.

Normal memories have the following characteristics:

- Normal memories are organized and continuous (i.e. they contain a beginning, middle and end)
- Normal memories can be recalled when you *want* to think about it
- Normal memories are easy to access in conversation and make sense of
- Normal memories are experienced as happening in the past
- Normal memories are updated; with new information our memories change
- Normal memories do not overwhelm us; we feel safe as we access them

Traumatic memories have the following characteristics:

- Traumatic memories are fragmented and disorganized; pieces of the event are not organized into a story
- Traumatic memories are recalled involuntarily, and often are uncomfortable when they surface
- Traumatic memories are not easily accessed in conversation and are hard to make sense of; instead they appear when triggered by situations (e.g. smells, locations, people, noises)
- Traumatic memories feel like they are happening in the present
- Traumatic memories are frozen in time; they do not get updated with new information about the event
- Traumatic memories overwhelm us with negative feelings and body sensations

Hippocampus and the amygdala: Under normal circumstances we store memories in the hippocampus, a region of our brain that is responsible for both short- & long-term memory as well as regulating our emotions. When we are overwhelmed by a traumatic event or hardship, however, we store those memories in our amygdala. The amygdala, is located in a more primitive part of our brain, sometimes called the reptilian brain. This part of our brain triggers the threat system (e.g. fight, flight, freeze, submit) and a variety of associated feelings designed to help keep us safe (e.g. anger, anxiety, fear, shame/guilt).

The body keeps the score: The hippocampus stores memories in a more cognitive and rationale way. The amygdala, however, stores memories as emotions and bodily responses. That means the traumatic memories we have yet to process often have a strong bodily/emotional component. That's why we have the saying "The body keeps the score".

Example: If you go out to a party and ate bad shellfish that got you sick, your amygdala would say "I got sick from eating bad shellfish, I should remember not to eat bad shellfish". Your amygdala would not say anything at all. Instead, it would unconsciously trigger fear and a flight response with all shellfish moving forward, good or bad. Your feelings of fear would manifest as body sensations (e.g. nausea) designed to keep you away from shellfish again.

The traumatized-self: The traumatized-self carries the emotional burdens of the hardship or traumas of our past. Often times, these feelings include fear and other more vulnerable feelings that are difficult to tolerate. When we experience a flashback, our initial feelings are those associated with the traumatized self.

Traumatized-self triggers the threat system: When a memory from the traumatized self surfaces as a flashback, the associated feelings are treated as if they were a threat occurring in the present. As a result, the memory activates our threat system (e.g. fight, flight, freeze) in the hopes of protecting us. These coping strategies, however, are maladaptive because they are not appropriate to context. We are stuck using them over and over again in an effort to avoid feelings associated with the initial trauma.

Shame maintains trauma memories: It is not uncommon for people to feel as though they are broken, damaged, worthless or powerless because of what they have been through. They might also develop the mindset that other people and the world are fundamentally unsafe. As a result, flashbacks often trigger an additional guilt or shame response coupled with negative, often self-critical thoughts. Guilt and shame worsen our threat response and create a feedback loop. Being stuck in this cycle prevents us from ever fully processing our flashbacks.

Therapists should now initiate a conversation about how to manage flashbacks and nightmares using a number a number of skills that will be reviewed in the workshop. Facilitators should emphasize that these skills are designed to manage the sense of being stuck in the past by helping the individual ground themselves back into the present moment.

Workshop: Self-compassion in daily life

Facilitators should begin the self-compassion in daily life activity by explaining how self-compassion can take form in a behavior. Next, they should hand out the self-compassion in daily life worksheet and encourage participants to fill out the worksheet by listing self-compassionate behaviors.

Once participants are done, they will be invited to share with the group the activities they have identified.

Workshop: Here-and-now stone

Facilitators should bring to class natural, polished stones and hand them out to participant prior to beginning the meditation. When the meditation concludes, facilitators should let participants know that they can take the stones with them and use them whenever they feel stressed. Additionally, facilitators should also encourage participants to find their own grounding object, that either focuses their attention to the present or helps them remember safe and soothing memories. If they like, therapists may want to introduce the stone through a brief guided meditation:

- Let's start by carefully examining our stones. Noticing the colors, the angles, and the way the light plays on the curves of your stone.
- Allowing yourself to enjoy your stone.
- Now, closing your eyes and exploring the stone with your sense of touch. First closing your hand around the stone and squeezing it, feeling its hardness. Then noticing its texture. Is it smooth or rough?
- What is its temperature?
- Opening your eyes again and letting your gaze become absorbed in your stone, and the experience of handling this beautiful stone.
- Noticing that when you are focused on your stone, with appreciation, what happens to regret or worry, or anything you were experiencing-noticing what it's like to be home in the present moment.

- Feel free to take you're here-and-now stone home with you. You can keep it in your pocket and, whenever you're under stress, you can feel your stone, enjoy the sensation of rubbing it, and come into the present moment.

Workshop: RAIN-It's in the past

Facilitators should now talk about how to apply the RAIN skill to flashbacks. This can include nurturing the self through soothing language that reassures the individual that they are safe, and not stuck re-experiencing the trauma. Facilitators should offer the following suggestions for self-talk:

- This is just a memory. Painful as it might be, it is not happening to me now. That was then-this is now. This happened in the past. I am safe
- This is now and I am safe now (*for short*)

Facilitators should emphasize that the above are merely suggestions, and that participants can develop their own phrases if they like. Facilitators should provide time for participants to write out phrases on worksheet II and take them with them if they like.

Home Practice: Affectionate breathing, self-compassion in daily life, here-and-now stone, RAIN

Worksheet I: Self-Compassion in daily life

Instructions: Write out as many ways that you take care of yourself. If it is helpful, try and use each of the five categories to help you come up with ideas.

Physical (e.g. exercise):

Mental (e.g. read):

Emotional (e.g. listen to music):

Relational (e.g. meet with friends):

Spiritual (e.g. pray, meditate):

Worksheet II: It's in the past

Instructions: Write out as many phrases that would kindly ground you into the present and might help you when you are experiencing a flashback/nightmare. Feel free to take your written phrases with you, so you have them available when you need, including before bed if you experience nightmares.

Session IV: Meeting our protectors

Core meditation: Affectionate Breathing

Homework review: Affectionate breathing, self-compassion in daily life, here-and-now stone, RAIN: it's in the past worksheet.

Break

Psychoeducation IV: Meeting our protectors

Workshop: Identifying our protectors, RAIN: meeting our protectors

Home Practice: Investigating our protectors, prepare for individual session

Core (opening) meditation: affectionate breathing

Instructions (20 min): See session two for full meditation instructions

Home practice review: Affectionate breathing, self-compassion in daily life, here-and-now stone, it's in the past worksheet, RAIN

Break**Psychoeducation IV: Meeting our protectors**

Emotion as an impulse: We all inherit the capacity for different emotional responses (e.g. fear, anger, compassion/love, etc.). They are all designed to motivate us towards behavior that is adaptive and helps our survival.

Emotions organize our experience: When we express a particular emotion, it triggers a set of psychological experiences including our motivations, impulses, behaviors, thoughts, mental images, body sensations and attentional patterns. All of these different psychological experiences are inter-related; they work together to address the same emotional impulse for survival. Sometimes it is helpful to use terms like parts or selves to describe our psychological experience as we feel a particular emotion (e.g. the angry self or the anxious self).

The threat system and our protectors: Our impulses from the threat system (i.e. fight, flight, freeze/dissociate, submit) are organized around negative emotions; emotions for our immediate and individual survival. The fight response is often organized around anger. Flight is often organized around fear and anxiety. Freeze is often organized around overwhelming fear or terror. Submit is often organized around shame/guilt and depressive feelings.

Adaptive vs. maladaptive self-expression: Like emotions, our parts or selves are as adaptive as the context they are in. We suffer when we use a part or emotion in the wrong context and thrive when our self and emotional expression matches the needs of our environment. When people experience a trauma

or hardship, they often choose the wrong part or emotional response to help them cope at the time of the event. As a result, they often leave the experience feeling stuck or spinning as they misuse the same protector part over and over again in the future.

Mental health as harmony among parts: There is a saying; “The seeds of our resilience are often found in our problems [pathology]” (Russell, 2014). What might look like a problem, or something that is wrong with you, may actually be a personality strength in a different context. A feature of mental health is learning how to more skillfully use the different parts of our personalities to meet the different needs of our environment.

Workshop: Identifying our protectors

After completing the psychoeducational component, the therapist should handout worksheet 1 and review this additional information about organizing experience around emotions. The facilitator may also use the case example on worksheet 2, or another case example of their choosing if they feel it is more appropriate. Prior to sharing the case example, facilitators should once again emphasize the importance of practicing non-judgment, kindness and common humanity, even if it is a case example of someone not presently in the group. Next, facilitators should hand out worksheet 3 and ask participants to select any of the protector selves with which they identify. Patients are encouraged to share with the group any common protector selves with which they identify. Therapists should be sensitive to any participants needs not to be too forthcoming regarding this exercise. During this exercise it may be particularly useful to try and leverage the group to promote shared identification among members as more share about their reactions to trauma. Therapists should also explain that participants may struggle to identify a protector self and that this is normal. Furthermore, therapists should let group members know that they will have a number of weeks to work with this new material. If they struggled with the exercise, they will have an opportunity in their individual session to work through any difficulties.

Workshop: RAIN-meeting our protectors**Instructions** (12 min):

Prior to beginning this exercise, facilitators should let participants know this can be a particularly challenging exercise and participants can stop at any time. Additionally, participants are encouraged to discuss their practice with the facilitator if anything comes up during the practice. Please close your eyes, partially or fully

- Think of a situation in your life that is difficult, that is drawing out one of your protectors. This could be a problem in a relationship, a work problem or perhaps someone disrespected you because of your age, your ability or another identity. Please choose a problem in the mild range, not a big problem. We don't want to overwhelm ourselves as we're first learning the skill of self-compassion
- Now allow yourself to feel your way into this protector, to the extent that you feel some uneasiness. Now **recognize** that discomfort by bringing awareness to all of what is in your awareness. What thoughts, body sensations, images/fantasies, motivations/urges and feelings do you notice?
- As you recognize all parts of your experience, say to yourself, slowly and clearly, "This is a moment of suffering." Other options include "This hurts," "Ouch!" Or "This does not feel good."
- Next give yourself permission to **allow** rather than resist that discomfort. Sit with it. Ask yourself "Can I accept this moment exactly as it is, can I accept that this moment couldn't be any other way given everything that has led up to it?"
- Can I accept that suffering is a part of life, that we all experience hardship and none of us are alone in our moment of suffering?

- Now try and **investigate** what's behind that discomfort. Can I take a moment and piece together my experience? The thoughts, feelings, body sensations, mental images and motivations. What part of me may be surfacing right now?
- If you can, try to acknowledge how this part of you is just trying to protect you. Despite its good intentions it may also be causing you pain.
- Now, if you'd like, put your hands over your heart, or wherever in your body you need to be soothed. Say to yourself, "May I be kind to myself" "May I give myself what I need" Perhaps asking yourself "May I accept myself just as I am" or "May I care for myself tenderly in this moment" Or perhaps you need something different. Maybe you need to say "No, I will not allow myself to be harmed in this way" or "May I have the courage and strength to make a change."
- If you're having difficulty finding the right words, imagine that a dear friend or loved one is having the same problem as you. What would you say to this person, heart to heart, without giving advice? If your friend were to hold just a few of your words in their mind, what would you like them to be? What message would you like to deliver? (Pause) Now, can you offer the same message to yourself?
- Slowly come back to the room

Inquiry: Therapists should offer an inquiry at this point with a special sensitivity to the challenging nature of this exercise. They should try to emphasize, when appropriate, language from the window of tolerance to help participants better describe and identify the nature of distress that may have surfaced during the exercise.

Home practice: RAIN skill, affectionate breathing meditation, identifying our protectors worksheet

Worksheet 1: Organizing our experience around negative emotions

The emotions that motivate our threat responses are often classified by researchers as having a negative valence. These emotions organize our psychological experience (i.e. our thinking/reasoning, motivations, fantasy life, behavior, felt emotions/body sensations and attentional patterns) so we are better suited to survive an oncoming threat. Negative emotions are not bad, but often cause us suffering when they get stuck in an emotional pattern that is inappropriate to the needs of the environment.

Motivation: Negative emotions motivate us towards behavior that encourage our short-term survival. These might be experienced as impulses or flashes/bursts of energy. Such motivations tend to prioritize our individual survival, rather than the survival of the social groups to which we belong.

Attention: Our attention fixates on that which is threatening while overlooking anything that would suggest we are safe. This might produce a sense of tunnel vision. Focusing on just the negative, also helps maintain our negative feelings.

Behavior: We engage in impulsive behaviors designed to respond to a perceived threat. These maladaptive behaviors, however, do not neutralize the threat because they are motivated by an emotional response that is inappropriate to the environment. As a result, we are often left feeling stuck repeating the same behavior hoping it will neutralize a threat that is not even there.

Imagery/fantasy: We tend to access memories or imagined worlds (perhaps in the future) that overlap with what we are feeling in the present. When we are sad, we might remember a loss from the past. When we are anxious/fearful, we image something going wrong in the future.

Thinking/reasoning: We tend to stereotype threats as all bad and our thinking becomes more rigid as a result. For example, when we are angry someone else is only a jerk and nothing more. We often lose our capacity to see others or situations for both their good and bad qualities.

Felt emotions/body sensations: We experience the body sensations associated with emotions as aversive or unpleasant. Our body feels on edge (e.g. fight/flight) or empty/depleted (e.g. freeze/submit).

Worksheet 2: Flight protector “Anxious Joe”

Joe was in a car accident. Following the event, he began having difficulties related to his trauma that centered around his fear/anxiety. He was recently triggered boarding a bus.



Core emotion: Fear/anxiety

Motivation: Flight. Joe’s emotional response gave him the impulse to flee by getting off the bus as soon as possible.

Attention: All Joe could focus on was what was unsafe about the bus. He focused on the driver to see if he appeared competent or not. He also looked at the surrounding traffic to see if anyone was going to make a false move.

Imagery/fantasy: Joe imagined an oncoming car crashing into the bus multiple times.

Thinking/reasoning: Joe was already planning how he was going to escape the bus if and when the imagined car accident happened. He was also thinking how crazy this was and how there must be something wrong with him for being so irrational.

Emotional experience/body sensations: Joe felt tense, carrying his anxiety/fear in his shoulders.

While unpleasant, this anxious/fearful state has energized Joe to quickly move. Joe also feels shame. At one level he knows this is unreasonable and thinks he is just crazy.

Behavior: Joe gets off at the next stop, well before his destination.

Worksheet 3: Common negative emotions

High arousal emotions: High arousal emotions are associated with behavior to actually control or neutralize the threat (e.g. fight, flight, attach). These emotions prime us for action, leave us feeling tense, increase our heartrate and makes us more alert.

Anger: Anger is associated with our fight response. It is designed to protect us from threat by attempting to control it through aggression and hostility. **Related feeling words:** Rage, irritation, exasperation, agitation, frustration.

Disgust/contempt: Disgust/contempt is associated with our flight response. It produces the impulse to avoid that which we think is harmful or noxious. It can originate from unpleasant smells, taste, or people whom we find off-putting. In particular, contempt focuses on people, implies a sense of superiority, a need to exclude others, and pessimism about the possibility of their betterment. Chronic contempt is often a way of suppressing shame/guilt and may lead to alienation from others. **Related feeling words:** Revulsion, disdain, scorn.

Fear/anxiety: Fear is associated with our flight response. It is evoked by a specific threat, and manifests in the impulse to flee or avoid a particular situation. The brain systems for fear and anxiety overlap and anxiety is considered a type of fear. Anxiety is based in a more general/vague sense of threat and is associated with a greater sense of conflict or uncertainty over how to address the situation. Often times there is a lingering sense of something being. People often find themselves torn between motivations to control the threat through a compulsive behavior or fleeing/escaping the situation.

Related feeling words: nervousness, tense, keyed up, on edge, horrified, terrified, alarmed

Low arousal emotions: Low arousal emotions are associated with protective behaviors when we cannot neutralize the threat (i.e. freeze, submit, attach). These emotions slow us down and deactivate us.

Sadness: When we no longer believe our needs for help will be answered, sadness can trigger low arousal emotions in the form of depressive feeling. This might include prolonged crying, dampened moods, lethargy, quietness, and withdrawal from others. Hopelessness often occurs with these depressive feelings and this protects us from initiating new relationships where we may experience loss again. **Related feeling words:** Disappointment, depression, suffering, grief, disinterest, hopelessness.

Guilt/shame: Guilt and shame are associated with the submit response. Shame is associated with feeling bad about oneself. Guilt is associated with feeling poorly about something you have done to someone else. They generate the impulse to hide out of fear of being rejected. When we experience guilt/shame we feel weak, shrunken, defeated and are self-critical. The body contracts and our head tilts down. **Related feeling words:** Defeated, deflated, worthless, broken, damaged, unworthy, inferior.

Overwhelming fear: Overwhelming fear is associated with the freeze and dissociate response. We shut down and withdraw (e.g. deer in headlights). It is a survival mechanism where we play dead in an attempt to avoid being preyed upon. **Related feeling words:** Numb, checked-out, withdrawn, spaced-out.

Worksheet 4: Meeting our protectors
Fight protectors

Protectors organized around feelings of anger typically trigger our fight response. They are designed to overcome or dominate the threat.

Vigilant protector: Keeps us on guard, ready to fight if need be.

- Feels jumpy
- Watches out for danger all the time
- Struggles to pay attention to things because they were so tense
- Stereotypes groups of people as threats
- Struggles to fall asleep from feeling tense/jumpy
- Looks for fights

Angry protector: Fights and overcome threats.

- Gets angry easily and about unimportant things
- Wants to hit someone or something
- Starts arguments, pick fights, yell and tell people off
- Seeks to dominate others

Judgmental protector: Identifies what is wrong with the person or situation. Justifies attacking or dominating by stereotyping others or situations as all bad.

- Unusually high standards
- Little toleration for failure in self or others
- Relentless self-criticism, often to help motivate oneself
- Judges self and others harshly
- Perfectionistic
- Externalizes blame
- Avoids sharing vulnerability
- Believes oneself to be superior

Controlling protector: Seeks to dominate, control or manipulate others or situations in an attempt to prevent being vulnerable.

- Lies, cheats, distorts the truth
- Makes false promises to others
- Seeks relationships with uneven power dynamics
- Privileges own needs in relationships
- Manipulates others
- Never shares vulnerability or needs in relationships out of fear of not being taken care of

Flight protectors

Protectors organized around feelings of fear and anxiety typically trigger our flight response. They are designed to help us escape the threat.

Avoidance protector: Avoids external and internal triggers of the threat.

- Tries to forget or avoid thinking about bad times in their past
- Tries to deny or avoid having any feelings about their past
- Avoids talking or thinking about painful/traumatic topics
- Avoids people/places/things that remind them of the trauma
- Doesn't let themselves ever feel bad about the past
- Tries and block out or push away certain memories

Worrying protector: Controls future threats by planning ahead

- Feels nervous a lot of the time
- Irrationally believes something bad will happen
- Worries that they might get injured or die
- Plans ways of escaping future situations
- Imagines negative events happening again

Escape protectors: Escapes fears by chasing short term gratification.

- Drinks alcohol to excess
- Uses drugs
- Suicidal thinking/gestures
- Self-harming (e.g. cutting)
- Overeats
- Numbs oneself from feelings
- Engages in compulsive sex
- Excessively watches TV

Distracting protectors: Distracts from fear through productive behavior that produces self-efficacy, a useful short-term coping mechanism, but not a long-term solution.

- Works out excessively
- Becomes overly engaged in work/school
- Cleans the house excessively
- preoccupied with achievement and accomplishment
- Overloads one's schedule
- Avoids relationships/intimacy by doing
- Obsesses about work, school or other life responsibilities

Freeze and dissociate protectors

Protectors organized around overwhelming terror trigger freeze and dissociative responses. Freeze and dissociate are designed to help us play dead, so we are less desirable as a target. They are often the protectors of last resort when fight, flight and attach are no longer options.

Freezing protector: Plays dead in order to make us less desirable to be attacked.

- Feels stuck in some parts of the body
- Feels cold/frozen, numb
- Has a sense of heaviness and struggle to move
- Has a sense of dread
- Experiences slowed heart rate and breath

Dissociating protector: Keeps us from feeling pain we know we will have to experience by dissociating or checking-out psychologically.

- Feels as if they are in a dream or that things weren't real
- Feels outside your body
- Spaces out
- Ends up in some place and doesn't know how they got there
- Doesn't pay enough attention to what is going on
- Feels like there are two or more people inside of you
- Has trouble remembering the details about something bad that happened
- Feels like they are watching oneself from far away

Submissive & depressive protectors

Protectors organized around feelings such as guilt/shame and depressive moods typically trigger our submit response.

Submissive protector: Surrenders to their aggressor, so they hurt the individual less.

- People pleases, appeases other's needs, or seeks out relationship with controlling others
- Closes down, makes oneself as small as possible
- Criticizes themselves
- Don't advocate for wants/needs/desires
- Believes the world and other people are bad
- Blames themselves for their hardships/traumas

Depressive protector: Stops seeking life outside of negative relationships or negative life circumstances. Is hopeless and avoids goals & relationships to prevent future disappointment

- Feels sad or worthless
- Forgets to eat, sleep, take care of oneself
- Feels hopeless, not believe they will get better, or give up on recovery
- Avoids people
- Stops enjoying things, sacrifices passions/ambitions
- Hates oneself

Attach Protectors

Attach protector: Seeks out relationships for help and is overly dependent on them

- Clings to relationships, comes off as needy
- Prioritizes other people's needs, in hopes this will keep the other person around
- Fails to take care of oneself
- Lacks a sense of autonomy, control and confidence in one's abilities
- Feels uncomfortable without being in a relationship
- Craves intimacy
- Exaggerates medical issues, feigns suicide and self-injury for attention

Worksheet 5: Meeting our protectors

What does your protector look like? What are the different components of my experience that make up your protector? If you are able, can you come up with a name to describe your protector?

Motivation:

Attention:

Imagery/Fantasy:

Thinking/Reasoning:

Emotional experience/Body sensations:

Behavior:

What negative emotion/emotions is at the core of your protector?

What threat response (e.g. fight, flight, freeze) do you think is associated with this feeling?

How did this protector develop in order to keep you safe? How might it be related to any previous traumas or hardships?

Might you have learned to use this protector from your family, community or culture? If so, how might this protector have been used to survive any traumas or hardships in your family or community?

How is this protector not working for you now? In what ways is it inappropriate to context?

How might this be a strength in a different context? Could it reflect a strength of personality if used in the right way? Could it reflect a strength of your family, community or cultural background?

Group V: Shame

Core Mediation: Affectionate breathing

Homework review: reading, RAIN, meeting our protectors worksheet, affectionate breathing meditation

Break

Psychoeducation V: Shame

Workshop: RAIN with the inner-critic, getting to know your inner critic worksheet

Home Practice: Reading, RAIN, Affectionate Breathing, Getting to Know your Inner Critic Worksheet

Core (opening) meditation: Affectionate breathing

Instructions (20 min): See session two for full meditation instructions

Home practice review: Affectionate breathing, RAIN, meeting our protectors

Break**Psychoeducation V: Shame**

Guilt vs. shame: Guilt and shame are both negative emotions, that in excess can lead to significant psychological issues. Guilt is the collection of negative feelings associated with believing that we did something wrong, often times an action that hurt another person. Shame, however, is associated with the belief that there is something fundamentally wrong with us.

Shame and social threat: Humans are a social species; we rely on our ability to participate in community as a means of survival. As a result, our brains evolved over time to be very sensitive to social threat, the threat of being rejected by relationships and communities on which we rely.

Small amounts of guilt and shame are adaptive: Guilt and shame serve an important purpose in groups, communities and societies. Because they are unpleasant emotions, guilt and shame motivate people to avoid engaging in behaviors that the group or society might see as negative, unethical or shameful. If it doesn't overwhelm us, guilt and shame can be helpful because it discourages us from participating in negative behavior that may be harmful to the community.

What guilt and shame look and feel like: Guilt and shame can include a variety of feelings such as, humiliation, embarrassment, disgust, anxiety, fear, anger, self-hatred, and contempt. Research has identified a number of common thought patterns associated with guilt/shame (Briere, & Spinazzola 2005). The following are examples of these patterns:

- **Self-Blame:** Blaming oneself for unwanted negative events (not just one's trauma's or hardships).
- **Self-Criticism:** Criticizing or putting oneself down. This is often related to criticizing or putting down others.

- **Helplessness:** Belief that you cannot control certain aspects of your life. This may lead to being passive when face with danger.
- **Hopelessness:** The belief that one's future is bleak, and they are destined to suffer and fail. Hopelessness is often associated with pessimism and a failure to persevere.
- **Preoccupation with danger:** Believing the world is a dangerous place. This is often associated with distrust and fears of being vulnerable with other people.

Common examples of such negative thoughts might include:

- "Others think poorly of me"
- "I'm not good enough"
- "I'm different than others, and there's something fundamentally wrong with me"
- "I don't deserve love, kindness or care from others"
- "I deserved what happened to me because I'm such a bad person"
- "If people knew what happened to me, they would think I'm weak, disgusting, or damaged"
- "I should have done this during the traumatic event, it's my fault"
- "I should be able to get over this, I'm weak"

Excessive shame maintains our suffering: Shame worsens the threat response (i.e. fight, flight, freeze, submit) by adding social threat to the mix and leaving us stuck in a feedback loop; our threat system gets activated, then we feel shame for having such a response, which further triggers our threat system. In some cases, we may choose self-destructive coping mechanisms to deal with these feelings and regret our actions, further reinforcing our shame. Getting stuck in the cycle of shame makes it harder to access the parts of ourselves that might better solve our problems on our own. Additionally, when we feel shame, we are less likely to share our vulnerabilities with others, and this makes it harder to receive help.

Where shame comes from: As children, we internalize the attitudes of others around us. If we grow up in rejecting, critical environments we may internalize attitudes of shame from others. Sources of shame include:

- **Childhood neglect:** Children who were neglected may internalize the message that they are not worth caring for.
- **Critical households:** Children growing up in households with critical parents may internalize the negative messages they received and learn them to be true.
- **Bullying:** Children who experienced bullying may internalize the negative messages of their

peers and also learn them to be true.

- **Cultural identity pain:** Having a marginalized identity (e.g. race, ethnicity, religion, sexual orientation, body image) may contribute to feelings of being lesser than the norms set by mainstream society.
- **Intergenerational shame:** Communities that have experienced a shared trauma (e.g. Jews during the holocaust, African Americans during slavery) may experience collective traumas that produce feelings of shame or survivor guilt that are internalized by the next generation.
- **Genetic and neurologic predispositions:** Some individuals having genetic predispositions to feel shame more or less strongly.
- **Traumatic experiences:** Individuals who experienced a traumatic event may leave the experience feeling ashamed or guilty about it. It's common to blame one's self or feel damaged in some way following the event.

Shame, self-identity and trauma: Not knowing how to deal with shame constructively makes our identities more vulnerable to injury following a trauma or hardship. For example, individuals who have internalized self-critical beliefs about themselves, may be more prone to believing a hardship was their fault. The hardship confirms the negative view of themselves. For other people who cope with shame by cultivating self-efficacy, confidence in one's ability for success, a trauma or hardship may shatter the belief that they can have control in their life or that good things should happen to them.

Self-compassion for dealing with shame: In addition to shame, we also internalize compassion from our environment. This occurs when we experience acceptance and warmth in the context of social relationships. We feel cared for and at ease with others. Accessing the compassion we have already internalized allows us to accept the parts of our identity we experience as shameful and meet them with self-kindness.

Workshop: RAIN: Meeting our inner-critic

Instructions (12 min):

Prior to beginning this exercise, facilitators should let participants know this can be a particularly challenging exercise, and if they need to, they should use any necessary grounding techniques. Additionally, patients are encouraged to discuss their practice with the therapist if any difficulties come up.

- Please close your eyes partially or fully.
- Please think of an event in your life, clearly in the past, when you felt embarrassed or mildly ashamed in public.
- Now allow yourself to feel your way into the situation, to the extent that you feel some uneasiness. Now **recognize** that discomfort by bringing awareness to all of what is in your awareness. What thoughts, body sensations, images/fantasies, motivations/urges and feelings do you notice?
- As you recognize all parts of your experience, say to yourself, slowly and clearly, “This is a moment of suffering.” Other options include “This hurts,” “Ouch!” Or “This does not feel good.”
- Next ask yourself if it’s okay to **allow** rather than resist that discomfort. Allow yourself to sit with it. Ask yourself “Can I accept this moment exactly as it is, can I accept that this moment couldn’t be any other way given everything that has led up to it.”
- Can I accept that suffering is a part of life, that we all experience hardship and none of us are alone in our moment of suffering.
- Now try and **investigate** what's behind that discomfort. Can I take a moment and piece together my experience, the thoughts, feelings, body sensations, mental images and motivations? How do they make up my inner critic?
- If you can, try to acknowledge how your inner critic may be just be trying to protect you. Despite its good intentions, however, it may also be causing you pain.
- Now, if you’d like, put your hands over your heart, or wherever in your body you need to be soothed. Say to yourself, “May I be kind to myself. May I give myself what I need.” Perhaps asking yourself “May I accept myself just as I am” or “May I care for myself tenderly in this moment.” Or perhaps

you need something different. Maybe you need to say “No, I will not allow myself to be harmed in this way” or “May I have the courage and strength to make a change.”

- If you’re having difficulty finding the right words, imagine that a dear friend or loved one is having the same problem as you. What would you say to this person, heart to heart, without giving advice? If your friend were to hold just a few of your words in their mind, what would you like them to be? What message would you like to deliver? (Pause) Now, can you offer the same message to yourself?
- Slowly come back to the room.

Inquiry: Therapists should offer an inquiry at this point with a special sensitivity to the challenging nature of this exercise. They should try to emphasize, when appropriate, language from the window of tolerance to help group members better describe and identify the nature of the distress that may have surfaced during the exercise.

Workshop: Getting to know my inner critic

After briefly processing the meditation exercise with the group, therapists should now encourage participants to take out the getting to know my inner critic worksheet and begin filling it out on their own. After a few minutes, therapists should provide an opportunity for group members to share their experience of completing the worksheet. Therapists should continue to emphasize common humanity and seek to highlight common experiences among participants. It is possible, that a number of students may not finish completing the worksheet. If that is the case, therapists should encourage participants to complete it for homework.

Home practice: RAIN: recognizing shame, affectionate breathing, getting to know my inner critic.

For home practice, participants should apply the RAIN skill to moments when they experience shame or their inner critic.

Worksheet 1: Getting to know my inner critic

What does my inner critic look like? What are the different components of my experience that make up the inner critic? Can you come up with a name to describe your inner critic?

Motivation:

Attention:

Imagery/Fantasy:

Thinking/Reasoning:

Emotional experience/Body sensations:

Behavior:

What form of negative core belief is it (i.e. self-blame, self-criticism, helplessness, hopelessness, preoccupation with danger)?

Can I remember key memories when I learned to talk to myself like that?

Has anyone else in my life spoken to me like that?

How might your inner critic be trying to help or protect you?

Despite its best efforts, does my inner critic really have my best interests at heart?

What is my inner critic trying to do to me? Help me or hinder me?

Would I speak to other people the way my inner critic speaks to me?

If not, then why not?

What makes me accept what the inner critic says without question or without defending myself?

Session VI: Self-empathy & forgiveness

Core/opening Meditation: Forgiveness meditation (Cullen & Brito-Pons, 2014)

Homework review: Stages of progress, getting to know my inner critic, RAIN: recognizing shame

Break

Psychoeducation: Self-empathy and forgiveness

Workshop: Forgiveness meditation

Home Practice: Forgiveness meditation, RAIN as needed.

Core (opening) Meditation: RAIN: Meeting our protectors**Instructions (12 min):**

Prior to beginning this exercise, facilitators should let participants know this can be a particularly challenging exercise, and if they need to, group members should allow themselves to close if need be. Additionally, participants are encouraged to discuss their practice if anything distressing comes up during the break.

- Please close your eyes, partially or fully.
- Think of a situation in your life that is difficult, that is drawing out one of your protectors. This could be a problem in a relationship, a work problem or perhaps someone disrespected you because of your age, your ability or another identity. Please choose a problem in the mild range, not a big problem. We don't want to overwhelm ourselves.
- Now allow yourself to feel your way into this protector, to the extent that you feel some uneasiness. Now **recognize** that discomfort by bringing awareness to all of what is in your awareness. What thoughts, body sensations, images/fantasies, motivations/urges and feelings do you notice?
- As you recognize all parts of your experience, say to yourself, slowly and clearly, "This is a moment of suffering." Other options include "This hurts," "Ouch!" Or "This does not feel good."
- Next give yourself permission to **allow** rather than resist that discomfort. Allow yourself to sit with it. Ask yourself "Can I accept this moment exactly as it is? Can I accept that this moment couldn't be any other way given everything that has led up to it?"
- Can I accept that suffering is a part of life, that we all experience hardship and none of us are alone in our moment of suffering

- Now try and **investigate** what's behind that discomfort. Can I take a moment and piece together my experience? The thoughts, feelings, body sensations, mental images and motivations. What part of me may be surfacing right now?
- If you can, try to acknowledge how this part of you is just trying to protect you. Despite its good intentions, however, it may also be causing you pain.
- Now, if you'd like, put your hands over your heart, or wherever in your body you need to be soothed. Say to yourself, "May I be kind to myself, may I give myself what I need" Perhaps asking yourself "May I accept myself just as I am" or "May I care for myself tenderly in this moment." Or perhaps you need something different. Maybe you need to say "No, I will not allow myself to be harmed in this way" or "May I have the courage and strength to make a change."
- If you're having difficulty finding the right words, imagine that a dear friend or loved one is having the same problem as you. What would you say to this person, heart to heart, without giving advice? If your friend were to hold just a few of your words in their mind, what would you like them to be? What message would you like to deliver? (Pause) Now, can you offer the same message to yourself?
- Slowly come back to the room

Inquiry: Therapists should offer an inquiry at this point with a special sensitivity to the challenging nature of this exercise. They should try to emphasize, when appropriate, language from the window of tolerance to help participants better describe and identify the nature of distress that may have surfaced during the exercise.

Homework review: Stages of progress, getting to know my inner critic, RAIN: recognizing shame

During the homework review, therapists should acknowledge the halfway point in the program. Consistent with the earlier individual session, therapists should ask the group how they feel they are progressing, particularly in identifying a focus or self-state/social mentality. There should be an open

discussion where hopefully all members feel free enough to join and share their experience. Therapists should seek to validate both progress as well as negative experiences that are seen as obstacles to progress. Therapists should integrate into this conversation brief psychoeducation on stages of progress by defining the following; striving, disillusionment and radical acceptance.

Striving is the beginning stage of change characterized by high hopes, ambitions and enthusiasm. Disillusionment occurs when we begin to experience doubt in the program, usually as a result of excessive ambition, exaggerated hopes and the exhaustion of our initial enthusiasm. Lastly, radical acceptance is accepting whatever the program has to offer without expectation. It is about simply enjoying what is available to be received, without resistance. This often includes feelings of gratitude and benefiting from experiences that we may not have initially expected. Therapists may want to check in with each group member and ask at what stage of progress they believe they are in. Therapists should seek to be understanding and accepting of wherever group members appear to be.

Following this discussion, group members will be asked to share the protectors they have each identified thus far through their work in the group and most recently in the individual session. To facilitate this process, therapists may encourage participants to share their work from the getting to know their inner critic and getting to know their protectors worksheets. Additionally, there should be time made available for the group to process their reactions to each individual's sharing. Group process, however, should be largely limited to group members identifying with similar experiences. When appropriate, facilitators should play an active role in this process by highlighting commonalities or inviting other group members to volunteer similar experiences. It is critical that facilitators limit crosstalk that may provide any potential judgment or invalidation of the experience of the individual sharing.

Break

Psychoeducation VI: Self-empathy and forgiveness

Self-empathy recognizes and integrates experience: Self-empathy requires recognizing the different aspects of our experience (e.g. thoughts, body sensations, fantasies etc.) and then integrating or piecing them together into a whole. It is like building a map of your experience.

Self-empathy cultivated in relationships: Self-empathy can be developed as an individual skill (e.g. RAIN), but also in groups and in relationships. When we receive empathy from another person (e.g. therapist/friend), we internalize the capacity for empathy for ourselves. Additionally, empathizing with another person who experienced a similar hardship also builds self-empathy (Sherman, 2014). We identify with another person; “Oh my god, that’s what happened to me too!”. This is called ***Common-Humanity***.

Self-empathy and guilt/shame: Guilt and shame often distort our understanding of our hardship by making us believe the event/s were entirely our fault. Self-empathy provides us with a more accurate self-assessment of prior experiences and often facilitates self-forgiveness; the sense of “It’s not my fault”. Self-empathy also produces a sense of clarity or insight about how/why one suffers.

Forgiveness and self-compassion: Forgiveness is a response to having been wronged or done wrong yourself. It is the letting go of anger/resentment or other negative feelings directed toward yourself or another. When directed towards ourselves, anger/resentment may manifest as guilt/shame. Holding onto resentments or failing to forgive yourself creates additional suffering. Because forgiveness helps us let go of suffering, it is first and foremost an act of self-compassion, rather than a compassionate act for another.

Forgiveness is not submission/compliance: Forgiveness does not mean going along with something wrong or excusing a misdeed. True forgiveness is actually a form of empowerment because it allows the individual to approach similar wrongdoings in the future without resentment or emotional reactivity. Instead, forgiveness allows us to tackle future injustice with openness and creativity.

Forgiveness is not reconciliation: Reconciliation involves multiple parties committed to healing together. The person who is at fault needs to commit to changing. Forgiveness, however, is a personal act not requiring any commitment from another.

Forgiveness is a process: Forgiveness occurs when we are ready. However, with practice we can create greater opportunities to forgive. Forgiveness is easier when we have greater psychological resources to care for our own suffering. This makes it easier to be less upset with what we did not get from others, or how we failed ourselves in the past. We feel content with what we can give to ourselves now.

Workshop: Forgiveness meditation (Cullen & Brito Pans, 2014):

Instructions (20 min):

- Please find a posture in which your body is comfortable and will feel supported for the length of the meditation. Then let your eyes gently close, partially or fully. Taking a few slow, easy breaths, releasing any unnecessary tension in your body.
- Only if it feels right, please begin now to notice the sensation creating within your body, feeling the body breathe in and feeling the body breathe out. (Pause)
- Take a moment to breathe gently into the center of your heart and notice any barriers you might have erected or emotions you've been carrying because you *haven't* forgiven yourself or others. Allow yourself to feel the pain of keeping your heart closed. Feel into the places in the heart that have *not* forgiven.
- Now, breathing softly, let yourself remember and visualize the ways you may have hurt others. It's usually most effective to begin with the small things, and to bring to mind only that which you can meet with kindness and equanimity. As best you can, let yourself bear witness to the pain you have caused out of your own fear and confusion, feeling any sorrow or regret that might arise as you do

this and holding the pain of the situation-theirs *and* yours-with as much tenderness as you can. Sense the possibility of finally releasing these burdens by asking for forgiveness. Take as much time as you need to picture each memory, each situation, that still weighs on your heart. And then, as each person comes to mind, gently repeat: “For any way I’ve hurt or harmed you, I ask for your forgiveness. I ask for your forgiveness.”

- Now allow yourself to see how these hurtful actions were tragic expressions of your own unmet needs. Perhaps the need to be loved or respected, or the need for safety or peace. And notice how the fact that we hurt others as much as they hurt us just makes us part of the human family. Allow yourself to feel moved by the poignancy of this dilemma-by how we all fall short of our ideals and often don’t know *what* we’re needing, let alone how to get our needs met.
- Now, if you would like, bring to mind any ways you might have hurt or harmed yourself. We can be experts at self-sabotage. See if you can bring the same honest but tender awareness to the ways you’ve inflicted suffering on yourself, whether through self-criticism, overeating, or other physical harm. As you picture these scenarios, allow your heart to be penetrated, to be moved by the poignancy of these expressions of self-betrayal or self-abandonment. Feel the sorrow you’ve carried, and sense the possibility of releasing these burdens. Extend forgiveness for each act of harm, one by one, repeating to yourself: “For any ways I’ve hurt myself through action or inaction, out of my own fear, pain, and confusion, I now extend heartfelt forgiveness...I forgive myself. I forgive myself.”
How does it feel, just in this moment, to offer yourself the gift of forgiveness?
- Now, bring to mind those who may have hurt or harmed *you*. Here, it’s especially important to begin with the smaller hurts, not the most difficult ones. Feel the sorrow you’ve carried from the past. Can you touch a place in your heart that longs to be free of this burden? There are so many ways we’ve all been harmed by others-abused or abandoned, knowingly or unknowingly, in thought, word or deed.

As you recall each incident, remember that each person, too, has caused suffering out of his or her own fear, blindness, and sorrow.

- Now sense that you can release this burden of pain by gradually extending forgiveness as your heart is ready, letting the images and feelings arise and be met with tenderness. Reciting to yourself “I’ve carried this pain in my heart long enough, go the extent that I’m ready, I offer you forgiveness.”
- Remember, forgiveness neither condones nor minimizes wrongdoings. You can forgive in this moment and return to non-forgiveness if you need to. Try dipping your toes into the cold waters of forgiveness, even if you choose to take them right out again. In the next few minutes, continue remembering ways you’ve been hurt, and see if the heart is willing to let go. “I forgive you...I forgive you...”

Homework: Forgiveness meditation, RAIN

Session VII: Self-Love and kindness

Core Meditation: Loving kindness meditation

Homework review: Reading, Forgiveness Meditation, RAIN

Break

Psycho-Education VI: Loving-kindness

Workshop: Finding loving kindness phrases for ourselves

Home Practice: Loving kindness meditation, RAIN; using our own loving kindness phrases

Core (opening) meditation: Loving-kindness meditation for a loved one

Prior to beginning this meditation, therapists should acknowledge how this meditation is different than previous opening meditations. Unlike affectionate breathing, which focused more on mindful awareness, the loving kindness meditation focuses more on self-nurturance. Therapists should briefly describe how the meditation uses phrases or language to cultivate positive feeling states related to kindness.

Instructions (15 min):

- Allow yourself to settle into a comfortable position, either sitting or lying down. If you like, offering yourself soothing or supportive touch as a reminder to bring not only awareness, but loving awareness, to your experience and to yourself.
- Now bring to mind a person or other living being who naturally makes you smile. Someone with whom you have an easy, uncomplicated relationship. This could be a child, a grandparent, your cat or dog. Whomever naturally brings happiness to your heart. If many people or other living beings arise, just choose one.
- Letting yourself feel what it's like to be in that being's presence. Allowing yourself to enjoy the good company. Create a vivid image of this being in your mind's eye. (Pause)
- Now, recognize how much this being wishes to be happy and free from suffering, just like you and every other living being. Repeating softly and gently, feeling the importance of your words:
 - May you be happy
 - May you be peaceful
 - May you be healthy
 - May you live with ease (Repeat twice slowly, then pause)

- You can use your own words to capture your deepest wishes for your loved one, or continue to repeat these phrases. (Pause)
- When you notice that your mind has wandered, returning to the words and the image of the loved one you have in mind. Savoring any warm feelings that may arise. Taking your time.
- Now, adding *yourself* to your circle of good will. Creating an image of yourself in the presence of your loved one, visualizing you both together.
 - May you and I (we) be happy
 - May you and I (we) be peaceful
 - May you and I (we) be healthy
 - May you and I (we) live with ease (Repeat twice, slowly, and then pause)
- Now, letting go of the image of the other, perhaps thanking your loved one before moving on, and then letting the full focus of our attention rest directly on yourself.
- Offering yourself soothing or supportive touch and feeling the warmth and gentle pressure of your hand. Visualizing your whole body in your mind's eye, noticing any stress or uneasiness that may be lingering within you, and offering yourself the phrases:
 - May I be happy
 - May I be peaceful
 - May I be healthy
 - May I live with ease (Repeat twice, slowly, and then pause)
- Finally, taking a few breaths and just resting quietly in your own body, accepting whatever your experience is, exactly as it is.

Therapists should facilitate a group discussion processing the experience of the meditation. In addition to asking if the exercise evoked feelings of loving kindness, they should explore and normalize any barriers to such feelings as well.

Homework Review: Reading, forgiveness meditation, RAIN

Break (15 min)

Psychoeducation VII: Loving-kindness

Love is a positive emotion: Love is an emotion that motivates behavior to tend to the well-being of ourselves or another. Like most positive emotions, love is rooted in the safety system. Positive emotions are designed for our long-term survival, often across multiple generations as a member of a community or larger system (e.g. eco-system). This is different than negative emotions rooted in the threat system, which are designed for our immediate and individual survival.

Love takes many forms: Love is the most common positive emotion, and it takes many forms from romantic love, maternal/paternal love, love of a community etc. As long as it is a positive emotion associated with the desire for the wellbeing of self or other, it is considered love.

Self-empathy + self-love = self-Compassion: Self-empathy allows us to understand our suffering with clarity and therefore identify exactly what we need to feel better. Self-love is the emotional force that drives action to meet these needs. Together they form self-compassion.

Love transforms guilt/shame: Positive feeling states, such as love, expand our awareness and allow us to see the whole picture. When this new perspective is applied to our imperfections, which often produce guilt/shame, our self-view is positively reframed or transformed. Instead of being self-critical, we appreciate our idiosyncrasies, find humor in them or even see them as part of a personality strength. This mindset produces an enduring sense of security/self-worth.

Love is unconditional: There is a saying “We give ourselves compassion not because we want to feel better, but because we feel bad”. Love is not about our own personal needs to see the suffering of

ourselves or another stop. Love is selfless and is based in the hope for well-being.

Love is a courageous act: Choosing love requires courage because it produces the possibility of disappointment. This may test one's hope or faith in getting better or healing from a hardship or difficulty.

Practicing self-love is not always easy: There is a saying "Love reveals everything unlike it".

Experiencing love from oneself or another may feel new, and it often reminds us of all of the ways we have been treated poorly by ourselves or others. This can be difficult, and it is not uncommon to experience resistance to exercises/meditations that encourage us to feel love.

Workshop:

Finding loving-kindness phrases

Prior to beginning this exercise, therapists should briefly provide guidelines for developing loving-kindness phrases:

- Phrases should be simple, clear, authentic and kind.
- You don't need to use "May I" phrases. Any language that helps evoke goodwill are acceptable.

When developing your own language, think of the phrases as blessings if you'd like.

- The phrases are not positive affirmations, rather they are good intentions.
- Phrases are designed to evoke goodwill, not good feelings. It's common to expect that we will experience positive feelings from this exercise. Loving kindness practice does not directly change emotions, but good feelings are an inevitable byproduct of goodwill.
- Phrases should be general.
- Phrases should be said slowly.
- Phrases should be said warmly.

- You may address yourself as I or your proper name, or perhaps address a self or protector that needs care.
- One way to find authentic and meaningful phrases is to focus on the core question of self-compassion training: “What do I need?”
- Needs are different from wants. Wants are personal and are finite (e.g. a fancy car), while needs are more universal (e.g. validation, love, connection, respect).

Instructions (20 min):

- This is a pen and paper exercise. We will close our eyes and do some reflection, then open our eyes and write.
- Please wait until *after* the exercise if you have any questions.
- The exercise is designed to help you discover loving-kindness and compassion phrases that are deeply meaningful to you. If you already have phrases and wish to continue using them, you can try this exercise as an experiment but please don't feel you need to find new phrases.
- To start, please close your eyes if you'd like, place a hand over your heart or elsewhere, and feel your body gently breathe.
- Please take a moment and allow your heart to gently open-to become receptive-like a flower opens in the warm sun. (Pause)
- Then asking yourself this question, allowing the answer to arise naturally within you:
 - What do I need, what do I *truly* need? (Pause)
 - If this need has not been fulfilled in a given day, your day does not feel complete (Pause)

- Letting the answer be a universal human need, such as the need to be loved, whole, connected, healthy, peaceful, safe, valued and free (Pause)
- When you are ready, open your eyes and write down what arose for you. (Pause)
- The words you discovered can be used in meditation just as they are or you can rewrite them as wishes for yourself, such as:
 - May I be kind to myself
 - May I know that I belong
 - May I know my own value
 - (Longer Pause)
- Now, please close your eyes again and consider a second question. This question may take you a little deeper so feel free to only go as deep as you feel comfortable going. The question is:
 - If I could, what do I need to hear from others? (Pause) What words do I need to hear because, as a person, I really need to hear words like this? (Pause) For example:
 - I love you
 - I'm here for you
 - I believe in you
 - You're a good person
 - I want things to be just and fair for you
- Opening the door of your heart and waiting for words to come. (Pause)

- If I could, what words would I like to have whispered into my ear every day for the rest of my life- words that might make me say, oh, thank you, thank you every time I hear them.
- Allowing yourself to be vulnerable and open to this possibility, with courage. Listening. (Pause)
- Now gently opening your eyes again and writing down what you heard. (Pause)
- If you heard a lot of words, seeing if you can make the words into a short phrase-a message to yourself.
- The words you wrote down could be used in loving-kindness meditation just as they are, or you can rewrite them as wishes for yourself. Actually, words that we would like to hear from others again and again are words that we easily forget or point to qualities we would like to realize in our own lives, or attitudes that we wish to firmly implant in our hearts. For example, needing to hear “I love you” might mean that we wish to know we are truly lovable. That’s why we need to hear it over and over again.
- What do you want to know for sure? If you like, you can reframe your words as wishes for yourself.
For example:
 - I love you can become the wish “May I love myself just as I am.”
- Now please take a moment to review what you have written and settle on two to four words or phrases you would like to use in meditation. (Pause) These words or phrases are gifts you will give to yourself. Please take a moment to memorize your words.
- Finally, Let’s close our eyes for a last time, if you’d like. We will repeat the words over and over to ourselves. See if you can let the process be as easy as possible, much like slipping into a warm bath. Nothing to accomplish. Just letting the words do all the work.

- Beginning by saying your words or phrases, slowly and gently, perhaps whispering them into your own ear as if into the ear of a loved one (Pause 3-4 min)
- Nothing to do, nowhere to go. Just surrounding yourself with kind words, letting them wash over you and through you-words that you need to hear.
- And whenever your mind wanders, you can refresh your aim by offering yourself soothing or supportive touch, or by just feeling the sensations in your body. And then offering yourself the phrases again.
- And now, gently *releasing* the phrases and allowing yourself to rest in the experience, letting this practice be just what it was and letting yourself be just as you are. (Pause)
- Please consider this exercise to be only the beginning of a search for phrases that are just right for you. Finding loving-kindness phrases is a soulful journey, a poetic journey. Hopefully you will find yourself returning to this process.
- And gently opening your eyes.

Home practice: loving-kindness meditation, RAIN; using loving kindness phrases

Worksheet 1: Organizing our experience around positive feelings and love

The emotions associated with the safety system are often classified by researchers as having a positive valence or hedonic tone. Love is a positive emotion that motivates behavior toward care for ourselves and others.

Motivation: Positive emotions motivate us towards behavior that ensure our long-term survival as a member of a group, community or larger system (e.g. nature). Like negative emotions, positive emotions also are experienced as an impulse or flashes/bursts of energy to move to action.

Attention: Our awareness is broader and expanded. We see the whole picture, and how everything pieces together. We pay attention to the things that bring us long-term happiness, that we often overlook or under-appreciate. This is contrary to the tunnel vision produced by negative emotions, where we fixate on just the threat.

Behavior: We engage in behaviors that put us in-sync with the environment and we become more connected with the world and communities around us. Our behavior typically offers something of value to the overall health and resilience of the system in which we are participating.

Imagery/Fantasy: We have memories or imagine fantasy worlds in which we feel connected, calmed or soothed. Our memories and fantasy often have a newness to them; they are not of the negative events or things we long for that we have repeated in our mind. Our memories often produce a sense of gratitude for the people or things we might not have appreciated beforehand.

Thinking/Reasoning: We tend to look at situations with greater clarity as we stereotype things less. We don't see things as either all good or all bad. Our thinking is also more creative and holistic. Our thoughts are also more positive and promote appreciation/gratitude for what is around us.

Felt emotions/Body sensations: Our emotions produce positive body sensations that are different from more immediate gratification or pleasure (e.g. eating, drugs/alcohol, excessive pride). This produces a sense of feeling content. Our bodies also have a felt sense of lightness and aliveness. There is also an energizing quality to these feelings.

The flight protector: “Anxious Joe”

Joe was in a car accident. Following the event he began having difficulties related to his trauma that centered around his fear/anxiety. He was recently triggered boarding a bus.



Core emotion: Fear/anxiety

Motivation: Flight. Joe’s emotional response gave him the impulse to flee by getting off the bus as soon as possible.

Attention: All Joe could focus on was what was unsafe about the bus. He focused on the driver to see if he appeared competent or not. He also looked at the surrounding traffic to see if anyone was going to make a false move.

Imagery/Fantasy: Joe imagined an oncoming car crashing into the bus multiple times.

Thinking/Reasoning: Joe was already planning how he was going to escape the bus if and when the imagined car accident happened. He was also thinking how his thought process and how there must have been something wrong with him for being so irrational.

Emotional experience/Body sensations: Joe feels tense, carrying his anxiety/fear in his shoulders. While unpleasant, this anxious/fearful state has energized Joe to quickly move. Joe also feels shame. At one level he knows this is unreasonable and thinks he is just crazy.

Behavior: Joe gets off at the next stop, well before his destination.

The Compassionate Self: “Compassionate Joe”

After getting off the bus, Joe uses the RAIN skill to help him transition from a threat response to the soothing system. He accesses the feeling of self-love and compassion as he does so.



Core emotion: Love/compassion

Motivation: Joe’s compassionate motivation was to care for his needs and help himself calm down.

Imagery/Fantasy: Joe thought about the calming and empathic presence of his therapist who he had talked to about his struggles. He remembered something she said while learning the RAIN skill that made him feel like she truly cared for him.

Behavior: Joe uses soothing touch on the part of his body that feels tense (i.e. his shoulders) and uses a loving kindness phrase his therapist helped him come up with while learning the RAIN skill; “You’re not crazy, this is just anxious Joe and you deserve a break from him.”

Thinking/Reasoning: Joe did not see himself as a crazy person, but rather having a part of him that needed care. He thought of himself as a “compassionate mess” and could now see the humor in his behavior.

Emotional experience/Body sensations: Joe feels calm and soothed. There is a surge of warmth that comes from the place he practiced soothing touch.

Attention: Joe could focus on the things in his environment that were also soothing (e.g. the breeze, trees, sky).

Group VIII: Finding our compassionate voice

Core Meditation: Loving kindness for ourselves

Homework review: Reading, loving kindness meditation, RAIN; using our loving kindness phrases

Break

Psychoeducation VIII: Review

Workshop: Motivating ourselves with compassion

Home practice: Reading, compassionate letter to my protectors

Core (opening) meditation: Loving-kindness meditation for ourselves**Instructions (20 min):**

- We will be using phrases in meditation that you discovered over the past week. Please review your phrases and decide which ones you will use in this meditation, rather than using the time to find new phrases. (Pause)
- Also, please practice with the phrases in a relaxed manner without worrying if you are doing the meditation right-just letting the words do the work, like slipping into a warm bath and letting the warm water do all the work.
- Now finding a comfortable position, sitting or lying down. Letting your eyes close, fully or partially. Taking a few deep breaths to settle into your body and into the present moment.
- Placing a hand wherever you find it comforting or supportive, as a reminder to bring not only awareness, but loving awareness, to your experience and to yourself.
- Now, feeling your breath move in your body whenever you notice it most easily. Feeling the gentle rhythm of your breathing (Pause), and when your attention wanders, returning to the sensation of the gentle rhythm of breathing in your body.
- Now releasing the focus on your breathing-allowing the breath to slip into the background of your awareness-and beginning to offer yourself the words or phrases that are most meaningful to you. If you like, whispering them into your own ear. (Long Pause)
- Nothing to do, nowhere to go. Just bathing yourself with kind words, letting them wash over you and through you-words that you need to hear. (Long Pause)
- Or if it feels right, absorbing the words, letting them fill your being. Allowing the words to resonate in every cell of your body. (Pause)

- And whenever you notice that your mind has wandered, you can refresh your aim by offering yourself soothing or supportive touch, or by just feeling the sensations in your body. Coming home to your own body. And then offering yourself the words. (Pause)
- Finally, releasing the phrases and resting quietly in your own body.
- And then slowly opening your eyes.

Homework review: Loving kindness meditation, loving kindness phrases, RAIN; using our loving kindness phrases.

Therapists should now transition to a discussion about the group's overall experience of using the loving kindness meditation over the last week. After an open-ended dialogue about the group's general reactions to these exercises, the therapist will encourage each individual to share their phrases, if they feel comfortable. Therapists might find it helpful to write on a flip chart each of the loving kindness phrases. Participants should be encouraged to identify any phrases produced by their peers that they themselves might like to use. Therapists should also review the use of the RAIN skill by explicitly asking if any participants were able to use their phrases to offer themselves kind words of nurturance.

Break

Psychoeducation VIII: Review

Therapists should initiate an open-ended dialogue by first highlighting that at this point in the program we have reviewed, in detail, all of the components of self-compassion. Therapists may want to briefly summarize the sequence of topics and describe how they overlap with the four components of RAIN. Therapists should field any questions participants may have thus far. Therapists may want to review prior psychoeducational material as appropriate, in particular any case examples that describe the use of the RAIN skill.

Throughout the course of this review, therapists should make clear the core intention of the program, which is to develop a self-to-self relationship more strongly grounded in self-love and self-compassion. They should also emphasize how the subsequent exercise is an opportunity to practice this skill in-vivo.

Workshop: Motivating ourselves with compassion

Instructions: (20 min)

- Please take out a sheet of paper.
- Think about the behavior of one of your protector selves, that you would like to change and often beat yourself up about. Please choose the behavior of a protector that is actually causing you problems, and something you can actually change.
- Now, please write down this protector's behavior that you usually try to change through self-criticism. Also write down the *problems* this protector is causing you. (Long pause)
- Now please write down *how* you typically react to yourself when you find this protector acting this way. How does your inner critic express itself? Are there unkind words that are used? (Pause) Or is the *tone* of the voice harsh? Sometimes it's all in the tone of voice.
- Sometimes there are no words at all, but rather a sense of coldness or disappointment when you become critical of this part of yourself. If so, does a physical posture or image come to mind? A felt-sense in the body? How does a critical attitude express itself for you? (Pause)
- Now, switching perspectives, and taking a moment to get in touch with the part of yourself that feels criticized. Please take a moment to notice how it *feels* to receive this message. What is the impact on you?

- If you wish, try giving yourself compassion for how hard it is to be the recipient of such harsh treatment--taking a sympathetic moment for yourself, perhaps by validating the pain “This is hard, this hurts.”
- Now turning toward your protector self with interest and curiosity. Please reflect for a moment on *why* this protector has been causing you suffering for so long. Is it trying to protect you from something, to keep you safe from danger, or to help you-even if the result has been unproductive? If so, please write down what motivates this protector. (Long pause)
- If you cannot find anything valuable in this protector, or any way it is trying to help you- sometimes protectors have no redeeming value whatsoever. Please just continue to give yourself compassion for how you’ve suffered from this protector in the past. (Pause)
- But if you can identify some redeeming qualities in this protector or ways it might be trying to keep you safe, see if you can acknowledge its efforts, perhaps even by writing down a few words of thanks. Let your protector know that even though it may not be serving you very well now, its intention was good, and it was doing its best. (Long pause)
- Now that the protector has been heard, we are going to switch gears and connect with our compassionate voice. But before we do that, if you like, please take a big inhalation and hold it a moment, then exhale and release. (Pause)
- Now let’s make some space for another voice: your *inner compassionate voice*. This part of yourself loves and accepts you unconditionally. It is also wise and clear-sighted and recognizes how the protector is creating problems in your life-is causing you harm. It also wants you to change, but for the right reasons.

- If you'd like, please close your eyes. Put your hands over your heart or another soothing place, feeling the warmth. Allow the compassionate side of yourself to emerge, perhaps as an image, a posture or simply a warm feeling. (Pause)
- Now reflect again on the protector that's causing you suffering. Your inner compassionate self would like you to try to make a change, not because you're unacceptable as you are, but because it wants the best for you. Begin to repeat a phrase that captures the essence of your compassionate voice.
 - Therapists may insert their own phrases as examples at this point (e.g. I love you and don't want you to suffer).
- If you prefer, you can bring to mind the image of a person who cares deeply about you, or a figure in your community who means a lot to you, or an ideal image that represents compassion to you. Imagine what this person might say to you right now.
- Now, please open your eyes and begin to write a little letter to yourself in a compassionate voice, freely and spontaneously, addressing the protector that is causing you suffering. What emerges from the deep feeling and wish of "I love you and don't want you to suffer? What words do you need to hear to make a change?" (Pause)
- If you're struggling to find words, it might be easier to write down the words that would flow from your heart when speaking to a dear friend who is struggling with the same issue as you. (Give at least 5 minutes to write, if possible)
- Please wrap up your writing for now and feel free to continue writing this letter at home or start a new letter whenever you need one.
- If you managed to write a few compassionate words to yourself, please read them now and savor the feeling of those words. If you had difficulty finding compassionate words, that's okay too. It takes

some time. The important thing is that we set our intention to try to be kinder to ourselves, and eventually new habits will form.

Home practice: Compassionate letter, Loving kindness meditation, RAIN skill; using loving-kindness phrases.

Facilitators should hand out letter paper and an envelope as they describe the compassionate letter activity. They should let participants know that they can direct the letter to themselves, or any part of themselves they feel would benefit from compassionate attention. This might include the inner-critic or a particular protector self. Facilitators should also offer three different perspectives from which participants can write the letter. This might include speaking from your compassionate self to yourself (i.e. the self-critic or a protector). Alternatively, this might be a compassionate other speaking to yourself (e.g. a kind imaginary friend speaking to you) or your compassionate self speaking to another (e.g. speaking to a friend who has the same obstacle).

Group IX: Positive feelings and true self states

Core mediation: Loving kindness for ourselves

Homework review: Compassionate letter to my protectors, loving kindness meditation, RAIN skill-using loving-kindness phrases.

Break

Psycho-Education IX: Positive feelings and true self states

Workshop: Self at best meditation, Self at best worksheet

Home Practice: Loving kindness for ourselves, RAIN as needed

Core (opening) meditation: Giving and receiving compassion**Instructions (20 min):**

- Please sit comfortably, closing your eyes-and, if you like, offering yourself soothing or supportive touch as a reminder to bring not just awareness, but loving awareness, to your experience and to yourself.
- Taking a few deep, relaxing breaths, noticing how your breath nourishes your body as you inhale and soothes your body as you exhale.
- Now letting your breathing find its own natural rhythm. Continue feeling the sensation of breathing in and breathing out. If you like, allowing yourself to be gently rocked and caressed by the rhythm of your breathing.
- Now, focusing your attention on your in-breath only- letting yourself savor the sensation of breathing in, one breath after another, perhaps noticing how the inbreath energizes your body.
- If you like, as you breathe in, breathing in kindness and compassion for ourself. Just feeling the quality of kindness and compassion as you breathe in, or if you prefer, letting a word or image of kindness ride on your breathing.
- Now, shifting your focus to your out-breath, feeling your body breathe out, feeling the ease of exhalation.
- Now, calling to mind someone whom you love or someone who is struggling and needs compassion. Visualize that person clearly in your mind.
- Begin directing your out-breath to this person, offering the ease of breathing out.
- If you wish, sending kindness and compassion to this person with each out-breath, one breath after another.

- If it's easier for you, you can breathe out to others in general, or to people in your community rather, than visualizing a particular person.
- Now, focusing again on the sensation of breathing both in and out, savoring the sensation of breathing in and out.
- Beginning to breathe in for yourself and out for the other person or persons. "In for me and out for you. One for me and one for you."
- As you breathe, drawing kindness and compassion in for yourself, and sending something good out for another.
- Feel free to adjust the balance between breathing in and out—"Five for me and one for you" or "One for me and two for you" – or just let it be an equal flow, whatever feels right to you at this moment.
- Letting go of any unnecessary effort, allowing this meditation to be as easy as breathing.
- Allowing your breath to flow in and out, like the ocean going in and out—a limitless, boundless flow. Letting yourself be a part of this limitless, boundless flow. An ocean of compassion.
- Gently opening your eyes.

Home practice review: Therapists should transition to an open-ended discussion reviewing the use of the loving kindness meditation as well as loving kindness phrases within the RAIN skill. Next, therapists should initiate a group share of each participant's compassion letter. While participants are strongly encouraged to share, they can elect not to do so if they feel unsafe. Consistent with prior group shares, therapists should reassert the boundaries. Comments and crosstalk that might potentially invalidate, judge or criticize another person's experience are not allowed. Again, therapists should encourage shared identification of experience among participants sharing.

It's at this point in the program, that the therapist should begin to expand their repertoire of

interventions in the group process to include greater reflection of positive affects elicited among those sharing, as well as those listening. For some, the compassionate letter may be emotionally evocative, eliciting positive feelings states such as self-love, hope, pride, or inspiration. Therapists should attune themselves to the moment-to-moment expression of such affects and gently encourage participants to share these feelings in the group as they arise. Therapists may also self-disclose their personal reactions to such emotional expressions (e.g. I felt moved/inspired/touched by when you shared...). When appropriate, therapists may encourage group participants to offer similar sharing, while keeping their sharing to their own emotional experience. If negative affects surface in resistance to the exercise, therapists should validate and normalize those experiences as well. If need be, therapists may help to work through these stuck points with participants on an individual basis.

Including this wider range of interventions, marks the beginning of a critical shift away from the group processing offering, almost exclusively, empathy and opportunities for shared identification or common humanity. Now the group, at least explicitly, is encouraged to function more as a mechanism for the sharing and exchanging of positive affects among group members. This is a deliberate strategy to subtly demonstrate, in-vivo, the interpersonal nature of cultivating self-compassion and positive feeling states. Additionally, this strategy is based in the belief that interpersonal relationships within the group can be leveraged to help internalize self-compassion and therefore better use the skills within the program to meet individual needs.

Break

Psycho-Education IX: Positive feelings and true self states

We all have potential for positive feelings: We are all biologically hardwired for positive feelings. Positive feelings play a critical role in helping us survive as a species over longer periods of time or multiple generations. This is different from negative emotions, which help us survive as an individual in the immediate term.

Positive feelings broaden our awareness: Positive feelings expand the possibilities we see. We have a wider range of options available to us to approach difficulties in our lives when we meet them with positive emotions. This often creates new, more creative ways of approaching and transforming our difficulties into opportunities for growth.

Positive feelings build psychological resources: The more we allow ourselves to experience positive feelings, the more psychological resources we develop to approach later life difficulties with resilience. There are many different kinds of positive feelings, and each helps us develop different kinds of psychological resources (see worksheet 1).

Flourishing vs. languishing: People's behavior tends to have momentum. Negative feelings often promote languishing, entrenched, rigid and predictable patterns of negative behavior. Positive feelings, however, promote flourishing, an upward trend of more creative, energized and less predictable patterns of behavior. Research also suggests that positive feelings both produce and reflect happiness and success.

3-1 ratio: Research suggests that experiencing 3 positive feelings for every 1 negative feeling tips the scales towards happiness and success. So, you don't need to be experiencing positive emotions all the time. You just need to be good enough.

Insincere positivity: Insincere positive feelings that gloss over negative feelings, are not really positive feelings. They are defensive feelings that often suppress other negative feelings and maintain our suffering. Genuine and sincere positive feelings do not require effort, they come on their own terms, but are more likely to occur if you create the right conditions for them.

Workshop: Discovering your true self

Instructions: (20 min)

- Please find a posture in which your body is comfortable and will feel supported for the length of the meditation. Then, if you would like, let your eyes gently close, partially or fully. Taking a few slow, easy breaths, releasing any unnecessary tension in your body.
- If you'd like, offering yourself soothing or supportive touch and feeling your body as you settle into this meditation.
- In this meditation, we will be focusing on the memories of our life. Like all of us, you have memories of both good and bad experiences. We aim to bring our awareness to the memories of the good, the ones that left us feeling most happy and alive. The moments in our lives where we could be our best self.
- Even if you feel these moments have been few and far between for you, give yourself permission to connect with those moments as best that you can. And know that if this is difficult for you, you are not alone, and that we all struggle to connect with the best parts of ourselves.
- Now try to imagine a moment in your life when you felt most happy, joyful and alive.
- Perhaps these moments include:
 - A hobby that brought you great joy
 - Learning about something you were passionate about
 - Having a good laugh with friends
 - Time off that brought you great serenity
 - Something that made you feel part of a greater whole
 - Or quality time with loved ones

- Whatever memory comes up, allow yourself to sit with and experience it fully (Pause)
- As each memory surfaces, ask yourself to bring awareness to the body sensations that arise. How do they feel...good, bad or neutral? Can we bring awareness to any thoughts we have about each memory? How about any images that come to mind? (Pause)
- Perhaps, a person comes to mind as you recall a memory of you at your best. What was it that person gave you, or that you shared with them that helped you have such a wonderful moment in time? And if it feels right, can we give ourselves permission to feel gratitude towards that person? (Pause)
- When you are ready, open your eyes and bring your attention back to the room
- Now, please take out a pencil and paper and begin to list the different activities you were doing during the visualization meditation.
- Once you've written that down, begin listing any other activities that would be examples of you at your best. What are the things that help you feel most happy and alive? (Pause)
- Once you've completed your list, go through each one and ask yourself; what feeling is behind this behavior? If you'd like, try using the worksheet on positive emotions for help. (Pause)
- Perhaps you're struggling to pick a feeling, maybe there are multiple feelings you feel at the same time, that's all okay. Just do your best to find what you think describes your experience as best as possible.
- As you go through this exercise, do you notice any particular feeling or feelings come up more than others? If so which emotion or emotions?

Home Practice: Giving and Receiving compassion meditation, RAIN, finding our true self worksheet

For homework therapists should encourage participants to apply behavioral self-compassion to the RAIN skill. This means practicing self-nurturance through self-compassionate actions. Therapists should encourage group members to consider what positive feelings get triggered through such actions. Additionally, therapists should let participants know that in the homework review in the subsequent week, they are strongly encouraged to share their experience completing the Self-at-Best exercise. If they like, participants can bring in any objects, mementos, songs, or videos that they found to complete the exercise. Lastly, participants should focus their mindfulness practice on the giving and receiving compassion exercise.

Worksheet 1: Common positive emotions

Joy: Joy occurs when your environment feels safe and familiar or when we experience good fortune. Everything is going our way. Joy is sparked doing something fun and easy (e.g. playing your favorite game). Joy makes you want to jump into the world. Joy helps us develop skills by engaging in the world more fully.

Gratitude: Gratitude occurs when you appreciate something that has come your way. Gratitude prompts us to give back in a way that feels free, spontaneous and creative. We want to pay forward what we have been given, without expectation of receiving anything back. Gratitude helps us develop greater capacities to be kind to ourselves and others.

Serenity: We experience serenity when our environment is comforting, familiar and unthreatening. It is that feeling of relaxation after a long day of work, it makes you want to sit back and soak it all in. Serenity helps us better balance our priorities, especially our need to work.

Interest: Interest occurs in an environment that is safe, but there is something unfamiliar that you seek to understand. It is like joy, but it requires additional effort. When we are interested, we feel open, alive, and motivated to explore new possibilities. Interest helps us develop useful knowledge.

Hope: Hope occurs in environments that do not feel safe or familiar. Rather we experience our situation as bleak or dire. Hope fears the worst, but still strives for better. It sparks our inventiveness to improve things. It can be based in a sense of faith or trust in a higher power. Hope helps us develop resilience in the face of adversity.

Pride: When not in excess, pride is a healthy emotion. It occurs when we achieve something valued by our community. Pride encourages us to share our achievements and be seen by others. It is opposite to shame in that it motivates us towards behavior that makes us more visible (e.g. head up, upright posture). Pride helps us develop motivation to achieve goals.

Amusement: Amusement occurs when we feel safe and something unexpected happens. A good joke often highlights something that is ill-fitting or out of place, but it does so in a non-threatening or tactful

way. It is lighthearted and non-offensive. Amusement plays a crucial role in solidifying social bonds.

Inspiration: Inspiration occurs when we see excellence in other people. We feel motivated to reach our own potential, not for our own benefit, but for that of our environment. Inspiration is what drives us to find our purpose as a contributing member of a group, community or larger system. It motivates us towards personal growth.

Awe: Awe is when we see goodness or excellence on a grand scale (e.g. the ocean). You feel overwhelmed by being a part of something so vast. Like inspiration and gratitude, awe is an emotion that promotes a sense of selflessness or self-transcendence. Awe plays an important role in changing how we think; it promotes new worldviews that appreciate the bigger picture.

Love: Love is a socially based emotion, it occurs in the context of relationship. It motivates us to do something for someone, or even yourself, unconditionally without expecting something in return. We do it because we want the other person or ourself to experience well-being and happiness. Love plays an important role in developing social bonds and communities that maintain our survival.

Home-practice Worksheet: The self at best

Instructions: For this assignment identify one emotion that is either easy for you to access or one you feel strongly compelled to explore. What is important is that you select an emotion that will allow you to engage with the exercise as fully as possible. Once you have identified your emotion, read through the related questions to that emotion below. Write down any thoughts or memories that come to mind as you engage with each question. When you are ready, start searching for any objects or mementos that help spark that particular emotion. This could also include a song or video clip. Next, collect these objects in a positivity portfolio to revisit them whenever you would like.

In the same way you named a protector part or self, try naming the part of you or the self that experiences this positive feeling. If you would like, try identifying when this part of you or this self surfaced during your week.

Joy

- When have you felt safe, relaxed, and joyful, utterly glad about what was happening in that moment?
- When have things truly gone your way, perhaps even better than you expected?
- When have you felt a spring in your step, an unstoppable smile, or a warm glow?
- When have you felt playful, as if you wanted to jump in and get involved?

Gratitude

- When have you felt grateful or thankful, deeply appreciative of someone or something?
- What gifts do you treasure most? When has someone gone out of their way to do something good for you?
- When have you simply basked in how lucky you are?
- When do you feel the urge to repay a kindness? What inspires you to get creative about giving back?

Serenity

- When have you felt fully at peace and serene, truly content with where you are?
- When has your life felt so comfortable and so very right?
- When does your body feel completely relaxed, with all your physical tensions melted away?
- When do you feel like simply sitting back and soaking it all in, savoring the goodness you feel, thinking of new ways to get this feeling in your life ore often?

Interest

- When have you felt fully alert and curious, deeply interest in the mysteries or possibilities unfolding before you?
- When have you felt both safe and yet also captivated by something new and unknown?
- When have you felt intensely open and alive, as though your own inner horizons were expanding before your eyes?
- When have you felt an intense pull to explore and learn more, to fully immerse yourself in your new discoveries and take in a feast of new ideas?

Hope

- When have you felt hopeful and optimistic, encouraged by the possibilities of a good outcome?
- When faced with uncertainty, when have you feared the worst but still somehow believed that things could change for the good?
- When have you physically yearned for something better to happen?
- When have you tapped into your inventiveness to work toward a better future?

Pride

- When have you felt most proud of yourself, fully confident in your abilities, and self-assured?
- When have you done something praiseworthy? Achieved something through your own concerted efforts?
- What makes you hold your head high and stand up tall? What makes you want to share your good news with others?
- What draws you to dream big, into visions of what you might accomplish in the future?

Amusement

- What makes you feel silly and fun-loving? What amuses you?
- When have you and others uncovered or kicked up some unforeseen bit of humor?
- What makes you laugh? When have you and others infected one another with irrepressible laughter?
- When do you have the urge to share your joviality with others, to goof off and perhaps in the process build a friendship?

Inspiration

- When have you felt truly inspired, uplifted, or elevated by goodness?
- When have you come across true human excellence or virtue? When have you seen someone perform or act better than you ever imagined was possible?
- When have you felt drawn to simply witness the excellence that was unfolding before your eyes? When has your jaw silently dropped when seeing the best in humankind?
- When have you felt an urge to do your best, so that you too might reach your higher ground?

Awe

- When have you felt intense wonder or amazement, truly in awe of your surroundings?
- When have you felt overwhelmed by greatness, or by beauty on a grand scale?
- When have you been stopped in your tracks, transfixed by grandeur?
- When have you felt part of something much larger than your-self?

Love

- When do you most readily feel the warmth of love well up between you and another? When do you feel close, safe, and secure within your relationship, trusting?
- When does a relationship of yours spark the many other forms of positivity-joy, gratitude, serenity, interest, hope, pride, amusement, inspiration, awe?
- When do you find yourself leaning in toward those you love, affirming their uniqueness and appreciating them in spite of their quirks or idiosyncrasies?
- When do you have the urge just to be with and enjoy the companionship of those you love, to cherish them?

Lastly, might you have learned how to access your best self through your family, community or culture? If so, how might this have been an asset to your family or community, particularly during difficult times?

Session X: The Traumatized-self

Core mediation: Loving-kindness for ourselves

Homework review: Giving and receiving compassion Meditation, RAIN, self-at-best worksheet

Break

Psycho-Education VI: The traumatized self

Workshop: Being with difficult emotions, compassionate letter writing (optional)

Home Practice: Loving-kindness for ourselves, RAIN

Opening Meditation: Loving kindness for ourselves**Instructions (10-20 min):**

- We will be using phrases in meditation that you discovered over the past week. Please review your phrases and decide which ones you will use in this meditation, rather than using the time to find new phrases. (Pause)
- Also, please practice with the phrases in a relaxed manner without worrying if you are doing the meditation right-just letting the words do the work, like slipping into a warm bath and letting the warm water do all the work.
- Now finding a comfortable position, sitting or lying down. Letting your eyes close, fully or partially. Taking a few deep breaths to settle into your body and into the present moment.
- Placing a hand wherever you find it comforting or supportive, as a reminder to bring not only awareness, but loving awareness, to your experience and to yourself.
- Now, feeling your breath move in to your body whenever you notice it most easily. Feeling the gentle rhythm of your breathing. (Pause) And when your attention wanders, returning to the sensation of the gentle rhythm of breathing in your body.
- Now releasing the focus on your breathing-allowing the breath to slip into the background of your awareness-and beginning to offer yourself the words or phrases that are most meaningful to you. If you like, whispering them into your own ear. (Long Pause)
- Nothing to do, nowhere to go. Just bathing yourself with kind words, letting them wash over you and through you-words that you need to hear. (Long Pause)
- Or if it feels right, absorbing the words, letting them fill your being. Allowing the words to resonate in every cell of your body. (Pause)

- And whenever you notice that your mind has wandered, you can refresh your aim by offering yourself soothing or supportive touch, or by just feeling the sensations in your body. Coming home to your own body, and then offering yourself the words. (Pause)
- Finally, releasing the phrases and resting quietly in your own body.
- And then slowly opening your eyes.

Homework Review:

Therapists should review how participants experienced the giving and receiving compassion meditation exercise over the past week. Additionally, they should explore how participants were able to use the behavioral self-compassion within the RAIN skill. Therapists should then review the finding our true self exercise, providing 3-5 min for each individual sharing. The group may be pressed for time in order to accommodate for all participants. As such, therapists may consider shortening the opening meditation if required.

As each participant shares, therapists should continue to reflect positive feelings as appropriate and normalize any resistance that may surface for each participant. In addition, therapists should aim to provide each individual, as best that they can, a sense of being seen, valued and appreciated as a unique individual. Therapists should seek to understand that the expression of each participants feelings, particularly positive ones, communicate what is central to their unique personality strengths and identity. In some instances, the group members sharing may also reflect a part of their identity that is embedded in their cultural background.

Break**Psycho-Education X: The traumatized self**

Primary emotions and the traumatized self: Primary emotions are the emotions we first experience in response to an event. When we experience a trauma or hardship, our primary emotions often center

around fear or other more vulnerable feelings that we would prefer not to feel. These emotional burdens are felt by the traumatized self.

Secondary emotions and protector selves: Secondary emotions are the ones we feel in response to primary emotions. They protect us from feeling undesirable primary emotions. Our protector selves are often organized around secondary emotions.

Secondary emotions occur outside conscious awareness: The transition from primary to secondary emotional responses happens quickly and often outside our conscious awareness.

Maladaptive secondary emotions and trauma/PTSD: Often times our secondary emotions are maladaptive. This means they are inappropriate to the needs of the environment or context in which we are living. There is often a stickiness or stuckness associated with these feelings because they tend to persist over time without solving any of our problems. We keep accessing these feelings because they provide the short-term benefit of avoiding more unpleasant primary emotions.

Healing the traumatized self with self-compassion: Transforming the suffering of our trauma or hardship often requires meeting the emotional burdens of the traumatized-self with self-compassion. A number of trauma focused therapies focus on this. Healing often takes place in a slow gradual process which requires building compassionate resources before working with the traumatized-self.

Workshop: Being with difficult emotions

Instructions (10-20 min):

- Please find a comfortable position, sitting or lying down, close your eyes, and take three relaxing breaths. You should be very comfortable when practicing with difficult emotions.
- Offering yourself soothing or supportive touch for a few moments to remind yourself that you are in the room, and that you, too, are worthy of kindness.

- Let yourself recall a mildly to moderately difficult situation that you are in right now-perhaps a health problem, stress in a relationship, or a work issue. Please reflect carefully on the problem, choosing a situation that generates some stress in your body when you think of it, but doesn't overwhelm you.
- Because we are trying to access the feelings of the traumatized self, try to choose a situation that doesn't trigger the emotions or parts of yourself that are designed to protect you. See if you can feel into the more vulnerable feelings buried underneath.
- Clearly visualize the problem. Who was there? What was said? What happened? Or what might happen?
- **Labeling Emotions**
- As you relive this situation, notice if any emotions arise. (Pause) And if so, seeing if a label for an emotion comes up-a name. Perhaps
 - Fear
 - Sadness
 - Grief
 - Confusion
 - Worry
 - Longing
 - Shame
 - Despair
- If you are unsure what emotion you are feeling, that's okay for now – simply experiencing the emotion is enough.

- Perhaps you are having many emotions, some may be trying to protect you from feeling into the difficulty of your situation.
- With whatever is coming up, see if you can name the strongest emotion associated with the situation.
- Now, repeating the name of the emotion to yourself in a tender, understanding voice, as if you were validating for a friend what they were feeling; “That’s fear” or “That’s grief.”
- **Mindfulness of Emotion in the Body**
- Now expanding your awareness to your body as a whole. (Pause)
- Recalling the difficult situation again (if it has begun to slip out of your mind), naming the strongest emotion you feel, and scanning your body for where you feel it most easily. In your mind’s eye, sweeping your body from head to toe, stopping where you can sense a little tension or discomfort. Just feel what is “feel-able” in your body right now. Nothing more. (Longer pause)
- Now if you can, please choose a single location in your body where the feeling expresses itself most strongly - perhaps a familiar place or a new place – a point of muscle tension in your neck, a painful feeling in your stomach, or an ache in your heart.
- In your mind, inclining gently toward that spot.
- See if you can experience the sensation directly, as if from the inside. If that’s too specific or feels too strong, see if you can just feel the general sense of discomfort.
- **Soften-Soothe-Allow**
- Now, begin softening into that location in your body. Letting the muscles soften and relax, as if in warm water. Softening...softening...softening...remember that you’re not trying to change the feeling – you’re just holding it in a tender way. If you wish, just softening a little around the edges

- If you need, feel free to open your eyes whenever you wish, or let go of the exercise and just feel your breath.
- Now, soothing yourself because of this difficult situation. If you wish, placing a hand over the part of your body that feels uncomfortable, and just feeling the warmth and gentle touch of your hand. Perhaps imagining warmth and kindness flowing through your hand into your body. Maybe even thinking of your body as if it were the body of a beloved child, or some being you care about. Soothing...soothing...soothing.
 - And are there some comforting words that you might need to hear? For instance, you might imagine if you had a friend who was struggling in the same way. What would you say to your friend?
 - Can you offer yourself a similar message?
- Finally, allowing the discomfort to be there. Making room for it, releasing the need to make it go away. Allowing...allowing...allowing.
- And allowing yourself to be just as you are, just like this, if only for this moment.
- Softening...soothing...allowing. Softening...soothing...allowing. Taking some time and going through the three steps on your own. (Pause)
- You may notice the feeling starts to shift or even change location, that's okay. Just stay with it. Softening...soothing...allowing.
- Now letting go of the practice and focusing on your body as a whole. Allowing yourself to feel whatever you feel, to be exactly as you are in this moment.

Home Practice: Loving-kindness for ourselves, RAIN, self-compassion letter (optional)

Therapists should provide participants with the option to complete another self-compassion

letter. This time, however, the group member is asked to write a self-compassion letter to the traumatized self. Obviously, this exercise has the potential of being more emotionally evocative than the previous compassion letter as this may include greater potential sharing about the individual's experience/s of trauma. Therapists should make themselves available for an individual session in order to prepare any group members who wish to take on this additional exercise.

Session XI: Attachment styles

Core meditation: Compassionate friend

Homework review: Loving kindness for Ourselves, RAIN, self-compassion letter (optional)

Break

Psychoeducation XI: Attachment styles

Workshop: Meeting unmet needs

Home Practice: Compassionate friend, RAIN: relationships, identifying protectors in relationships worksheet

Opening Meditation: Compassionate friend**Instructions (10-20 min):**

- Please find a comfortable position, either sitting or lying down. Gently close your eyes. If you like, taking a few deep breaths to settle into your body. Perhaps putting one or two hands over your heart or another soothing place to remind yourself to give yourself loving attention.
- Now imagining yourself in a place that is safe and comfortable, as comfortable as possible. It might be a cozy room with a fireplace, or a peaceful beach with a warm sun and a cool breeze, or a forest glade. It could also be an imaginary place, like floating on clouds...anywhere you feel reasonably peaceful and safe. Letting yourself enjoy being in the place. (Pause)
- Soon you'll receive a visitor, a warm and compassionate presence, a compassionate friend, whom embodies the qualities of wisdom, strength, and unconditional love.
- This being may be a spiritual figure; an ancestor; a wise, compassionate therapist; a person from your past like a grandparent-someone whom you feel truly understands you. Or this being may have no particular form, perhaps more like light, or a warm presence.
- Your compassionate friend cares deeply about you and would like you to be happy and free from unnecessary struggle.
- Please allow an image or being to come to mind. (Pause)
- You have a choice to go out from your safe place and meet your compassionate friend, or invite them in. (Pause) Please take that opportunity now, if you like.
- Placing yourself in just the right position in relation to your compassionate friend. You may have some respectful distance, or you may be very close, whatever feels right.

- Imagining your compassionate friend in as much detail as possible, especially allowing yourself to feel what it's like to be in their presence. There is nothing you need to do except experience the moment. (Pause)
- Your compassionate friend is wise and all-knowing, and understand exactly where you are in your life journey. Your friend might want to tell you something, something that is just what you need to hear right now. Please take a moment and listen carefully to what your compassionate friend might have to say. (Pause) If not words come, that's okay too, just continue to experience the good company. That's a blessing in itself. (Pause)
- And perhaps you would like to say something to your compassionate friend. Your friend listens deeply, and completely understands you. Is there anything you'd like to share? (Pause)
- Your friend may also like to leave you with a gift, an object that might simply appear in your hands, or you can put out your hands and receive one, something that has special meaning to you. (Pause) If something appears, what is it? (Pause)
- Now taking a few more moments to enjoy your friend's presence (Pause) and as you continue to enjoy the good company, allowing yourself to realize that your friend is actually a part of yourself (Pause) All the compassionate feelings, images, and words that you are experiencing flow from your own inner wisdom and compassion.
- Finally, when you're ready, allowing the images to gradually dissolve in your mind's eye, remembering that compassion and wisdom are always within you, especially when you need them the most. You can call on your compassionate friend anytime you wish.
- Settling back into your body and letting yourself savor what just happened, perhaps reflecting on the words you may have heard or the object that may have been given to you. (Pause)

- And finally letting go of the reflection and allowing yourself to feel whatever you feel and to be exactly as you are.
- Gently opening your eyes.

Homework review: Loving kindness for ourselves, RAIN, self-compassion letter (optional)

Therapists should approach the compassion letter in this home practice review similar as before. It's especially, important, however that boundaries and norms around sharing are reestablished before sharing.

Break

Psychoeducation XI: Interpersonal love/compassion and secure attachment

Secure vs. Insecure attachment: The quality of care we receive as children influences how we relate to others later in life. If our emotional and physical needs are met by our early caregivers, we are likely to internalize a capacity for self-love and self-compassion. This internal resource facilitates the development of a secure attachment style. Without the internalization of love/compassion, we are more likely to develop an insecure attachment style. Secure attachment includes a willingness to trust others to meet our needs. An insecure attachment style, however, is just the opposite; it is based in a distrust that others will care for us.

Four components of attachment: There are four key ingredients to building secure attachment.

1. Protection & Safety: This involves keeping the child protected from danger so they can experience life without constant anxiety. As infants, being physically soothed (e.g. warm embrace) communicates being held in safety.

2. Provision: This involves offering of food, clothing, shelter and other materials for survival.

3. Compassion: Compassion is the combination of empathy and love. Empathizing with a child helps them develop awareness of their own feelings and needs. It also allows parents to intuit the

child's needs and tend to them. Love is the emotion that motivates care taking behavior.

4. Socialization: Teaching the child the rules of the world, and how to work within the boundaries of society. Parents can also help children learn mentalization.

Attachment styles

Secure attachment: As a child, the individual received consistent, adequate and continued care in childhood. They have a positive view of themselves and others and trust others easily. They strike a healthy balance between relying on relationships for emotional support and their own autonomy.

Preoccupied: As a child, the individual received inconsistent care. As a result, they develop a preoccupation with another person's capacity to help them. This can lead to being overly dependent or needy in relationships. These individuals, however, still struggle to get their needs met in relationships because they prioritize the needs of others. They often have a negative self-view and esteem others as better than themselves. They can come off as overly sensitive or thin-skinned.

Dismissive: As a child, the individual received consistently inadequate care. As a result, they develop distrust of others. They struggle to use relationships for emotional support and are overly self-sufficient. In relationships, they often have little sense of their deeper emotional needs for support and rarely risk communicating them out of fear of being hurt. They can have an exaggerated self-concept, thinking themselves as superior to others.

Fearful/disorganized attachment style: As a child, the individual received cold, violent or abusive care. This attachment style is more common among survivors of childhood trauma. The child learns that the people they need to depend on the most, are the people most likely to hurt them. As adults, they often find themselves in highly dysfunctional/abusive relationship patterns. The person can erratically alternate between mental states of wanting and not wanting another person. People with disorganized attachment styles often see themselves and others in a negative light.

Emotion regulation and attachment: Instances of secure attachment produce shared positive feelings that occur while we are in the soothing system. Instances of insecure attachment, however, produce and

maintain negative shared feelings associated with the threat system. Anger, contempt and resentment are particularly common negative feelings associated with insecure attachment relationships.

Regulating our emotions through self-compassion allows us to enter the soothing system and become more open to entering securely attached relationships.

Love and secure attachment: The emotion of love plays a critical role in securely attached relationships. Love contains 4 key elements.

- 1) Safety
- 2) Sharing one or more positive emotions with another person
- 3) Synchrony between you and the other person (e.g. eye contact, shared smile, copying body postures, finishing each other's sentence)
- 4) mutual motivation to care for each other

Positivity resonance: Positive emotions resonate, or move between, two or more people. Your own positivity, warmth, and openness evoke-and is simultaneously evoked by-the warmth and openness of the other person. When they resonate, the positive energy sustains itself and can even grow over time.

Mirroring: When positive emotions resonate among people, they are mirrored. People feel the same positive emotions, they have the same body sensations, they think similar thoughts. Their psychological experience is one. Many psychologists call the union of psychological experience *intersubjectivity*.

Prior to beginning the next meditation, facilitators should explain how mindfulness and self-compassion skills can be used to build greater capacities for secure attachment. This includes the following:

- Validating secondary emotions: This includes validating any negative emotions (e.g. anger, contempt, anxiety) that are trying to protect us in the context of a relationship. For this meditation, we will focus on anger as it is common in relationships.

- Identifying primary emotions: This includes identifying and labeling negative emotions that we might be trying to avoid. These are often soft, tender, or sensitive feelings (e.g. fear, sadness, shame).
- Identifying unmet needs: Soft feelings are often caused by unmet needs such as being seen, validated, respected, known, loved.
- Compassionate response: A compassionate response occurs when we let go of the emotions designed to protect us and gift ourselves kindness, love and compassion to the parts of us that may be hurt.

Opening Meditation: Meeting unmet needs

Instructions (20 min):

- Please close your eyes and think of a past relationship that you still feel angry about, a relationship that was mildly to moderately disturbing, but not retraumatizing. It's important for this exercise that you choose a relationship in which your anger no longer serves a purpose and you're ready to let it go. (Pause)
- Please choose a situation that made you angry because of how you were treated, not how a loved one was treated.
- And now choose a specific event in that relationship that still troubles you. You are more likely to stay alert and follow this exercise if you pick an event and a relationship that was not too easy and also not too tough. (Long pause)
- Remember the details as vividly as possible, getting in touch with your anger comes up, and feeling it in your body.
- Know that it's completely natural for you to feel as you do, perhaps saying to yourself:
 - It's okay to feel angry. You were hurt. This is a natural human response.

- You are not alone. Lots of people would have felt just like you in this situation.
- Fully validate the experience of being angry, while trying not to get too caught up in who said or did what to whom.
- There is no need to move on from here, if validating your anger is what you need the most right now. Maybe you have suppressed your anger in the past and need to fully feel it right now. If that is the case, just let the remaining instructions slip into the background and allow the anger to flow through your body, without judgment. It's just energy. If you like, you can offer yourself a supportive gesture, such as placing a fist over your heart (a sign of strength) and covering it with the other hand (a sign of warmth)
- If you are sure that your anger is no longer protecting you, and you want to release it, let's begin to see what's underneath.
- Are there any soft feelings behind the hard feeling of anger?
 - Hurt?
 - Fear?
 - Sadness?
 - Loneliness?
 - Shame?
- If you can identify a soft feeling, try naming it for yourself in a gentle, understanding voice, as if you were supporting a dear friend. "Oh that's sadness" or "That's fear"
- Again, if you need to, you can stay right here. What feels right to you?
- If you feel ready to move on, see if you can release the storyline of this hurt, if only for a while. You may have thoughts of right and wrong. See if you can set those thoughts aside for just a moment, asking yourself

- What basic human need do I have, or did I have at that time, that was not met?
- The need to be:
 - Seen
 - Heard
 - Safe
 - Loved
 - Belong
 - Equal
 - Accorded dignity
 - Valued
 - Special
 - Respected
 - Free
- Again, try naming the need in a gentle, understanding voice. (Pause)
- If you wish to move on, try putting one or two hands on your body in a supportive way if you are not doing that already. The hands that have been reaching outward, longing to receive compassion from others, can become the hands that give you what you need. Even though you wished to receive kindness or understanding from another person, that person was unable to do so for a variety of reasons.
- But you have another resource, your own compassion, and you can start to meet your needs more directly. What did you want to hear? Can you begin to say that to yourself? For example:
 - If you needed to be seen, the compassionate part of you can say to hurt part, I see you
 - If you needed to feel connected, your compassionate part can say, I'm here for you, you belong
 - If you needed to be respected, you can say, may I know my own value
 - If you needed to feel loved, perhaps you can say, I love you, you matter to me or I see you
 - In other words, you can say to yourself, or a part of yourself, right now what you may have been longing to hear from someone else, perhaps for a long, long time (Pause)

- And how did you want to be treated by this other person? Would it make sense to commit to taking action, however small, to care for yourself as you always wanted to be treated by others? *(Pause)*
- If you're having trouble giving yourself compassion for your unmet needs, or if you feel confused and can't identify an unmet need, can you give yourself compassion for that difficulty?
- Now letting go of the exercise, and simply resting in your experience, letting this moment be exactly as it is, and yourself exactly as you are.
- And gently opening your eyes.

Workshop: RAIN in relationships

Therapists should now emphasize how RAIN can be used in relationships. When anger, or other negative feelings are surfacing in relational conflict, we can excuse ourselves from the interaction. They can then go through the steps of RAIN. When they feel they have regulated feelings from the threat system, they can proceed from the caregiving system and reengage with the other person. Therapists may recommend taking a “time-out” of 1-2 minutes before re-engaging.

Home practice: Compassionate friend, RAIN in relationships

Session XII: Gratitude & self-appreciation

Core meditation: Compassion for self and others

Homework review: Reading, Compassionate Friend, RAIN in relationships

Break

Psychoeducation XII: Gratitude & Self-Appreciation

Workshop: What would I like to remember

Closing

Opening Meditation: Compassionate friend**Instructions (20 min):**

- Please sit in a comfortable position, close your eyes, and take three, deep, relaxing breaths.
- Offering yourself soothing or supportive touch and letting yourself feel the gentle touch or the warmth of your hands.
- Then opening to the world of sensation in your body-the pulsations and vibrations-noticing how it feels to have a human body right now. (Pause)
- Beginning to connect with your breathing, feeling the sensation of breathing in and breathing out. (Pause)
- Now beginning to offer yourself some kindness-perhaps just breathing in for yourself again and again, or offering yourself an inner smile with each breath, or letting some words ride on your breathing, such as “May I be happy and free from suffering.” (Pause)
- When you are ready, allowing yourself to be aware of any persons or other living beings that may enter your mind. When someone appears, sending something good to that person-perhaps a relaxing out-breath, an inner smile, or words such as “May you be happy and free from suffering.” (Pause)
- Lingering with this being for a while and offering good wishes for as long as you like, any way you like, and then waiting for the next being to appear in your mind.
- Letting the process be slow and easy, lingering for at least a few breaths with each being.
- Returning anytime to yourself-returning to home base-whenever you need for as long as you like. (Pause)
- And then opening again to whoever appears in your mind

- Finally, letting go of the meditation and allowing yourself to feel exactly what you are feeling and to be just as you are, if only for this one moment

Inquiry

Homework Review: Compassionate friend meditation, RAIN in relationships

Break

Psychoeducation XII: Cultivating happiness

Happiness and the negativity bias: In order to keep us safe, our mind is predisposed to threats. This is called the negativity bias. Because of this, it is critical to intentionally teach our minds to focus on positive things that bring us positive feelings and well-being. This can be accomplished through savoring, gratitude, and self-appreciation.

Savoring and gratitude: Savoring is mindfulness of positive experience and refers to recognizing pleasant experiences, allowing oneself to be drawn into it, lingering with it, and letting it go. Gratitude is appreciating the good things that life has given us. Focusing on what we have puts us in positive emotional states that promote well-being.

Research on gratitude: Research found that regularly using gratitude practices decreased levels of hopelessness in 88% of suicidal patients and increased hopefulness in 94% of them. Gratitude also appears to be a protective factor against developing PTSD. Research found that gratitude reduced the risk of students developing PTSD following a school shooting. (Vieselmeyer, Holguin, & Mezulis, 2017). Among Vietnam veterans, those with higher levels of gratitude showed lower levels of PTSD (Kashdan, Uswatte, & Julian, 2006).

Gratitude, wisdom and relationships: Practicing gratitude may include seeing the complexity of a situation. Gratitude may require us to reframe how we see things, particularly experiences that at first, we saw as negative. Gratitude also produces positive feeling states that help us connect with others, and the world around us.

Healthy self-appreciation: Self appreciation is like savoring, but with our positive qualities. It includes feeling positive emotions about our good qualities, lingering with them, and allowing them to fade. Self-appreciation is not selfish or self-centered, as long as we don't fixate or become preoccupied with our good qualities. Healthy self-appreciation provides self-confidence and a sense of intrinsic self-worth.

Developing self-appreciation: Recognizing our good qualities can be difficult. Practicing common humanity helps this process, as it acknowledges that we all have both good and unique qualities. Gratitude also helps us see that none of our positive qualities were developed alone. Rather, we inherited them from others and others helped us cultivate those strengths over time.

Workshop: What Would I like to Remember?

Instructions (10 min):

- The program is nearly over, and you have learned a lot about trauma, as well as a number of practices for cultivating self-compassion. More importantly, you've shared a process with this group that has likely impacted your journey of recovery in some way. You might feel overwhelmed by the volume of practices, or the experiences you've shared with others in this group. This is also the last day we will be together as a group. Therefore, let's take a moment to reflect on what we would like to take with us moving forward.
- Please take out a pen and paper.
- First write down any practices that were most interesting, enjoyable, or meaningful to you and that you might wish to remember and practice after the program is over. The question is: "What worked for me?" (Long pause)

- Next take a moment and reflect on the work you have done, and try to identify one, or if you like a couple phrases, that captures your progress and spirit of your work. If you'd like, try drawing on a loving-kindness phrase you came up with during program.
- Now, please close your eyes, if you'd like. Then scanning the terrain of your heart, asking yourself the question: "What touched me, moved me, or shifted inside me?" (Long pause)
- As you write, try to consider the other people in the group, the twelve weeks you have spent with them, and the ways they have impacted you over that time. In what moments might they have helped you no longer feel alone? When have you felt their kindness and support, or perhaps even felt inspired by them? (Long pause)
- Try and take a moment, if you can, to feel whatever gratitude you can for this experience, the group or any individuals in it. If you can, allow yourself to appreciate the people around you for their unique gifts and strengths they shared with you through this experience. (Long pause)

Closing: Therapists should now seek to guide a group discussion processing this experience. This should start with the therapist asking for each individual to share what came up during the meditation exercise. This should include an invitation to share what exercises work best as well as the statement of self-kindness they developed for themselves. Therapists should invite each participant to express how they arrived at their particular statement, and what it means to them. Next therapists should ask participants what the most important thing is they believe they will be taking with them from the group experience.

When this line of questioning finishes with each individual, group therapists should open the discussion to the group as a whole and invite other group members to share how they have been impacted by this individual. As this process will include providing interpersonal feedback, it is important that therapists reiterate boundaries surrounding appropriate sharing. Therapists should guide

feedback by asking group members to share any of the following; how they may have identified with similar experiences, what strengths they appreciate about this person, and what contributions to the group they have made they most grateful for. Lastly, therapists should encourage group members to express their hopes for the individual moving forward in their recovery. Therapists should also involve themselves in this discussion, modeling feedback when appropriate. Once this sequence completes with all group members, therapists should conclude this discussion expressing their own personal reaction to the group experience, how it has impacted them and what they uniquely appreciated about the experience.

Chapter V: Discussion

In an attempt to fill a gap in the literature, this dissertation offered a novel SG-MBI adapted for trauma survivors, in particular those with complex or shame-based presentations of PTSD. To meet the unique needs of this population, the proposed program offered an important innovation, that is to ground a mindfulness curriculum in 3rd wave behavioral principles through the use of CFT. This is a significant departure from the MBIs that have defined our literature for much of the last 40 years. Initial programs like MBSR lacked a theoretical model for explaining the transformational dimensions of the practice as it reconceptualized mindfulness primarily as an emotion regulation technique designed to reduce, neutralize or better tolerate distress. This new, westernized version of mindfulness was then placed into 1st and 2nd wave behavioral frameworks in order to meet the clinical needs of persons with depression (i.e. MBCT) and borderline personality disorder (i.e. DBT). These adaptations reflect an understanding of mindfulness as an isolated skill, one that can be manipulated to achieve specific therapeutic aims regardless of whether or not they are philosophically or ethically consistent from the ancient wisdom traditions that produced these practices. As a result, a number of elements of Buddhist psychology, particularly those that articulated transformational processes, were lost while change mechanisms of behavior therapies took hold. As we continue to expand the clinical uses for mindfulness, it appears we are on a similar trajectory with PTSD. Currently, the literature refers to mindfulness as a secondary or “adjunctive” treatment for PTSD designed to facilitate primary or “gold standard” exposure treatments (i.e. PE, TF-CBT, CPT). Placed inside the 1st and 2nd wave behavioral frameworks of these interventions, mindfulness now functions as an accessory to therapies that articulate change as occurring through the extinction of the fear response, modifying negative cognitive schemas and developing a sense of self-efficacy or mastery over the traumatic event.

While these goals may be appropriate for some trauma survivors, individuals with more complex cases of PTSD may not only need a different set of goals, but a fundamentally different philosophical approach to treatment. Previously disregarded as either superfluous, too

spiritual/religious or simply incompatible with contemporary science, the transformational dimensions of mindfulness practice may appear to be useful in these cases. As articulated through the CFT model, mindfulness and self-compassion meditations extend beyond the mere reduction of distress as they facilitate a transition into a different emotion regulation system, one that is characterized by positive affective experiences, which promote human flourishing as well as greater kindness for self and other. As has been previously discussed, such a transformational and relational account of mindfulness may be uniquely helpful in treating issues that extend beyond traditional symptoms of PTSD such as insecure attachment, guilt/shame, feelings of emptiness, and a restricted access to positive feelings.

The importance of transitioning to 3rd wave behavioral principles to ground mindfulness curricula extends beyond clinical need. It demonstrates a significant evolution in our literature, one where there is a more culturally sensitive exchange of information between East and West. In developing CFT, Gilbert (2009) has successfully articulated a transformational account of mindfulness that jives with a number of foundational elements of Buddhist psychology. Equally as important, he has explained these principles through contemporary scientific theories that are widely accepted. This presents an exciting opportunity for mindfulness to finally have a home, one which not only expands the clinical usefulness of the practice, but more fully celebrates the spirit of the wisdom traditions that produced it.

Appendix A

Description

This study researches the effects of a 10 week mindfulness and psycho-educational group for veterans with histories of psychological trauma. All members of this group are veterans seeking services for trauma and like you are patients at this Veteran's Affairs Hospital. You will not be asked to discontinue any other services, but you will be asked prior to joining the group about your treatment history and any other current treatment concerns.

Attendance, participation and homework

It is critical that you regularly attend group sessions and participate to the best of your ability with all group exercises. You will likely not benefit from the group if you do not participate in the group exercises. The focus, topics and skills emphasized in each group often build on the previous group, so failing to attend even one group may limit your ability to participate in the following group. Benefiting from the treatment requires practice outside of the group so it is important that you make your best attempt to complete weekly practice exercises.

Your participation in the interviews before and after the group is critical. These interviews are designed to gather valuable research data designed to improve our services at the hospital. You will be asked to answer a number of questions and fill out questionnaires during these interviews.

Expectations

Each group will begin with a presentation describing the topic/focus of the day. This time will also include a review of practice exercises from the past week. Following each presentation you will be asked to participate in a number of mindfulness/meditation exercises. The group leader, who has training in the use of these techniques, will provide you with guidance as you learn each exercise. You may also be asked to talk about your experience with each exercise. The group will last an hour and a half and it will be offered weekly for a total of 12 weeks.

Potential Risk

While some trauma treatments focus on the exploration of your traumatic, this program is explicitly designed to avoid revisiting your traumatic experiences. While unlikely, meditation/mindfulness exercises can elicit traumatic distress. This program is designed with this in mind and has done its best to adapt the techniques in this program to avoid such distress. If you begin to experience any distress while engaging in any mindfulness exercises in or outside this group please let the group facilitator know.

Research Data

We will collect data from your responses to the questionnaires and interview questions at the beginning and end of the study. All of this data will be kept strictly anonymous and confidential. All data collected is de-identified, meaning it will never be attached to your name or any other Private Health Information (PHI). The data collected would only be used to produce future publications, writings, or presentations, but none of this information could be used to identify you. To conceal your identity, you will be given a

participant ID number at the beginning of the study and all the information you provide will be kept in an anonymous file. Your file will be kept under lock and key and only relevant research personnel and group leaders will have access to your information. Group leaders, will produce clinic notes documenting your participation in each group. This information is kept separate from the research data collected discussed and is included in your medical file as deemed ethical and required by law.

Clarification of Voluntary Participation

You do not have to take part in this research if you do not wish to do so and refusing to participate will not affect your current or future treatment in this program or any other VA hospital. You will still have all the benefits that you would otherwise have in this program and any other VA hospital. You may stop participating in the research at any time that you wish without losing any of your rights as a patient at this program or any other VA hospital. Your treatment at this clinic will not be affected in any way based on any decision to end your participation in the group prematurely.

I have read the foregoing information, or it has been read to me. I Have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this research.

Patient Signature

Date

Mental Health Clinical Signature

Date

Notice Policies and Practices to Protect the Privacy of Your Health Information**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

PHI refers to information in your health record that could identify you.

Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

Use applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that

authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

Child Abuse: If I have reasonable cause to believe that a child has been subject to abuse, I must report this immediately to the New Jersey Division of Youth and Family Services.

Adult and Domestic Abuse: If I reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, I may report the information to the county adult protective services provider.

Health Oversight: If the New Jersey State Board of Psychological Examiners issues a subpoena, I may be compelled to testify before the Board and produce your relevant records and papers.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.

Serious Threat to Health or Safety: If you communicate to me a threat of imminent serious physical violence against a readily identifiable victim or yourself and I believe you intend to carry out that threat, I must take steps to warn and protect. I also must take such steps if I believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps I take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

Worker's Compensation: If you file a worker's compensation claim, I may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau.

When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law: This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for

public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket: You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

Right to Be Notified if There is a Breach of Your Unsecured PHI: You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologists' Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

If I revise my policies and procedures, I will send this information by mail.

V. Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact [Facilitator Name, VA Hospital Contact & Address]. If you believe that your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to [Facilitator Name, VA Hospital Contact & Address].

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on [agreed upon date and time]

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing by mail.

Patient Signature

Date

Mental Health Clinician

Date

Appendix B

PCL for Mindfulness Group Research Study

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then fill in the circle of the response to indicate how much you have been bothered by that problem IN THE PAST MONTH. Please fill in ONE option only for each question.

	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?					
2	Repeated, disturbing dreams of a stressful experience from the past?					
3	Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?					
4	Feeling very upset when something reminded you of a stressful experience from the past?					
5	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?					
6	Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?					

7	Avoid activities or situations because they remind you of a stressful experience from the past?					
8	Trouble remembering important parts of a stressful experience from the past?					
9	Loss of interest in things that you used to enjoy?					
10	Feeling distant or cut off from other people?					
11	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12	Feeling as if your future will somehow be cut short?					
13	Trouble falling or staying asleep?					
14	Feeling irritable or having angry outbursts?					
15	Having difficulty concentrating?					
16	Being “super alert” or watchful on guard?					
17	Feeling jumpy or easily startled?					

PRE / POST (Clinician Circle one)

DATE _____

ID # _____

FACILITATOR NAME _____

OQ-45 For Mindfulness Research Study

PRE / POST (Clinician Circle one)

DATE _____

ID # _____

FACILITATOR NAME _____

Never	Rarely	Sometimes	Frequently	Almost Always
-------	--------	-----------	------------	---------------

INSTRUCTIONS: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and circle the number which best describes your current situation. Circle only one number for each question and do not mark more than one. If you want to change an answer, please "x" it out and circle the correct one.

- | | | | | | |
|---|---|---|---|---|--|
| 0 | 1 | 2 | 3 | 4 | 1. I get along well with others. |
| 0 | 1 | 2 | 3 | 4 | 2. I tire quickly. |
| 0 | 1 | 2 | 3 | 4 | 3. I feel no interest in things. |
| 0 | 1 | 2 | 3 | 4 | 4. I feel stressed at work/school. |
| 0 | 1 | 2 | 3 | 4 | 5. I blame myself for things. |
| 0 | 1 | 2 | 3 | 4 | 6. I feel irritated. |
| 0 | 1 | 2 | 3 | 4 | 7. I feel unhappy in my marriage/significant relationship. |
| 0 | 1 | 2 | 3 | 4 | 8. I have thoughts of ending my life. |
| 0 | 1 | 2 | 3 | 4 | 9. I feel weak. |
| 0 | 1 | 2 | 3 | 4 | 10. I feel fearful. |
| 0 | 1 | 2 | 3 | 4 | 11. After heavy drinking, I need a drink the next morning to get going (If you do not drink, mark "never") |
| 0 | 1 | 2 | 3 | 4 | 12. I find my work/school satisfying. |
| 0 | 1 | 2 | 3 | 4 | 13. I am a happy person. |
| 0 | 1 | 2 | 3 | 4 | 14. I work/study too much. |
| 0 | 1 | 2 | 3 | 4 | 15. I feel worthless. |
| 0 | 1 | 2 | 3 | 4 | 16. I am concerned about family troubles. |

- 0 1 2 3 4 17. I have an unfulfilling sex life.
- 0 1 2 3 4 18. I feel lonely.
- 0 1 2 3 4 19. I have frequent arguments.
- 0 1 2 3 4 20. I feel loved and wanted.
- 0 1 2 3 4 21. I enjoy my spare time.
- 0 1 2 3 4 22. I have difficulty concentrating.
- 0 1 2 3 4 23. I feel hopeless about the future.
- 0 1 2 3 4 24. I like myself.
- 0 1 2 3 4 25. Disturbing thoughts come into my mind that I cannot get rid of.
- 0 1 2 3 4 26. I feel annoyed by people who criticize my drinking (or drug use) (if not applicable, mark "never")
- 0 1 2 3 4 27. I have an upset stomach.
- 0 1 2 3 4 28. I am not working/studying as well as I used to.
- 0 1 2 3 4 29. My heart pounds too much.
- 0 1 2 3 4 30. I have trouble getting along with friends and close acquaintances.
- 0 1 2 3 4 31. I am satisfied with my life.
- 0 1 2 3 4 32. I have trouble at work/school because of my drinking or drug use (if not applicable, mark "never")
- 0 1 2 3 4 33. I feel that something bad is going to happen.
- 0 1 2 3 4 34. I have sore muscles.
- 0 1 2 3 4 35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
- 0 1 2 3 4 36. I feel nervous.
- 0 1 2 3 4 37. I feel my love relationships are full and complete.
- 0 1 2 3 4 38. I feel that I am not doing well at work/school.
- 0 1 2 3 4 39. I have too many disagreements at work/school.
- 0 1 2 3 4 40. I feel something is wrong with my mind.
- 0 1 2 3 4 41. I have trouble falling asleep or staying asleep.
- 0 1 2 3 4 42. I feel blue.
- 0 1 2 3 4 43. I am satisfied with my relationships with others.
- 0 1 2 3 4 44. I feel angry enough at work/school to do something I might regret.
- 0 1 2 3 4 45. I have headaches.

SCS for Mindfulness Group Research Study

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

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

- | | Almost
never
1 | 2 | 3 | 4 | Almost
always
5 |
|---|-------------------------------|----------|----------|----------|--------------------------------|
| _____ 1. I'm disapproving and judgmental about my own flaws and inadequacies. | | | | | |
| _____ 2. When I'm feeling down I tend to obsess and fixate on everything that's wrong. | | | | | |
| _____ 3. When things are going badly for me, I see the difficulties as part of life that everyone goes through. | | | | | |
| _____ 4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world. | | | | | |
| _____ 5. I try to be loving towards myself when I'm feeling emotional pain. | | | | | |
| _____ 6. When I fail at something important to me I become consumed by feelings of inadequacy. | | | | | |
| _____ 7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am. | | | | | |
| _____ 8. When times are really difficult, I tend to be tough on myself. | | | | | |
| _____ 9. When something upsets me I try to keep my emotions in balance. | | | | | |
| _____ 10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people. | | | | | |
| _____ 11. I'm intolerant and impatient towards those aspects of my personality I don't like. | | | | | |
| _____ 12. When I'm going through a very hard time, I give myself the caring and tenderness I need. | | | | | |
| _____ 13. When I'm feeling down, I tend to feel like most other people are probably happier than I am. | | | | | |
| _____ 14. When something painful happens I try to take a balanced view of the situation. | | | | | |
| _____ 15. I try to see my failings as part of the human condition. | | | | | |
| _____ 16. When I see aspects of myself that I don't like, I get down on myself. | | | | | |
| _____ 17. When I fail at something important to me I try to keep things in perspective. | | | | | |

- _____ 18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
- _____ 19. I'm kind to myself when I'm experiencing suffering.
- _____ 20. When something upsets me I get carried away with my feelings.
- _____ 21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
- _____ 22. When I'm feeling down I try to approach my feelings with curiosity and openness.
- _____ 23. I'm tolerant of my own flaws and inadequacies.
- _____ 24. When something painful happens I tend to blow the incident out of proportion.
- _____ 25. When I fail at something that's important to me, I tend to feel alone in my failure.
- _____ 26. I try to be understanding and patient towards those aspects of my personality I don't like.

Interview for Mindfulness Study

Date _____

ID # _____

Facilitator _____

Trauma History:

What was the nature of their trauma? Did this include physical, relational, emotional or sexual abuse of any kind? Was it one discrete event? Or was it a more prolonged course of traumatic experiences?

Psychiatric History:

What symptoms do they currently have that they believe are the result of their trauma history?

How much do they struggle to maintain interest in hobbies, relationships or anything else they used to enjoy prior to the traumatic event? Do they struggle to feel positive feelings associated with these things?

Do they currently struggle with guilt/shame and view themselves more critically as a result of their trauma?

Do they feel like they have much ability to manage negative feelings as they arise in daily life?

What other psychiatric issues have they had that are not related to the trauma?

Have they experienced sexual-abuse, physical abuse, neglect or emotional abuse?

Treatment History:

What services have they previously received for mental health issues? What was helpful and what wasn't?

Needs/wants/expectations:

What do you feel you need most from treatment now?

What, if anything do you hope to get from a mindfulness curriculum? What concerns, if any do you have about joining the group?

Brief Screening Questionnaire:**Name:****Address:****Phone:****Email:****Have you ever met with a mental health care professional at this VA Hospital?****Circle one: Y N Not Sure****Did this mental health care professional or any other in this VA Hospital refer you to this group?****Circle one: Y N Not Sure****Are you currently receiving mental health services from the VA of any kind (e.g. psychotherapy, psychiatric medication management)?****Circle one: Y N Not Sure****Are you currently receiving group treatment or any other treatment using mindfulness or meditation techniques?****Circle one: Y N Not Sure****Are you experiencing significant psychological/emotional difficulties as a result of your participation in the military?****Circle one: Y N Not Sure****Are you experiencing any significant psychological/emotional difficulties as a result of any traumatic experiences outside your participation in the military?****Circle one: Y N Not Sure**

Are you open to a mental health professional from this program contacting you about receiving free mental health services as part of confidential research study?

Circle one: Y N Not Sure

Post-Group Interview for Mindfulness Group Research Study

Part A: Mindfulness Group

Psychiatric History:

What symptoms do they currently have that they believe are the result of their traumatic history?

How much do they struggle to maintain interest in hobbies, relationships or anything else they used to enjoy prior to the traumatic event? Do they struggle to feel positive feelings associated with these things?

Do they currently struggle with guilt/shame and view themselves more critically as a result of their traumatic history?

Do they feel like they have much ability to manage negative feelings as they arise in daily life?

What other psychiatric issues have they had that are not related to the trauma?

Part B: Mindfulness group

What do you think you got out of the group? What specific exercises or modules stuck out as particularly helpful?

Have you noticed any increased enjoyment in hobbies, relationships or any other activities of importance to you? Did you feel any increased positive feeling states associated with these changes?

Have you found it easier to let go of negative thoughts and feelings over the course of treatment?

Did you feel what you learned about the threat response and self-states help you understand your distress better? If so, did this information make it easier to manage negative feelings as they arose in your daily life?

Do you feel the program helped improve your relationship with guilt/shame as well as self-criticism?

What other changes not discussed thus far have you noticed since beginning the group, both positive and negative.

Were you ever in distress or experienced your symptoms getting worse during the course of this treatment and did you believe the program may have contributed to this? Did you consider dropping out as a result?

Would you consider attending future drop-in mindfulness groups here at this setting or another community resource?

Are you more or less interested in pursuing future trauma treatment now that you have completed this program?

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