3

Cultivating Self-Compassion in Trauma Survivors

Christopher K. Germer and Kristin Neff

> Whatever your difficulties—a devastated heart, financial loss, feeling assaulted by the conflicts around you, or a seemingly hopeless illness—you can always remember that you are free in every moment to set the compass of your heart to your highest intentions.
>
> —JACK KORNFIELD (2011)

Most of us treat ourselves rather unkindly when bad things happen to us. Rather than offering ourselves the same sympathy and support we would give to a loved one, we tend to criticize ourselves ("What's the matter with you!"), we hide from others or ourselves in shame ("I'm worthless"), and we get stuck in our heads trying to make sense of what happened to us ("Why me?"). And when *very* bad things happen, we attack ourselves from two directions saying, for example, "I'm bad because I was abused" and "I was abused because I'm bad." If we do not numb ourselves through dissociation, we may try drugs, alcohol, or self-injury. And no matter how much we wish to get out of our heads and get on with our lives, we find ourselves locked in a struggle with intrusive memories, nightmares, and flashbacks.

Such reactions make our suffering persist and even amplify it, but they're not our fault. They're how we're wired (Gilbert, 2009a). When we feel threatened by *external* danger, our survival often depends on our capacity to fight, flee, or freeze. But when we're threatened *internally* by intense emotions such as dread or shame, the fight–flight–freeze response turns into an unholy trinity of self-criticism, self-isolation, and self-absorption.

Fortunately, we also have a hardwired capacity to respond to our own

suffering in a soothing, healing way—*self-compassion*. The Dalai Lama (1995) defines compassion as "an openness to suffering with the wish to relieve it," and *self*-compassion is that same attitude directed toward oneself. This may seem like a tall order to a person suffering from childhood abuse, neglect, or later trauma, but self-compassion has been linked to so many measures of psychological well-being and mental health, including emotional resilience in the face of negative events, that it warrants careful consideration. Additionally, therapists working in any treatment model—cognitive-behavioral, psychodynamic, humanistic, family systems—can help their clients *cultivate* self-compassion. This chapter reviews our current understanding of self-compassion and offers suggestions for helping traumatized clients treat themselves with greater care, understanding, and respect.

What Is Self-Compassion?

Self-compassion is a relatively new psychological construct derived from ancient Buddhist contemplative psychology. Neff (2003), a developmental psychologist and student of Buddhist meditation, first defined the concept and developed the Self-Compassion Scale (SCS) that is used in most research. Self-compassion has three main components: (1) self-kindness, (2) a sense of common humanity, and (3) mindfulness. *Self-kindness* entails being warm and caring toward ourselves when things go wrong in our lives. *Common humanity* recognizes the shared nature of suffering when difficult situations arise, rather than feeling desperately alone. And *mindfulness* refers here to the ability to open to painful experience ("this hurts!") with nonreactive, balanced awareness. Taken together, self-compassion is precisely the opposite of our typical reaction to internal threat—self-criticism, self-isolation, and self-absorption.

Even in ancient times, the Buddha prescribed kindness, a sense of common humanity, and mindfulness as an antidote to unrealistic fear and dread. Our current method of practicing loving-kindness meditation derives from a talk given by the Buddha to a group of monks who were too terrified to live in the forest and practice meditation during the rainy season. An excerpt from that discourse (*metta sutta*) reads as follows:

> Let no one work to undo another.
> Let no one think badly of anyone.
> Either with anger or with violent thoughts,
> One would not wish suffering on others.
> Just as a mother would watch over her
> Son—her one and only son—with her life,
> In just the same way develop a mind

Unbounded toward all living creatures.
Develop a mind of loving kindness
Unbounded toward the entire world:
Above and below and all the way 'round,
With no holding back, no loathing, no foe.
(Olendzki, 2008)[1]

By shifting their mind-set from fear to loving-kindness, the monks were able to return to the forest and meditate until they could resume their wanderings when the monsoon season ended.

In those days, a "mind of loving-kindness, unbounded toward the entire world" included oneself as well. Because everyone is born with the wish to be happy and free from suffering, the practice of cultivating compassion toward others traditionally begins by anchoring our awareness in how we naturally feel toward ourselves. Ironically, in modern times, it is easier to evoke loving states of mind by remembering how we feel toward *others*—special people or other living beings—and then sneak ourselves into that circle of compassion to evoke love for ourselves. Self-compassion feels especially foreign to people suffering from shame and self-criticism as a consequence of trauma, but it is no less essential.

Self-Compassion and Trauma

Three symptom clusters commonly found in posttraumatic stress disorder (PTSD) are (1) arousal, (2) avoidance, and (3) intrusions. Interestingly, these three categories closely correspond to the stress response (fight–flight–freeze) and to our reactions to internal stress (self-criticism, self-isolation, and self-absorption) mentioned earlier (see Figure 3.1). Together they point toward self-compassion as a healthy, alternative response to trauma. Self-kindness can have a calming effect on autonomic hyperarousal, common humanity is an antidote to hiding in shame, and balanced, mindful awareness allows us to disentangle ourselves from intrusive memories and feelings.

Research shows that people who lack self-compassion are likely to have critical mothers, to come from dysfunctional families, and to display insecure attachment patterns (Neff & McGeehee, 2010; Wei, Liao, Ku, & Shaffer, 2011). Childhood emotional abuse is associated with lower self-compassion, and individuals with low self-compassion experience more emotional distress and are more likely to abuse alcohol or make a serious suicide attempt (Tanaka, Wekerle, Schmuck, Paglia-Boak, & the MAP Research Team, 2011; Vettese, Dyer, Li, & Wekerle, 2011). Research also indicates that self-compassion mediates the relationship between childhood maltreatment and later emotional dysregulation, meaning that abused

[1]Reprinted with permission from Andrew Olendzki.

Stress Response	Stress Response Turned Inward	PTSD Symptoms	Self-Compassion
Fight	Self-Criticism	Arousal	Self-Kindness
Flight	Self-Isolation	Avoidance	Common Humanity
Freeze	Self-Absorption	Intrusions	Mindfulness

FIGURE 3.1. Components of the stress response, PTSD, and self-compassion.

individuals with higher levels of self-compassion are better able to cope with upsetting events (Vettese et al., 2011). This relationship holds even after accounting for history of maltreatment, current distress level, or substance abuse, suggesting that self-compassion is an important resiliency factor for those traumatized as children.

In a study of undergraduate students who met criteria for PTSD (mostly with adult traumas such as accidents or deaths), Thompson and Waltz (2008) found that only the "avoidance" cluster of symptoms was negatively correlated with self-compassion. Self-compassion may protect against the development of PTSD by decreasing avoidance of emotional discomfort and facilitating desensitization.

Early trauma, such as childhood neglect or abuse, is more likely to lead to self-criticism and shame because those people did not receive sufficient warmth, soothing, and affection in childhood (Gilbert & Proctor, 2006). Paul Gilbert, the leading force behind compassion-focused therapy (CFT; Gilbert, 2009b, 2010), notes that survivors of childhood maltreatment can readily identify their maladaptive thought patterns ("I'm unlovable") and provide alternative self-statements ("*Some* people love me") but that they do not necessarily find cognitive restructuring emotionally reassuring. Therefore, the goal of CFT is to "warm up the conversation" (Gilbert, personal communication, 2011). In a pilot study of compassionate mind training (CMT; a structured program based on compassion-focused therapy; Gilbert & Irons, 2005), hospital day treatment clients struggling with shame and self-criticism showed significant decreases in depression, self-attacking, shame, and feelings of inferiority (Gilbert & Procter, 2006).

Self-compassion seems to be a mechanism of action in different forms of therapy (Baer, 2010). For example, following short-term psychodynamic treatment, decreases in anxiety, shame, and guilt and increases in the willingness to experience sadness, anger, and closeness were associated with higher self-compassion (Schanche, Stiles, McCollough, Swartberg, & Nielsen, 2011). In the same study, increases in self-compassion predicted fewer psychiatric symptoms and interpersonal problems. Because self-compassion is predicated upon connecting with difficult emotions without self-judgment, it appears to lead to healthier psychological functioning.

Mindfulness and Self-Compassion

In Buddhist psychology, compassion is one of the four *Brahmaviharas*, or wholesome attitudes, that contribute to psychological well-being. The other three are loving-kindness, empathic joy, and equanimity. Whereas loving-kindness is "the wish that all sentient beings be *happy*," "compassion is the wish that all sentient beings be *free from suffering*" (Dalai Lama, 2003, p. 67). Compassion emerges when love meets suffering (and the loving attitude remains!). Suffering is a prerequisite for compassion.

Ironically, when we suffer, we may be the last to know it. Usually we shoot up into our heads and ruminate about the problem ("Why did this happen to me?" "What does this say about me?" "What should I do about it?"), losing touch with the simple experience of emotional pain ("ouch!"). That is where mindfulness comes in—the moment-to-moment opening to emotional pain that can trigger a compassionate response. In this way, mindful awareness is the foundation of compassion.

Mindfulness is "awareness of present experience with acceptance" (Germer, 2005), and self-compassion may be considered the *heart of mindfulness*—the emotional attitude of mindfulness—especially in the context of psychotherapy, in which suffering is the focus of our attention. Self-compassion is a particular kind of acceptance: It is *self*-acceptance in the face of sorrow and pain. Mindfulness typically focuses on acceptance of moment-to-moment *experience,* whereas self-compassion focuses on acceptance of the *experiencer.* Mindfulness says, "Feel your pain with spacious awareness." Self-compassion adds, "*Be kind to yourself* in the midst of the pain." When a traumatized individual is drowning in negative emotions such as dread, confusion, or hopelessness, he or she cannot stay open to emotional pain long enough to investigate and transform it. That is when a trauma therapist needs to help the client to feel safer and more comfortable in the body, perhaps through yoga (Emerson & Hopper, 2011), focused awareness exercises (e.g., sensing one's feet on the floor, feeling the breath; R. D. Siegel, 2010), or self-soothing techniques such as petting the dog, loving-kindness meditation, or compassionate self-talk.

Self-compassion may be considered the heart of mindfulness from a research perspective, as well. For example, the multicomponent definition of self-compassion (which includes mindfulness but also kindness and a sense of common humanity) reflected in the SCS accounts for 10 times more variance than the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003) when predicting depression, anxiety, and overall quality of life (Van Dam, Sheppard, Forsyth, & Earlywine, 2011). Additionally, although mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002) reduces depression through enhancement of mindfulness and self-compassion, self-compassion was the only factor associated with the decoupling of depressive thinking and positive outcome (Kuyken et al., 2010).

A common healing element found in both mindfulness and self-compassion is the gradual shift from resistance to friendship with emotional pain. Mindfulness primarily invites the question "What are you *experiencing*?" and self-compassion asks, "What do you *need?*" It is often difficult for survivors of severe trauma to know what they need or to be kind to themselves, so the therapist can keep those questions in mind until the client can do it for him- or herself.

Mindfulness is a way of inclining toward the sharp points in our lives, slowly and safely, and gradually desensitizing them. Self-compassion adds an explicit element of comfort and warmth to the process of desensitizing. Together, mindfulness and self-compassion allow us to engage difficult thoughts, feelings, and sensations with open eyes and an open heart. When mindfulness is in full bloom, it is naturally full of self-compassion whenever we're suffering.

What Self-Compassion Isn't

There are some common misconceptions about self-compassion that are worth addressing, as they can interfere in the treatment of traumatized individuals. As a platform for healing, traumatized individuals need to reestablish a sense of safety and control over their lives. A common misconception about self-compassion is that it's something weak, similar to submissiveness, complacency, resignation, or passivity. But compassion can actually be an incredibly powerful agent of change (just think of Martin Luther King, Jr., or Mahatma Gandhi). Self-compassion is a force of will, too—goodwill. It's about providing care and support and demanding fair treatment, not feeling inferior or subordinating ourselves to others (McEwan, Gilbert, & Duarte, 2012). When we're self-compassionate, we validate our own suffering and are more likely to respond in a decisive manner. If a victim of domestic violence can assert "This hurts, this *really* hurts! And it's not okay!" and is committed to caring for her- or himself, that person is less likely to make excuses for the perpetrator ("He had a difficult childhood"), engage in denial ("It's not so bad. It will get better"), and place her- or himself in jeopardy again and again.

Many people believe that self-compassion is selfish. Paradoxically, self-compassion is needed to sustain compassion for others:

> For someone to develop genuine compassion towards others, first he or she must have a basis upon which to cultivate compassion, and that basis is the ability to connect to one's own feelings and to care for one's own welfare. . . . Caring for others requires caring for oneself.

To use an airplane analogy, when cabin air pressure drops, we need to put the oxygen mask on ourselves first. This isn't easy for some victims of trauma.

Childhood trauma survivors may also equate self-compassion with self-pity or self-centeredness. They may have been told as children to "get over yourself" when they suffered and complained. It is important to understand that by entering into our emotional pain with kindness, we are *less* likely to wallow in self-pity. The reason is that self-compassion recognizes the shared nature of human suffering and avoids egocentrism. Sometimes only a few minutes is all that is needed to validate our pain and disentangle ourselves from it.

Even individuals with a minimum of trauma in their lives assume that self-criticism has certain benefits (Gilbert, McEwan, Matos, & Rivis, 2011). Without self-criticism, the argument goes, we will never correct our mistakes and improve. But there is an alternative to self-criticism—self-*encouragement*. Like a good coach, we can say to ourselves, "That didn't work, but it was a good try. At least you learned something. Would you like to try a different approach?" rather than "You fool! What's the matter with you!" Self-criticism is closely associated with feelings of shame, anxiety, and depression (Gilbert & Proctor, 2006), as well as underachievement and self-handicapping strategies such as procrastination (Powers, Koestner, & Zuroff, 2007).

Self-compassion is often confused with narcissistic self-love, although research indicates that there is no link between narcissism and self-compassion (Neff, 2003; Neff & Vonk, 2009). Narcissism is a reactive attempt to bolster our self-image when we fail ("I'm smart—it was just a stupid test!"), whereas self-compassion implies openness to failure, the ability to comfort ourselves, to assess the situation, and to work to improve it (Neff, Hseih, & Dejitthirat, 2005; Neff & McGeehee, 2010). Self-compassion is a healthy inner response to misfortune that makes us feel better, yet it is relatively independent of social evaluation—praise and blame, success and failure (Neff & Vonk, 2009). This is particularly important for trauma survivors who suffer from shame and wish to rebuild their shattered sense of self on a solid foundation.

Victims of childhood trauma often do not have *enough* narcissism, feeling that meeting their own basic survival needs is a forbidden indulgence. Anxiety may arise from the looming possibility of breaking an invisible bond with a primary caregiver who thought the child should suffer for his or her misdeeds or bad nature. Self-deprivation becomes "safety behavior" (Gilbert & Proctor, 2006). It is a necessary compromise made by an abused child in order to survive, so the client becomes frightened, viscerally and unconsciously, when he or she breaks the contract. For this reason, sincere efforts by therapists to help abused or neglected clients may be met with resistance. These clients first need to contact their emotional pain, see how it originated through no fault of their own ("you're not to blame!"), and then gradually bring the same tenderness to themselves that they are likely to give to other, vulnerable beings.

For example, Beth's mother was physically abusive during her

childhood and often punished her by withholding food. As an adult, Beth took excellent care of her daughter, despite living on a limited budget, but she deprived herself of food until her hair fell out. She felt that nourishing herself was unnecessary. Beth had internalized the messages of powerful, threatening caregivers ("You get what you deserve, and you don't deserve anything!") to remain connected and survive. In therapy, Beth was determined to reverse her pattern of self-deprivation. Toward that end, Beth started saying loving-kindness phrases for her daughter ("May *you* be safe," "May *you* be healthy"), which flowed easily for her. Then she tucked herself into the circle of compassion, understanding that her daughter could not be well if she weren't ("May *you and I* be safe," "May *you and I* be healthy"), and finally Beth could put her hand over her heart and say to herself ("May *I* be safe," "May *I* be healthy").

Self-Compassion in Trauma Treatment

Self-compassion is a challenge and an opportunity for trauma survivors. It gets to the heart of how we instinctively treat ourselves after catastrophic events, yet it also has the potential to tip the fragile emotional balance between turning toward and turning away from traumatic memories. Self-compassion is a double-edged sword—it cuts through the pain of the present as it opens the pain of the past. Therefore, self-compassion in the broadest clinical sense refers to taking very good care of oneself in both the short run and the long run. In the short run, we want to build the client's capacity to tolerate and transform traumatic memories, and in the long run we want to encourage safe exposure and nonavoidance of the same memories.

"What Do I Need Now?"

The main question of self-compassion training is "What do I need now?" For some clients, simply asking this question can trigger traumatic memories.

I (C. K. G.) had a client, Sarah, who was so severely traumatized as a child that auditory hallucinations ("You are garbage!") arose whenever she asked herself "What do I need?" Earlier on, Sarah reported that stroking her cat made her feel calmer, but when she *noticed* that she felt calmer, she stopped what she was doing. Care and comfort gave way to visceral fear. Intellectually, Sarah knew that she *should* be able to pet her cat, but as a child she had been beaten for so many years by her angry, depressed mother whenever she smiled or felt happy that Sarah became afraid to feel good. During a year of therapy, Sarah courageously increased the length of time that she stroked her cat, starting with a few seconds, allowing herself to experience the comforting sensation of her cat's soft fur while a storm of

threats and recriminations raged on in her mind. Gradually Sarah discovered that she could feel good without consequence. She let the voices in her mind storm on without reacting to them, and she could ask herself what else she needed.

Self-compassion can come in an infinite variety of ways, such as drinking a cup of tea, taking a hot bath, talking with friends, exercising, or listening to music. Such behavioral self-care is often safer than mind-training practices such as meditation. Taking antianxiety medication can also be what a person really needs, although in the long run it can be a form of experiential avoidance. If a trauma client is able to meditate, that will probably increase the likelihood that he or she will meet the challenges of daily life in a self-compassionate way. Self-compassion meditation (see Germer, 2009, and Neff, 2011) cultivates the intention or attitude of goodwill. The ultimate goal is to be in the presence of personal suffering with a sense of safety, so that the pain is felt and the process of healing can begin.

Progress in self-compassion training can be measured by the refinement of intention. We all start out by striving to feel better through self-compassion, then we become disillusioned when we still feel bad at times, and finally we learn to embrace ourselves "not to feel better, but *because* we feel bad." It's a riddle, a koan. When self-compassion training is used to manipulate our moment-to-moment experience, it will inevitably fail, because this is a subtle form of resistance that tends to amplify our symptoms. Try to fight sleeplessness, and we develop insomnia. Struggle with grief, and we become depressed. But when we're kind to ourselves simply *because* we feel bad, as we might be toward a child with the flu, then profound relief can occur as an inevitable side effect. As meditation teacher Rob Nairn put it, our goal is not to become perfect; it is to "become a compassionate mess" (Nairn, 2009)—fully human, struggling and uncertain, with great compassion.

Self-Compassion in the Therapy Relationship

Most emotional suffering is created in relationship and is alleviated in relationship. The healing power of empathic attunement with another person who has a soothing presence cannot be overstated (D. Siegel, 2007, 2010). In therapy, a client's hardwired capacity to subjectively experience the feelings and intentions of a therapist in the client's own body can downregulate a hyperaroused, traumatized brain (Cozolino, 2010; Iacoboni et al., 2005).

Compassion is a resource that allows clients to tolerate and transform suffering, but it's also a personal resource for therapists to help them bear vicarious suffering. Some trauma therapists worry that they might have too much compassion, leading to compassion fatigue. In that case, we're talking about "empathy fatigue" rather than "compassion fatigue" (Klimecki & Singer, 2011; Ricard, 2010). Empathy is an "accurate understanding

of the [client's] world as seen from the inside" (Rogers, 1961, p. 284), whereas compassion has the added element of warmth and goodwill. Compassion is a positive emotion, and it is usually energizing. The ability to feel inner warmth for our clients and for ourselves, even as we listen to horrific reports of abuse and trauma can be a powerful buffer against compassion fatigue.

Of course, every human being has limits, and a compassionate stance means knowing our own limits and the limits of our clients. When do we orient together *toward* suffering and when do we *turn away*, sharing a light reflection, respectfully noting the feelings in the room, reminding the client that he or she is not to blame, anchoring a disturbing feeling in body sensation, musing about the universality of suffering, or simply changing the subject? Psychotherapy is a bait and switch—the client usually comes to therapy with the desire to be free of suffering, yet the healing process occurs by moving together into difficult thoughts, feelings, and sensations in a supportive, responsive, compassionate, transformative relationship.

Over time, compassion seems to rub off on the client in the form of a new relationship to traumatic experience and to him or herself. How does this happen? One explanation is that our clients bring us their emotional suffering and sense of personal brokenness, we "receive" it all with open eyes (mindful awareness) and open hearts (compassion), we "hold" the client and his or her struggle in compassionate awareness throughout the course of therapy, and gradually "lend" back a more benign attitude which can be carried into daily life.

Backdraft

Most clinicians have witnessed how difficult memories resurface when a client feels truly seen, heard, and loved in therapy. A metaphor for this process is "backdraft." Backdraft occurs when a firefighter opens a door with a hot fire behind it. Oxygen rushes in, causing a burst of flame. Similarly, when the door of the heart is opened with compassion, intense pain can sometimes be released. Unconditional love reveals the conditions under which we were unloved in the past (see earlier example of Sarah). Therefore, some clients, especially those with a history of childhood abuse or neglect, are fearful of compassion (Gilbert et al., 2011).

Backdraft is an intrinsic part of healing, but what if a clinet leaves the therapy office and does not have the capacity to contain the feelings that arose? Without the skill of self-compassion, a client may find it necessary to fight off disturbing emotions by self-medicating or other forms of self-harm. A compassion-based therapist needs to have the ability to stop a client from opening too much in session, especially during trauma treatment (Herman, 1997; Rothschild, 2010). Our clients only need to "contact" underlying emotional pain, not necessarily dive into it, and then apply the

emotional resource of comforting and soothing themselves. Soothing and comfort are prerequisites for safe exposure and desensitization.

Self-Compassion Interventions

It's often helpful to teach traumatized clients specific skills for soothing and comforting themselves when they need it the most. Consider the following example of mild to moderate trauma:

Rachel was an introspective, middle-aged woman who discovered to her horror that her husband had been conducting a 2-year affair with a mutual friend at the summer home owned by her family for generations. Overnight her lifelong place of refuge became a trigger for traumatic images of her husband having sex in their bed, enjoying leisurely walks with his lover, and sharing dinner at sunset on their porch. Two years later, Rachel presented in therapy with nightmares and with intrusive thoughts occurring 10–100 times each day; she had not visited the summer home since receiving this shocking news. Visibly shaking in my office after telling her story, Rachel wondered aloud if she would ever recover the safe world she had lost. Rachel was otherwise okay: She had been in individual and couples therapy, she was taking antianxiety medication, her husband was deeply regretful about the affair, they were making love again, and her family relationships were otherwise solid.

After listening to Rachel's story, and not wanting to send her home without support, I (C. K. G.) asked Rachel if she'd like to learn a way to comfort and soothe herself when disturbing images arose in her mind. She agreed, so we practiced the following exercise, the *self-compassion break* (Neff & Germer, 2013; Neff, 2011). I asked Rachel to take a deep breath and slowly say to herself, "*This is a moment of suffering*" followed by "*Suffering is a part of life.*" Rachel was also invited to reflect for a moment on the fact that many people around the globe were also suffering from the trauma of marital betrayal, just like she was.

Then I asked Rachel to put both hands over her heart and (1) feel the warmth of her hands, (2) notice the gentle touch of her hands over her heart, and (3) feel the rhythmic rising and falling of her chest as she breathed. After a minute, I invited Rachel to repeat the following two phrases to herself, or similar ones that might fit better with her: *"May I be kind to myself"; "May I live with ease."* She was told to simply place the words *on* her heart, not expecting them to go right in. Practicing in this way over the following months, Rachel discovered that her intrusive thoughts, nightmares, and anxiety gradually diminished.

The three components of the self-compassion break correspond to the three elements of self-compassion mentioned earlier: (1) mindfulness ("*This is a moment of suffering*"), (2) common humanity ("*Suffering is a part*

of life"), and (3) self-kindness ("*May I be kind to myself*"). Each element allowed Rachel to let go of her ruminations and soften into her distress, gradually desensitizing it.

Of course, no single practice works for everyone. For example, a client with severe childhood trauma, Elissa, discovered that she felt more and more hatred toward her abusive father as she slowly moved her hands toward her heart. The "backdraft" was too intense for her. Elissa modified the exercise to simply noticing her breathing in the chest region, then placing her hand on her chest to feel her breathing, and finally offering goodwill to herself because of the pain she carried in her heart. Some people find they are better able to soothe themselves by cupping their faces in their hands, or by placing a hand on the abdomen. In self-compassion training, we try to stay on the side of comfort and soothing—building resources—until the client feels safe and strong enough to open to his or her trauma.

Some therapists feel uneasy about teaching self-compassion exercises to clients during therapy. For example, some trauma clients just want a witness to hear their story and may not be ready to practice self-compassion at home. Other clients feel ashamed that they have difficulty evoking self-compassion and may withdraw from therapy. It is important that therapists working within the mindfulness- and compassion-based paradigm have personal experience of the transformational process before teaching it, especially to navigate the paradox of suffering in order to alleviate it (see Briere, Chapter 1, this volume) and knowing how to modify the practices for clients, as needed. Personal practice is especially critical when working with trauma clients for whom the stakes of opening to emotional pain are higher than usual.

Self-Compassion Training Programs

Some trauma clients may be candidates for structured programs that directly or indirectly teach self-compassion, such as mindfulness training (Briere, 2012). Research has demonstrated that the mindfulness-based stress reduction program (MBSR; Kabat-Zinn, 1991) significantly increases self-compassion (Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007; see also Kearney, Chapter 17, this volume), as does the mindfulness-based cognitive therapy program for treating recurrent depression (MBCT; Kuyken et al., 2010; see also Semple & Madni, Chapter 18, this volume). People who practice mindfulness meditation are more self-compassionate than those who are less experienced (Lykins & Baer, 2009; Neff, 2003; Orzech, Shapiro, Brown, & McKay, 2009), and self-compassion appears to be a "crucial attitudinal factor" in the relationship between mindfulness training and positive mental health (Hollis-Walker & Colosimo, 2011).

There are a number of training programs that are specifically designed to cultivate compassion: the compassion-cultivation training program (Rosenberg, 2011), cognitive-based compassion training (see Williams & Barnhofer, Chapter 6, this volume), and nonviolent communication (NVC; Rosenberg, 2003). Programs that focus on cultivating *self*-compassion are mindful self-compassion training (MSC; Germer & Neff, 2013; Neff & Germer, 2013; see also *www.CenterForMSC.org*) and compassionate mind training (CMT; Gilbert & Proctor, 2006; see also *www.Compassionate-Mind.co.uk*). The latter two programs have different origins— MSC developed out of mindfulness, and CMT arose primarily out of evolutionary psychology—but there is some overlap among the exercises and meditation practices of the two programs.

The MSC program has structural elements similar to Kabat-Zinn's MBSR course (eight sessions plus a retreat day; formal and informal meditation). In a randomized controlled study of the MSC program, results indicated that participation in the course significantly increased self-compassion, mindfulness, compassion for others, and life satisfaction while significantly decreasing depression, anxiety, stress, and emotional avoidance. The degree to which participants' self-compassion level increased was significantly linked to how much informal and formal self-compassion practice they did over the course of the program (Neff & Germer, 2013).

Finally, while reading through the subsequent chapters in this book, you may discover elements of self-compassion, explicit or implicit, in each approach. For example, the dialectical behavior therapy (DBT) program was specifically designed to "radically accept" clients who have difficulty with emotion regulation and trauma histories (see Fiorillo & Fruzzetti, Chapter 5, this volume). Acceptance and commitment therapy (ACT), which encourages an accepting, compassionate response to our own pain, has been successfully applied to trauma treatment (see Engle & Follette, Chapter 4, this volume), and internal family systems (IFS) is an emerging treatment model based on compassion for the many different parts of ourselves which have suffered, sometimes intensely, in our lifetimes (see Schwartz & Sparks, Chapter 8, this volume). Each program offers an array of interventions that enhance self-compassion.

In conclusion, self-compassion provides a promising vision for trauma treatment derived from the ancient wisdom of Buddhist psychology. Self-compassion is strongly linked to emotional well-being, is an important mechanism of change in psychotherapy, and touches the core of trauma-related symptomatology. Our modern, scientific understanding of self-compassion opens the possibility of developing uniquely effective self-compassion-based treatments designed specifically for survivors of childhood and adult trauma.

References

Baer, R. (2010). Self-compassion as a mechanism of change in mindfulness and acceptance-based treatments In R. Baer (Ed.), *Assessing mindfulness and acceptance processes in clients: Illuminating the theory and practice of change* (pp. 135–153). Oakland, CA: Context Press/New Harbinger.

Briere, J. (2012). Working with trauma: Mindfulness and compassion. In C. K. Germer & R. D. Siegel (Eds.), *Wisdom and compassion in psychotherapy: Deepening mindfulness in clinical practice* (pp. 265–279). New York: Guilford Press.

Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology, 84,* 822–848.

Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain.* New York: Norton.

Dalai Lama. (1995). *The power of compassion.* New Delhi, India: HarperCollins.

Dalai Lama. (2003). *Lighting the path: The Dalai Lama teaches on wisdom and compassion.* South Melbourne, Australia: Thomas C. Lothian.

Dalai Lama. (2012). Training the mind: Verse 7. Retrieved March 3, 2012, from *www.dalailama.com/teachings/training-the-mind/verse-7.*

Emerson, D., & Hopper, E. (2011). *Overcoming trauma through yoga: Reclaiming your body.* Berkeley, CA: North Atlantic Books.

Germer, C. K. (2005). Mindfulness: What is it? What does it matter? In C. K. Germer, R. D. Siegel, & P. F. Fulton (Eds.), *Mindfulness and psychotherapy* (pp. 3–27). New York: Guilford Press.

Germer, C. K. (2009). *The mindful path to self-compassion.* New York: Guilford Press.

Germer, C. K., & Neff, K. D. (2013). Self-compassion in clinical practice. *Journal of Clinical Psychology*, *69*(8), 856–867.

Gilbert, P. (2009a). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*, 199–208.

Gilbert, P. (2009b). *The compassionate mind: A new approach to life's challenges.* Oakland, CA: New Harbinger Press.

Gilbert, P. (2010). *Compassion focused therapy.* London: Routledge.

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). London: Routledge.

Gilbert, P., McEwan, K., Matos, M., & Rivis, A. (2011) Fears of compassion: Development of three self-report measures. *Psychology and Psychotherapy: Theory, Research, and Practice*, *84*, 239–255.

Gilbert, P., & Proctor, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology and Psychotherapy*, *13*, 353–379.

Herman, J. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror.* New York: Basic Books.

Hollis-Walker, L., & Colosimo, K. (2011). Mindfulness, self-compassion, and happiness in non-meditators: A theoretical and empirical examination. *Personality and Individual Differences*, *50*(2), 222–227.

Iacoboni, M., Molnar-Szakacs, I., Gallese, V., Buccino, G., Mazziotta, J., & Rizzolatti, G. (2005). Grasping the intentions of others with one's own mirror neuron system. *PloS Biology*, *3*(3), e79.

Kabat-Zinn, J. (1991). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Dell.

Klimecki, O., & Singer, T. (2011). Empathic distress fatigue rather than compassion fatigue?: Integrating findings from empathy research in psychology and social neuroscience. In B. Oakley, A. Knafo, G. Madhavan, & D. S. Wilson (Eds.), *Pathological altruism* (pp. 368–384). New York: Oxford University Press.

Kornfield, J. (2011). Set the compass of your heart. *Tricycle*. Retrieved March 14, 2012, from *www.tricycle.com/brief-teachings/set-compass-your-heart*.

Kuyken, W., Watkins, E., Holden, E., White, K., Taylor, R., et al. (2010). How does mindfulness-based cognitive therapy work? *Behaviour Research and Therapy, 48,* 1105–1112.

Lykins, E., & Baer, R. (2009). Psychological functioning in a sample of long-term practitioners of mindfulness meditation. *Journal of Cognitive Psychotherapy: An International Quarterly, 23,* 226–241.

McEwan, K., Gilbert, P., & Duarte, J. (2012.). An exploration of competitiveness and caring in relation to psychopathology. *British Journal of Clinical Psychology, 51*(1), 19–36.

Nairn, R. (2009, September). *Foundation training in compassion, Kagyu*. Lecture presented as part of Foundation Training in Compassion, Kagyu Samye Ling Monastery, Dumfriesshire, Scotland.

Neff, K. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity*, *2*, 223–250.

Neff, K. (2011). *Self-compassion: Stop beating yourself up and leave insecurity behind*. New York: Morrow.

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self-compassion program. *Journal of Clinical Psychology*, *69*(1), 28–44.

Neff, K. D., Hseih, Y., & Dejitthirat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, *4*, 263–287.

Neff, K. D., & McGeehee, P. (2010). Self-compassion and psychological resilience among adolescents and young adults. *Self and Identity*, *9*, 225–240.

Neff, K. D., & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. *Journal of Personality*, *77*, 23–50.

Olendzki, A. (Trans.). (2008). *Metta Sutta, Sutta Nipata* 145–151. Barre, MA: Barre Center for Buddhist Studies.

Orzech, K., Shapiro, S., Brown, K., & McKay, M. (2009). Intensive mindfulness training-related changes in cognitive and emotional experience. *Journal of Positive Psychology*, *4*, 212–222.

Powers, T. A., Koestner, R., & Zuroff, D. C. (2007). Self-criticism, goal motivation, and goal progress. *Journal of Social and Clinical Psychology*, *26*, 826–840.

Ricard, M. (2010). *The difference between empathy and compassion*. Retrieved October 15, 2010, from *www.huffingtonpost.com/matthieu-ricard/could-compassion-meditati_b_751566.html*.

Rogers, C. (1961). *On becoming a person*. New York: Houghton Mifflin.

Rosenberg, E. (2011, July 21). *Compassion Cultivation Training Program (CCT)*. Paper presented at the conference on "How to Train Compassion," Max-Planck Institute for Human and Cognitive Brain Sciences, Berlin, Germany.

Rosenberg, M. (2003). *Nonviolent communication: A language of life*. Encinitas, CA: Puddle Dancer Press.

Rothschild, B. (2010). *8 keys to safe trauma recovery: Take-charge strategies to empower your life*. New York: Norton.

Schanche, E., Stiles, T., McCollough, L., Swartberg, M., & Nielsen, G. (2011). The relationship between activating affects, inhibitory affects, and self-compassion in patients with cluster C personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, *48*(3), 293–303.

Segal, Z., Williams, J., & Teasdale, J. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: Results from a randomized trial. *International Journal of Stress Management*, *12*, 164–176.

Shapiro, S. L., Brown, K. W., & Biegel, G. M (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology*, *1*(2), 105–115.

Siegel, D. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. New York: Norton.

Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. New York: Norton.

Siegel, R. D. (2010). *The mindfulness solution: Everyday practices for everyday problems*. New York: Guilford Press.

Tanaka, M., Wekerle, C., Schmuck, M., Paglia-Boak, A., & the MAP Research Team. (2011). The linkages among childhood maltreatment, adolescent mental health, and self-compassion in child welfare adolescents. *Child Abuse and Neglect*, *35*, 887–898.

Thompson, B. L., & Waltz, J. (2008). Self-compassion and PTSD symptom severity. *Journal of Traumatic Stress*, *21*, 556–558.

Van Dam, T., Sheppard, S., Forsyth, J., & Earleywine, M. (2011). Self-compassion is a better predictor than mindfulness of symptom severity and quality of life in mixed anxiety and depression. *Journal of Anxiety Disorders*, *25*, 123–130.

Vettese, L., Dyer, C., Li, W., & Wekerle, C. (2011). Does self-compassion mitigate the association between childhood maltreatment and later regulation difficulties? A preliminary investigation. *International Journal of Mental Health and Addiction*, *9*(5), 480–491.

Wei, M., Liao, K., Ku, T., & Shaffer, P. A. (2011). Attachment, self-compassion, empathy, and subjective well-being among college students and community adults. *Journal of Personality*, *79*, 191–221.