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To the Graduate Council:

I am submitting herewith a dissertation written by Philip Held entitled "The Effect of Self-Compassion Training on Trauma-Related Guilt in a Sample of Homeless Veterans in Transitional Housing." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Gina P. Owens, Major Professor

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Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

The Effect of Self-Compassion Training on Trauma-Related Guilt in a Sample of Homeless Veterans in Transitional Housing

A Dissertation Presented for the
Doctor of Philosophy Degree
The University of Tennessee, Knoxville

Philip Held
August 2014

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Dedication

I dedicate this project to all men and women who are currently serving and who have previously served in the Armed Forces, as well as their families and providers around the world who work to combat the impact of deployments and related struggles. I specifically want to thank the veterans who took the time to participate in this study and share stories of their struggles and the impact of this research with me. I also want to thank the staff at Steps House, Inc. for making this project possible.

Acknowledgments

First and foremost I would like to thank my academic advisor, Dr. Gina Owens, for giving me the opportunity to make a difference in other people's lives. Throughout my time in graduate school she has supported my efforts to help improve veterans' lives without any personal agendas other than to help make a student's dream become a reality. I also want to acknowledge my dissertation committee members Dr. Brent Mallinckrodt, Dr. Dawn Szymanski, and Dr. Joanne Hall who all provided unconditional support throughout graduate school and who made this project possible. I want to thank the staff members at Steps House who have continuously encouraged my work with veterans, especially those who are currently struggling with homelessness, and who have gone above and beyond to help me with this project. Lastly, I believe that this project would have not been possible without the strong clinical training foundation that I have received as a doctoral student at Cornerstone of Recovery and the University of Tennessee Counseling Center.

Abstract

This study examined the effects of a four-week long self-administered self-compassion training on trauma-related guilt in a sample of homeless veterans in transitional housing. Changes in self-compassion, trauma-related guilt, resilience, PTSD severity, and general distress in the self-compassion intervention group ($N = 13$) were studied and compared to a coping with stress (control) group ($N = 14$). Participation in the four-week long self-administered self-compassion training led to significant reductions in trauma-related guilt. Both interventions seemed equally effective at reducing trauma-related guilt. The results from this study lay the foundation for the use of self-compassion training as an effective treatment for trauma-related guilt. This research suggests that self-administered trainings in the form of workbooks may be a viable, cost-effective form of intervention for disadvantaged populations, such as homeless veterans in transitional housing, who lack resources or access to professionals or paraprofessionals. The role of self-compassion training as a possible adjunct to existing evidence-based treatments for PTSD, the effects of coping with stress training on the study variables, and directions for future research on self-compassion and trauma-related guilt are discussed.

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Chapter 1

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2011) has defined homelessness as living on the streets, being enrolled in a transitional housing program, or living in a shelter. According to a SAMHSA report (SAMHSA, 2011), roughly 1.5 million individuals experienced homelessness between 2009 and 2010. Approximately 600,000 individuals are homeless on any given night and close to 110,000 individuals are thought to be "chronically homeless" (SAMHSA, 2011). Homelessness does not discriminate and affects everyone from single individuals to children and entire families. According to the SAMHSA report (2011), the majority of individuals who experience homelessness are male and between the ages of 31 and 50. These rates are alarming and suggest that more attention needs to be given to the issue of homelessness (Bailey & Arrigo, 2012).

Individuals who are homeless often struggle with a multitude of mental health problems, including substance abuse and psychiatric illnesses (Shelton, Taylor, Bonner, & van den Bree, 2009). In fact, the existence of mental health problems and/or substance abuse has been identified as the main risk factor for homelessness (Foscarinis, 1996; Shelton et al., 2009). The prevalence rates for mental health and substance abuse problems among sheltered individuals are high, with approximately 26% of all sheltered individuals diagnosed with mental health problems and 37% diagnosed with substance abuse difficulties (U.S. Department of Housing and Urban Development, 2009). Although these rates have been stable over the past six years (U.S. Department of Housing and Urban Development, 2009), it is important to note that these official rates only capture individuals who sought out a shelter rather than those who live on the streets. Only approximately 37% of individuals who are homeless are sheltered (U.S. Department of

Housing and Urban Development, 2009). Thus, it is possible that rates of mental health and substance abuse problems may be higher for other individuals who are homeless.

Veterans and Homelessness

One of the populations at increased risk of homelessness due to high levels of mental health problems are veterans (Fargo et al., 2012; U.S. Department of Housing and Urban Development & U.S. Department of Veterans Affairs, 2009). Veterans represent approximately 15% of the sheltered homeless population (U.S. Department of Housing and Urban Development, 2009). Older veterans, especially those from the Vietnam era, appear to be at the highest risk for chronic homelessness (Gamache, Rosenheck, & Tessler, 2001). As a result of chronic mental health problems and substance abuse issues, many homeless veterans struggle with reintegration into the workforce (Tsai, Mares, Rosenheck, & Rosenheck, 2012). Some efforts to reintegrate homeless veterans have shown promise in decreasing the time between relapses (LePage & Garcia-Rea, 2012). Subsidized housing projects also have been effective in reducing rates of homelessness among veterans (O'Connell, Kasprov, & Rosenheck, 2008). However, research suggests that rates of homelessness among veterans will remain high unless underlying mental health problems that increase the risk of becoming and remaining homeless are resolved (cf. Iraq and Afghanistan Veterans of America, 2009).

One type of mental health problem that is prevalent among veterans is posttraumatic stress disorder (PTSD). Epidemiological studies suggest that PTSD is one of the most commonly diagnosed mental health problems in active duty military personnel and veterans (Hoge, Auchterlonie, & Milliken, 2006; Tanielian & Jaycox, 2008; Thomas et al., 2010). While there is some controversy about the exact percentage of service members who suffer from PTSD due to possible overdiagnosis (Sundin, Fear, Iversen, Rona, & Wessely, 2010), studies have

consistently reported that approximately 14-20% of military personnel who return from deployment meet criteria for the disorder (Gates et al., 2012; Hoge et al., 2006; Tanielian & Jaycox, 2008). PTSD develops in response to a potentially life threatening event, such as combat, that elicits feelings of fear, helplessness, and/or terror in the survivors of the event and is characterized by re-experiencing symptoms, such as nightmares or flashbacks (American Psychiatric Association, 2000). Individuals who suffer from PTSD tend to avoid trauma-related cues and experience emotional numbing. Another cluster of PTSD symptoms is hyperarousal, which leads individuals to experience difficulty with falling and staying asleep, exaggerated startle responses, and becoming easily irritated and angered (American Psychiatric Association, 2000).

In addition to experiencing the symptoms of PTSD, veterans who suffer from this disorder also commonly face other difficulties at higher rates than veterans without PTSD. For example, veterans who struggle with PTSD are more likely than those without PTSD to report problems with their marriages and families (Jordan et al., 1992); legal issues (Kulka et al., 1990); physical health problems (Boscarino, 2004; Hoge, Terhakopian, Castro, Messer, & Engel, 2007; O'Toole, Catts, Outram, Pierse, & Cockburn, 2009); and comorbid mental health issues, such as depression, anxiety, and substance abuse (Hoge et al., 2004). Although PTSD does not appear to be directly related to homelessness (Perl, 2012), having to face the aforementioned barriers to well-being may further increase the risk of veterans with PTSD to become and remain homeless (Fargo et al., 2012; Iraq and Afghanistan Veterans of America, 2009; U.S. Department of Housing and Urban Development & U.S. Department of Veterans Affairs, 2009).

PTSD and Trauma-Related Guilt

In attempts to find ways to improve treatment for PTSD, research has examined various risk factors that contribute to its development and maintenance (e.g., Ehlers & Clark, 2000). One risk factor for PTSD that has been consistently associated with increases in symptom severity is trauma-related guilt (e.g., Held, Owens, Schumm, Chard, & Hansel, 2011; Street, Gibson, & Holohan, 2005). Survivors of traumatic events often try to extract meaning from their experiences (Owens, Steger, Whitesell, & Herrera, 2009). In hindsight, it is not uncommon for trauma survivors to believe that they could have and should have done more to influence or prevent the situation. This perceived responsibility and control of what transpired has been linked to feelings of trauma-related guilt and shame (Tangney & Dearing, 2004). Preceding these feelings is the appraisal of the traumatic incident and cognitions of guilt and shame, such as "I should have known better" or "I am a horrible person for allowing it to happen" (Kubany & Watson, 2003). Veterans often suffer from guilt related to the loss of a fellow service member, taking the life of another person, or surviving situations that others did not. Further, stronger beliefs of having violated personal values has been positively associated with symptoms of PTSD (Kubany et al., 1995). Trauma survivors often may have difficulty with integrating their experiences with beliefs they held prior to traumatic events. The inability to adaptively process experiences leads to internal conflicts, also known as *stuck points* (Resick, Monson, & Chard, 2007), which have been linked to increased distress and PTSD (Resick, 2001).

Trauma survivors who seek therapy frequently report the experience of guilt and shame – feelings that were found to be positively associated with PTSD severity (Held et al., 2011; Owens et al., 2009; Street et al., 2005; Wilson, Droždek, & Turkovic, 2006). Despite the existence of advanced, evidence-based treatments for PTSD, studies have suggested that guilt

cognitions may remain almost unchanged over the course of treatment despite reductions in PTSD and depression (Nishith, Nixon, & Resick, 2005; Owens, Chard, & Cox, 2008). Consequently, cognitions and feelings of trauma-related guilt may continue to burden individuals who struggle with PTSD and potentially prevent them from being able to fully recover (Kubany & Watson, 2003), which may ultimately lead to continual homelessness (Iraq and Afghanistan Veterans of America, 2009). Trauma-related guilt also may increase the already heightened sense of hopelessness that survivors often describe (D. R. Johnson, Fontana, Lubin, Corn, & Rosenheck, 2004). Many trauma survivors in clinical practice report having a logical understanding for why their cognitions are faulty and being able to challenge them effectively but at the same time continue to feel guilty for what they did or did not do. Thus, it seems appropriate to suggest that existing treatments could be enhanced by improving current treatments for trauma-related guilt or by introducing new guilt-altering techniques (Held et al., 2011).

Coping with Trauma

In attempts to cope with their traumatic experiences, many individuals try to disengage and avoid thinking about what has happened (Held et al., 2011). While this form of coping initially helps lower cognitive distress and emotional disturbances for short periods of time, avoidance coping has been found to be maladaptive, as it prevents individuals from adaptively processing their experiences (Kubany & Watson, 2003; Snyder & Pulvers, 2001). In addition to the avoidance of thoughts and feelings related to the stressor, individuals who rely on avoidance coping strategies tend to disengage from social support, which could function as a protective factor against PTSD (Hourani et al., 2012). Individuals employing avoidance coping also are frequently in denial about the severity of their struggles (Littleton, Horsley, John, & Nelson,

2007). Avoidance coping styles positively predict PTSD severity (Gil, 2005) and reliance on this form of coping is associated with increased distressed, especially when used long-term (Littleton et al., 2007). Studies with military personnel have shown that a change in coping styles to a more adaptive approach or engagement coping strategies resulted in changes in PTSD severity (Benotsch, Brailey, Vasterling, & Uddo, 2000; Solomon, Mikulincer, & Flum, 1988). The use of disengagement or avoidance coping strategies therefore seems to be a risk factor for the development and maintenance of PTSD – a disorder that is characterized by avoidance.

A more adaptive form of coping with PTSD may be engagement coping strategies. Engagement coping strategies are characterized by seeking emotional support, making active plans to resolve the stressor, and seeking information about the stressor (Tobin, Holroyd, Reynolds, & Wigal, 1989). However, studies exploring engagement coping strategies as protective factors for PTSD have yielded mixed results (e.g., Benotsch et al., 2000; D. M. Johnson, Sheahan, & Chard, 2003; Solomon et al., 1988). Since guilt may remain unchanged over the course of PTSD treatment (Nishith et al., 2005; Owens et al., 2008), new approaches of targeting cognitions and feelings of guilt in trauma survivors may need to be investigated to further increase trauma survivors' well-being.

Self-Compassion

One construct that has been consistently associated with well-being is self-compassion. Self-compassion is defined as directing the basic feeling of compassion toward oneself and applying kindness and care, as well as having understanding for one's pain and suffering (Neff, 2011b). As a result of feeling understood and cared for (including by oneself), an individual may experience a desire to end the suffering he or she is in. Unlike self-pity, which involves becoming immersed in one's own problems, self-compassion allows individuals to see that they

are not the only ones who are struggling. Further, self-compassion differs from self-esteem in that self-compassion focuses on interconnectedness rather than competition with others and, as such, is related to more emotional stability (Neff, 2012). The practice of self-compassion has been associated with reductions in anxiety and depression, even after controlling for self-criticism and negative affect (Neff, Kilpatrick, & Rude, 2007). Results from a study that investigated the effects of self-compassion on PTSD suggested that the practice of self-compassion was associated with a reduction in the avoidance symptom cluster of PTSD (Thompson & Waltz, 2008). Individuals who practice self-compassion seem to be more aware of their suffering and, instead of turning away from their pain, choose to be attentive, caring and kind toward themselves, knowing that they are not the only ones who have these sorts of experiences (Neff, 2012). The results of a study that examined negative life events showed that those individuals who were more self-compassionate reported less anxiety and self-consciousness when thinking about their struggles (Leary, Tate, Adams, Allen, & Hancock, 2007). Further, individuals who were more self-compassionate also had a better perspective on their problem and were less likely to feel alone with their problems compared to individuals who were less self-compassionate (Leary et al., 2007). Translating these results to work with veterans could mean that, if veterans were more self-compassionate with themselves, they would be able to feel less overwhelmed by their problems and might be better able to extract meaning from their experiences. Self-compassion could function as a protective factor for individuals who suffer from trauma, as it may reduce comorbid symptoms of depression and anxiety.

The practice of self-compassion also has important implications for interpersonal relationships. In heterosexual couples self-compassion has been linked to greater relationship satisfaction and attachment security (Neff & Beretvas, 2013). Further, individuals who were

more self-compassionate described their partners as emotionally connected and accepting, as well as being less detached, controlling, and physically and verbally aggressive compared to individuals who were less self-compassionate (Neff & Beretvas, 2013). As described earlier, veterans who suffer from PTSD tend to have greater marital and family problems compared to veterans without PTSD (Jordan et al., 1992). Training veterans in self-compassion and thus ultimately helping them maintain or repair their relationships with their support network could further benefit veterans who are trying to work through their traumatic experiences.

To date, little is known about the role of self-compassion as a protective factor for trauma (Briere, 2012). Although it is believed that compassion in trauma therapy eases the fear and difficulties associated with processing traumatic memories, research in this area is lacking (Briere, 2012). Because trauma-related guilt has been identified as a relatively common stuck point in the processing of traumatic experiences, it is worth examining whether self-compassion may aide in working through guilt cognitions and feelings. Specifically, due to stuck points being related to an internal locus of control, it seems plausible that self-compassion training could help veterans with gaining a broader perspective (Leary et al., 2007). As a result, self-compassion may function as a protective factor against cognitions and feelings of trauma-related guilt as the sense of being a worthless person or the belief that one should have known better would be approached from a place of love, kindness, understanding, and care, rather than self-criticism. One study that examined the effects of self-compassion on shame and self-criticism found a negative association between the two concepts (Gilbert & Procter, 2006). Ultimately, the practice of self-compassion could help veterans automatically correct thinking errors and reach a place of forgiveness, which have been associated with reductions in both guilt and shame (Kubany & Watson, 2003), without having to directly process the traumatic experience.

The Present Study

Given the debilitating effects of trauma-related guilt (Kubany & Watson, 2003) and the suggestion that existing treatments for PTSD could be improved by enhancing guilt-altering techniques (Held et al., 2011), the purpose of this study was to examine whether self-compassion training has an effect on trauma-related guilt, resilience, PTSD severity, and general psychological distress. The practice of self-compassion has yielded many positive results for the reduction and prevention of anxiety and depression (Leary et al., 2007), as well as decreases in avoidance symptoms of PTSD (Thompson & Waltz, 2008), and has been associated with overall well-being (Neff, 2012), improved interpersonal relationships (Neff & Beretvas, 2013) and reductions in shame and self-criticism (Gilbert & Procter, 2006). Given these positive effects, the author hypothesized that self-compassion may have protective properties for the development and maintenance of trauma-related guilt and PTSD more broadly. Specifically, the author hypothesized that participation in a four-week long self-administered training on self-compassion will 1) increase veterans' levels of self-compassion, and 2) decrease veterans' levels of trauma-related guilt. Further, it was the author's goal to 3) determine whether the self-compassion training increases resilience and 4) explore the effects that the self-administered self-compassion training has on PTSD and 5) general distress. The results of the self-compassion training were compared with the results from a similarly structured "coping with stress" intervention, which was administered to a control group. The author hypothesized that individuals who practiced self-compassion would have a significantly greater increase in self-compassion and resilience and a significant greater decrease in trauma-related guilt, PTSD severity, and general distress, compared to individuals who practiced relaxation and stress reduction techniques in the coping with stress condition. Finding alternate ways of reducing trauma-related guilt is paramount in

helping veterans effectively work through and process their traumatic experiences and be able to live more fulfilled lives. In the long-term, improving cost-effective ways to reduce mental health problems may also aid in lowering levels of homelessness among veterans.

Chapter 2

Methods

Participants

The data for the present study was collected at a Southeastern transitional housing facility for homeless male veterans. A total of 47 male veterans were initially recruited for participation through verbal announcements by the author and the organization's staff. Participants were informed that participation in this study required active completion and practice of homework assignments and that their reading ability needed to be equivalent to a 9th grade reading level. Individuals were also advised that participation in the present study was completely voluntary and that they would be required to complete three intervention-related assessment batteries before, during, and after their respective intervention. Participants were asked to commit to participate in this study for four weeks. Over the four-week intervention period 43% of the participants dropped out and did not return for the post-intervention assessment, leaving a sample of 27 veterans who completed all three assessments. Reasons for not continuing to participate were not provided by the veterans who left the study.

All of the assessments participants were asked to complete contained two validity check questions ("Nighttime is followed by daytime" and "Every day of the week is a Tuesday"). The validity check questions were built into the assessments to ensure that individuals were paying attention to the questions they were answering and giving thought to their responses. Of the 27 veterans who completed all three assessments, 9 answered the two validity check questions correctly. To determine the impact of the validity check questions on the study variables, effect sizes for the aforementioned validity check questions in relation to the hypothesized variables were calculated. First, dummy coding was performed to place individuals into groups of

individuals who either answered the validity check questions correctly or incorrectly. Next, effect sizes for the validity check questions were calculated by performing t-tests. The mean of the group of individuals who answered the validity check questions incorrectly was subtracted from the mean of individuals who answered them correctly and the result was then divided by the respective standard deviations for each variable. These steps were taken to determine the effect size for each of the validity check questions. The effect sizes of the validity check questions were small, ranging from .04 to .60 with the majority of effect sizes being between .2 and .3. The only large effect size for the validity check questions, which may indicate it having an impact on the study variables, was the effect size for the mid-intervention assessment of PTSD severity ($r = .60$). However, because the majority (73%) of effect sizes were smaller than .35, and thus likely too small to significantly impact the study variables, the author of this dissertation chose to include the 27 veterans who completed all three post-intervention assessments for the analyses. Calculations and results for the effect sizes of the validity check questions are shown in Table 1.

The mean age of the sample that completed all three assessments was 51.30 ($SD = 8.421$, range 33-64). With regard to ethnic identification, 81% were Caucasian, 15% African American, 4% Native American. Of all veterans in the sample, 37% reported being divorced, 30% single, 22% separated, 11% widowed. With regard to employment status, 78% reported being unemployed, 15% employed full-time, and 7% students. In terms of education, 48% reported being a “high school graduate,” 37% had “some college,” 7% “some high school,” 4% “college degree,” and 4% “graduate/professional degree.” Of the 27 veterans in the sample, 56% had served in the Army, 22% Air Force, 18% Navy, and 4% Marine Corps. Ninety-six percent of the veterans reported having served on Active Duty, 11% Reserves, and 7% National Guard. With

regard to service era, 37% reported having served during the Vietnam War, 22% post-Vietnam War, 26% Persian Gulf War, 4% OEF, and 15% served in other conflicts. Participants could select multiple service eras. Of all the veterans in the initial sample, 44% had never deployed, 26% deployed once, 19% deployed twice, 4% deployed three times, and 7% chose not to answer this question. The average deployment length was 5 months, with a range of 0 to 18 months. Ninety-six percent of the veterans reported having been enlisted and 4% having been Warrant Officers.

A number of homeless veterans in the transitional housing facility from which the sample was drawn struggle with substance use problems. In the current sample, 67% reported having used alcohol, 22% depressants other than alcohol, 22% stimulants, 7% opioids, 4% hallucinogens. The time individuals had been abstinent from alcohol or drugs ranged from 0 months to 24 years, with an average length of abstinence of 2.19 years. On average, individuals in the present sample had spent 7 months at the transitional housing facility, with a range of 0 months to 1.76 years. The veterans were also asked to indicate the types of traumas they have experienced. Eighty-two reported having experienced a "sudden move or loss of home and possessions," 78% "sudden death of close family or friend," 56% "suddenly abandoned by spouse, partner, parent, or family," 56% "attacked with a gun, knife, or weapon," 52% "a really bad car, boat, train, or airplane accident," 48% "during military service seeing something horrible or being really scared," 63% "seeing someone die suddenly or get badly hurt or killed," 41% "a really bad accident at work or home," 41% "a hurricane, flood, earthquake, tornado, or fire," 41% "hit or kicked hard enough to injure as an adult,"41% "some other sudden event that made you feel very scared, helpless, or horrified," 37% "hit or kicked hard enough to injure as a child," and 7% "forced or made to have sexual contact as a child."

Measures

Participants of both groups were asked to complete three separate assessment batteries. The assessments were administered prior to the four-week intervention, two weeks after starting the intervention, and upon its completion. The assessment batteries were identical for both groups. Participants first completed a demographics questionnaire that asked about the participants' age, ethnicity, education level, relationship status, service branch, last military rank, service era, years since military service, current length of abstinence from alcohol and drugs, and current length of stay with the organization. In addition to completing a demographics questionnaire, participants were asked to complete measures about self-compassion, resilience, trauma history, trauma-related guilt, PTSD symptoms, and a general distress measure, all of which were given at the mid- and post-intervention assessments.

Self-Compassion Scale. The Self-Compassion Scale (SCS; Neff, 2003) is a 26-item self-report measure used to determine how self-compassionate individuals are. The SCS consists of six subscales: Self-Kindness, Self-Judgment, Common Humanity, Isolation, Mindfulness, and Over-Identification. The subscales Self-Judgment, Isolation, and Over-Identification are reverse-scored. Respondents are asked to rate how often they behave in the stated manners on a 5-point scale ranging from 1 (*Almost never*) to 5 (*Almost always*). Total scores on the SCS range from 26 to 130, with higher scores indicating greater self-compassion. Sample items for the SCS are "I am kind to myself when I experience suffering" (Self-Kindness) and "I try to see my failings as part of the human condition" (Common Humanity). The SCS has high internal consistency reliability of .92 with its subscales ranging from .75 to .81 (Neff, 2003). Content validity, convergent validity, and discriminant validity of the SCS were supported by correlating it with measures of life satisfaction, depression, anxiety, and perfectionism (Neff, 2003) and using it

with different samples and cultures (e.g., Neff, 2003; Neff, Pisitsungkagarn, & Hsieh, 2008; Neff & Vonk, 2009). Internal consistency reliabilities for the pre-, mid-, and post-assessment for the present sample were .85, .75, and.87, respectively. Test-retest reliability for the SCS in this study ranged between .73 and .88. Only the total score on the SCS was used for the present study.

Brief Resiliency Scale. The Brief Resiliency Scale (BRS; Smith et al., 2008) is a 6-item self-report measure designed to assess individuals' resiliency. Respondents are asked to rate how much they agree with the statements on a 5-point Likert scale ranging from 1 (*Strongly disagree*) to 5 (*Strongly agree*). Total scores on the BRS range from 5 to 30, with higher scores indicating greater resilience. Sample items for the BRS are "I tend to bounce back quickly after hard times" and "I usually come through difficult times with little trouble." The BRS has high internal consistency reliability ranging from .70 to .95 (Smith et al., 2008; Windle, Bennett, & Noyes, 2011). Validity of the BRS was supported by correlating it with existing measures of resiliency, such as the Connor-Davidson Resiliency Scale (Connor & Davidson, 2003) and the Ego Resiliency Scale (Block & Kremen, 1996), as well as measures of other personal characteristics, such as life orientation and purpose of life, coping styles, social relationships and health related outcomes (Smith et al., 2008). Convergent validity and discriminant validity of the BRS were supported by correlating it with similar resiliency measures and using it with a variety of samples ranging from college students to cardiac rehabilitation patients and women with fibromyalgia (Smith et al., 2008; Windle et al., 2011). Internal consistency reliabilities for the pre-, mid-, and post-assessment for the present sample were .54, .88, and .79, respectively. Test-retest reliability for the BRS in this study ranged between .53 and .69.

Trauma History Screen. The Trauma History Screen (THS; Carlson et al., 2011) is a 14-item self-report measure used to assess individuals' trauma histories. The THS assesses 14

different traumatic events. Respondents are asked to indicate whether an incident has occurred by checking “yes” or “no” and stating the number of times they have experienced the event. Respondents are also asked to indicate whether an event was “traumatic” and briefly describe what happened (Carlson et al., 2011). The THS has good internal consistency reliability ranging from .60 to 1.00 (Carlson et al., 2011). Content validity, construct validity, and convergent validity of the THS were supported by correlating it with measures of combat exposure and traumatic life events (Carlson et al., 2011). The THS has been used with veterans (Carlson et al., 2011).

Trauma-Related Guilt Inventory. The Trauma-Related Guilt Inventory (TRGI; Kubany et al., 1996) is a 32-item self-report measure designed to assess event-specific cognitions and feelings of guilt. The TRGI consists of three scales: Global Guilt, Distress, and Guilt Cognitions. The Guilt Cognitions scale has three subscales: Hindsight Bias/Responsibility, Wrongdoing, and Lack of Justification. Respondents are asked to rate their feelings about the statements on a 5-point scale ranging from 1 (*Not at all true* or *Never true*) to 5 (*Extremely true* or *Always true*). Total scores on the TRGI range from 32 to 160, with higher scores on the TRGI indicating greater trauma-related guilt. Sample items for the TRGI are “I experience intense guilt related to what happened” (Global Guilt) and “I was responsible for what happened” (Guilt Cognitions). The TRGI has high internal consistency reliability with its scales ranging from .86 to .90 and its subscales ranging from .67 to .82 (Kubany et al., 1996). Content validity, convergent validity, and discriminant validity of the TRGI were supported by correlating it with measures of trait guilt, social anxiety and avoidance, and self-esteem (Kubany et al., 1996). The TRGI was validated with different samples of trauma survivors including veterans (Kubany et al., 1996). Internal consistency reliabilities for the pre-, mid-, and post-assessment for the present sample

were .73, .86, and .87, respectively. Test-retest reliability for the TRGI in this study ranged between .76 and .87. Only the total trauma-related guilt cognition score was used for the present study.

PTSD Checklist – Specific Stressor Version. The PTSD Checklist – Specific Stressor Version (PCL-S; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item self-report measure to assess symptoms of PTSD. Respondents are asked to report "how much each problem has bothered them during the past week" on a 5-point scale, ranging from 1 (*Not at all*) to 5 (*Extremely*). Total scores on the PCL-S range from 17 to 85, with higher scores on the PCL-S indicating greater PTSD severity. The PCL-S has good internal consistency ranging from .89 to .92 (Weathers et al., 1993). Content validity, convergent validity, and discriminant validity of the PCL-S were supported by correlating it with measures of traumatic stress, general psychopathology, and personality, and using it with various samples of trauma survivors including veterans (Norris & Hamblen, 2004; Weathers et al., 1993). Internal consistency reliabilities for the pre-, mid-, and post-assessment for the present sample were .94, .94, and .95, respectively. Test-retest reliability for the PCL-S in this study ranged between .71 and .85.

Hopkins Symptom Checklist-21. The Hopkins Symptom Checklist-21 (HSCL-21; Deane, Leathem, & Spicer, 1992) is a 21-item self-report inventory developed to determine symptom distress. The measure contains three subscales (General Feelings of Distress, Somatic Distress, and Performance Difficulty). Respondents are asked to use a 4-point scale ranging from 1 (*Not at all*) to 4 (*Extremely*) to describe how distressing they have found various symptoms over the past seven days. The sum of the three subscales gives a Total Distress Score. Internal consistency reliability for adult therapy patients ranged from .80 (Performance Difficulty) to .87 (General Feelings of Distress) for subscales and was .89 for the Total Distress Score (Deane et

al., 1992). Deane et al. (1992) also found that the measure has good construct and concurrent validity. Content validity, convergent validity, and discriminant validity of the HSCL-21 were supported by correlating it with measures of state and trait anxiety and therapist-completed symptom scales, and using it in general outpatient settings and with veterans (Clark & Owens, 2012; Deane et al., 1992). Internal consistency reliabilities for the pre-, mid-, and post-assessment for the present sample were .92, .96, and .94, respectively. Test-retest reliability for the HSCL-21 in this study ranged between .56 and .80. Only the total distress score was used for the present study.

Procedure

After the participants were recruited, they were randomly assigned to either the "self-compassion" (*N* = 13) or the "coping with stress" (*N* = 14) groups. The self-compassion group received a workbook with five self-compassion exercises (see Appendix A). The coping with stress group functioned as a control group; individuals in the coping with stress group received a coping with stress workbook with five different relaxation exercises, such as deep breathing, progressive muscle relaxation, safe place visualization, and "cook's hookup" (see Appendix B). Individuals in both groups were asked to practice the exercises for 5-15 minutes daily. All participants completed identical assessment batteries in the same time frame before beginning the intervention, after two weeks of practicing the exercises outlined in the respective workbooks, and after four weeks, upon completion of the workbooks. In addition to benefits individuals may have directly received from participating in this study, individuals in both groups were compensated at the post-intervention assessment for their participation with a $20 gift card to a local retailer.

Self-Compassion Workbook

The author of this dissertation created the self-compassion and the coping with stress workbooks for this study. The self-compassion training workbook was based on basic self-compassion exercises that have been effectively used in practice (Neff, 2009, 2011b) and research (Neff, 2012). It was written so that individuals with a high-school reading level could comprehend the concept of self-compassion and follow the exercises without difficulty. The author's goal was to create a training booklet through which participants in this study could learn about and practice self-compassion without having to depend on professionals or paraprofessionals to teach them the concepts and exercises. The rationale behind using a self-administered self-compassion and coping with stress training was that many veterans have negative attitudes toward seeking mental health treatment (Held & Owens, 2012). For this reason the author of this dissertation decided to provide a sample of homeless veterans in transitional housing with self-administered training workbooks rather than relying on in-person training, which would have been administered by professionals or paraprofessionals.

Week 1. During the first week of the self-compassion training, individuals learned to be more mindful and understand the connection between situations they encounter and feelings they experience. Increasing individuals' mindful awareness of their emotions will help with responding to their emotions compassionately (Neff, 2011b). Individuals were asked to practice identifying emotions in response to events daily for 7 days.

Week 2. The second week of the self-compassion training focused on identifying automatic thoughts that preceded emotions, which individuals experienced. Helping individuals become more mindful and recognize their automatic thoughts is a vital step in being able to compassionately challenge their self-critical thoughts. Individuals also learned how to

compassionately challenge their initial critical thoughts (Neff, 2011b). Individuals were asked to practice identifying their critical thoughts and compassionately challenging them daily for 7 days.

Week 3. The third week was divided into two different exercises. The first exercise was to compose a compassionate letter to a real or imagined close friend or loved one. Individuals could choose to share or not share what they wrote with the individual they addressed. Individuals were given 3 days to compose the compassionate letter to a friend or loved one. The second exercise for the third week was to compose a compassionate letter to themselves. Learning how to attend to oneself and express love, kindness, and care are vital components of well-being (Neff, 2012). Individuals were given 4 days to compose the compassionate letter to themselves and were encouraged to reread the letter at a later point in time.

Week 4. The fourth week of the self-compassion training built on the previous weeks. In the fourth week, individuals learned how to use compassion as a form of encouragement. Learning how to become motivated in a less self-critical but more compassionate way is important to prevent individuals' relapsing into old behaviors (Neff, 2011a, 2011b). Individuals were asked to practice using compassionate encouragement daily for 7 days.

Data Analysis

The data from the present study was analyzed using the statistical software SPSS. First, a series of descriptive analyses was conducted to determine the composition of the study sample, specifically examining participants' age, ethnicity, education level, relationship status, service branch, last military rank, service era, years since military service, current length of abstinence from drugs and alcohol, and current length of stay with the organization. Ranges, means,

standard deviations, and intercorrelations between all study variables were conducted. Internal consistency reliability for all continuous scales was also calculated.

In order to test hypotheses 1-5, a repeated measures multivariate analysis of variance (MANOVA) was performed. Through the use of repeated measures MANOVA possible changes in individuals' levels of self-compassion, resilience, trauma-related guilt, PTSD severity, and general distress after the self-compassion or coping with stress training were assessed. In addition, repeated measures MANOVA allowed for determination of whether there were significant differences between the self-compassion and the coping with stress interventions on the study variables. Intervention type was the between subjects factor. Time of assessments was the within subjects factor in this model. One-way ANOVAs were performed when significant main effects for time were found to determine the differences in study variables between groups at the different time points. Repeated measures ANOVAs were performed for each group individually when significant interactions between the intervention and the study variables were found in the original repeated measures MANOVA.

Chapter 3

Results

Bivariate correlations for the study variables are shown in Table 2. In order to test hypotheses 1-5 stated above, a repeated measures multivariate analysis of variance (MANOVA) was performed to test the study hypothesis that individuals in the self-compassion group would have higher levels of self-compassion and resilience and lower levels of guilt, PTSD, and general distress over time than individuals in the coping with stress group. Intervention type was the between subjects factor. Time of assessments was the within subjects factor in this model. One-way ANOVAs were performed when significant main effects for the type of intervention were found in order to explore the differences in mean scores between the two interventions at the different time points. Repeated measures MANOVAs were executed for each intervention when significant interactions between the interventions and the time of the assessments were found to examine changes in study variables between time points.

Results of the repeated measures MANOVA yielded significant main effects for time, intervention, and the interaction, time by intervention. Mauchly's Test of Sphericity for the study variables self-compassion, trauma-related guilt, resilience, PTSD severity, and general distress indicated that the assumption of sphericity had not been violated (all *p*-values ns). Examination of univariate Within Subjects effects indicated that significant differences across time for self-compassion ($F(2, 44) = 3.983$, $p = .026$, partial $\eta^2 = .153$; Figure 1) and trauma-related guilt ($F(2, 44) = 28.431$, $p < .001$, partial $\eta^2 = .564$; Figure 2). The interaction between time and intervention was significant for trauma-related guilt ($F(2, 44) = 4.861$, $p = .012$, partial $\eta^2 = .181$, Figure 3), resilience ($F(2, 44) = 5.074$, $p = .010$, partial $\eta^2 = .187$; Figure 4), and PTSD severity

($F(2, 44) = 6.578$, $p = .003$, partial $\eta^2 = .230$; Figure 5). Univariate Between Subjects effects indicated a significant difference between intervention groups on trauma-related guilt ($F(1, 22) = 12.718$, $p = .002$, partial $\eta^2 = .366$), but none of the other dependent variables of interest. Bonferroni adjustments were performed to determine the significance of mean differences. To further explore significant findings for main effects between intervention groups at different time points, a series of one-way ANOVAs was conducted. To explore significant interaction effects, a series of repeated-measures ANOVAs for each intervention were performed. The results from both follow-up analyses will be detailed by variable below.

Hypothesis 1 - Self-Compassion

Hypothesis 1 explored whether participation in either the self-compassion training or the coping with stress training would significantly increase veterans' levels of self-compassion. Results of the repeated-measures MANOVA indicated that self-compassion was significantly different at the three time points ($F(2, 44) = 3.983$, $p = .026$, partial $\eta^2 = .153$; Figure 1). Bonferroni adjustment was performed to determine the significance of mean differences. There was a significant increase in self-compassion from the pre-intervention (M =72.00, 95% CI [66.32, 77.68]) to the post-intervention assessment (M = 76.46, 95% CI [71.34, 81.58]), $p = .019$. There was no statistically significant interaction between the interventions and time of assessments ($F(2, 44) = .526$, $p = .594$, partial $\eta^2 = .023$).

Hypothesis 2 – Trauma-Related Guilt

Hypothesis 2 investigated whether participation in either the self-compassion or the coping with stress training would decrease veterans' levels of trauma-related guilt. Results of the repeated-measures MANOVA indicated that trauma-related guilt levels were statistically

significantly different at the three time points ($F(2, 44) = 28.431$, $p < .001$, partial $\eta^2 = .564$; Figure 2). Bonferroni adjustment was performed to determine the significance of mean differences. There was a significant decrease in trauma-related guilt from the pre- (M =60.42, 95% CI [50.19, 70.64]) to post-intervention assessment (M = 39.750, 95% CI [32.73, 46.77]), $p < .001$ as well as from the mid- (M = 60.13, 95% CI [50.50, 69.75]) to post-intervention assessment, $p < .001$.

Because there was a significant Between-Subjects effect for the intervention used ($F(1, 22) = 12.718$, $p = .002$, partial $\eta^2 = .366$), a series of one-way ANOVAs was performed to determine the differences between intervention groups at different time points. Statistically significant differences in trauma-related guilt were detected for the mid-intervention assessment ($F(2, 24) = 13.553$, $p = .001$, partial $\eta^2 = .361$) and the post-intervention assessments ($F(2, 25) = 5.303$, $p = .030$, partial $\eta^2 = .175$). Levels of trauma related guilt were significantly higher in the self-compassion intervention (Mid: M = 78.69, SD = 23.803; Post: M = 50.54, SD = 17.453) compared to the coping with stress intervention (Mid: M = 44.08, SD = 24.140; Post: (M = 41.74, SD = 20.652.

Since there was a statistically significant interaction between the interventions and time of assessments ($F(2, 44) = 4.861$, $p = .012$, partial $\eta^2 = .181$; Figure 3), follow-up repeated measures ANOVAs were performed to determine changes in trauma-related guilt between time points for each of the two interventions independently. For the self-compassion intervention, trauma-related guilt was statistically significantly different at the three time points ($F(2, 22) = 24.703$, $p < .001$, partial $\eta^2 = .692$). Bonferroni adjustment was performed to determine the significance of mean differences. There was a significant decrease in trauma-related guilt from

the pre- (M = 71.17, 95% CI [56.01, 86.33]) to post-intervention assessment (M = 51.750, 95% CI [40.537, 62.963]), p = .001 and from the mid- (M = 79.92, 95% CI [64.40, 95.44]) and post-intervention assessment, $p < .001$.

For the coping with stress intervention, trauma-related guilt was statistically significantly different at the three time points ($F(2, 22) = 10.668$, $p = .001$, partial $\eta^2 = .492$). Bonferroni adjustment indicated that there was a significant decrease in trauma-related guilt from the pre-intervention (M = 49.67, 95% CI [34.13, 65.20]) to the post-intervention assessment (M = 27.75, 95% CI [17.94, 37.56]), p = .011.

Hypothesis 3 - Resilience

Hypothesis 3 explored whether participation in either the self-compassion or the coping with stress training would increase veterans' resilience. Results of the repeated measures MANOVA indicated that resilience did not change significantly over the three time points ($F(2, 44) = 2.375$, $p = .672$, partial $\eta^2 = .018$).

There was a statistically significant interaction between the interventions and time of assessments ($F(2, 44) = 5.074$, $p = .010$, partial $\eta^2 = .187$; Figure 4). Statistically significant differences in resilience were detected for the mid-intervention assessment ($F(2, 23) = 6.775$, $p = .016$, partial $\eta^2 = .228$). Follow-up repeated measures ANOVAs were performed to determine changes in resilience between time points for each of the two interventions independently. For the self-compassion intervention, resilience was statistically significantly different at the three time points ($F(2, 22) = 4.486$, $p = .023$, partial $\eta^2 = .290$). Bonferroni adjustment was performed to determine the significance of mean differences. There was a borderline significant decrease in

resilience from the pre- (M = 18.08, 95% CI [15.45, 20.72]) to mid-intervention assessment (M = 15.50, 95% CI [12.323, 18.68]), p = .050.

For the coping with stress intervention, resilience was not statistically significantly different at the three time points ($F(2, 22) = 1.675$, $p = .210$, partial $\eta^2 = .132$).

Hypothesis 4 - PTSD Severity

Hypothesis 4 investigated whether participation in either the self-compassion or the coping with stress training would decrease veterans' PTSD severity Results of the repeated-measures MANOVA indicated that PTSD severity was not statistically significantly different at the three time points ($F(2, 44) = 1.390$, $p = .260$, partial $\eta^2 = .059$).

Because there was a Between-Subjects effect for the intervention used ($F(2, 44) = 6.578$, $p = .003$, partial $\eta^2 = .230$), a series of one-way ANOVAs was performed to determine the differences between intervention groups at different time points. No statistically significant differences in PTSD severity were detected for the pre-, mid-, or post-assessments ($F(2, 25) = .000$, $p = .996$, partial $\eta^2 = .000$; $F(2, 24) = 2.259$, $p = .146$, partial $\eta^2 = .086$; $F(2, 25) = 2.097$, $p = .160$, partial $\eta^2 = .077$; respectively); levels of PTSD severity were not significantly different in the self-compassion intervention compared to the coping with stress intervention.

Since there was a statistically significant interaction between the interventions and time of assessments ($F(2, 44) = 6.578$, $p = .003$, partial $\eta^2 = .230$; Figure 5), follow-up repeated measures ANOVAs were performed to determine changes in PTSD severity between time points for each of the two interventions independently. For the self-compassion intervention, PTSD severity was not statistically significantly different at the three time points ($F(2, 22) = 2.876$, $p = .078$, partial $\eta^2 = .207$).

For the coping with stress intervention, PTSD severity was statistically significantly different at the three time points ($F(2, 22) = 5.334$, $p = .013$, partial $\eta^2 = .327$). Bonferroni adjustment was performed to determine the significance of mean differences. There was a borderline significant decrease in PTSD severity from the pre-intervention ($M = 49.00$, 95% CI [39.84, 58.16]) and post-intervention assessment ($M = 44.08$, 95% CI [34.82, 53.35]), $p = .052$.

Hypothesis 5 - General Distress

Hypothesis 5 explored whether participation in either the self-compassion or the coping with stress training would decrease veterans' levels of general distress. The results of the repeated-measures MANOVA indicated that general distress was not statistically significantly different at the three time points ($F(2, 44) = .186$, $p = .831$, partial $\eta^2 = .008$). There was no statistically significant interaction between the interventions and time of assessments ($F(2, 44) = .921$, $p = .406$, partial $\eta^2 = .040$).

Chapter 4

Discussion

Previous research indicated that trauma cognitions tend to remain unchanged in individuals' treatment for PTSD despite significant reductions in PTSD symptom severity (Nishith et al., 2005; Owens et al., 2008). The practice of self-compassion has been associated with reductions in anxiety and depression (Neff, 2012; Neff & Germer, 2013; Neff et al., 2007) and reduced shame and self-criticism (Gilbert & Procter, 2006). Despite the multitude of positive effects associated with the practice of self-compassion, to date, no research had examined the effects of self-compassion training on trauma-related guilt. The purpose of the present study was to examine whether self-administered self-compassion training had an effect on self-compassion, resilience, trauma-related guilt, PTSD severity, and general psychological distress. Participants were randomly assigned to either a self-compassion intervention or a coping with stress intervention group. Both groups received workbooks that contained five different exercises on self-compassion or coping with stress, respectively. Participants were asked to work through the workbooks daily for 5-15 minutes on their own time for four weeks. The present study yields important findings that add to the current literature on self-compassion and trauma-related guilt.

The first goal of this research was to determine whether participating in a four-week long self-administered training on self-compassion would increase veterans' levels of self-compassion. Examining the overall results suggested that levels of self-compassion increased for the entire sample. The veterans in this study reported increases in self-compassion between the pre- and post-intervention assessment. Reported levels of self-compassion did not differ by intervention across time. These results support the hypothesis that practicing either deep breathing and other relaxation exercises or self-compassion for four weeks does appear to

increase the ability to be self-compassionate. The hypothesis that practicing self-compassion increases individuals' abilities to be compassionate, kind, and caring with themselves to a greater extend than general relaxation training was not supported.

Practicing either deep breathing and other relaxation exercises or self-compassion for four weeks appears to increase the ability to be self-compassionate. One possible explanation for the increased ability to be self-compassionate after beginning to practice relaxation exercises is that the effective practice of these techniques may give individuals hope that change is possible, which, in turn, allows them to be kinder with themselves. It is noteworthy that other self-compassion trainings (e.g., Gilbert & Procter, 2006; Neff & Germer, 2013) commonly include mindful breathing or other relaxation exercises. While finding that participation in either intervention increased individuals' levels of self-compassion was surprising, this finding may be explained by individuals' increased awareness of what self-compassion is. Specifically, for participants in the self-compassion training group it is possible that individuals believe that they are kind and loving to themselves, and therefore score initially highly on the self-compassion assessment, until they learn what self-compassion practice looks and feels like, which is when they adjust their scores.

The second goal of this study was to examine whether veterans' levels of trauma-related guilt would decrease as a result of participating in the self-compassion training. Over the course of the four-week intervention, veterans' trauma-related guilt cognitions reduced significantly for the entire sample. By the end of the study veterans' mean scores of trauma-related guilt dropped 20 raw score points on the TRGI (Pre: $M = 60.42$; Post: $M = 39.75$), regardless of the intervention they received. It is notable that the levels of trauma-related guilt were significantly

higher during the mid- and post-intervention assessments for the self-compassion compared to the coping with stress group.

Interestingly, trauma-related guilt remained mostly unchanged over the first two weeks. After the first two weeks, the level of trauma-related guilt significantly dropped below the levels of trauma-related guilt reported during the pre-assessment. For individuals in the self-compassion intervention, a possible explanation for this pattern is the content of the self-compassion training workbook. During the first two weeks, participants learned to become more aware of their emotions and negative self-talk, which may have led to an increased awareness of their feelings of guilt, and therefore to an increase in trauma-related guilt. For individuals in the coping with stress intervention, the aforementioned pattern may be explained by the fact that newly acquired coping skills, such as deep breathing or progressive muscle relaxation, take practice and time to work effectively.

The drastic reduction in trauma-related guilt between the mid- and post-intervention assessments of 20 raw score points on the TRGI and an overall significant reduction in levels of trauma-related guilt in only four weeks highlights the effectiveness of self-compassion as a possible intervention for trauma-related guilt. Conducting follow-up assessment could further supported the notion that self-compassion is an effective approach to reducing trauma-related guilt that has lasting effects beyond the time individuals spend practicing the exercises in their workbooks. As described above, individuals in the coping with stress treatment condition reported a steady reduction in levels of trauma-related guilt. These findings are consistent with previous research, in which a positive effect of general relaxation training on trauma-related guilt was reported (Stapleton, Taylor, & Asmundson, 2006).

The third goal of the present study was to examine whether self-compassion training affects individuals' general resilience. Levels of resilience did not significantly change for individuals in this study when overall results were considered. However, there were differences in resilience between the two groups. Whereas there were no changes in resilience in the coping with stress group, the self-compassion group reported borderline significant reductions in resilience scores in the first two weeks. Interestingly, individuals' levels of resilience initially dropped significantly at the mid-intervention assessment and then increased prior to the post-assessment, but did not reach significance. It is possible that one's ability to recover quickly from stressful events is weakened initially as a result of learning how to identify one's emotions and negative self-talk. Realizing and becoming aware of emotions and negative self-talk patterns might have been a "shock" for some, especially if this increased self-awareness was new to them. After self-compassion had been practiced for more than two weeks, the ability to be compassionate and kind with, as well as care for oneself appeared to re-develop and individuals' resilience score tended to move toward initial levels. These findings are inconsistent with the literature that suggests that self-compassion is associated with increased resilience (Neff, 2012) and do not support the hypothesis that participation in self-compassion training will increase individuals' resilience. Most research on self-compassion practice has examined trainings that last for 8-12 weeks (e.g., Gilbert & Procter, 2006; Neff & Germer, 2013). It is possible that a longer intervention with this sample would have yielded similar results with regards to increases in individuals' resilience.

The fourth aim of this study was to determine whether completion of a four-week long self-compassion or coping with stress training would reduce PTSD severity. In the initial repeated measures MANOVA, no significant changes in PTSD severity over time were

associated with either treatment condition. However, the time by intervention was significant in the model. Follow-up analyses showed that there was a difference between the two treatment groups with regards to PTSD symptom severity. Specifically, individuals who were assigned to the coping with stress treatment condition reported borderline significant reductions in PTSD severity in the first two weeks of the intervention. These findings are in line with previous research on relaxation training, which has found it to be effective at reducing levels of PTSD (Taylor et al., 2003). There was no significant change in PTSD severity for individuals who were asked to practice self-compassion. Research that has examined the association between self-compassion and PTSD severity in a correlational study found that individuals with PTSD tended to have lower levels of self-compassion than those without PTSD (Thompson & Waltz, 2008). However, because of the design of the correlational study, the specific relationship between self-compassion and PTSD severity remains unclear. It is possible that positive changes in self-compassion lead to reductions in PTSD long-term. Due to the brevity of the interventions used in the present study it is possible that potential changes that may occur after prolonged practice of self-compassion were not detected. Future studies that investigate the effects of self-compassion training on PTSD severity should therefore assess levels of PTSD up to a year post-intervention.

The last goal of the present study was to examine the effect of participating in a four-week long self-compassion or coping with stress intervention on general distress. Participation in either treatment group did not have any significant effect on general distress; symptoms of general distress remained unchanged over the course of the four weeks during which the study took place. The findings on PTSD severity and general distress are not surprising given that many homeless veterans have been struggling with chronic mental health problems for long periods of time (Iraq and Afghanistan Veterans of America, 2009; Tsai, 2012).

Overall, the results from the present study are a valuable addition to the existing literature on both self-compassion and trauma-related guilt. To the author's knowledge, this research is the first to evaluate the effectiveness of self-administered self-compassion training on trauma-related guilt and other associated mental health problems. Findings from this study suggest that self-compassion training may be an effective intervention to help reduce trauma-related guilt. The brevity of the four-week self-compassion further demonstrates that not much time is needed in order for the effects of practicing self-compassion to set in and become effective. Furthermore, the present research showed that self-study is an effective form of delivery for self-compassion interventions aimed at reducing trauma-related guilt. Similar research that also reported significant reductions in shame and self-criticism required individuals to attend two-hour long in-person training sessions over the course of 12-weeks (Gilbert & Procter, 2006). In addition, the present study shows that self-compassion training can be effective for homeless veterans. The majority of research that has previously been conducted on self-compassion used more advantaged populations (e.g., Gilbert & Procter, 2006; Neff, 2012; Neff & Germer, 2013). Consequently, self-administered self-compassion training appears to be a cost-effective intervention for individuals who are hoping to become more self-compassionate and experience reductions in trauma-related guilt.

Upon beginning the present study, many of the veterans approached the author of this dissertation and shared about having received psychotherapy for many years without any noticeable change. It is therefore even more surprising how quickly individuals were able to change and experience reduced trauma-related guilt. Most notably is that the self-compassion intervention was written in a general way and was not designed to specifically target trauma-related guilt. Thus, it appears that the practice of self-compassion changes the entire belief

system regardless of which beliefs are targeted and compassionately challenged. Negative beliefs about oneself are the hallmark of trauma-related guilt and often prevent individuals from successfully recovering from their traumatic experiences. The approach coping qualities of self-compassion (Neff, 2012; Neff & Germer, 2013) seem to allow individuals to process and adjust their sometimes deeply engrained negative beliefs about themselves. Existing evidence-based treatments for PTSD effectively reduce symptoms of PTSD but appear to leave trauma-related guilt cognitions unchanged (Nishith et al., 2005; Owens et al., 2008). Therefore, self-compassion training may prove to be a successful adjunct to existing treatments for PTSD, such as prolonged exposure therapy, cognitive processing therapy, or eye-movement desensitization and reprocessing.

Limitations

There are a number of limitations in the present study that need to be addressed. First, the participants were asked to complete the exercises in the self-compassion and coping with stress workbooks on their own time. Although the workbooks and the description of the study instructed them to work on the outlined exercises on a daily basis, it is difficult to determine whether individuals actually practiced the exercises as intended. Thus, adherence to the instructions cannot be concluded. To resolve this issue, future studies could note how many pages individuals have actually worked through and filled out.

Second, the fact that both interventions were delivered through self-administered training, although well-intended, may have not been the ideal method of delivery for homeless veterans in transitional housing facilities. Homeless individuals tend to require a lot of direction, structure, and support. Asking them to complete assignments and follow a workbook daily may have been too unstructured for their needs. Consequently, a more effective way of delivering the self-

compassion and coping with stress interventions might be through in-person groups, in which individuals are taught and asked to practice skills related to self-compassion or deep breathing and relaxation.

Third, in addition to the $20 gift cards that the individuals received for completing the four-week long study, the organization's staff allowed the participants to miss three-hour long meetings in their transitional houses, as long as they signed up for the study. This latter incentive may have been too influential and wrongly timed, and may have negatively influenced individuals' motivation for being part in the study. While $20 does not appear to be too big of an incentive given that individuals were asked to actively complete homework assignment for 5-15 minutes daily for four weeks and participate in three 30-40 minute assessment session, allowing them to no longer attend weekly three-hour long in-house meetings as long as they sign up for the study may have influenced some of the participants' decisions to be a part of the present study, regardless of their initial interest and motivation. If the organization's staff wanted to reward individuals for participating in the study beyond the monetary incentive that was provided by the author, it would have likely been more effective if individuals had been allowed to skip a certain number of three-hour long in-house meetings after they have completed the study to ensure that they are motivated to complete the study in order to get "time off" rather than get "time off" for simply signing up for the study, regardless of whether they complete it. The 43% dropout rate might be indicative of people's lack of motivation to be part of the study. Further, the large number of participants who missed the validity check questions that were included in the assessments might be another indication of people's investment in the present study. Repeating this study using a larger sample may more accurately portray the actual effects of the two interventions used in this research.

Fourth, another limitation of the present study is the reliance on self-report assessments. As explained above, it is possible that the participant delivered certain results that they believed to be expected by the author of this dissertation or the organization's staff, despite staff not being involved in this research project beyond the initial introduction. Impression management is common among homeless individuals and is used to cope with the feelings of devaluation associated with becoming and being homeless (cf. Boydell, Goaring, & Morrell-Bellai, 2000). For this reason, objective, researcher-administered assessments for the study variables and possibly assessments for impression management could have provided greater validity.

Future Directions

Despite the aforementioned limitations, the present study provides a strong foundation for further research in the area of self-compassion and trauma-related guilt. To date, very little is known about the relationship between these variables. The present study demonstrated that self-administered self-compassion training is an effective way of reducing trauma-related guilt in homeless veterans. It is imperative to build on the foundation laid by this study and improve the use of self-compassion training as an intervention for trauma-related guilt.

Future research should continue to evaluate the impact self-compassion has on trauma-related guilt, as self-compassion training may function as an addition to existing evidence-based treatments for PTSD, such as prolonged exposure therapy, cognitive processing therapy, or eye-movement desensitization and reprocessing. As such, the role of practicing self-compassion would be to help teach trauma survivors new ways of relating, caring for, and understanding themselves beyond challenging the validity of their trauma-cognitions or lessening the intensity of trauma-related experiences. Self-directed learning, such as working through a workbook, requires a lot of drive and motivation. Thus, individuals who are introduced to self-compassion

practice may benefit from in-person learning, such as classes, groups, or individual sessions in which self-compassion is taught and practiced, as have used by other self-compassion programs, such as the compassionate mind training (Gilbert & Procter, 2006) or the mindful self-compassion program (Neff & Germer, 2013).

Further, the present research used general self-compassion exercises and the workbook did not specifically target trauma-related guilt. Future research in this area could possibly benefit from specifically evaluating trauma-focused self-compassion that directly targets trauma-based negative beliefs, such as “I should have known better” or “I am a horrible person for allowing it to happen.” Such specificity would allow for directly determining and possibly enhancing the effectiveness of self-compassion for reducing trauma-related guilt.

Conclusion

Results from the present study add to the existing literature on self-compassion and trauma-related guilt. Specifically, this research highlights the interrelation between these two concepts. The findings suggest that self-administered self-compassion training is effective at reducing levels of trauma-related guilt in homeless veterans in transitional housing. It is crucial to continue to focus on developing ways to help individuals reduce their trauma-related guilt to prevent relapse on PTSD or substances to help cope with the overwhelming sense of responsibility that many trauma survivors assume. Given that the present study is the first to examine the effects of self-compassion training on trauma-related guilt, more work in this area is needed to strengthen the foundation for self-compassion as an effective intervention for trauma-related guilt that the present study has laid. It is crucial to find effective ways of reducing trauma-related guilt to help veterans and non-veterans alike effectively work through and process their traumatic experiences so that they can maximize their quality of life.

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Appendix

Table 1
Effect sizes for study variables

Study Variable	Effect Size
1. TRGI[a], Pre	-.435
2. TRGI[a], Mid	-.263
3. TRGI[a], Post	-.337
4. SCS[b], Pre	.482
5. SCS[b], Mid	-.039
6. SCS[b], Post	.275
7. BRS[c], Pre	-.243
8. BRS[c], Mid	.052
9. BRS[c], Post	.113
10. PCL[d], Pre	-.203
11. PCL[d], Mid	-.603
12. PCL[d], Post	-.409
13. HSC[e], Pre	-.037
14. HSC[e], Mid	-.297
15. HSC[e], Post	-.318

[a] TRGI = Trauma-related guilt as measured by the Trauma-Related Guilt Inventory

[b] SCS = Self-Compassion as measured by the Self-Compassion Scale

[c] BRS = Resilience as measured by the Brief Resilience Scale

[d] PCL = PTSD severity as measured by the PTSD Checklist – Specific Stressor Version

[e] HSC = Mental health symptoms as measured by the Hopkins Symptom Checklist-21

Table 2

Means, standard deviations, and correlations between study variables

	N	Range	Mean	*SD*	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. TRGI[a], Pre	27	12-116	61.22	24.911	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
2. TRGI[a], Mid	26	9-128	61.38	29.380	.757**	--	--	--	--	--	--	--	--	--	--	--	--	--	--
3. TRGI[a], Post	27	4-78	41.74	20.652	.846**	.873**	--	--	--	--	--	--	--	--	--	--	--	--	--
4. SCS[b], Pre	27	43-97	72.19	12.896	-.341	-.232	-.242	--	--	--	--	--	--	--	--	--	--	--	--
5. SCS[b], Mid	26	56-94	74.31	9.636	-.364	-.385	-.392*	.733**	--	--	--	--	--	--	--	--	--	--	--
6. SCS[b], Post	27	54-102	76.00	12.728	-.312	-.355	-.284	.837**	.878**	--	--	--	--	--	--	--	--	--	--
7. BRS[c], Pre	27	12-24	18.26	3.665	-.115	-.126	-.019	.300	.289	.223	--	--	--	--	--	--	--	--	--
8. BRS[c], Mid	25	6-26	17.84	4.810	-.310	-.395	-.246	.475*	.438*	.410*	.540**	--	--	--	--	--	--	--	--
9. BRS[c], Post	27	12-25	18.26	3.986	-.161	-.323	-.151	.617**	.639**	.646**	.532**	.691**	--	--	--	--	--	--	--
10. PCL[d], Pre	27	17-70	48.63	15.320	.314	.301	.146	-.489**	-.400*	-.524**	-.236	-.287	-.388*	--	--	--	--	--	--
11. PCL[d], Mid	26	17-75	47.46	14.978	.573**	.604**	.461*	-.607**	-.494*	-.562**	-.028	-.290	-.359	.725**	--	--	--	--	--
12. PCL[d], Post	27	18-80	49.19	14.552	.198	.185	.173	-.456*	-.406*	-.651**	-.099	-.459*	-.546**	.705**	.851**	--	--	--	--
13. HSC[e], Pre	26	25-70	46.85	11.949	.318	.510**	.353	-.561**	-.579**	-.536**	-.096	-.155	-.245	.596**	.569**	.510**	--	--	--
14. HSC[e], Mid	26	26-84	48.85	15.785	.318	.510**	.353	-.561**	-.579**	-.665**	-.286	-.562**	-.633**	.602**	.705**	.735**	.556**	--	--
15. HSC[e], Post	27	29-80	48.74	13.438	.405*	.550**	.379	-.577**	-.526**	-.624**	-.129	-.450*	-.509**	.677**	.796**	.838**	.702**	.799**	--

* $p<.01$, ** $p<.001$

[a] TRGI = Trauma-related guilt as measured by the Trauma-Related Guilt Inventory

[b] SCS = Self-Compassion as measured by the Self-Compassion Scale

[c] BRS = Resilience as measured by the Brief Resilience Scale

[d] PCL = PTSD severity as measured by the PTSD Checklist – Specific Stressor Version

[e] HSC = Mental health symptoms as measured by the Hopkins Symptom Checklist-21

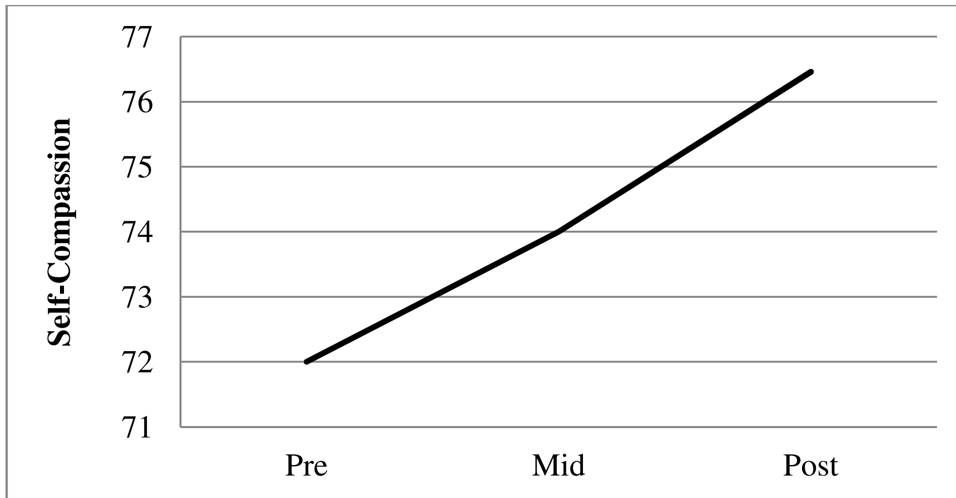

Figure 1. Self-compassion main effects for time.

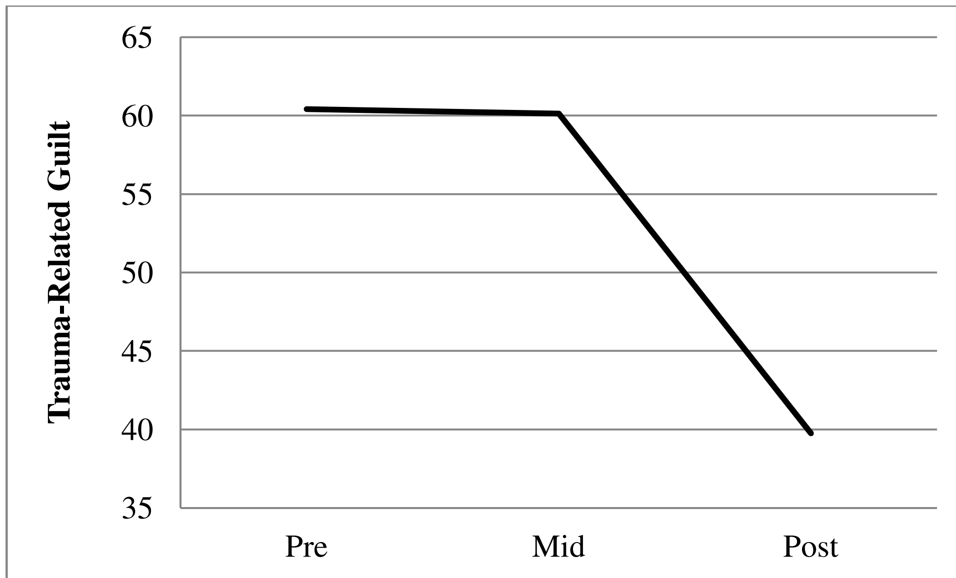

Figure 2. Trauma-related guilt main effects for time.

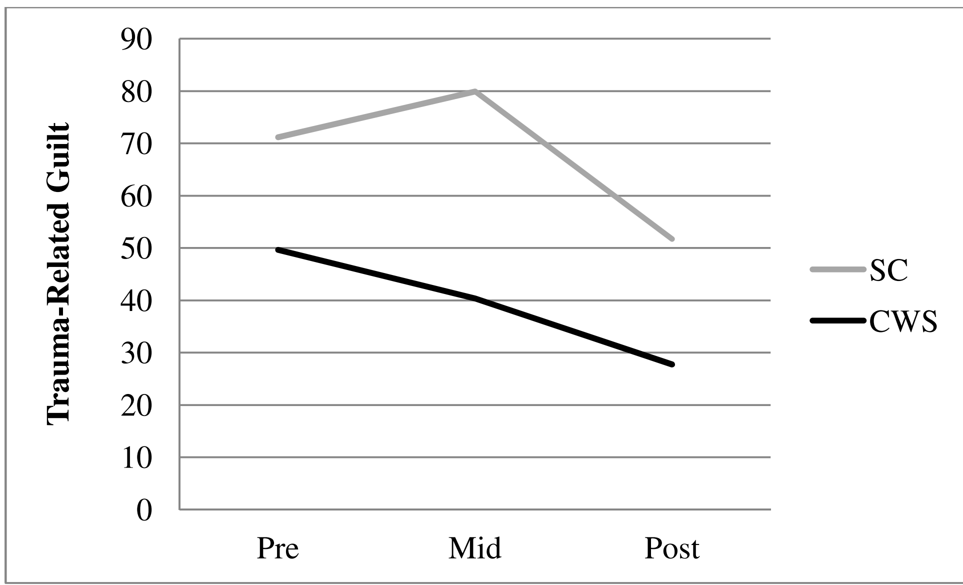

Figure 3. Trauma-related guilt interaction effects between intervention and time. SC = Self-compassion training; CWS = Coping with stress training.

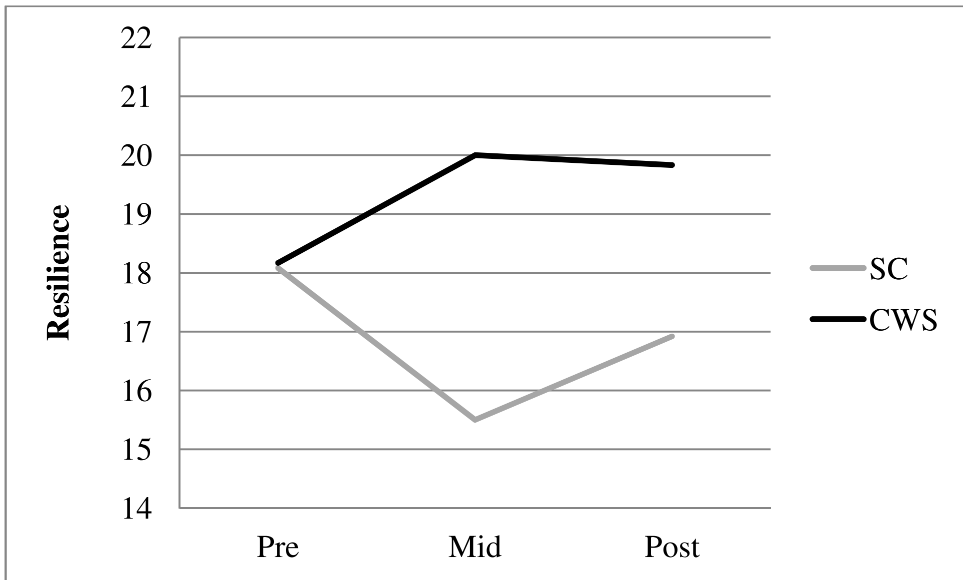

Figure 4. Resilience interaction effects between intervention and time. SC = Self-compassion training; CWS = Coping with stress training.

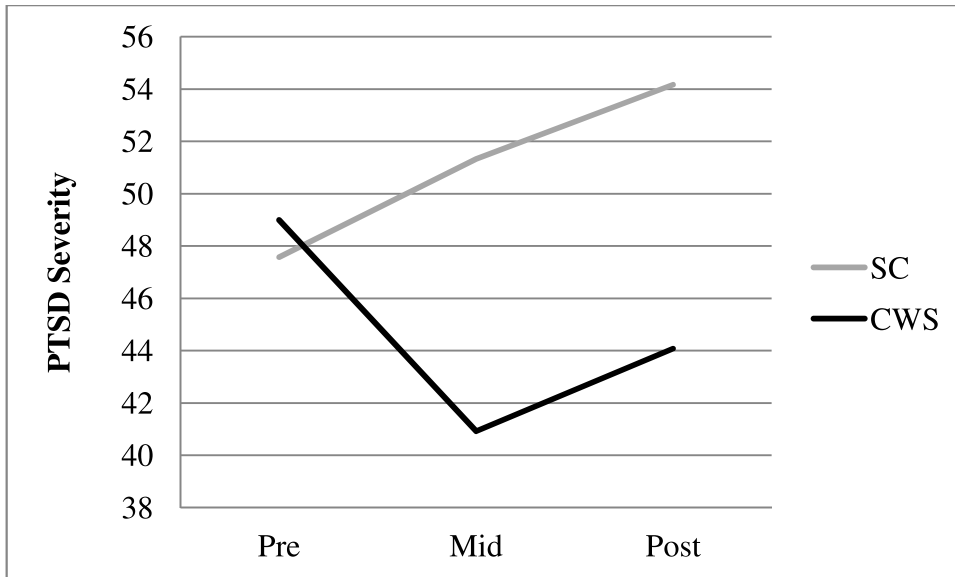

Figure 5. PTSD severity interaction effects between intervention and time. SC = Self-compassion training; CWS = Coping with stress training.

Appendix A

Self-Compassion Workbook

Introduction

Introduction

Welcome to the four-week long self-compassion training. My name is Philip Held and I am currently a fourth-year doctoral student in Counseling Psychology at the University of Tennessee. I have written this training manual because I benefited from self-compassion myself and wanted to share the things I have learned with you. Throughout this workbook, I will share a few personal examples, so don't be surprised if you feel as though you get to know me a little bit.

The definition of self-compassion is to attend to one's own needs and have an attitude of love and care toward oneself. Through exercises that have helped me grow in the area of self-compassion and changed my life for the better, I hope to guide you in a similar direction.

I have written this self-compassion training so that you can follow it and complete the exercises in this booklet. You do not need anything other than a pen and yourself to participate. What I want to ask of you is to commit to this training for the four weeks that it takes to complete. Any change that we are hoping to make is going to take our efforts and some time. Unfortunately, there is no magic pill (yet). Chances are that the more effort you put into this self-compassion training, the more benefits you will get from your participation. Keep in mind that your participation in this self-compassion training is completely voluntary. You do not have to share your answers with anyone and, at any point, if you feel like you do not want to participate anymore, you can stop without having to fear any consequences.

Week 1

Week 1 – Raising Awareness

Welcome to the first week of your self-compassion training. The focus of this week's training will be on helping you begin to identify your emotional reactions to various situations that you encounter throughout the day.

For each and every one of us there is something about ourselves that we do not like. This could be a personality characteristic, the way we look, something in our past that we have done or something that has happened to us, and so forth – you get the idea. Sadly, we tend to personalize and "become" the aspects of ourselves that we do not like, leading us to feel ashamed for being the way we are or having a sense that we are not good enough, that we will never amount to anything, that we are worthless, or that we are a lost cause. But I ask you, is it really this bad? To many of us, it may feel this way in the midst of everything that we have going on. But often times when we step back a little bit, take a few deep breaths, clear our minds, and reexamine the situation, we realize that we have overreacted.

We become so focused on trying to not make mistakes that we tend to forget that we are human. Being human means that we are imperfect. Look around, no one is perfect and there is really no need to be perfect in our world. However, we can't change the way we are unless we become aware of how we react to certain situations. That is exactly what this week's training is about. Below you see a completed example of the exercise. As you can see, there are two columns, one that requires you to write in events that took place throughout your day, and one in which you are asked to note the emotions that you felt in response to the situations. In the example I used to fill out the exercise myself, I recalled an event where I was filling up my drink in a restaurant and I accidentally dropped it in the middle of the floor. To be honest, initially it felt like it was the end of the world and I was unaware of what I was really feeling. Only after the incident passed and the mess was cleaned up did I realize that I felt really embarrassed and ashamed. In fact, I felt stupid for not being able to complete the simple task of carrying my drink from the fountain to my seat.

For this coming week, I would like to ask you to take some time to reflect each day and list issues that you had. Then after you have had time to step back from the situation and examine it, note what emotions you felt. The key to this exercise is to be as honest about what happened as you can be. Remember that this exercise is for you and no one else. There should be enough space to note several incidents per day – feel free to be as detailed as you would like to be.

Tip: It was really easy for me to get stuck on the emotion of anger. However, I learned that anger is a secondary emotion, meaning that it follows in response to another (primary) emotion. For me anger was a way to avoid feeling sad, worthless, and ashamed. When you feel angry, think about what emotions come right before your anger, such as feeling embarrassed or hurt. To help you identify your emotions I have included a list of different feelings on the next page.

Issue(s) – What happened?	Emotions
Spilled my drink in the restaurant	Embarrassed, ashamed, stupid,
	inadequate

Identifying Feelings

Happy	**Sad**	**Angry**	**Confused**
Elated	Depressed	Furious	Bewildered
Excited	Disappointed	Enraged	Trapped
Overjoyed	Alone	Outraged	Troubled
Thrilled	Hurt	Aggravated	Desperate
Exuberant	Left-out	Irate	Spaced-out
Fired-up	Hopeless	Seething	Lost
Delighted	Sorrowful	Upset	Disorganized
Cheerful	Crushed	Mad	Foggy
Up	Heart-broken	Annoyed	Misplaced
Good	Down	Frustrated	Disoriented
Relieved	Upset	Agitated	Mixed-up
Satisfied	Distressed	Disgusted	Unsure
Centered	Regret	Perturbed	Puzzled
Glad	Unhappy	Uptight	Bothered
Satisfied	Moody	Dismayed	Uncomfortable
Pleasant	Blue	Put out	Undecided
Fine	Sorry	Irritated	Baffled
Mellow	Lost	Touchy	Perplexed
Pleased	Bad		
	Dissatisfied		

Afraid	**Weak**	**Strong**	**Guilty**
Terrified	Helpless	Powerful	Sorrowful
Horrified	Hopeless	Aggressive	Remorseful
Petrified	Beat	Potent	Ashamed
Fearful	Overwhelmed	Super	Unworthy
Panicky	Impotent	Forceful	Worthless
Scared	Exhausted	Proud	Sorry
Frightened	Drained	Determined	Lowdown
Threatened	Dependent	Energetic	Sneaky
Insecure	Incapable	Capable	Embarrassed
Uneasy	Lifeless	Confident	
Spooked	Tired	Persuasive	
Apprehensive	Rundown	Sure	
Nervous	Lazy	Secure	
Worried	Insecure	Durable	
Timid	Shy	Adequate	
Unsure	Unsatisfied	Able	
	Unsure		
	Lethargic		
	Inadequate		

Week 1 – Day 1

Issue(s)	Emotions

Date completed: _________

Week 1 – Day 2

Issue(s)	Emotions
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Week 1 – Day 3

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Date completed: _________

Week 1 – Day 4

Issue(s)	Emotions

Date completed: _________

Week 1 – Day 5

Issue(s)	Emotions

Date completed: _________

Week 1 – Day 6

Issue(s)	Emotions

Date completed: _________

Week 1 – Day 7

Issue(s)	Emotions

Date completed: _________

Week 2

Week 2 – Learning Self-Compassion

Congratulations! You have made it through the first week of the self-compassion training. I hope that the Raising Awareness exercise provided you with some insight about how you react to situations – it certainly did for me. In this week's training we will learn how to use self-compassion in such situations.

As you think about last week's exercise and your emotional reactions to certain issues, did you, by any chance, notice what you were saying to yourself as the issues occurred? Usually when we feel an emotion, we can also observe having said something to ourselves. For example, in my spilling-the-drink incident, the thing that was running through my mind was something along the lines of "I am such an idiot. I just screw up all the time. I can't get anything right." For me, hearing these things was nothing new. This was the way I tended to talk to myself on a regular basis. For this week's training, I would like for you to begin to realize how you talk to yourself and begin to change it.

You might be thinking, "Change it? Why? This is how I have always talked to myself. It motivates me to do better the next time around." At least that is what I thought. But really, it never motivated me to do any better. If I am honest with myself, all it did was make me more fearful of screwing up again. What I didn't know was that the way I talked to myself affected me physically. This may sound strange but let's practice a brief exercise to demonstrate the physical effects this negative self-talk has on us. Ready? Try to read the instructions for the exercise first before you do it. Here we go:

Sitting or standing up, hold your arms out straight, just like you would if you were a zombie roaming the streets. Now look at your hands for approximately 30 seconds. Keep your focus on your hands for the remainder of the exercise. Without changing anything, begin to tell yourself the negative messages that you tend to tell yourself on a regular basis, such as "I am a screw up," "I can't amount to anything," "I am a lost cause," or whatever it is that you say to yourself. Do this for approximately 30 seconds. As you keep your focus on your hands, change your self-talk in a positive way, saying things like "I am a lovable person," "I can do this," "I deserve to be happy", and so on. It's okay to repeat the same positive messages. If you have practiced this for 30 seconds and noticed your hands, you are done. Good job!

Is there anything you noticed about your hands while doing the exercise? Chances are that you noticed how heavy your hands became as you were telling yourself all of the negative messages. It is not uncommon for our body to try to convince us to take our hands down at this point because there is "no way I can keep them up". I hope you didn't because usually what tends to happen as we tell ourselves positive messages is that our hands become much lighter. Out of nowhere we tend to gain more strength. I like this exercise so much because I never believed that these "little" messages had such a big effect on me. Just think about what they do to us when we talk negatively to ourselves for a longer period of time.

Let's shift our focus just a little bit. I want you to think of a really close friend or loved-one. Someone you deeply care about. Imagine that he or she was in one of your situations, such as spilling the drink, and you were to say all the negative things out loud to him or her that you

would be saying to yourself. How do you think that would go over? Probably not too well. I really struggled with this thought for a while and to this day believe that my loved-ones do not deserve to hear such harsh things - especially not for relatively small things, such as spilling a drink.

However, what I struggled with even more is the next question. If they don't deserve to hear such harsh things, then why do I deserve to hear them?

I want to leave you with these questions and introduce this week's exercise. In a way, this exercise is similar to last week's exercise. It is just a little more advanced and requires you to go through three different steps. First, in order to begin to *change* how we talk to ourselves we need to notice *how* we are talking to ourselves. Similar to last week's exercise, I want you to note situations that happen, what emotions you experience, and (this is the new part) the critical things you are saying to yourself. This first step is abbreviated as ICE (Issues, Critical Thoughts, Emotions), not only because of the words in this step but also because this is what freezes us. Our critical thoughts literally activate the fight-flight-or-freeze system in our brains. It keeps us stuck and prevents us from growing. Below is an example of this first step:

Step 1 ICE:

Issue(s)	Critical Thoughts	Emotions
Ate an entire bag of chips	*I am such a fat-ass, no wonder that no one likes me*	*Angry, disgusted, ashamed, sad*

Now that you have identified the critical thoughts that keep you stuck, let's move on to the second steps. After you have stepped back from the situation, reexamine your critical thoughts. Are they really justified? Let's look at the example above. In my situation I was convinced that I was a "fat-ass" just because I ate a bag of chips. Now that I have had a chance to step back from the situation, however, I realize that these thoughts may have been a little extreme. Thinking about it, I am almost convinced that everyone slips up like this sometimes. Once we realize that our critical thoughts may be exaggerated, especially given that we are human and make mistakes, it is time for us to challenge our critic.

Once again, think about what would happen if you told your critical thoughts to a friend who is in a similar situation. What would you say to a loved-one instead if they had been in a situation similar to a situation that you found yourself in, such as eating an entire bag of chips? Chances are that you would not be as critical as calling your loved-one a fat-ass. So again, how come you deserved to be called this? Aren't there worse things in life than eating a bag of chips? Putting someone (including yourself) down for slip-ups does nothing but increase guilt, shame, and general feelings of worthlessness. So guess what happens when we feel ashamed or worthless? We want to somehow cope and are probably not far from grabbing a second bag of chips, alcohol, or some other self-defeating habit.

What we need to do first is compassionately challenge our critical thought. This can happen in a couple of ways: The critical (uncompassionate) and the uncritical (compassionate) way. First, let's think about how we usually tend to judge our actions, most of which is in a critical way. We know where this takes us. So challenging our critical thoughts in critical ways, such as by calling them stupid or worthless ways of thinking will likely not get us anywhere other than help us repeat the cycle of having these negative thoughts again.

The non-critical way of challenging your inner critic would involve coming from a place of understanding. Sometimes it helps me to actively talk to my inner critic in my head—just like the two sides of your conscience on each shoulder—but instead of calling him names for criticizing me yet again, I have learned to communicate in a healthier, more assertive way. So, instead of calling him names, I try to be more loving and understanding. Something I would say in the situation described above would be something like: "I understand that you are only trying to look out for me and help me not make the same mistake again. But every time you are this harsh, I want to just repeat the same mistake again. I would like for you to be less critical and, instead, help me like a friend would." As silly as this sounds, it really helps me to become aware of how I talk to myself and to treat myself in a more kind and loving way.

Now that I have shared how I talk to my inner critic (and I hope you can try this as well) I would like for us to focus on the second step of challenging our critical thoughts. So, instead of harshly criticizing what we have done, what could we tell ourselves instead? Do you think it would be possible to come from a place of love and understanding? It will feel very uncomfortable at first, I know, but let's give it a try. I know that it took me a few weeks to become more comfortable with talking to myself in a more kind and loving way. After all, I had never done this before in my life. Maybe instead of calling myself a fat-ass after eating a bag of chips, I could acknowledge how sad I am after I realize that I ate the whole bag by myself. I could recognize that I really ate the bag of chips to try to cope with what had been going on and that the original intent of coping with my stress was relatively positive. It's just that the actual way of coping by eating a bag of chips may have not been the best coping style. As you are challenging your critical thought by talking to yourself in a kinder and more loving way, notice how your emotions shift and note these in the "New Emotions" column. Keep in mind that the things we invent to cope with our feelings are ingenious, no matter how bad some of them are. It takes a clever person to come up with these ways of coping and an even cleverer individual to recognize that our attempts of coping are not necessarily the healthiest ways all the time. Emotions, as unpleasant as they can be, are what make us human. When we were children we tried to find comfort through our parents or friends who (hopefully) responded in a loving way. That is how we get through our feelings. Acknowledge what we feel, be kind to ourselves, and notice what happens. While our emotions may not go away immediately they will stick around much shorter and have less control over us after our attempts of coping than if we were critical. Thus, this doesn't lead you to repeat the cycle of criticism all over, but starts a new cycle of compassion. The way I would compassionately challenge my critical thought would look something like this:

Step 2 Compassionate Challenge:

Issue(s)	Critical Thoughts	Emotions
Ate an entire bag of chips	*I am such a fat-ass, no wonder that no one likes me*	*Angry, disgusted, ashamed, sad*

Compassionate Challenge	New Emotions
I understand that what I wanted to do was feel better, which is why I ate that bag of chips. My intent was good and I am sorry that I now feel sad, disgusted and ashamed. Why don't I go for a walk to feel a little better?	*Understood, comforted, encouraged*

For the following week I would like for you to go through the two steps of ICE and Challenge with one or more situations daily. First, identify what is going on and what you are telling yourself in response to it and then challenge your critical thoughts.

Special tip: I want to share this extra tip with you but also want to warn you that this step could be extremely uncomfortable – it's okay to laugh at first. I did too! When you think about a friend or a loved-one who is in pain, what do we tend to do? Often times we comfort them physically. What keeps us from treating ourselves this way? Especially when we struggle with being kind to ourselves in the challenging part of the exercise, softly stroking our arms or even hugging ourselves can help activate our internal caregiver system and will help us feel warm and caring because you are acting in a loving and kind way to yourself. If someone walks in as you are softly stroking your arm or giving yourself a genuine self-hug you could always just tell them that your arm or back was itching. ☺

Week 2 – Day 1

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge	New Emotions

Date completed: _________

Week 2 – Day 2

Issue(s)	Critical Thoughts	Emotions
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Compassionate Challenge	New Emotions
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Date completed: _________

Week 2 – Day 3

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge	New Emotions

Date completed: _________

Week 2 – Day 4

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge	New Emotions

Date completed: _________

Week 2 – Day 5

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge	New Emotions

Date completed: _________

Week 2 – Day 6

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge	New Emotions

Date completed: _________

Week 2 – Day 7

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge	New Emotions

Date completed: _________

Week 3

Week 3, Part 1 – Compassionate Letter to Friend

Great job! You have made it to the third week of the self-compassion training. Now, two weeks do not equal a miracle but maybe you can notice little changes in the ways that you are talking to yourself throughout your days. Since I have brought up the miracles, I want to spend a couple of lines on this topic. I, too, was constantly waiting for different miracles to occur in my own work and guess what? I never had a "burning bush" moment. However, what I learned to appreciate much more were the smaller miracles that constantly occur. Every day. I was just too blind to see them at first because I thought that every change needed to be huge and groundbreaking. Give it a shot. I challenge you to look for the small miracles throughout the day. I bet you can find some.

Now let's move on to the third week's exercises. Yes, you read correctly. There are going to be *two* different exercises this week. I hope that you have been able to be more self-compassionate thus far. Throughout this training manual I have used the example of how we would communicate with a really close friend or loved-one and asked to explore what keeps us from talking to ourselves in a loving and kind way like we would to that person. You can probably guess where this week's exercises will take us, correct?

For this week I would like for you to think about the friend or loved-one that you have thought of throughout the last two weeks. (It's okay if you did not think of an actual person but rather an imaginary close friend.) For the first three days of this week, I want you to write an unconditional compassionate letter (as long or short as you would like) to this friend or loved-one who has loved, accepted, and supported you unconditionally. Thinking about him or her, chances are that you know his or her strengths really well. It's not uncommon for us to be more aware of other's strengths rather than our own. However, chances are that your friend or loved-one may not be as aware of his or her strengths or how much he or she has meant to you as you do. That is the point of the letter. Share with your friend what he or she has meant to you and how you have benefited from his or her care and compassion toward you.

You may wonder if you need to mail the letter to your friend if he or she does in fact exist. The answer is no. However, you may choose to send the letter. Or you could simply share what you wrote in person if you see your friend or loved-one every now and then. If you end up deciding to share your letter, however, it's important that you put your expectations aside. Remember, the key here is to be unconditionally loving, which implies not expecting a reaction from the other person but rather expressing what another person means to us because we really want to express it, rather than because we want to hear from them how much we mean to them. Also, keep in mind that the letter does not have to be perfect. Remember: we are humans and imperfect. And yet, we can express compassion in many ways, even imperfect ones. Don't worry about getting your compassion across – it will!

On the following pages you will find enough space to write the letter. Work on the letter for the first three days of this week. After three days of writing the letter, check back for the second assignment this week.

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Week 3, Part 2 – Compassionate Letter to Self

Welcome back! How was it to write the letter to your friend or loved-one? Did you end up sharing your letter with your friend or loved-one? Whether or not you shared your letter with him or her is up to you, as I said before. However, now we are going to move to the more difficult of this week's training, Part 2.

For the second part of this week's assignment, I would like for you to think of your loved-one or friend who loves, cares, and supports you unconditionally and is very compassionate. Become this loved-one or friend over the course of this exercise and imagine what this person feels toward you and how he or she accepts, loves, and cares simply for who you are without requiring you to change a single thing. Keep in mind that your friend or loved-one probably understands that we – humans – are flawed and that we are lovable nonetheless. He or she likely already knows that you have been through numerous things to make you who you are at exactly this moment and he or she loves you for who you are.

Once you have assumed the role of this friend or loved-one (real or imagined), begin to write a letter to yourself from their perspective. What would this person say about you including your perceived "flaws," given that he or she is unconditionally compassionate? How would this unconditional compassion be expressed by your friend or loved-one in this letter, especially in moments when your hurt or pain feels unbearable? What would this person say to remind you that you are human and not superman? What strengths does your friend or loved-one see in you that may be difficult for you to see yourself? Are their changes that you think your friend or loved-one would suggest you make? How would these suggestions for change be expressed in a compassionate way? Be sure to write this letter from a compassionate point of view and don't forget that your friend would not talk to you as critically as you tend to talk to yourself.

I really struggled with writing this letter and found that I kept getting stuck with my own self-critical thoughts. Soon I began to judge this exercise as "stupid" and was determined that it was not going to do anything for me. However, it was not until I tried the exercise that I noticed how nice it can be to receive such a compassionate letter for myself. When writing it, it may help to move to a different place in your room from where you can look at where you tend to sit. You can then write the letter to yourself from this new place. That is what helped me the most other than to just write it and see what happens.

One more thing that I would like to make you aware of is that your body may react to writing a compassionate letter to yourself (possibly because it has been a long time since you have heard such wonderful words). It can happen, for example, that you begin to feel sad or upset – even cry – as you are writing the letter. Given our harsh tendencies it would be easy to think, "Why in the world am I crying? Suck it up, this is a positive letter." By saying these things you would completely neglect how you are feeling. Should this or something similar happen to you it is important that you use the compassionate challenge that we learned about in the second week. It will also be important to comfort yourself and not follow your tendency to be harsh with yourself, even if they are deeply engrained.

You have space on the following pages to write your letter over the remainder of this week. However, throughout the last week, I want to encourage you to look at your letter again so that what you have written can sink it. As one of my colleagues, Kristen Neff[1] says: "Feel the compassion as it pours into you, soothing and comforting you like a cool breeze on a hot day. Love, connection and acceptance are your birthright. To claim them you need only look within yourself."

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[1] Neff, K. D. (2011). *Self-compassion: Stop beating yourself up and leave insecurity behind (p. 17).* New York, NY: William Morrow.

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Week 4

Week 4 – Self-Criticism as a Motivator

You have made it to the last week of your self-compassion training. Is there anything you notice? I want to use this week to get you thinking about how we can use the self-critical thoughts we have as a motivator rather than a roadblock. It is completely normal to have self-critical thoughts. Our brains are designed to look out for dangers and motivate us to do better or refrain from doing certain things in the future. However, what our brains don't know is that self-criticism actually inhibits us and therefore is the complete opposite of a motivator. Instead, our brains are trying to tell us that we will never grow if we speak too softly to ourselves. Chances are, until now we haven't tried to speak to ourselves in a positive way and therefore have no evidence that self-compassion helps us or stalls our progress.

Think about the parts of yourself that you tend to criticize the most. Do you think of yourself as too fat and lazy, too screwed up, or too impulsive? Think about what the traits are that you are criticizing yourself for, try to notice the emotional pain that comes with criticizing yourself in the ways that you do. Often we initially find it difficult to identify any emotional pain because we have gotten so used to our own criticism. You have read this many times since beginning this training but one thing that helps with identifying painful emotions is imagining how one of your close friends or loved-ones would feel if they were called too fat, too screwed up, too impulsive, or whatever it is that you are telling yourself.

Once you identify the negative self-talk, try to think of a more caring and loving way of getting across what your self-critic is saying while being motivating rather than inhibiting your growth. Usually this motivation comes from a place of understanding and kindness. Similar to challenging your critical thoughts that we went over in the second week, think of what a nurturing and loving close friend or loved-one would tell you. Then think about what this friend or loved-one would tell you when he or she is trying to encourage you to make a change. If your friend is truly compassionate, he or she will not be likely to tell you that you "have to" do certain things. He or she likely knows that every time we are told or tell ourselves that we "have to" do something we set expectations that we often times can't meet.

Let me share an example with you: When I first began to practice self-compassion I "had to" be kind and loving to myself at all times because that is what self-compassion was all about. Guess what? Since self-compassion was so new to me at that point I often times (unknowingly) let my inner critic speak uninhibited. Because I had learned how to catch my own thoughts as part of self-compassion training, I quickly became aware of how I talked to myself and remarked that it, once again, was not nice and that I didn't deserve to be talked to in such a way. I also noticed that I had failed my expectation that I "had to" be nice to myself at all times and failed. What a chance for my inner critic to chime in -- and you know that our inner critics rarely ever miss opportunities like this one. Quickly I began to tell myself that I would never get this self-compassion thing and that self-compassion in general was a stupid idea. What I wasn't aware of is that I became irritated quickly and felt empowered – at least in that moment. However, the longer I continued to talk in such ways, the less happy I became. Fortunately I remembered what I had learned in my training thus far and began to talk to myself in a more compassionate way, such as "I understand that you wanted to get this idea of self-compassion and do it perfectly since that is what you are used to. However, you just learned about self-compassion not too long

ago and there is no way that you can be perfect at it. Remember, we are human and therefore inherently imperfect. I am proud of you for having caught yourself as you were talking in such harsh terms. Now let's continue with being self-compassionate and see what happens."

By catching myself and changing the way I talked to myself I was able to change the way I felt rather quickly. My sadness and aggravation turned into hope and motivation. The "see what happens" part evoked curiosity. Who would have thought that four simple phrases like the ones I told myself had such an effect on my well-being? I certainly didn't. What I also didn't realize until later was that the last sentence "Now let's continue with being self-compassionate and see what happens" is something a friend would say to encourage me. I had done it on my own simply by remembering what I had learned until that point.

So, all you really need to do for this week is continuing what you have been doing thus far: notice what is going on, what you have been telling yourself, and how you are feeling (ICE). Then, like you have been doing, challenge your critical thoughts with self-compassion. The only addition is to add a small supportive and encouraging statement to motivate you, just like I did above. Here is an example of what the exercise looks like:

Issue(s)	Critical Thoughts	Emotions
I was self-critical although I have to be self-compassionate	*I will never get this self-compassion thing - it's stupid*	*Empowered at first, aggravated, angry*

Compassionate Challenge and Encouragement	New Emotions
I understand that you wanted to get this idea of self-compassion and do it perfectly since that is what you are used to. However, you just learned about self-compassion not too long ago and there is no way that you can be perfect at it. Remember, we are human and therefore inherently imperfect. I am proud of you for having caught yourself as you were talking in such harsh terms. Now let's continue with being self-compassionate and see what happens.	*Hopeful, motivated, curious*

Week 4 – Day 1

Issue(s)	Critical Thoughts	Emotions
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Compassionate Challenge and Encouragement	New Emotions
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Date completed: _________

Week 4 – Day 2

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge and Encouragement	New Emotions

Date completed: _________

Week 4 – Day 3

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge and Encouragement	New Emotions

Date completed: _________

Week 4 – Day 4

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge and Encouragement	New Emotions

Date completed: _________

Week 4 – Day 5

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge and Encouragement	New Emotions

Date completed: _________

Week 4 – Day 6

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge and Encouragement	New Emotions

Date completed: _________

Week 4 – Day 7

Issue(s)	Critical Thoughts	Emotions

Compassionate Challenge and Encouragement	New Emotions

Date completed: _________

Congratulations!

Congratulations. You have successfully completed four weeks of the self-compassion training. What an accomplishment! Now I have sad news and good news for you. The good news first: By completing this training you have gained the foundational skills of self-compassion and are now able to apply them whenever and wherever you want. Now to the sad news: As I brought up in the fourth week, self-compassion is a process and it will take continued practice in order to remain self-compassionate. However, since you know how to be self-compassionate I believe that you are more than able to keep it up yourself if that is what you would like to do. Feel free to return to the worksheets at any point in time. They are yours now and may come in handy in the future.

Again, great job on completing the training. I sincerely hope that it helped you in becoming a more aware and more compassionate person who can enjoy life without having to get caught up in constant criticism.

I wish you all the best!

Sincerely,

Philip

Appendix B

Coping with Stress Workbook

Introduction

Introduction

Welcome to the four-week long coping with stress training. My name is Philip Held and I am currently a fourth-year doctoral Counseling Psychology student at the University of Tennessee. I have written this training manual because I benefited from the coping strategies that I will explain myself and wanted to share the things I have learned with you.

I have written this coping with stress training so that you can follow it and complete the exercises in this booklet on your own time. You do not need anything other than a pen and yourself to participate. What I want to ask of you is to commit to this training for the four weeks that it takes to complete. Any change that we are hoping to make is going to take our efforts and some time. Unfortunately, there is no magic pill (yet). Chances are that the more effort you put into this coping with stress training, the more benefits you will get from your participation. Keep in mind that your participation in this coping with stress training is completely voluntary. You do not have to share your answers with anyone and at any point, if you feel like you do not want to participate anymore, you can stop without having to fear any consequences.

Week 1

Week 1 – Deep Breathing

Welcome to the first week of your coping with stress training. The focus of this week's training will be on teaching you a breathing technique. Personally, I always believed that breathing techniques do not work. However, at that time I had never tried a breathing technique. My negative attitude toward them just always kept me from practicing them. What I ask you to do is follow the instructions below and practice the exercise for a few minutes (not just a few breaths). I want to encourage you to use the exercise below at least once per day. On the following pages, take some time to describe the situations when you used the breathing technique and your experiences with it. Was it helpful? What changed as a result of practicing it? Maybe nothing changes and that would be okay too. The reason I ask you to write about your experiences with the exercises is because it may help you get a better understanding of the impact of the coping skills.

Breathing Awareness and Deep Breathing

1. Lie down or sit in a comfortable chair, maintaining good posture. Your body should be as relaxed as possible. Close your eyes. Scan your body for tension.
2. Pay attention to your breathing. Place one hand on the part of your chest or abdomen that seems to rise and fall the most with each breath. If this spot is in your chest you are not utilizing the lower part of your lungs.
3. Place both hands on your abdomen and follow your breathing, noticing how your abdomen rises and falls.
4. Breathe through your nose.
5. Notice if your chest is moving in harmony with your abdomen.
6. Now place one hand on your abdomen and one on your chest.
7. Inhale deeply and slowly through your nose into your abdomen. You should feel your abdomen rise with this inhalation and your chest should move only a little.
8. Exhale through your mouth, keeping your mouth, tongue, and jaw relaxed.
9. Relax as you focus on the sound and feeling of long, slow, deep breaths.

Complete Natural Breathing

1. Sit or stand with good posture.
2. Breathe through your nose.
3. Inhale, filling first the lower part of your lungs then the middle part, then the upper part.
4. Hold your breath for a few seconds.
5. Exhale slowly. Relax your abdomen and chest.

Practice these two exercises, in whatever combination feels best for you, for a few minutes as much as you would like.

Week 1 – Day 1

Which exercise did you use?

[ ] Breathing Awareness and Deep Breathing
[ ] Complete Natural Breathing

Date completed: _________

What was it like practicing the exercise? (For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

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Week 1 – Day 2

Which exercise did you use?

[ ] Breathing Awareness and Deep Breathing
[ ] Complete Natural Breathing

Date completed: _________

What was it like practicing the exercise? (For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

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Week 1 – Day 3

Which exercise did you use?

[ ] Breathing Awareness and Deep Breathing
[ ] Complete Natural Breathing

Date completed: _________

What was it like practicing the exercise? (For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

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Week 1 – Day 4

Which exercise did you use?

[ ] Breathing Awareness and Deep Breathing
[ ] Complete Natural Breathing

Date completed: _________

What was it like practicing the exercise? (For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Week 1 – Day 5

Which exercise did you use?

[ ] Breathing Awareness and Deep Breathing
[ ] Complete Natural Breathing

Date completed: _________

What was it like practicing the exercise? (For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

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Week 1 – Day 6

Which exercise did you use?

[ ] Breathing Awareness and Deep Breathing
[ ] Complete Natural Breathing

Date completed: _________

What was it like practicing the exercise? (For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

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Week 1 – Day 7

Which exercise did you use?

[ ] Breathing Awareness and Deep Breathing
[ ] Complete Natural Breathing

Date completed: _________

What was it like practicing the exercise? (For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

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Week 2

Week 2 – Progressive Muscle Relaxation

Congratulations! You have made it through the first week of the coping with stress training. I hope that the breathing exercises provided you with some peace –they certainly did for me. In this week's training we will learn progressive muscle relaxation.

I want you to spend some time thinking about how you know when you are stressed? I would not be surprised if you thought of headaches, tightness in your neck and chest, or physical exhaustion. Stress often manifests itself in the form of physical symptoms. While some symptoms of stress are more severe, other signs of stress are ones we often ignore, such as clenching our jaws.

One thing we want to do when we are stressed is become physically relaxed. Progressive muscle relaxation is one technique that can help with it. The key to progressive muscle relaxation is to tense up particular muscle groups purposely and then relax them. We want to go through a variety of different muscle groups as described below. Before we get started I want to make sure you are prepared. First, if you have any injuries or a history of physical problems that may cause muscle pain, make sure you consult with your doctor before participating in the exercises. Since progressive muscle relaxation is a relaxation exercise, we want to try to minimize or eliminate the distractions in our surroundings. Make sure you find a place where you can sit comfortably, such as a comfortable chair. Lastly, when we are trying to relax our whole body is involved. This means that relaxation is difficult if our body is in the process of actively processing food after meals, for example. So, make sure you are ready to practice a relaxation exercise before you do it.

For this practice, tense the muscle groups listed below for approximately 10 seconds at a time. After these 10 seconds, release the tension and study the difference between the tension and relaxation. One thing that may help you with relaxing is actually saying "relax" out loud. One thing to keep in mind is that practice makes perfect. Chances are that the more you practice the exercise, the better you will get. On the following pages I want to encourage you to note your experiences with progressive muscle relaxation each day of the week.

Progressive Muscle Relaxation

1. **Right hand and forearm.** Make a fist with your right hand and squeeze for 10 seconds, then relax.
2. **Right upper arm.** Bring your right forearm up to your should to “make a muscle” for 10 seconds, then relax.
3. **Left hand and forearm.** Make a fist with your left hand and squeeze for 10 seconds, then relax.
4. **Left upper arm.** Bring your left forearm up to your should to “make a muscle” for 10 seconds, then relax.
5. **Forehead.** Raise your eyebrows as high as they will go, as though you were surprised by something for 10 seconds, then relax.
6. **Eyes and cheeks.** Squeeze your eyes tight shut for 10 seconds, then relax.
7. **Mouth and jaw.** Open your moth as wide as you can, as you might when you’re yawning for 10 seconds, then relax.
8. **Neck.** Face forward and then pull your head back slowly, as though you are looking up to the ceiling for 10 seconds, then relax.
9. **Shoulders.** Tense the muscles in your shoulders as you bring your shoulders up to your ears for 10 seconds, then relax.
10. **Shoulder blades and back.** Push your shoulder blades back, trying to almost touch them together, so that your chest is pushed forward for 10 seconds, then relax.
11. **Chest and stomach.** Breathe in deeply, filling up your lungs and chest with air, then breathe all the way out.
12. **Hips and buttocks.** Squeeze your buttock muscles for 10 seconds, then relax.
13. **Right upper leg.** Tighten your right thigh for 10 seconds, then relax.
14. **Right lower leg.** Pull your toes toward you to stretch the calf muscle for 10 seconds, then relax.
15. **Right foot.** Curl your toes downwards for 10 seconds, then relax.
16. **Left upper leg.** Tighten your left thigh for 10 seconds, then relax.
17. **Left lower leg.** Pull your toes toward you to stretch the calf muscle for 10 seconds, then relax.
18. **Left foot.** Curl your toes downwards for 10 seconds, then relax.

Week 2 – Day 1

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: _________

Week 2 – Day 2

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: _________

Week 2 – Day 3

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: _________

Week 2 – Day 4

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: _________

Week 2 – Day 5

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: _________

Week 2 – Day 6

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: _________

Week 2 – Day 7

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 3

Week 3 – Safe Place Visualization

Great job! You have made it to the third week of the coping with stress training. Now, two weeks do not equal a miracle but maybe you can notice little changes in the ways you are handling stress.

Now let's move on to the third week's exercise. This week we will talk about a visualization exercise. Practicing this exercise might be more difficult than the two exercises that we have talked about before. Remember me saying that practice makes perfect? That statement may be most applicable to this week's exercise, so I want to encourage you to be patient and continue to practice even if it doesn't work the first time.

What I would like for you to do for this exercise is think of a place that feels calm and secure to you. This place can be real or imagined. I have personally never been to the Fiji islands but I have seen beautiful pictures of white sandy beaches, palm trees, and crystal clear water in magazines and on the internet. So, even though I have never been there, the being on the beach of the Fiji islands is my safe place.

You may wonder how we get to our safe place. Good question. Well, we can get to our safe place without requiring any money or travel time. All we need is our mind. Read the instructions below first and then try your best to follow them on your own. The principle is to envision being in your safe place and use your five senses to make your experience as vivid as possible. On the following pages I would like for you to write down your experiences.

Safe Place Visualization

1. Sit in a comfortable chair and close your eyes.
2. Take a deep breath in, hold it for a second, and breathe out. Repeat this step a few times.
3. Notice how your belly expands as you breathe in and how it flattens as you breathe out.
4. Notice the cold air going into your nose, and how it is a little warmer as you breathe out.
5. Without using any force try to bring up an image of your safe place and try to make it as vivid as possible.
6. Using your imaginary eye, look around in your safe place and notice everything you see in your safe place.
7. Using your imaginary ear, notice all of the things you can hear in your safe place.
8. Notice if you can smell or taste anything in your safe place.
9. Notice any body sensations you have, as you are in your safe place. (Whenever I envision being on the beach in the Fiji islands I can feel the sand between my toes).
10. Once again, using your imaginary eye, look around again and notice if things have become more vivid.
11. Enjoy being in your safe place.
12. Notice any positive emotions you are currently experiencing. Notice where they are in your body and what they are.
13. Without using any force, try to spread the positive emotions throughout your body and notice what happens.
14. Using all your five senses (sight, sound, smell, taste, touch), notice what it is like to be in your safe place.
15. Shift your focus back to your breath, notice how your belly expands as you breathe in and how it flattens as you breathe out.
16. Whenever you are ready, open your eyes and come back to the room.

Week 3 – Day 1

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 3 – Day 2

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 3 – Day 3

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 3 – Day 4

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 3 – Day 5

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 3 – Day 6

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 3 – Day 7

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 4

Week 4 – Cook's Hookup

You have made it to the last week of your coping with stress training. Is there anything you notice? This week we will go over a fun little exercise termed "Cook's Hookup". Believe it or not, I learned this exercise from a small child with ADHD. He said that there was one thing that always helped him calm down when he was feeling stressed. I asked him to show me and after practicing it for a few minutes I was convinced. Now I want to share it with you. It is very simple and I wish I had a chance to show you but I will do my best to explain it in writing. As you have done before, on the following pages write daily about your experience with using this exercise for the next week.

Cook's Hookup

1. Sit on a chair and extend your legs.
2. Cross your left ankle over your right one.
3. Extend your arms, cross your right wrist over your left one, then turn your hands so the palms are touching
4. Clasp your fingers, and twist your hands down and toward your ribs, and rest them on your chest.
5. Hold this position for the remainder of the exercise.
6. Breathe through your nose.
7. As you breathe in, push your tongue against your upper palette.
8. As you breathe out, push your tongue against your lower palette.
9. Do this exercise for a couple of minutes. After this notice what you experience in your body.

Week 4 – Day 1

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 4 – Day 2

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 4 – Day 3

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 4 – Day 4

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

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Date completed: ________

Week 4 – Day 5

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 4 – Day 6

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

Date completed: ________

Week 4 – Day 7

What was it like practicing the exercise?
(For example, how long did you practice? Why did you decide to practice? What were the results of practicing?)

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Date completed: ________

Congratulations!

Congratulations. You have successfully completed four weeks of the coping with stress training. What an accomplishment. Now I have sad news and good news for you. The good news first: By completing this training you have gained the foundational skills of how to cope with stress and are now able to apply them whenever and wherever you want. Now to the sad news: Coping with stress is a process and it will take continued practice in order to be able to handle your stress. However, since you know how to cope with stress I believe that you are more than able to keep it up yourself if that is what you would like to do. Feel free to return to the exercises in this workbook at any point in time. They are yours now and may come in handy in the future…

Again, great job on completing the training – I sincerely hope that it helped you in becoming more able to cope with stress.

I wish you all the best!

Sincerely,

Philip

Vita

Philip Held was born in Düsseldorf, Germany and grew up in Wilhelmshaven, Germany. He attended the University of Indianapolis for his undergraduate education and graduated summa cum laude in 2009 with a degree in psychology. Philip attended the University of Tennessee in pursuit of a doctor of philosophy degree in counseling psychology. He will graduate in August 2014 after completion of a year-long clinical internship at the University of Tennessee Student Counseling Center.