

Supplementary Table S1

Treatment Components

Session	Content
1	<p>Main goals: General PTSD psychoeducation and mindfulness instruction. Key exercises: PTSD psychoeducation, mindful breathing, grounding Participants received information on the nature of posttraumatic stress and the factors that maintain it. They then learned and practiced mindful breathing and simple grounding techniques (i.e., orienting oneself to the present; using the five senses to increase nonjudgmental awareness of the present).</p>
2	<p>Main goals: Define self-compassion, build motivation to increase self-compassion, and practice self-compassion for everyday difficulties. Key exercises: Coach A vs Coach B, Self-Compassion Break, self-compassion letter The session started with a brief mindful breathing exercise to promote mindfulness in session and to review skills from the previous session, followed by homework review. Then, as part of the rationale for practicing self-compassion, psychoeducation was provided on the interactions between three emotion regulation systems: the threat/self-protection, achievement/activating, and contentment/soothing systems (Gilbert & Procter, 2006). Fear of compassion was normalized, and misconceptions about self-compassion were explored with the vivid story of a young child who is either berated by a harshly critical <i>Coach A</i> versus treated compassionately by a <i>Coach B</i> (Otto, 2000). Participants reflected on which coach they would choose for a loved one and which coach they tend to pick for themselves. Participants practiced the <i>Self-Compassion Break</i> exercise, which involved recalling a stressful, non-trauma-related difficulty and repeating individualized phrases to practice the three parts of self-compassion: mindful awareness of suffering, common humanity, and kindness (Neff & Germer, 2013). They practiced this exercise for homework and also wrote a compassionate letter to themselves about a current difficulty unrelated to the trauma.</p>
3	<p>Main goal: Practice self-compassion for everyday, non-trauma-related difficulties. Key exercises: compassionate scent, Sending Compassion, Perfect Nurturer First, participants briefly practiced the previous session's self-compassion break exercise and reviewed homework. Smell was discussed as a sensory experience that is often associated with both negative and positive memories and can trigger strong emotions (Lee & James, 2013). Participants chose a scent to keep from various essential oils and then paired this scent with the remaining exercises. Participants learned two new experiential exercises. The first one, <i>Sending Compassion</i> involved silently repeating four phrases commonly used in <i>loving kindness meditation</i> (e.g., "May you be safe, may you be healthy...") to imagine sending compassion to a loved one, repeating the phrases as they pictured themselves with their loved one, and finally repeating the phrases as they focused on only themselves (Neff & Germer, 2013). The second exercise, the <i>Perfect Nurturer</i> involved vividly imagining themselves in the company of someone epitomizing compassion (e.g., an idealized figure, an animal, or a fictional character) (Lee & James, 2013; Gilbert, 2010). Participants were encouraged to use sensory descriptions to create a strong felt impression of their perfect nurturer (i.e., imagining what they would see, hear, smell, etc. when in the presence of their perfect nurturer). For homework, participants practiced both of these exercises.</p>

4	<p>Main goal: Apply self-compassion practices from Sessions 2 and 3 to the index trauma. Key exercise: <i>Perfect Nurturer</i></p> <p>At the beginning of session, participants engaged in a brief mindful walking exercise. After reviewing the homework, participants identified the worst moment of their trauma and brainstormed how they would ideally imagine their perfect nurturer comforting and supporting them if they showed their perfect nurturer what they had experienced (Lee & James, 2013). They practiced vividly imagining their perfect nurturer before showing their nurturer their memory of the trauma, and then imagining how their perfect nurturer would comfort and support them and respond to any feelings of shame and self-blame. This exercise was then practiced for homework.</p>
5	<p>Main goal: Continue practicing self-compassion in response to the trauma. Key exercise: <i>Compassion Antidote</i></p> <p>They started the session by engaging in a brief mindful eating exercise before reviewing the homework. They then identified difficult trauma-related emotions such as shame and disgust and described their typical reactions to those difficult emotions (e.g., self-criticism, distraction). They were introduced to the alternative response of opening up to and accepting the emotion with self-compassion. Participants were introduced to the <i>Compassion Antidote</i> exercise, which entailed locating and visualizing the emotion in the body, mindfully describing the qualities of the emotion, and then softening into the emotion, allowing it to be there, and soothing themselves for experiencing the difficult emotion (Germer & Neff, 2014; Neff & Germer, 2013). The exercise ended with visualizing compassion in the body (Lee & James, 2013). For homework, participants practiced this exercise and wrote a second self-compassionate letter to themselves about the trauma and its sequelae.</p>
6	<p>Main goal: Review and wrap-up Key exercise: mindfulness/self-compassion exercise of participant's choosing</p> <p>In the final session, participants discussed the previous week's homework and then engaged in a general review of self-compassion skills from the intervention. Participants picked a mindfulness or self-compassion exercise to practice briefly at the beginning of the session. They then identified the exercises that they had found most helpful, reflected on their progress and changes they had experienced since starting the intervention, and made a plan for continued self-compassion practice.</p>

Supplementary References:

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. New York, NY: Routledge.

Otto, M. W. (2000). Stories and metaphors in cognitive-behavior therapy. *Cognitive and Behavioral Practice*, 7(2), 166–172.

Supplementary Information on Calculating S_{diff} and 95% Confidence Intervals

For each participant, change scores were calculated as follows:

- Baseline change = last baseline score before starting treatment - first baseline score
- Pre- to post-treatment (Pre-Post) change = score after treatment session 6 - last baseline score before starting treatment
- Pre-treatment to follow-up (Pre-FU) change = 4-wk follow-up score - last baseline score before starting treatment

For each measure, a standard error of the difference (S_{diff}) was calculated as follows:

$$S_{diff} = \text{sqrt}[2(SE)^2], \text{ where } SE = SD \times \text{sqrt}(1 - r_{xx})$$

SE = standard error of measurement; sqrt = square root

SD = the standard deviation of the measure taken from published data (e.g., data from published norms or large clinical sample)

r_{xx} = a reliability coefficient taken from published data

The resulting S_{diff} represents the difference between scores (i.e., the change score) that would be expected by chance variation alone on a specific measure. For calculating S_{diff} , it is possible to use the pre-treatment SD from the study sample, but given the small sample size of this study, using the SD and r_{xx} from larger samples in published psychometrics studies yielded a more stringent and conservative S_{diff} . For r_{xx} , some studies have used the test-retest reliability coefficient, but using the internal consistency is especially recommended for clinical populations (Martinovich, Saunders, & Howard, 1996). We used internal consistency to calculate S_{diff} in this study, since our change score intervals of interest do not match the test-retest intervals in most published studies, and test-retest reliability can be confounded with real change. In addition, overall findings in this study were the same, regardless of whether test-retest or internal consistency was used. SDs and internal consistency coefficients from these psychometrics studies were used: Bovin et al., 2015 (SD=21.16, Cronbach's $\alpha = .96$); Goss, Gilbert, & Allan, 1994 (SD=16.20, Cronbach's $\alpha = .94$); Foa et al., 1999 (SD=1.74, Cronbach's $\alpha = .86$); Neff, 2003 (SD=0.625, internal consistency = .92). The S_{diff} for each outcome variable are as follows: PCL-5 $S_{diff} = 5.98$, ISS $S_{diff} = 5.61$, PTCI-sb $S_{diff} = .92$, SCS $S_{diff} = .25$. For each measure, S_{diff} was then multiplied by 1.96 to create a 95% confidence interval (CI) around each change score.

Ex: On the PCL-5, $S_{diff} = 5.98$, indicating that an individual's PCL-5 scores are likely to deviate by 5.98 points on average, from chance variation alone. On the PCL-5, $1.96 \times S_{diff} = 11.73$. For each participant, a 95% CI 11.73 points above and below each change score was calculated. For instance, if a participant's PCL-5 pre-post treatment change score was -30, we can be 95% confident that the true amount of change for this participant was between -41.73 to -18.27.

Supplementary References:

- Goss, K., Gilbert, P., & Allan, S. (1994). An exploration of shame measures—I: The Other As Shamer scale. *Personality and Individual Differences, 17*(5), 713–717.
- Martinovich, Z., Saunders, S., & Howard, K. (1996). Some comments on “Assessing clinical significance”. *Psychotherapy Research, 6*(2), 124–132.