



ELSEVIER

Contents lists available at ScienceDirect

Journal of Contextual Behavioral Science

journal homepage: www.elsevier.com/locate/jcbs

Brief Empirical Reports

Fear of self-compassion and psychological inflexibility interact to predict PTSD symptom severity



Lynsey R. Miron*, Andrew M. Sherrill, Holly K. Orcutt

Department of Psychology, Northern Illinois University, DeKalb, IL, USA

ARTICLE INFO

Article history:

Received 31 May 2014

Received in revised form

8 October 2014

Accepted 27 October 2014

Keywords:

Self-compassion

Experiential avoidance

Psychological flexibility

Posttraumatic stress

Contextual behavioral science

ABSTRACT

Evidence suggests that increasing self-compassion is a worthwhile therapeutic target and may be adaptive in the context of trauma recovery. Recently, researchers have noted that particular individuals respond to self-compassion with fear and resistance, a phenomenon known as fear of self-compassion. We argue that fear of self-compassion may increase post-trauma suffering, particularly for individuals who routinely attempt to control difficult private experiences. The present study investigated relations among fear of self-compassion, psychological inflexibility, and posttraumatic stress symptoms (PTSS) in a sample of trauma-exposed undergraduates ($N=201$). Hierarchical regression analyses revealed a significant interaction between fear of self-compassion and psychological inflexibility ($B=1.22, p<.05$), controlling for negative affect. Follow-up simple effects indicated that psychological inflexibility moderated the relationship between fear of self-compassion and PTSS, such that there was a significant positive association between fear of self-compassion and PTSS among participants with higher psychological inflexibility ($B=3.81, p<.01$), but not for those with lower psychological inflexibility. The prospect of fear of self-compassion as a contextual-behavioral treatment target is discussed.

© 2014 Association for Contextual Behavioral Science. Published by Elsevier Inc. All rights reserved.

1. Introduction

Lack of self-compassion has been regarded as a particularly toxic and pathological process (Hayes, 2008). Indeed, a growing evidence base suggests that self-compassion, a method of kindly and non-judgmentally relating to oneself and one's emotional experiences (Neff, 2003), is a worthwhile therapeutic target (Germer & Neff, 2013; MacBeth & Gumley, 2012) and may be protective against pathological responses to trauma (i.e., PTSD; Kearney et al., 2013; Thompson & Waltz, 2008). Although an implicit foundation of compassion underlies contextual behavioral therapies such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999), only recently have treatment protocols explicitly included self-compassion components (e.g., Forsyth & Eifert, 2008). However, a complete contextual behavioral conceptualization of self-compassion should take into account that particular individuals respond to self-compassion with fear and resistance, a phenomenon known as fear of self-compassion (Gilbert, McEwan, Matos, & Rivis, 2011). We argue that fear of self-compassion may impede values-based action and

increase suffering, particularly when individuals are psychologically inflexible.

Fear of self-compassion differs from the absence of self-compassion, and instead describes the active resistance of extending compassion toward oneself (Gilbert et al., 2011; Kelly, Carter, Zuroff, & Borairi, 2013). Greater baseline fear of self-compassion has been shown to result in poor treatment outcomes (Kelly et al., 2013), and emerging research suggests that individuals with heightened fear of self-compassion are both threatened by and avoidant of self-compassionate aims (Gilbert et al., 2011). In this way, fear of self-compassion appears related to the ultimate therapeutic target of ACT, psychological inflexibility (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

Psychological inflexibility (or experiential avoidance) describes the reduced likelihood of engaging in values-based actions due to rigid rule following and attempts to control difficult internal experiences, such as thoughts, emotions, and physical sensations (Hayes et al., 2006). Psychological inflexibility is associated with lower quality of life and reduced well-being across pathologies (Fledderus, Bohlmeijer, & Pieterse, 2010; Kashdan, Barrios, Forsyth, & Steger, 2006) and has been shown to be implicated in the onset and maintenance of posttrauma distress (e.g., Marx & Sloan, 2005). ACT functions to shape psychological flexibility, or the ability to fully contact private experiences in the present moment in order

* Correspondence to: Department of Psychology, Northern Illinois University, Psychology-Computer Science Building, Room 400, DeKalb, IL 60115, USA.

E-mail address: lmiron1@niu.edu (L.R. Miron).

to pursue values-based actions (Hayes et al., 1999). The clinical utility of ACT's psychological flexibility model in treating PTSD is supported by several case studies representing diverse index traumas and treatment settings (Batten & Hayes, 2005; Burrows, 2013; Codd, Twohig, Crosby, & Enno, 2011; Orsillo & Batten, 2005; Thompson, Luoma, & LeJeune, 2013; Twohig, 2009), as well as an ongoing randomized controlled trial (Lang et al., 2012).

Typically, psychological inflexibility is used to describe maladaptive responses to experiences most people would find unpleasant (e.g., anxiety). However, individuals may also attempt to avoid or control experiences normatively viewed as pleasant (e.g., self-kindness when one "should" be critical; Bond et al., 2011). Thus, while psychological inflexibility affords substantial scope by encompassing a broad response class, it may have limited precision in targeting more narrow change mechanisms, such as avoiding what might be normatively considered positive experiences.

Fear of self-compassion may have clinical utility by promoting a more precise analysis of the treatment-interfering process of resisting self-compassion. When an individual is psychologically flexible, fear of self-compassion may not necessarily be a barrier to taking pragmatic action towards values. For example, fear of self-compassion may reflect one's refusal to lower standards or accept failure, which may be consistent with flexible, values-driven behavior. However, most individuals, particularly those seeking treatment, are not able to remain perpetually flexible. To the extent that a person is unable to act flexibly, fear of self-compassion may increase vulnerability for pathology by obstructing compassionate gestures toward oneself that may otherwise soothe suffering. During instances of suffering, self-compassion may function as a values-consistent behavior that brings awareness to the present moment, which can help the individual contact the environment and continue acting on values. Conversely, fear of self-compassion may increase distance from meaningful living and exacerbate suffering. Thus, the combination of fear of self-compassion and psychological inflexibility may increase distress.

The present study investigates relations among self-reported fear of self-compassion, psychological inflexibility, and posttraumatic stress symptoms (PTSS) in a sample of trauma-exposed university students. Following our conceptualization of fear of self-compassion as a vulnerability factor to the extent that an individual is psychologically inflexible, we predicted that high levels of fear of self-compassion would predict increased PTSS when psychological inflexibility is also high. Further, to increase the likelihood that results reflect relations among variables of interest, the present study controlled for the influence of a potentially confounding third variable, negative affect.

2. Method

2.1. Participants and procedure

Data were obtained from 263 undergraduate students enrolled in Introductory Psychology at a large Midwestern university. Recruitment, informed consent, and questionnaires were completed via a secure online survey program. Participants received course credit for their participation. Inclusion criteria included 18+ years of age, fluency in English, and at least one prior Criterion A traumatic event (APA, 2000). A total of 205 students endorsed at least one lifetime traumatic event (78.0% of the total participant pool; 64.9% female) and were deemed eligible. The mean age of participants was 20.3 years old ($SD=1.69$). Sixty-one percent of participants identified as White, 21.5% as Black, 14.7% as a different race, and 2.9% chose not to respond. Additionally, 15.6% of participants endorsed a separate item self-identifying as Hispanic/Latino/a.

2.2. Measures

2.2.1. Demographics

Age, sex, and race/ethnicity were evaluated as potential covariates in planned analyses. Race and ethnicity were collapsed into a single dummy coded variable (coded as Non-Hispanic White [55.1%] versus all others [43.9%]).

2.2.2. Positive and negative affect schedule (PANAS)

Items from the PANAS (Watson, Clark, & Tellegen, 1988; see Appendix G) were used to assess negative affect. Respondents rate the extent they have experienced 20 mood adjectives within the last week, using a 5-point Likert scale (1 = *Very slightly or not at all*; 5 = *Extremely*). The PANAS has demonstrated excellent psychometric properties (Watson et al., 1988). Mean negative affect scores were calculated and the internal consistency estimate for the present sample was good ($\alpha=.84$).

2.2.3. Traumatic life events questionnaire (TLEQ)

The TLEQ (Kubany, Haynes, et al., 2000) is a brief measure of trauma exposure with good psychometric properties (Kubany, Haynes, et al., 2000). Respondents indicate the frequency of experiencing 22 potentially traumatic events. The TLEQ was used as an initial trauma history screen; participants reporting at least one Criterion A traumatic event (APA, 2000) provided additional information on PTSS.

2.2.4. PTSD screening and diagnostic scale (PSDS)

The PSDS (Kubany, Leisen, Kaplan, & Kelly, 2000) is a self-report measure of PTSS according to DSM-IV-TR criteria (APA, 2000) with strong psychometric properties (Kubany, Leisen, et al., 2000). Items are rated from 0 = *Absent or did not occur* to 4 = *Present to an extreme or severe degree*. Total scores of 18 or higher represent clinically-significant levels of PTSS (Kubany, Leisen, et al., 2000). PSDS mean scores were calculated and internal consistency in the present sample was good ($\alpha=.94$).

2.2.5. Acceptance and action questionnaire-II (AAQ-II)

The AAQ-II (Bond et al., 2011) is a 7-item, single-factor self-report measure of psychological inflexibility. Items are rated from 1 = *Never true* to 7 = *Always true*, with higher scores indicating greater inflexibility. The AAQ-II has demonstrated strong internal consistency, test-retest reliability, and validity (Bond et al., 2011). AAQ-II mean scores were calculated and internal consistency in the present sample was good ($\alpha=.92$).

2.2.6. *Fear of compassion scales-self-compassion (FCS-SC)*. The FCS-SC (Gilbert et al., 2011) is a 15-item, single-factor measure of fear of self-compassion (e.g., "I worry that if I start to develop compassion for myself I will become dependent on it"). Respondents rate how much they agree with each statement (0 = *Don't agree at all* to 4 = *Completely agree*). The FCS-SC has demonstrated good psychometric properties (Gilbert et al., 2011). Mean scores were calculated and internal consistency in the present sample was good ($\alpha=.96$).

3. Results

Data were screened for quality and distribution. Negative affect, fear of self-compassion, psychological inflexibility, and PTSS were positively skewed, though not outside of the recommended range of skewness and kurtosis given a sample size greater than 200 (range = -2 to 2). Variable ranges and leverage indices were screened and no significant outliers were detected. Data found to

Table 1
Descriptive statistics and correlations for potential covariates and main study variables ($N=201$).

	1	2	3	4	5	6	7
1. Age (years)	–						
2. Sex (1=female, 2=male)	.19**	–					
3. Race/Ethnicity (0=other/1=non-Hispanic White)	.16*	.14	–				
4. Negative affect	–.08	–.16*	–.08	.84			
5. Psychological inflexibility	.01	–.18*	–.11	.63***	.92		
6. Fear of self-compassion	.01	.08	.11	.37***	.47***	.96	
7. Posttraumatic stress symptoms	.03	–.07	–.11	.42***	.52***	.38***	.94
<i>M</i>	20.26	1.34	.57	2.12	2.81	1.0	12.01
<i>SD</i>	1.64	.47	.50	.69	1.38	.95	13.33
<i>Minimum</i>	19.00	1	0	1	1.00	0	0
<i>Maximum</i>	28.00	2	1	5	6.43	3.73	62.00

Note. Coefficient alphas (where appropriate) are on the diagonal.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Table 2
Regression analysis with PTSD symptoms as the outcome variable ($N=201$).

Predictor	PTSD symptoms				
	ΔR^2	Step 1 <i>B</i>	Step 1 <i>t</i>	Step 2 <i>B</i>	Step 2 <i>t</i>
Step 1	.27***				
Sex		.86	.48	.83	.46
NA		2.60	1.71	2.54	1.68
PIF		3.10***	3.72	2.83***	3.38
FOSC		2.50*	2.49	2.12*	2.09
Step 2	.02*				
PIF \times FOSC				1.22*	2.03

Note. NA=negative affect; PIF=psychological inflexibility; FOSC=fear of self-compassion. Sex coded as 1=female 2=male.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

be missing in a systematic manner (1.95%) were eliminated from subsequent analyses, leaving a final sample of 201 participants.

Descriptive statistics are presented in Table 1. Negative affect, fear of self-compassion, psychological inflexibility, and PTSS were significantly positively correlated. Participant sex was significantly associated with psychological inflexibility; women reported higher rates of psychological inflexibility ($M=3.00$, $SD=11.76$) than men ($M=2.36$, $SD=1.16$). Both participant sex and negative affect were included as covariates in subsequent analyses.

A hierarchical multiple regression analysis was conducted to examine psychological inflexibility as a moderator of the relationship between fear of self-compassion and PTSS. Predictor variables were mean centered and an interaction term was computed by multiplying the centered predictors (Aiken & West, 1991). In the first step of the model, participant sex, negative affect, fear of self-compassion, and psychological inflexibility served as predictor variables and PTSS served as the outcome. In the second step, an interaction term comprised of fear of self-compassion and psychological inflexibility was entered into the model as a predictor.

Results from the hierarchical multiple regression analysis are provided in Table 2. There was a significant main effect of psychological inflexibility ($B=3.10$, $p < .001$) and fear of self-compassion ($B=2.50$, $p < .05$) on PTSS, controlling for participant sex and negative affect. In the second step of the model, the interaction term predicted significant variance in PTSS ($B=1.22$, $p < .05$; $\Delta R^2=.02$, $p < .05$). The effect size of this interaction was small in magnitude (Cohen's $f^2=.02$; Aiken & West, 1991). Following Aiken and West's (1991) recommendation for interpreting

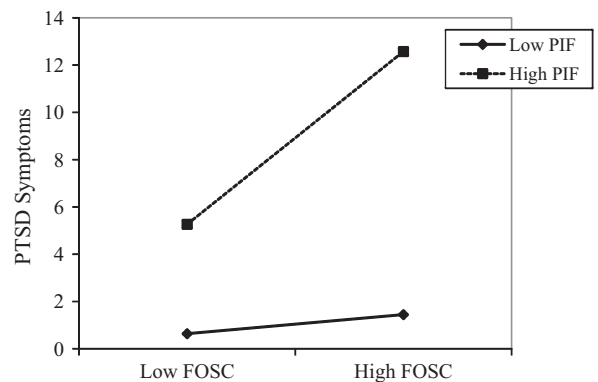


Fig. 1. Interaction effect (psychological inflexibility [PIF] \times fear of self-compassion [FOSC]) predicting PTSD symptoms, ($B=1.24$, $p < .05$). Simple slopes analysis revealed a significant positive association between FOSC and PTSD symptoms among participants with relatively higher PIF ($B=4.01$, $p < .01$). There was not a significant association between FOSC and PTSD symptoms for those with relatively lower PIF. $N=201$.

significant interaction effects, follow-up simple slopes analysis was conducted. Two simple regression equations were constructed in which the relationship between fear of self-compassion and PTSS was tested at both high (+1 SD) and low (–1SD) levels of psychological inflexibility. Analyses revealed a significant positive association between fear of self-compassion and PTSS for participants who reported high psychological inflexibility ($B=3.81$, $p < .01$), but there was no significant association between fear of self-compassion and PTSS for participants who reported low psychological inflexibility ($B=.43$, $p=.77$). Results indicate that individuals reporting high fear of self-compassion were especially likely to report elevated PTSS when concurrently reporting high levels of psychological inflexibility (see Fig. 1).

4. Discussion

Developing a self-compassionate perspective has been regarded as a valuable treatment target (MacBeth & Gumley, 2012), and may be adaptive in the context of trauma exposure (Kearney et al., 2013; Thompson & Waltz, 2008). However, emerging literature suggests that particular individuals respond to self-compassion with fear and resistance, which may contribute to adverse outcomes (Gilbert et al., 2011; Kelly, Carter, Zuroff, & Borairi, 2013). The present study sought to examine the influence of fear of self-compassion and psychological inflexibility on PTSS

in a sample with diverse forms of trauma exposure. As predicted, psychological inflexibility was a significant moderator of the relation between fear of self-compassion and PTSS, controlling for the influence of negative affect. Specifically, higher fear of self-compassion was only predictive of elevated PTSS for participants with relatively higher levels of psychological inflexibility. Findings are consistent with our hypothesis that fear of self-compassion does not necessarily increase suffering if an individual is psychologically flexible, but may be a significant vulnerability factor if the person is inflexible. That is, when attempting to control aversive internal experiences, as often occurs in traumatized populations, suffering may be exacerbated by resisting self-compassion. Long-existing interest in self-compassion by the contextual behavioral science community is now manifesting in theoretical accounts (Neff & Tirsch, 2013) and empirical studies (Van Dam, Sheppard, Forsyth, & Earleywine, 2011). Results of the current study may warrant attention to fear of self-compassion by researchers and clinicians (also, see Kelly et al., 2013), as it may target a potentially critical process of pathology and recovery. While further research is needed to establish clinical utility, the current data suggest that clinical strategies may be needed to undermine fear of self-compassion as a treatment obstacle, particularly in the context of PTSS.

Results also have potential implications for self-compassion skills training. Encouraging and implementing self-compassion appears to be adaptive across clinical presentations. However, without carefully gauging the functional properties of self-compassion in clients' situational and historical contexts, efforts to generate self-compassion may function adversely, perhaps with the cost of premature termination. Just as some clients require sufficient preparation before engaging in exposure-based therapies, particular clients may find benefit in anticipating responses and adequately preparing for self-compassion skills training. It may be important to prepare clients to increase willingness for fear while working to engender greater self-compassion. ACT might be helpful in preparing clients for exposure to aversive cues, and it is encouraging that current ACT approaches to PTSD already address barriers to self-compassion (see Walser & Westrup, 2007). Approaches to address fear of self-compassion may be borrowed from emerging treatments such as Compassion-Focused Therapy (CFT; Gilbert, 2010) and Mindful Self-Compassion (MSC; Neff & Germer, 2013), both of which share philosophical and theoretical roots with ACT (Neff & Tirsch, 2013).

The current study demonstrates that fear of self-compassion is related to PTSS, and that coexisting psychological inflexibility may contribute to poor posttrauma functioning. Understanding the origins of fear self-compassion, while a worthwhile research question, is beyond the scope of the present study. One possibility is that fear of self-compassion reflects avoidance of one's own suffering, as awareness of suffering is a prerequisite for cultivating self-compassion (see Neff, 2003). Alternatively, fear of self-compassion may emerge from viewing one's own suffering as an unacceptable "thing," rather than part of the human experience. This "objectified" suffering may function to provide rationale for current life circumstances or motivation to improve life circumstances. Trauma survivors may become overly-identified or entangled with their conceptualized selves (e.g., "I am worthless" or "I must be repaired"), which may lead to inflexible rule following (e.g., "I don't deserve kindness" or "If I let go of my past I will get hurt again"). Accordingly, unconditional self-compassion may be viewed as threatening because it could potentially undermine the function of one's objectified suffering (e.g., reason-giving, self-motivation). By acting in accordance with fear of self-compassion, additional suffering may result, rather than freely chosen values. Thus, shaping a psychologically flexible repertoire may undermine the aversive control of fear of

self-compassion, as well as provide opportunity to engage in compassionate self-soothing.

The present study has several limitations. First, the study design precludes insight on causality and instead reflects associations among variables. By controlling for negative affect, the present study limits the possibility that results are due to a predisposition toward aversive mood states and distress. Other potential third variables, such as self-criticism or perfectionism, may influence findings. As such, longitudinal investigations that include other theoretically relevant variables are needed. An additional limitation is the use of an undergraduate sample. While a significant number of participants reported experiencing a prior traumatic event (78% of the original participant pool), only 20.2% ($n=53$) of participants included in the final analyses endorsed clinically significant levels of PTSS. Thus, examining relations among variables in a more symptomatic sample may be worthwhile. Lastly, the effects in the present study are quite small. However, effect size alone does not determine the practical importance of a given finding, particularly when the research domain is nascent (McCartney & Rosenthal, 2000). The present study is the first to examine fear of self-compassion in the context of PTSD symptom severity and psychological inflexibility. Thus, while the present effects are small, results warrant further investigation of the variables examined and their potential impact on posttrauma recovery. In particular, the influence of fear of self-compassion should be investigated within the context of valued ends and the cultivation of self-compassion.

Despite these limitations, the present study contributes to an emerging literature on self-compassion in relation to PTSD (e.g., Kearney et al., 2013; Thompson & Waltz, 2008), and is the first study to examine fear of self-compassion as a predictor of PTSD symptom severity. By examining the functional relationships between fear of self-compassion and psychological inflexibility with respect to clinical outcomes (i.e., PTSS), results demonstrate how distinct theories of psychotherapy (e.g., ACT, CFT, and MSC) can be linked to provide insight toward a common therapeutic goal. Overall, findings suggest that the combination of heightened psychological inflexibility and fear of self-compassion may represent an important vulnerability factor for PTSD. As such, the utility of compassion-based interventions may be contingent not only on successfully increasing self-compassion but also reducing attempts to avoid self-compassion at the onset of treatment.

References

- Aiken, L. S., & West, S. G. (1991). *Multiple Regression: Testing and interpreting interactions*. Newbury Park, CA: Sage.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: American Psychiatric Association.
- Batten, S. V., & Hayes, S. C. (2005). Acceptance and commitment therapy in the treatment of comorbid substance abuse and post-traumatic stress disorder: A case study. *Clinical Case Studies*, 4, 246–262. <http://dx.doi.org/10.1177/1534650103259689>.
- Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., et al. (2011). Preliminary psychometric properties of the Acceptance and Action Questionnaire-II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy*, 42, 676–688. <http://dx.doi.org/10.1016/j.beth.2011.03.007>.
- Burrows, C. J. (2013). Acceptance and Commitment Therapy with survivors of adult sexual assault: A case study. *Clinical Case Studies*, 12, 246–259. <http://dx.doi.org/10.1177/1534650113479652>.
- Codd, R. T., Twohig, M. P., Crosby, J. M., & Enno, A. (2011). Treatment of three anxiety disorder cases with acceptance and commitment therapy in a private practice. *Journal of Cognitive Psychotherapy*, 25, 203–217. <http://dx.doi.org/10.1891/0889-8391.25.3.203>.
- Fledderus, M., Bohlmeijer, E. T., & Pieterse, M. E. (2010). Does experiential avoidance mediate the effects of maladaptive coping styles on psychopathology and mental health? *Behavior Modification*, 34, 503–519. <http://dx.doi.org/10.1177/0145445510378379>.
- Forsyth, J. P., & Eifert, G. H. (2008). *The mindfulness & acceptance workbook for anxiety: A guide to breaking free from anxiety, phobias, and worry using Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger.

- Germer, C. K., & Neff, K. D. (2013). Self-compassion in clinical practice. *Journal of Clinical Psychology, 69*, 856–867. <http://dx.doi.org/10.1002/jclp.22021>.
- Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. New York: 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. <http://dx.doi.org/10.1348/147608310x526511>.
- Hayes, S. C. (2008, November). The roots of compassion. Presented at the 42nd annual convention of the Association of Behavioral and Cognitive Therapies. Orlando, FL. Retrieved from <http://www.globalpres.com/mediasite/Viewer/?peid=017fe6ef4b1544279-d8cf27adbe92a51>.
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behavior Research and Therapy, 44*, 1–25. <http://dx.doi.org/10.1016/j.brat.2005.06.006>.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press.
- Kashdan, T. B., Barrios, V., Forsyth, J. P., & Steger, M. F. (2006). Experiential avoidance as a generalized psychological vulnerability: Comparisons with coping and emotion regulation strategies. *Behavior Research and Therapy, 44*, 1301–1320. <http://dx.doi.org/10.1016/j.brat.2005.10.003>.
- Kearney, D. J., Malte, C. A., McManus, C., Martinez, M. E., Felleman, B., & Simpson, T. L. (2013). Loving-kindness meditation for posttraumatic stress disorder: A pilot study. *Journal of Traumatic Stress, 26*, 426–434. <http://dx.doi.org/10.1002/jts.21832>.
- Kelly, A. C., Carter, J. C., Zuroff, D. C., & Borairi, S. (2013). Self-compassion and fear of self-compassion interact to predict response to eating disorders treatment: A preliminary investigation. *Psychotherapy Research, 23*, 252–264. <http://dx.doi.org/10.1080/1-0503307.2012.717310>.
- Kubany, E. S., Haynes, S. N., Leisen, M. B., Owens, J. A., Kaplan, A. S., Watson, S. B., et al. (2000). Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. *Psychological Assessment, 12*, 210–224. <http://dx.doi.org/10.1037/1040-3590.12.2.210>.
- Kubany, E. S., Leisen, M. B., Kaplan, A. S., & Kelly, M. P. (2000). Validation of a brief measure of posttraumatic stress disorder: the Distressing Event Questionnaire (DEQ). *Psychological Assessment, 12*, 197–209. <http://dx.doi.org/10.1037/1040-3590.12.2.197>.
- Lang, A. J., Schnurr, P. P., Jain, S., Raman, R., Walser, R., Bolton, E., et al. (2012). Evaluating transdiagnostic treatment for distress and impairment in veterans: A multi-site randomized controlled trial of Acceptance and Commitment Therapy. *Contemporary Clinical Trials, 33*, 116–123. <http://dx.doi.org/10.1016/j.cct.2011.08.007>.
- MacBeth, A., & Gumley, A. (2012). Exploring compassion: A meta-analysis of the association between self-compassion and psychopathology. *Clinical Psychology Review, 32*, 545–552. <http://dx.doi.org/10.1016/j.cpr.2012.06.003>.
- Marx, B. P., & Sloan, D. M. (2005). Peritraumatic dissociation and experiential avoidance as predictors of posttraumatic stress symptomatology. *Behaviour Research and Therapy, 43*, 569–583. <http://dx.doi.org/10.1016/j.brat.2004.04.004>.
- McCartney, K., & Rosenthal, R. (2000). Effect size, practical importance, and social policy for children. *Child Development, 71*, 173–180. <http://dx.doi.org/10.1111/1467-8624.00131>.
- Neff, K. D. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*, 85–102. <http://dx.doi.org/10.1080/15298860390129863>.
- 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*, 28–44. <http://dx.doi.org/10.1002/jclp.21923>.
- Neff, K., & Tirsch, D. (2013). Self-compassion and ACT. In: T. B. Kashdan, & J. Ciarrochi (Eds.), *Mindfulness, acceptance, and positive psychology: The seven foundations of well-being* (pp. 78–106). Oakland, CA: New Harbinger Publications.
- Orsillo, S. M., & Batten, S. V. (2005). Acceptance and Commitment Therapy in the treatment of posttraumatic stress disorder. *Behavior Modification, 29*, 95–129. <http://dx.doi.org/10.1177/0145445504270876>.
- Thompson, B. L., Luoma, J. B., & Lejeune, J. T. (2013). Using Acceptance and Commitment Therapy to guide exposure-based interventions for posttraumatic stress disorder. *Journal of Contemporary Psychotherapy, 43*, 133–140. <http://dx.doi.org/10.1007/s10879-013-9233-0>.
- Thompson, B. L., & Waltz, J. (2008). Self-compassion and PTSD symptom severity. *Journal of Traumatic Stress, 21*, 556–558. <http://dx.doi.org/10.1002/jts.20374>.
- Twohig, M. P. (2009). Acceptance and commitment therapy for treatment-resistant posttraumatic stress disorder: A case study. *Cognitive and Behavioral Practice, 16*, 243–252. <http://dx.doi.org/10.1016/j.cbpra.2008.10.002>.
- Van Dam, N. T., Sheppard, S. C., Forsyth, J. P., & 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. <http://dx.doi.org/10.1016/j.janxdis.2010.08.011>.
- Walser, R., & Westrup, D. (2007). *Acceptance and commitment therapy for the treatment of post-traumatic stress disorder and trauma-related problems: A practitioner's guide to using mindfulness and acceptance strategies*. Oakland, CA: New Harbinger Publications.
- Watson, D., Clark, L., & Tellegen, A. (1988). Development and validation of a brief measure of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063–1070. <http://dx.doi.org/10.1037/0022-3514.54.6.1063>.