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Frequency of Interpersonal Trauma Types, Avoidant Attachment, Self-Compassion, and Interpersonal Competence: A Model of Persisting Posttraumatic Symptoms

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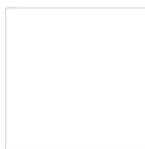
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Abstract and Figures

Given limited knowledge about how psychosocial factors interact to modulate posttraumatic stress symptoms, this study evaluated an integrative model proposing that experiencing more interpersonal trauma types (e.g., abuse, assault, rape, etc.) leads to greater avoidant attachment and lower self-compassion, which limits the development and use of effective interpersonal skills. In turn, lower levels of self-compassion and interpersonal competence perpetuate posttraumatic symptoms. Anonymous trauma-experienced adults (n = 132) completed self-report measures in an online study hyperlinked on trauma support websites. Data were subjected to confirmatory factor analysis and structural equation modeling, which provided support for the hypothesized model. Specifically, higher frequency of interpersonal trauma types experienced was linked to higher avoidant attachment and lower self-compassion, which in turn were associated with lower interpersonal competence, which correlated with greater posttraumatic stress symptoms. Although cross-sectional data cannot address directionality of associations, this study's findings emphasize the potential utility of future longitudinal research designed to examine possible causal relationships among these specific psychosocial factors. For example, study findings suggest that those who experience more types of interpersonal trauma and who are characterized by avoidant attachment and lower self-compassion and interpersonal competence may be the most susceptible to experiencing severe posttraumatic symptoms. However, findings also suggest that efforts to increase self-compassion and interpersonal skills may help reduce symptoms.

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Interpersonal Trauma Symptom Model 1

Running Head: INTERPERSONAL TRAUMA SYMPTOM MODEL

Frequency of interpersonal trauma types, avoidant attachment, self-compassion, and
interpersonal competence: A model of persisting post-traumatic symptoms

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Interpersonal Trauma Symptom Model 2

Frequency of interpersonal trauma types, avoidant attachment, self-compassion, and

interpersonal competence: A model of persisting post-traumatic symptoms

Abstract

Given limited knowledge about how psychosocial factors interact to modulate post-traumatic stress symptoms, this study evaluated an integrative model proposing that experiencing more interpersonal trauma types (e.g., abuse, assault, rape, etc.) leads to greater avoidant attachment and lower self-compassion, which limits the development and use of effective interpersonal skills. In turn, lower levels of self-compassion and interpersonal competence perpetuate post-traumatic symptoms. Anonymous trauma-experienced adults (n = 132) completed self-report measures in an online study hyperlinked on trauma support websites. Data were subjected to confirmatory factor analysis and structural equation modeling, which provided support for the hypothesized model. Specifically, higher frequency of interpersonal trauma types experienced was linked to higher avoidant attachment and lower self-compassion, which in turn were associated with lower interpersonal competence, which correlated with greater post-traumatic stress symptoms. Although cross-sectional data cannot address directionality of associations, this study's findings emphasize the potential utility of future longitudinal research designed to examine possible causal relationships among these specific psychosocial factors. For example, study findings suggest that those who experience more types of interpersonal trauma and who are characterized by avoidant attachment and lower self-compassion and interpersonal competence may be the most susceptible to experiencing severe post-traumatic symptoms. However, findings also suggest that efforts to increase self-compassion and interpersonal skills may help reduce symptoms.

Interpersonal Trauma Symptom Model 3

Interpersonal Trauma Symptom Model 4

Frequency of interpersonal trauma types, avoidant attachment, self-compassion, and

interpersonal competence: A model of persisting post-traumatic symptoms

Trauma exposure and post-traumatic stress symptoms (PSS) are strongly linked to

distress, psychosocial dysfunction, suicidality, and substantial societal costs (Marshall, Olfson,

Hellman, Blanco, Guardino, & Struening, 2001; Walker, Katon, Russo, Ciechanowski, Newman,

& Wagner, 2003). Although most people experience at least one traumatic event during their

lifetime, evidence suggests that only 8-15% experience persisting PSS, which may or may not

cross a diagnostic threshold for post-traumatic stress disorder (e.g., Kilpatrick, Resnick, Milanak,

Miller, Keyes, & Friedman, 2013). Given the prevalence and debilitating effects of PSS, there is

a need for greater understanding of factors that might modulate PSS in trauma-experienced

individuals. As explained below, we propose that experiencing more interpersonal trauma types

leads to greater avoidant attachment and lower self-compassion, which limits the development

and use of effective interpersonal skills (e.g., complex trauma; Cloitre et al., 2009). In turn, lower

levels of self-compassion and interpersonal competence perpetuate post-traumatic symptoms.

The present study sought to provide preliminary correlational evidence for or against this

conceptualization.

Increased frequency of trauma exposure is consistently associated with more negative

outcomes, including lower quality of life and daily functioning, and greater severity of PSS (e.g.,

Enlow, Blood & Egeland, 2013; Schnurr & Green, 2004). Similarly, interpersonal trauma,

which involves victimization due to some form of malice, betrayal, or abuse, is more strongly

associated with PSS than non-interpersonal traumas, such as natural disasters and accidents

(Fowler, Allen, Oldham, & Frueh, 2013). If increased trauma experiences and interpersonal

trauma each increase the likelihood of persisting PSS, then an integrative framework would

suggest that experiencing more types of interpersonal trauma (e.g., sexual abuse, robbery, physical assault) may directly and indirectly promote PSS (Follette, Polusny, Bechtle, & Naugle, 1996). Given that around half of those who experience interpersonal trauma experience more than one interpersonal trauma type (e.g., Dutton, Burghardt, Perrin, Chrestman, & Halle, 1994; Kemp, Rawlings, & Green, 1991), it is important to examine whether experiencing more interpersonal trauma types corresponds with how individuals relate to themselves and others, and whether these factors in turn modulate PSS.

Cognitive-behavioral models suggest that trauma experiences affect how those who develop post-traumatic symptoms view themselves, others, and the world; how they respond to internal experiences (e.g., hypervigilance; avoidance of unwanted thoughts, emotions, sensations); and how they behave in relation to the world (Ehlers & Clark, 2000). Resick, Monson, and Chard (2014) focus particularly on how following a trauma, core interpersonally-relevant schemas about safety, trust, power, and intimacy can be altered, generalized to other broadly similar exemplars, and become foci of distress. Based on these models, one might expect that the more contexts in which a person experiences interpersonal trauma (greater diversity of interpersonal trauma types), the more likely that person would be to develop strong, generalized negative schemas about the self and social relations.

Consistent with a diversity-generalization conceptualization, one retrospective study controlled for cumulative trauma experiences and showed that experiencing both childhood and adult interpersonal trauma increased the likelihood of developing PTSD by 17 times, whereas experiencing interpersonal trauma during only one of these two developmental stages increased likelihood by around 5-7 times (Schumm, Briggs-Phillips, & Hobfall, 2006; also see Cloitre et al., 2009). A diversity-generalization conceptualization would also suggest that an individual's

trauma-altered beliefs and perceptions might hinder adaptive social interactions (e.g., receiving social support) predicated on trust, intimacy, and safety, instead promoting detachment and avoidance in social situations, and facilitating PSS.

Perceived social support is a robust, consistently found trauma-resilience factor (Brewin, Andrews, & Valentine, 2000), however, it is likely that a broader set of interpersonal skills fosters resilience in navigating social and emotional sequelae of interpersonal trauma, such as shame, guilt, and broken trust (Domhardt, Munzer, Fegert, & Goldbeck, 2014). To begin with, skilled efforts in developing and maintaining intimate, trusting relationships are required to access social support. The ability and willingness to assert needs, manage conflict, and disclose personal experiences effectively can not only help maintain salutary relationships, but can yield shared positive emotions and validation of one's unique trauma-related thoughts and feelings (Ullman & Peter-Hagene, 2014). However, these interpersonal skills may be difficult for some individuals who have experienced interpersonal traumas (Cook et al., 2005, Schumm et al., 2006), and these skill difficulties might perpetuate PSS. In a suggestive correlational study examining couples affected by trauma, spouses of individuals who never developed PTSD reported fewer relationship problems and fewer struggles with intimacy than spouses of those who developed PTSD (Riggs, Byrne, Weathers, & Litz, 1998). This study reflects the significant empirical support linking interpersonal trauma and negative relationship outcomes (e.g., Cloitre, Scarvalone, & Difede, 1997; Zerach, Anat, Solomon & Heruti, 2010). However, research is lacking in terms of potential antecedent process variables, such as interpersonal competence, which would naturally vary among individuals and be potentially modifiable. One might expect that high interpersonal competence would attenuate PSS. However, other yet-to-be examined

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factors may intervene and modulate the relationship between interpersonal trauma types experienced and interpersonal competence, such as avoidant attachment and self-compassion.

Avoidant attachment is conceptualized as an inflexible interpersonal and intrapersonal style that involves a strong desire for autonomy, distancing from intimacy with others, and avoiding aversive emotions (Silverman, 2011). This stable attachment style is thought to predispose automatic rigid, restrictive repertoires of interpersonal behavior. As such, increased avoidant attachment style tendencies could limit the development and execution of effective interpersonal skills (Wei, Vogel, Ku, & Takalik, 2005), which could reduce interpersonal competence. For example, greater tendencies to avoid emotions may hinder communication and emotional connection in interpersonal relationships (Schumm et al., 2006). Thus, elevated avoidant attachment and its possible negative association with interpersonal competence are of particular interest in the present research, as avoidant attachment could then increase PSS (Ayers, Jessop, Pike, Parfitt, & Ford, 2014)[1] indirectly by way of low interpersonal competence. However, this conceptually intuitive pathway needs to be tested empirically.

By comparison, self-compassion tends to be positively associated with interpersonal competence (Barnard & Curry, 2011; Neff, 2009; Neff & McGehee, 2010) and could possibly reduce post-traumatic symptoms (Hiraoka, Meyer, Kimbrel, DeBeer, Gulliver, & 2015). Contrasted with common characteristics of PSS, self-compassion is a self-regulatory stance toward one's experiences that is defined by self-kindness instead of self-judgment, by connecting to a sense of common humanity instead of isolation, and by mindful awareness of

[1] Avoidant attachment style and avoidance PTSD symptoms are conceived as related but ultimately distinct constructs (Dieperink, Leskela, Thuras, & Engdahl, 2001). Avoidant attachment style represents a longstanding, general interpersonal-emotional style, whereas avoidance PTSD symptoms reflect a post-trauma shift from premorbid status, centered specifically on avoiding trauma-related stimuli. As such, those with stable avoidant attachment style may be more likely than securely attached individuals to respond to trauma experiences with avoidant PTSD symptoms, but some securely attached individuals still respond to trauma with avoidant PTSD symptoms.

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present experience rather than over-identifying with it (Neff, 2003a). Compared to individuals

with lower self-compassion, those with higher self-compassion are more flexible and able to adjust to a variety of social interactions (Seligowski, Miron, & Orcutt, 2015), and they tend to be more connected with others (Neff, Kirkpatrick, & Rude, 2007). More self-compassionate individuals also engage in less thought suppression and experience less anxiety. Instead, they are more willing to process unwanted, painful thoughts and emotions, and do so without reprimanding themselves for temporary failures (Seligowski et al., 2015). This likely enables these individuals to adapt to trauma-related stimuli via normal habituation processes and to allow trauma-consequent negative affects such as fear, anger, guilt, and shame to dissipate more effectively (Neff, 2009; Vettese, Dyer, Li, & Wekerle, 2011). In this way, self-compassion could attenuate PSS, both directly, by enabling the processing of thoughts and emotions about past traumatic experiences, and indirectly, via greater interpersonal competence.

In sum, although the current literature has generated conceptualizations of interrelated factors that might modulate relationships between interpersonal trauma and post-traumatic symptoms, the focus of empirical research has been largely restricted to examining single factors or single pathways. Research is needed to test models of multiple pathways involving theoretically interrelated factors where some of those factors might be modifiable. In particular, it would be beneficial to examine direct and indirect (i.e., interrelated) contributions of interpersonal trauma types, self-compassion, avoidant attachment, and interpersonal competence to variability in post-traumatic stress symptoms in a model that controls for each potential contribution. Understanding these relationships better could potentially help identify possible points of intervention and pathways through which interventions can be most effective. One effective way to study these relationships would be through an anonymous online sample of

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interpersonal trauma-experienced individuals, who might be more willing and able to disclose intimate trauma experiences via the internet than in in-person research contexts (Suler, 2004).

To address identified needs in the literature, the current study examined select pathways through which persistent post-traumatic stress symptoms might be modulated. Participants completed measures assessing the constructs of interest, and structural equation modeling and path analysis were employed. It was anticipated that experiencing more interpersonal trauma types would be linked to greater PSS, and that greater self-compassion would be associated with lower PSS. It was also hypothesized that experiencing more interpersonal trauma types would positively correlate with avoidant adult attachment and negatively correlate with self-compassion. Lastly, it was expected that avoidant attachment and self-compassion would negatively correlate, and that each would explain significant variability in interpersonal competence, which in turn would explain significant variance in PSS.

Method

Participants and Procedures

Participants were recruited primarily from organizations/websites that offer support/information for those who have experienced trauma. The study was also advertised to university students enrolled in courses that required research participation. For the purpose of anonymity, identification information was collected, but participants affirmed informed assent to participate. Study procedures were approved by the university's institutional review board.

A total of 132 trauma-experienced adults completed all measures needed to examine the proposed model. The sample averaged 35.7 years of age (SD = 12.2), was 86.4% female, and was 87.1% White, 5.3% Other/Biracial, 2.3% African American, 2.3% Asian/Pacific Islander, 2.3% Hispanic, and 0.8% Native American. Regarding relationship status, the sample was 38.6%

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married, 17.4% partnered, 23.5% single-dating, 16.7% single-not interested, 8.3% divorced, and 2.3 % widowed. Regarding sexual orientation, the sample was 75.8% heterosexual, 9.1% lesbian or gay, and 15.2% bisexual. Compared to heterosexual participants, non-heterosexual

participants endorsed significantly more types of interpersonal trauma experiences ($t(129) = 2.75$, $p < .01$, $d = .56$) and greater PSS ($t(130) = 2.00$, $p < .05$, $d = .42$).

Measures

Trauma History Questionnaire (THQ). The THQ is a 24-item questionnaire used to assess for various trauma experiences (Green, 1996). For each item, participants indicate whether or not they have experienced the given trauma and the frequency of the experience. For the purposes of this study, specific traumas were coded as either interpersonal trauma types (e.g., sexual assault, physical assault, etc.) or non-interpersonal trauma types (e.g., natural disaster). THQ items 1, 2, 3, 4, 18, 19, 20, 21, 22, and 23 were coded as interpersonal trauma types. The sum total of interpersonal trauma types experienced was the focal THQ variable of interest. Given this focal use of the overall measure, internal consistency (Cronbach's $\alpha = .66$) was not directly relevant to prior reported THQ reliability coefficients. However, the THQ has shown evidence of satisfactory validity (Green, 1996).

Experiences in Close Relationship Scale-Short Form (ECR-S). The ECR-S is a 12-item short-form measure used to assess the degree of avoidant and anxious adult attachment style tendencies (Wei, Russell, Mallinckrodt, & Vogel, 2007). Participants rate their level of agreement with relationship scenario statements, ranging from 1 (Strongly Disagree) to 7 (Strongly Agree). Planned analyses focused only on avoidance subscale items (e.g., "I try to avoid getting too close to my partner"). This subscale has acceptable internal consistency ($\alpha = .83$ in present study) and validity (Fraley, Brennan, & Waller, 2000; Wei et al., 2007).

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Self-Compassion Scale – Short Form (SCS-SF). The SCS-SF is a 12-item Likert scale that assesses one's tendency toward self-compassion in contexts of personal failure (Neff, 2003b). Participants are asked to indicate how often from 1 (Almost never) to 5 (Almost always) they engage in specific compassionate or non-compassionate behaviors towards themselves

during difficult experiences. The SCS has shown evidence of strong internal consistency (α = .91 in present study) and validity (Neff, 2003b).

Interpersonal Competence Questionnaire (ICQ). The ICQ is a 40-item self-report questionnaire that assesses perceived interpersonal ability across five domains: initiation of interactions and relationships, assertion of personal rights and displeasure with others, self-disclosure of personal information, emotional support of others, and management of interpersonal conflicts (Buhrmester, Furman, Wittenberg, & Reis, 1988). Participants rate items on a 5-point scale ranging from 1 ("I'm poor at this") to 5 ("I'm extremely good at this"). The ICQ has evidence for robust reliability (α = .95) and predictive validity (Graf & Harland, 2005).

PTSD Checklist-Civilian (PCL-C). The PCL is a 17-item Likert-type scale used to assess the existence and severity of PTSD symptomatology (Weathers, Litz, Herman, Juska, & Keane, 1993). Participants are asked to respond on a scale from 1 (Not at all) to 5 (Extremely) on how much they have been bothered by each symptom in the past month. The PCL-C has demonstrated high internal consistency (α = .96 in present study) and satisfactory validity in predicting a PTSD diagnosis (Ruggiero, Del Ben, Scotti, & Rabalais, 2003).

Analytic Plan

Structural equation modeling (SEM) was used to evaluate the hypothesized relationships among trauma history, PTSD symptoms, self-compassion, interpersonal competence, and avoidant attachment. All SEM models were analyzed using Mplus 7.31 (Muthén & Muthén,

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1998-2015) and maximum likelihood estimation procedures. Models were evaluated for goodness of fit using several common fit indices: the root mean square error of approximation (RMSEA; Steiger & Lind, 1980) and its 90% confidence interval (90% CI), the standardized root mean residual (SRMR; Joreskog & Sorbom, 1996), and the comparative fit index (CFI; Bentler,

1990). Given the sample size used in the present study, we focused on effect sizes and confidence intervals of parameter estimates when interpreting our findings. After SEM analyses, a post hoc bivariate correlation analysis was planned to confirm whether avoidant attachment as measured by the ECR-S, and avoidant PTSD symptoms as measured by the PCL-C reflected overlapping but differentiable constructs (as conceptualized), which would suggest that including avoidant attachment in the proposed model was appropriate.

Results

Psychosocial Functioning and Symptom Characteristics

Table 1 presents means, standard deviations, and a correlation matrix of measured constructs examined in this study's model. Nearly all participants (97.7%) endorsed at least one post-traumatic stress symptom, and more than half (54.5%) endorsed levels of symptoms suggestive of diagnosable PTSD ($\geq$ 50 on PCL-C). Additionally, this sample's mean ICQ item score was approximately 0.5 lower than the ICQ norm group's mean item score (Buhrmester et al., 1988), suggesting prevalent psychosocial impairment.

Confirmatory Factor Analysis

Prior to testing hypothesized indirect effects, we first specified a measurement model for the constructs. The latent construct of PTSD was identified using symptom cluster parcels for re-experiencing, avoidance, numbing, and hyperarousal rather than the DSM-IV model as previous factor analytic work has provided more support for the numbing model. The latent constructs of

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self-compassion and avoidant attachment were modeled using three parcels of items from the respective measures. Interpersonal competence was modeled using the five subscales of the ICQ as indicators of the latent construct. Finally, interpersonal trauma history, as measured by the THQ, was included as a manifest variable. All constructs were allowed to freely covary with one another in this measurement model. The fit for this model was adequate ($\chi2$ (df = 57) = 229.92, p

< .01; RMSEA = .09 (90% CI .07:.10); CFI = .92; SRMR = .07). As expected, the correlations among constructs in this model were all statistically significant and the magnitude of the latent correlations ranged from -.23 to .67.

Indirect Effects on PTSD

We next used SEM to evaluate the hypothesized indirect effects of interpersonal trauma history, self-compassion, and avoidant attachment on symptoms of PTSD via interpersonal competence. The model indirect command in Mplus was used to specify the hypothesized indirect effects and each indirect effect was evaluated based on the bias-corrected bootstrap confidence interval of the indirect effect. The model fit for this SEM (χ2 (df = 57) = 229.92, p < .01; RMSEA = .09 (90% CI .07:.10); CFI = .92; SRMR = .07) was adequate. The completely standardized results for this model are presented in Figure 1. Interpersonal trauma history had a direct effect on PSS (b = .124; 95% CI .08 : .183), but not a statistically significant indirect effect (ab = .008; 95% CI -.005 : .029) on PTSD via interpersonal competence. Self-compassion had a direct effect on PTSD symptoms (b = -.098; 95% CI -.042 : -.144) and a statistically significant indirect effect (ab = -.046; 95% CI -.014 : -.086) on PTSD via interpersonal competence.

Avoidant attachment did not have a significant direct effect on PSS (b = .065; 95% CI -.004 : .128), but did have a significant indirect effect (ab = .040; 95% CI .012 : .087) on PSS via interpersonal competence. Results therefore indicate that each of the constructs examined had an

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influence on PSS, but that the pathways by which these effects occurred varied for each construct. Together, the variables included in the SEM analysis predicted 57.2% of the variance in interpersonal competence and 58.3% of the variance in PTSD symptoms.

Post Hoc Correlation Analysis

As expected, the bivariate correlation between ECR-S avoidant attachment style inclinations and PCL-C avoidance symptoms (r (132) =.50, p < .001) reflected overlapping but

differentiable constructs. This analysis provided data-supported reassurance that including avoidant attachment in the model as a distinct construct was appropriate.

Discussion

The present study aimed to increase understanding of pathways through which post-traumatic stress symptoms (PSS) might be modulated by examining a sample of trauma-experienced individuals. Based on a cognitive behavioral trauma diversity-generalization framework, it was hypothesized that experiencing more interpersonal trauma types would be associated with greater PSS but also with greater avoidant attachment and lower self-compassion. In turn, greater avoidant attachment and lower self-compassion were expected to correspond with lower perceived interpersonal competence, which was expected to correspond with greater PSS. CFA and SEM results corroborated this hypothesized model. Although individual relationships among some of the constructs within this study's model have been investigated in other studies (e.g., Seligowski et al., 2014; Wei et al., 2005), this study is the first to characterize relationships among (and controlling for) all of these constructs.

Experiencing higher frequency of interpersonal trauma types was directly and indirectly linked to higher levels of persistent PSS but not directly related to interpersonal competence. Instead, indirect effects of interpersonal trauma type frequency on interpersonal competence and

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PSS worked through individuals' variability in avoidant attachment and self-compassion. The linkage between interpersonal trauma type frequency and avoidant attachment was expected given that repeated trauma experiences tend to be associated with aberrations in affective and interpersonal self-regulatory capacities, often including avoidance of emotional experience and interpersonal intimacy (e.g., complex trauma; Cloitre, et al., 2009; Stovall-McClough and Cloitre, 2006). Moreover, the linkage between avoidant attachment and lower interpersonal competence was expected based on a previously supported model linking avoidant attachment

and emotionally avoidant coping style with greater interpersonal problems (Wei et al., 2005). Given the current study's findings, it is possible that an avoidant style of emotional processing and expression might undermine interpersonal competence, which could increase interpersonal problems.

Conversely, self-compassion was negatively associated with interpersonal trauma types experienced and positively associated with interpersonal competence. Feelings of social connectedness, which have been associated with self-compassion (Seligowski et al., 2014), might positively bias perceptions of available social support and increase motivation to approach others in order to regulate emotions and meet other relational needs. Thus, self-compassion might reduce the selection of isolative or avoidant behavioral repertoires (Thompson & Waltz, 2008). Self-compassion has also been positively associated with psychological flexibility; more effective emotion regulation following induced, imagined, or recalled negative events; and a host of other positive mental health outcomes (Hiroaka et al., 2015; Seligowski et al., 2014; Vettese et al., 2011). In the present study, self-compassion showed both direct effects on PSS and indirect effects on PSS via self-compassion's association with interpersonal competence. In sum, self-compassion could serve as a resiliency factor.

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Interpersonal competence could also serve as a resiliency factor attenuating negative effects of interpersonal traumas, as suggested by studies of individuals who have experienced childhood sexual abuse (Domhardt et al., 2014; Simpson, 2010). After traumas have occurred, greater levels of interpersonal competence may enable individuals to re-establish trust, a sense of safety, and predictable social routines. For example, effectively initiating interactions, stating needs, disclosing personal experiences, and resolving conflicts in relationships can help develop and maintain a network of relationships that can increase a trauma survivor's positive moods, sense of meaning, feelings of validation, and support during challenging periods. Conversely,

lower levels of interpersonal competence can be associated with other socially maladaptive characteristics, such as lower self-esteem and greater tendency to seek negative feedback about one's self (Bistricky, Harrison, Tran, & Schield, 2016). Thus, interpersonal competence may be crucial in buffering distress and proceeding with an otherwise adaptive social life following interpersonal trauma.

The present findings may have additional implications for vulnerability, prevention, and treatment. For example, individuals high in attachment avoidance and low in self-compassion and interpersonal competence may have the greatest risk of experiencing persistent PSS. These individuals are also more likely to experience more interpersonal trauma types. Thus, this study's findings support efforts to leverage modifiable risk factors of interpersonal trauma revictimization. Increased probability of revictimization has been linked to lower effectiveness in specific interpersonal skills (Kearns & Calhoun, 2010), and interventions aimed at increasing knowledge and skills in interpersonal contexts can potentially reduce revictimization (e.g., Marx, Calhoun, Wilson, & Meyerson, 2001).

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Interventions can also attempt to prevent or attenuate post-traumatic symptoms after interpersonal traumas have occurred. One intervention objective identified in the present study would be to increase real and perceived interpersonal competence to build and maintain social support networks (Schumm et al., 2006). Future research might more closely examine effects of increasing various interpersonal skills on reducing interpersonal problems and persistent PSS.

A second, related intervention objective would be to reduce automatic responding from rigid avoidant attachment inclinations. Whether explicitly attachment-oriented or not, evidence supported treatments focused on minors, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) groups, encourage verbalizing thoughts and emotions with supportive trauma-

experienced peers and a trusted therapist, who attempts to forge a safe, trusting relationship via consistent, appropriate responsivity to the child's needs (Mannarino, Deblinger, & Cohen, 2014)[2]. Although underlying attachment inclinations might be resistant to change, TF-CBT groups have been shown to increase social competence behaviors and interpersonal trust (Cohen & Mannarino, 1998). Addressing avoidant attachment style in adults might be even more challenging, as avoidant adults are less likely to seek out mental health treatment (Vogel & Wei, 2005). However, those who present with distress from PSS may be more willing to modify ways of relating to others if doing so offers a credible route toward greater well-being. Indeed, recent research suggests that a primary therapeutic focus on current adaptive relational functioning, as facilitated through Interpersonal Therapy, may be acceptable to clients and reduce their PTSD symptoms as effectively as other evidence-based treatments (Markowitz et al., 2015).

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[2] Also see Attachment, Regulation, and Competency therapy (Blaustein, & Kinniburgh, 2010) and Schema Therapy (Cockram, Drummond, & Lee, 2010) for traumatized children and adults, respectively. Both interventions have evidence to support their use.

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Alternatively, Cognitive Processing Therapy may be effective in part because it supportively guides trauma-experienced individuals to confront, process, and consolidate traumatic memories and process new, oft-distorted meanings of conflict-fraught interpersonal mental constructs discussed previously (Resick et al., 2014). This therapy work could serve to decrease behaviors and coping strategies that bolster social- and self-alienation.

A third intervention objective would be to increase self-compassion. Habitual self-criticism (low self-compassion) could perpetuate negatively biased self-perceptions of interpersonal competence, which could stifle support-seeking behaviors. Developing greater self-compassion might counteract these patterns and be a way to boost interpersonal competence. For example, self-compassion's tripartite emphases (self-kindness, common humanity, mindfulness)

may enable an individual to circumvent avoidant strategies that result in greater negative affects and interpersonal problems in the long-term (Neff, 2003a; Vogel & Wei, 2005; Wei et al., 2005). Such an individual would presumably be more willing to "risk" seeking support (Barnard & Curry, 2011), which can lessen post-traumatic symptoms. However, model findings suggest that even those with avoidant attachment and/or lower interpersonal competence might get some protection from persistent PSS if they have or generate higher levels of self-compassion. Specifically, self-compassion could allow painful affects and thoughts to be habituated and integrated. One's propensity for self-compassion can be increased in children, adolescents, and adults, with significant benefits to psychological health (Neff, 2009; Neff & Germer, 2013; Neff & McGehee, 2010).

Lastly, following from the discussion of treatment objectives, model factors examined in this study could be used to accelerate and refine case conceptualization and treatment planning for survivors of interpersonal trauma. Different clients report varying levels of self-compassion,

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attachment avoidance, and interpersonal competence, so a client's treatment plan might focus on leveraging relative strengths and remediating modifiable deficits to lessen post-traumatic stress symptoms. Future research evaluating incremental effects of addressing model factors on treatment outcomes would be informative.

The present study also has several limitations to consider. First, the study examined post-traumatic stress symptoms dimensionally and without a standardized clinical interview. Thus, although the sample's PCL-C score distribution suggests that many participants could have met PTSD diagnostic criteria, categorical diagnostic status could not be confirmed. As such, study findings might not generalize to PTSD as defined by current diagnostic systems. Findings from this sample also might not generalize to male, non-White, or non-English-speaking populations. On the other hand, the study sample's substantial inclusion of individuals from sexual minority

groups represents a strength. Percentages of participants reporting lesbian/gay or bisexual sexual orientation far exceeded percentages obtained in many recent population surveys (see Gates, 2011 for review). However, these elevated percentages—and elevated frequency of trauma types reported by these groups—may also reflect the tendency for sexual minorities to experience greater rates of interpersonal violence than heterosexuals (e.g., Balsam, Rothblum, & Beauchaine, 2005).

A second limitation is that the study did not include direct measures of psychosocial functioning or prior mental health service use. Thus, although the process of psychotherapy can both reduce individuals' PSS and increase self-compassion (Barnard & Curry, 2011), this study could not quantify any possible influence of prior treatment. On the other hand, this study suggests that future research should investigate how accessing trauma survivor websites relates to patterns of help-seeking and coping in those with avoidant attachment styles. Similarly, future

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research could examine whether those who identify as survivors or victims, have more-developed self-compassion than those who do not yet identify as being part of such a community. Findings could have important treatment implications for both groups.

Third, this study's findings are based on retrospective self-report at a single time point, and time markers of when specific traumas occurred were not assessed. Thus, temporal proximity to traumas experienced could not be factored into analyses. Also, the directionality and temporal dynamics of relationships among PSS and conceptually relevant constructs could not be discerned from the study design. So while only pathways relevant to a priori predictions were tested, other pathways could be theorized. For example, it is plausible that lower interpersonal competence could render individuals more susceptible to multiple types of interpersonal victimization. That said, prospective research showing that avoidant attachment,

social support, and self-compassion can individually predict PSS longitudinally (e.g., Ayers et al., 2014; Brewin et al., 2000; Hiraoka et al., 2015) suggests that current model factors were probably not solely modulated by PSS (i.e., reversing modeled directionality). Instead, the predicted pathways appear to be the most plausible and empirically justified, and the model ultimately accounted for substantial variability in theoretically "downstream" interpersonal competence and PSS. As such, this correlational study represents an important advance in the still-underdeveloped literature about how key factors interact to modulate relationships between interpersonal trauma and PSS. Future longitudinal research that tracks these variables across developmental periods will be a vital next step.

Lastly, aspects of this study's data collection present potential limitations. For example, the free response data for frequency of traumas experienced (e.g., how many times a person has

Interpersonal Trauma Symptom Model 21

been beaten by a parent) did not allow for meaningful quantitative coding (e.g., many answers such as "more than I care to remember"), and thus quantitative analysis was not performed.

Despite limitations, the current study presents a novel, informative model of interrelated factors that are linked to persisting PSS. This model is compatible with hypothesized mechanisms of contemporary evidence-based therapies and could hold potential for focusing treatment on specific client deficits to improve outcomes. Future research might extend upon and apply these findings to help improve interventions that decrease the incidence of interpersonal trauma, decrease rigid patterns of interpersonal and emotional avoidance, and foster resiliency factors that mitigate post-traumatic stress symptoms.

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... Current evidence-based psychotherapeutic approaches for adolescent PTSD include but are not limited to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) and Eye Movement Desensitization and Reprocessing Therapy (EMDR; John-Baptiste Bastien et al., 2020;Mavranezouli et al., 2020;Smith et al., 2019;Dorsey et al., 2017;Morina et al., 2016;Haller et al., 2016;Watts et al., 2013). Although these approaches are distinct, they all involve patient recollection and discussion of traumatic experiences, exposure to specific trauma triggers (e.g., external or internal cues for physiological arousal) psychoeducation on the nature of trauma symptoms, and training in relaxation or emotion regulation strategies (Dorsey et al., 2017; Bistricky et al., 2017) . ...

... The majority of existing approaches for adolescent PTSD are based on the cognitivebehavioral model (Banks et al., 2015). Cognitive approaches, such as TF-CBT or CPT, utilize trauma discussion to facilitate cognitive reappraisal and behavioral engagement (i.e., exposure; de Arellano et al., 2014), consequently reducing avoidance (Bistricky et al., 2017) . Cognitive change, specifically reduced maladaptive trauma cognitions, represent a core mechanism of change in these approaches (Kangaslampi and Peltonen, 2019;Zalta, 2015), with critical cognitions about the self as incompetent or weak a particularly important target for improving PTSD symptoms (Kangaslampi and Peltonen 2019). ...

The Promise of Compassion-Based Therapy as a Novel Intervention for Adolescent PTSD

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... Moreover, participants showed strength through selfcare and feelings of worthwhile which helped them in dealing with their situation. This finding is also been supported by the research of McLean et al. (2018) and Bistricky et al. (2017) which revealed a negative relationship between self-compassion and PTSD symptoms. A higher level of self-compassion enables the individual to react to internal threats, self-judgments, self-blame, and negative attributions by becoming psychologically flexible, which is necessary for overcoming interpersonal trauma. ...

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... Moreover, self-compassion promotes adaptive emotion regulation (Inwood & Ferrari, 2018), aiding individuals in alleviating symptoms related to affect dysregulation. The common humanity aspect of self-compassion enhances an individual's interpersonal skills (Bistricky et al., 2017) , increasing individuals' sense of social connection and potentially alleviating relationship difficulties associated with CPTSD. As a balanced and healthy approach to self-relating, self-compassion aids in improving negative selfconcepts, which could decrease feelings of failure and worthlessness (Zhang et al., 2023). ...

Effects of a Brief Self-Compassion Online Intervention on Complex Posttraumatic Stress Symptoms Among Chinese University Students With Trauma History: A Pilot Randomized Controlled Trial

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... In fact, laboratory research has shown that loving-kindness meditation practice can increase participants' feelings of connection, suggesting that perceived social support can be selfgenerated (Hutcherson et al., 2008). Self-compassionate individuals are also more aware of their emotional needs, more socially skilled, and may create social environments that are in fact more supportive (Bistricky et al., 2017; Inwood & Ferrari, 2018). In this case, perceptions of available support would be realistically aligned with actual available support. ...

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... Self-compassionate individuals have an advantage in social functions, as they can see the positives rather than the negatives in their interactions with others (Dzwonkowska & Żak-Łykus, 2015). They also can regulate their emotions and possess more adaptive responses in the face of failure, which helps them to experience less interpersonal trauma and improve their interpersonal skills (Steven et al., 2017) . A seven-year longitudinal study found that self-compassion, at baseline, negatively predicted loneliness at follow-up, and as self-compassion increased, loneliness decreased (Lee et al., 2021). ...

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January 2009 · International Journal of Project Organisation and Management

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July 2015

○ Marie Danet · ○ Raphaële Miljkovitch

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