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Compassion focused therapy for complex posttraumatic stress disorder: A randomized controlled trial

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ABSTRACT

Objective: Compassion focused therapy (CFT) has been proposed for complex posttraumatic stress disorder (C-PTSD) due to its focus on shame and self-criticism. This study evaluated the efficacy of an individual CFT protocol specifically designed for C-PTSD. **Method:** Forty-one participants meeting ICD-11 criteria for diagnosis of C-PTSD (N = 41, ranged 18-65 yrs old; 75.6% were female) were randomly assigned to receive 12-15 individual sessions of CFT or prolonged exposure (PE) via teletherapy. Participants were assessed at baseline, posttreatment, and six-month follow-up. **Results:** Repeated measures ANOVAs indicated significant time effects across all outcomes. Both CFT and PE produced reductions in posttraumatic symptoms, shame, self-criticism, depression, anxiety, stress, and dissociation, along with increases in self-compassion and self-soothing ability. PE was associated with decreased compassion for others at follow-up, whereas CFT demonstrated an increase in compassion from others. Treatment completion rates were higher for CFT (76.2%) than for PE (60%). **Conclusions:** Findings suggest CFT is effective for C-PTSD, offering comparable outcomes to PE with potentially greater tolerability.

Keywords*:* Compassion focused therapy; complex PTSD; trauma therapy; randomized controlled trial; teletherapy

Terapia centrada en la compasión para el trastorno de estrés postraumático complejo: Un ensayo controlado aleatorizado

RESUMEN

Objetivo: La terapia centrada en la compasión (CFT) ha sido propuesta para el trastorno de estrés postraumático complejo (TEPT-C) por su enfoque en la vergüenza y la autocrítica. Este estudio evaluó la eficacia de un protocolo individual de CFT diseñado para TEPT-C. **Método:** Un total de 41 participantes que cumplieron los criterios CIE-11 para el diagnóstico de TEPT-C (N = 41, con rango de edad entre 18 y 65 años; el 75.6% eran mujeres) fueron asignados aleatoriamente para recibir 12-15 sesiones de CFT o exposición prolongada (EP) mediante teleterapia. Los participantes fueron evaluaron en línea base, post-tratamiento y seguimiento a seis meses. **Resultados:** Los ANOVAs de medidas repetidas indicaron efectos significativos en todas las variables de resultado. Ambos tratamientos produjeron reducciones en síntomas postraumáticos, vergüenza, autocrítica, depresión, ansiedad, estrés y disociación, con aumentos en autocompasión y autotranquilización. La EP se asoció a menor compasión hacia otros en el seguimiento, mientras que la CFT aumentó la compasión recibida. Las tasas de finalización del tratamiento fueron superiores para la CFT (76.2%) que para la EP (60%). **Conclusiones:** La CFT es eficaz para el tratamiento del TEPT-C, con resultados comparables a la EP, y potencialmente posee mayor tolerabilidad.

Palabras clave: Terapia centrada en la compasión; TEPT complejo; terapia de trauma; ensayo controlado aleatorizado; teleterapia.

Introduction

The complex posttraumatic stress disorder (C-PTSD) was introduced in the 11th edition of the International Classification of Diseases (ICD-11; World Health Organization, 2018) as a distinct diagnostic entity

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separate from posttraumatic stress disorder (PTSD). This change aimed to acknowledge the impact of severe or chronic trauma. Both disorders are associated with extremely distressing or life-threatening events; however, C-PTSD has been linked to polytraumatization and repetitive or prolonged events from which escape is difficult or impossible, with children and adolescents being the most vulnerable.

PTSD is characterized by reexperiencing traumatic events, avoidance of trauma-related stimuli, and persistent perceptions of threat. In contrast, C-PTSD requires the presence of these PTSD symptoms plus 3 additional symptoms representing disturbances in self-organization (DSO): severe emotion regulation difficulties, a negative self-concept accompanied by shame, guilt, and failure related to the trauma, and persistent difficulties in maintaining relationships or experiencing closeness with others (World Health Organization, 2018).

C-PTSD has been correlated with comorbidities such as suicidal behavior (Spikol et al., 2022), dissociation (Fung et al., 2023), psychotic symptoms, substance abuse, somatization, depression, and anxiety (Maercker et al., 2022). Salter and Hall (2022) propose that C-PTSD can be conceptualized as a disorder rooted in shame and humiliation. Supporting this notion, Saraiya et al. (2021) found that elevated levels of shame are associated with greater severity of C-PTSD symptoms. One cross-cultural network analytic study demonstrated that one of the most pervasive C-PTSD symptoms is perceived worthlessness, a cognitive manifestation of shame that is consistent with the DSO symptom category of negative self-concept (Knefel et al., 2020). Similarly, Békés et al. (2023), in their study on moral injury, propose a model in which shame mediates the impact of childhood trauma on psychological outcomes.

Regarding the prevalence of this disorder, studies conducted in European countries, Israel, and the United States reported rates ranging from 1% to 8%, whereas in African countries, prevalence rates ranged from 13% to 20% (Maercker et al., 2022). To the best of our knowledge, the prevalence of C-PTSD in Mexico has not yet been evaluated. However, Medina-Mora et al. (2005) found that 68% of the Mexican population had experienced at least one traumatic event, with 1.45% developing PTSD. Notably, this study was conducted prior to the publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and International Classification of Diseases (ICD-11), suggesting that current prevalence rates might differ.

Current treatment guidelines for C-PTSD are cautious in their recommendations due to the novelty of the diagnosis and limited data (Maercker et al., 2022). Although no meta-analyses have specifically addressed individuals formally diagnosed with C-PTSD, meta-analyses have been conducted with populations exhibiting complex PTSD presentations, such as war veterans, survivors of childhood sexual abuse, and torture victims. These studies suggest that therapies effective for PTSD also show efficacy for C-PTSD (Coventry et al., 2020; Karatzias, Murphy, et al., 2019; Niemeyer et al., 2022). However, these treatments have limitations. Keyan et al. (2024) identified that while trauma-focused therapies are effective when there is greater psychophysiological reactivity associated with fear, outcomes are less favorable in the presence of variables such as childhood trauma, veteran status, higher PTSD severity, elevated levels of depression, and anger, among others —all of which are characteristics commonly associated with C-PTSD. Moreover, traditional cognitive-behavioral treatments have demonstrated attrition rates upward of 40%, suggesting the need for more acceptable treatments that meet a broader range of clinical needs (Burback et al., 2024).

These limitations may be partially explained by the unique symptom profile of C-PTSD, which extends beyond the fear-based symptoms traditionally targeted by PTSD treatments. Specifically, variables such as shame, self-criticism, and self-compassion have been particularly linked to complex trauma presentations. Supporting this distinction, Karatzias et al. (2019) found that the association between DSO symptoms (i.e., negative self-concept, emotion dysregulation, and interpersonal relationship impairments) and low self-compassion is stronger than the association between self-compassion and core PTSD symptoms (i.e., reexperiencing, avoidance, and sense of threat). These findings suggest that therapeutic approaches that specifically focus on helping individuals process and resolve shame and other negative self-concept-related issues may be particularly beneficial for this population.

In response to this therapeutic gap and the specific symptomatology of C-PTSD, compassion focused therapy (CFT), has been suggested as a potentially effective treatment (Irons & Lad, 2017; Swee et al., 2024). CFT integrates elements from evolutionary psychology, attachment theory, and social mentality theory. Developed for individuals with high levels of shame and self-criticism, its goal is to enhance the capacity for compassion as a means of improving well-being (Gilbert, 2010). Given its theoretical foundation and therapeutic focus, CFT may be particularly well-suited for addressing DSO symptoms characteristic of

C-PTSD, including shame, negative self-concept, and difficulties with emotional regulation and interpersonal relationships.

In CFT, compassion is conceptualized as a sensitivity to suffering coupled with a commitment to alleviate it, manifesting through three interconnected flows: self-compassion, compassion for others, and compassion received from others. Central to CFT's approach is affective regulation and the development of self-soothing capacities, particularly crucial for trauma survivors who often experience the greatest difficulty with receiving compassion from others and extending compassion to themselves due to deeply held beliefs of unworthiness (Gilbert, 2014). CFT's theoretical framework is grounded in understanding how early relational experiences shape emotional regulation patterns. Early caregiving interactions fundamentally affect an individual's capacity for self-soothing and establish expectations regarding the trustworthiness of others. For individuals with C-PTSD, particularly those who experienced betrayal by trusted caregivers, CFT proposes that self-criticism and compassion deficits can be understood through a conditioning paradigm: care-seeking behaviors in childhood become paired with caregiver anger or withdrawal, creating a persistent association between care and threat (Cloitre et al., 2019; Swee et al., 2024). This conditioning process leads children to adopt submissive, self-blaming behaviors as protection against anticipated abuse or shame, resulting in adults who experience anxiety and fear when encountering warmth or kindness—emotions that were historically paired with punishment.

Therapeutically, CFT addresses these maladaptive patterns through a comprehensive multimodal approach that operates on neurobiological, cognitive, emotional, and relational levels. The intervention works to rebalance the three emotion regulation systems by activating the soothing-affiliative system while simultaneously addressing fears and resistances to compassion (Gilbert, 2014; Irons & Lad, 2017; Swee et al., 2024). This approach enables individuals to shift from threat-focused patterns characterized by self-criticism and shame to compassion-focused responses that promote emotional regulation, interpersonal safety, and psychological well-being—directly targeting C-PTSD's disturbances in self-organization.

Supporting this theoretical framework, empirical evidence demonstrates CFT's effectiveness across diverse clinical presentations. In a meta-analysis conducted by Millard et al. (2023) with a clinical population, CFT was identified as an effective treatment for several disorders, showing positive effects on depression, anxiety, and self-compassion, among others. Specifically, regarding trauma-related symptoms, research has consistently demonstrated CFT's efficacy in reducing posttraumatic presentations. One of the earliest studies was conducted by Beaumont et al. (2016) who worked with 17 firefighters experiencing posttraumatic symptoms. Using an individual therapy format, the study compared trauma-focused cognitive behavioral therapy with a combined trauma-focused CBT and CFT intervention, finding significant reductions in PTSD symptoms, hyperarousal, avoidance, depression, and anxiety, as well as increases in self-compassion for the combined treatment approach. Similarly, Au et al. (2017) reported significant reductions in PTSD symptoms and shame-related trauma, with 90% of participants no longer meeting posttreatment PTSD diagnostic criteria.

While no studies were identified specifically examining individuals formally diagnosed with C-PTSD, several investigations have been conducted with survivors of complex trauma-related events. Daneshvar et al. (2022) conducted group interventions with 42 survivors of intimate partner violence presenting with PTSD symptoms and found significant reductions in suicidal ideation and cognitive distortions. In a related investigation, McLean et al. (2022) evaluated a group-based CFT protocol for women who survived childhood sexual abuse, reporting significant decreases in posttraumatic stress symptoms, shame, self-criticism, depression, and anxiety. Additionally, Romaniuk et al. (2023) assessed a compassionate mind training program for 12 war veterans with PTSD and their partners, documenting significant reductions in posttraumatic symptoms and depression, as well as increases in quality of life and perceived social security.

However, not all CFT applications have shown consistent trauma-related benefits. Vrabel et al. (2024) evaluated a CFT program for patients with eating disorders, comparing outcomes for those with and without a childhood trauma history. For individuals with trauma histories, no statistically significant reduction in posttraumatic stress symptoms was observed, although a substantial decrease in eating disorder symptoms occurred. These mixed findings suggest the need for trauma-specific protocols to effectively address posttraumatic symptomatology in populations where eating disorders and trauma co-occur. In addition to the lack of studies examining CFT in the context of C-PTSD, Millard et al. (2023) highlighted the need for further research on individual CFT interventions with active control groups. Therefore, the current study aimed to evaluate the effectiveness of a CFT protocol specifically designed for individuals with C-PTSD in

an individual therapy format, using an active control comparison. Based on CFT's theoretical framework and its specific focus on addressing shame, self-criticism, and emotional dysregulation (core features of C-PTSD) we hypothesized that participants receiving CFT would demonstrate significant reductions in C-PTSD symptomatology comparable to those receiving prolonged exposure (PE), while potentially showing superior outcomes in measures related to compassion, self-criticism and shame.

Methods

Participants

A total of 318 adults aged 18–65 years were recruited between September and October 2021 through social media advertisements using convenience and snowball sampling. Participants were recruited from all states of Mexico. Among them, 104 participants (32.7%) met the International Trauma Questionnaire (ITQ; Cloitre et al., 2018) diagnostic criteria for complex C-PTSD, and 41 participants provided informed consent and were enrolled in the intervention phase. Inclusion criteria were as following: a) being 18 years or older, b) fulfilling ICD-11 diagnostic criteria for C-PTSD confirmed through questionnaire ITQ and clinical interview, c) and having stable internet access and d) availability for weekly teletherapy. Exclusion criteria included: a) current psychosis, b) substance dependence, and c) imminent suicidal risk. Figure 1 presents the flow diagram of participant progression through each study phase (screening, randomization, intervention allocation, follow-up, and analysis) following CONSORT 2025 guidelines (Hopewell et al., 2025). Table 1 summarizes the participants' sociodemographic characteristics, while Table 2 shows the distribution of traumatic events reported through the International Trauma Exposure Measure (ITEM; Hyland et al., 2019).

Procedure

Screening was conducted online using a set of self-report forms which included sociodemographic questions, the ITQ, and measures assessing shame, self-criticism, and compassion. Subsequently, candidates who met preliminary criteria completed a structured diagnostic interview to confirm inclusion and exclusion requirements. Eligible participants then completed baseline assessments evaluating depression, anxiety, stress, dissociation, and suicide risk. Participants scoring ≥ 6 on the Plutchik Suicidal Risk Scale

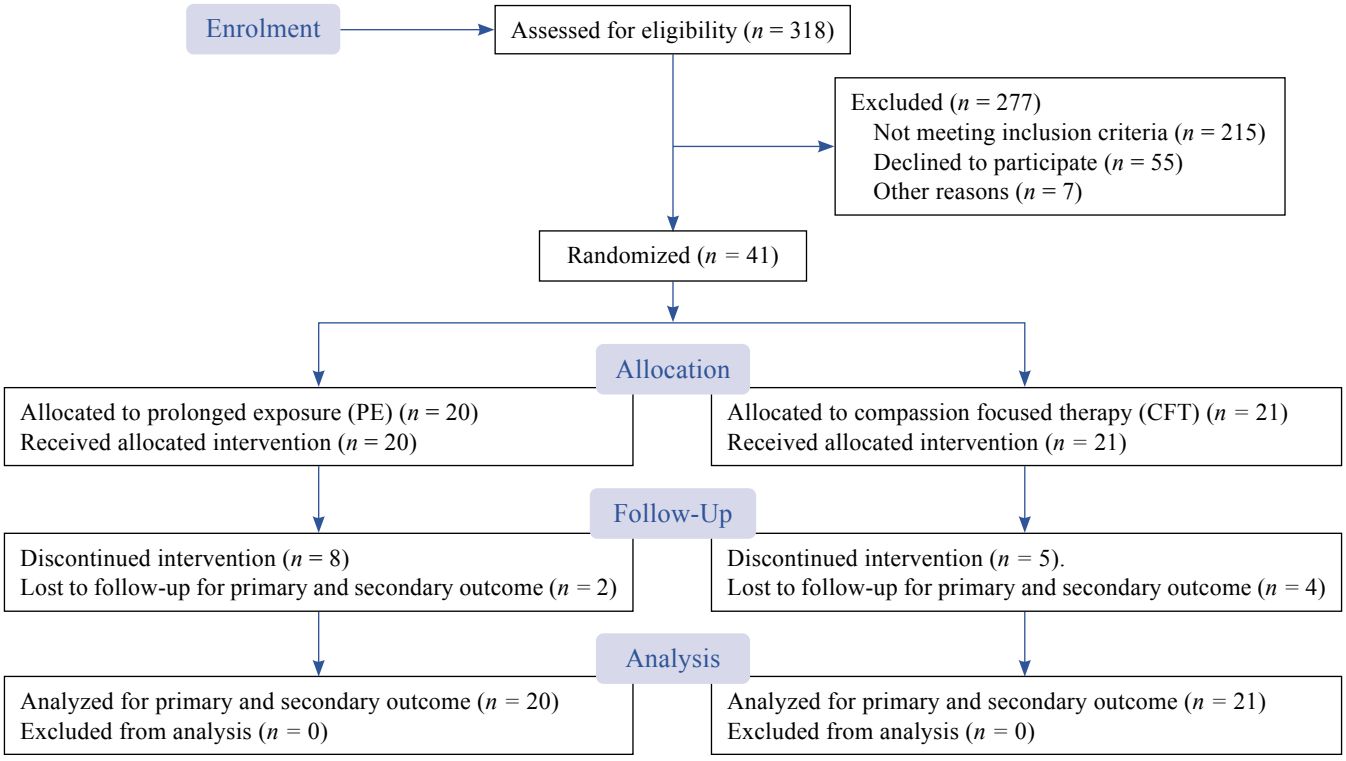

Figure 1. Distribution of Participants.

Table 1. Sociodemographic characteristics of the participants ($N = 41$)

Variable	Total (%)
Sex	
Female	31 (75.61)
Male	9 (21.95)
Chose not to disclose	1 (2.44)
Age	
M (SD)	42.10 (10.64)
Range	18-65
Education level	
Basic education	1 (2.44)
Highschool education	19 (46.34)
University education	18 (43.90)
Graduate education	3 (7.32)
Marital status	
Single	11 (27.5)
Married	9 (22.5)
Divorced	6 (15)
Free union	9 (22.5)
Separated	4 (10)
Widower	1 (2.5)
Employment Status	
Employed	10 (26.31)
Self-employed	8 (21.05)
Homemaker	5 (13.16)
Unemployed	11 (28.95)
Temporary Employment	4 (10.53)
Types of Traumatic Events	
Before age 13	3
Between ages 13-18	5.44
After age 18	6
Total	14.44
Lifetime Suicide Ideation	
Yes	35 (85.36)
No	6 (14.64)
Suicide Attempt	
Yes	19 (46.34)
No	22 (53.66)

Table 2. Traumatic events reported by participants ($N = 41$)

Event	%
Life-threatening (or potentially fatal) illness.	42.10
Someone close die in a terrible manner.	63.16
Someone close was diagnosed with a life-threatening illness or experienced a life-threatening accident.	68.42
Life-threatening threat with a weapon.	55.26
Physical assault by a parent or caregiver.	66.67
Physical assault by someone other than a parent or caregiver.	63.16
Sexual assault by a parent or caregiver.	23.68
Sexual assault by someone other than a parent or caregiver.	60.52
Sexual harassment.	78.95
Exposure to war or combat (as a soldier or civilian).	5.26
Captivity and/or torture.	15.79
Causing extreme suffering or death to another person.	5.26
Witnessing another person experience extreme suffering or death.	42.10
Accident where your life was in danger.	28.94
Natural disaster.	28.94
Human-made disaster where your life was in danger.	7.89
Harassment.	63.16
Bullying.	63.16
Being humiliated, belittled, or insulted by someone else.	97.37
Made to feel unloved, unwanted, or devalued.	84.21
Neglected, ignored, rejected, or isolated.	86.84
Any other event.	36.84

(Plutchik et al., 1989) were further assessed using the Linehan Risk Assessment and Management Protocol (L-RAMP; Linehan, 1997), leading to individualized crisis prevention plans when necessary. No participant was excluded for imminent suicide risk.

After the eligibility assessment, participants were randomly assigned by computer to one of two treatment conditions, CFT or PE. The intervention phase occurred from February to June 2022. Both treatments consisted of weekly 60-minute teletherapy sessions delivered through a secure platform for 12–15 weeks. Posttreatment and six-month follow-up assessments repeated baseline instruments, and all sessions were recorded for supervision and fidelity monitoring under encrypted storage.

A team of 22 therapists (16 women, 6 men; M = 31 years, SD = 3.5), all graduate students or recent graduates (≤ 2 years) from clinical psychology master's programs, participated in the study. Therapists were randomly assigned to one of the training conditions, each corresponding to one of the interventions assessed. Following completion of an 8-hour intensive training program, each therapist was assigned three participants and provided therapy exclusively using the protocol of their assigned condition. All therapy sessions were video-recorded for quality assurance. Therapists

received weekly supervision from a trauma specialist to verify adherence to the treatment manual, and none were involved in data analysis or received financial compensation.

Ethical approval was obtained from the Ethics Committee of the Psychology Department at Universidad Iberoamericana, Mexico City (registration number 2022-02-005). Informed consent forms were signed by all participants outlining the study's objectives, procedures, benefits, participant rights, and potential risks.

Intervention

CFT protocol (experimental group)

For this intervention, a protocol was specifically developed and tailored for this population. The 12-15 session protocol incorporated elements from Herman's (2001) 3 stages of trauma recovery, Gilbert's (2006) compassionate mind training, shame memory work by Matos and Steindl (unpublished), and functional behavior analysis. The protocol was structured around 3 key phases: 1) stabilization and psychoeducation (sessions 1-4), 2) development of compassion skills (sessions 5-9), and 3) integration and relapse prevention (sessions 10-12/15). Table 3 presents the detailed components of the CFT protocol, summarizing the content and therapeutic objectives of each module and session.

Core therapeutic objectives across modules included: enhancing emotional regulation through the activation of the soothing system, reducing shame and self-criticism through compassionate reframing, developing a compassionate identity through imagery and behavioral exercises, and improving interpersonal functioning through understanding the 3 flows of compassion (self-compassion, compassion for others, and compassion from others).

PE protocol (active control group)

PE is a manualized cognitive-behavioral treatment developed by Foa et al. (2019) with strong evidence supporting its effectiveness for PTSD. The protocol follows a structured approach consisting of three core components: (1) psychoeducation about trauma and PTSD symptoms, including treatment rationale and common reactions to trauma, (2) in vivo exposure involving repeated confrontation with avoided trauma-related but objectively safe situations, places, people, and activities, and (3) imaginal exposure requiring systematic, repeated recounting of the traumatic memory in detail, followed by emotional processing of the trauma memory and associated emotions and cognitions. The sessions were adapted from the original 90-minute format to 60 minutes to align with the CFT duration, based on research demonstrating comparable effectiveness for both formats (Nacasch et al., 2015). The treatment progresses systematically from psychoeducation and in vivo hierarchy development (sessions 1-2) to intensive imaginal exposure work (sessions 3-14), with the first imaginal exposure being extended to 90 minutes in session 3.

Instruments

Primary outcomes

The International Trauma Exposure Measure (ITEM; Hyland et al., 2019). A Spanish version of the ITEM available from the International Trauma Consortium

Table 3. Compassion focused therapy (CFT) protocol modules and therapeutic objectives

Module	Sessions	Duration	Main contents	Therapeutic objectives
Phase 1: Stabilization	1-2	60 min each	C-PTSD psychoeducation, CFT model introduction, breathing regulation	Establish therapeutic rapport, normalize symptoms, introduce safety skills
Phase 2A: Compassion foundation	3-5	60 min each	Safe space imagery, development of compassionate self, perfect caregiver exercise	Develop emotional regulation, build compassionate identity
Phase 2B: Trauma processing	6	90 min	Shame memory work, compassionate reframing	Process trauma-related shame with compassionate perspective
Phase 2C: Integration	7-9	60 min each	Compassionate biography, multiple selves	Integrate compassionate perspective into life narrative
Phase 3: Consolidation	10-12/15	60 min each	Choosing new paths, relapse prevention, closure	Solidify gains, relapse prevention, plan future growth

Note. C-PTSD: complex posttraumatic stress disorder.

was used. The ITEM is a 21-item checklist designed to assess exposure to traumatic events according to the ICD-11 definition of trauma. The instrument asked participants to indicate whether they had experienced each event during childhood (ages 0–13), adolescence (ages 13–18), or adulthood (ages 18 and older). The first 16 items corresponded to events classified as traumatic under the DSM-5, whereas the final 5 items (bullying, emotional abuse, emotional neglect, physical neglect, and harassment) were considered traumatic according to the ICD-11 but not the DSM-5. The ITEM did not yield global scores or subscales, as its purpose was to identify the presence or absence of exposure to each type of traumatic event across the lifespan.

The International Trauma Questionnaire (ITQ; Cloitre et al., 2018). A Spanish version distributed by the International Trauma Consortium was used. The ITQ is a 12-item self-report measure designed to assess PTSD and C-PTSD according to the ICD-11 diagnostic criteria. Participants rated the extent to which they had experienced each of the main symptoms related to their most significant traumatic experience during the past month using a five-point scale ranging from 0 ("not at all") to 4 ("extremely"). To be diagnosed with C-PTSD, participants had to meet the criteria for both PTSD and DSO symptoms, whereas a PTSD diagnosis required meeting only the PTSD criteria. Therefore, any participant could be classified as having PTSD or C-PTSD, but not both. PTSD symptoms were assessed with two items for reexperiencing, avoidance, and perception of current threat, while DSO symptoms were measured with two items each for affective dysregulation, negative self-concept, and relationship disturbances. A symptom was considered present when at least one of the two related items scored ≥ 2 ("moderately"). Additionally, a score of ≥ 2 on at least one of the three items assessing functional impairment was required for both PTSD and DSO domains. Separate scores were calculated for each symptom cluster by summing the scores of the corresponding items. In the original validation study (Cloitre et al., 2018), the ITQ demonstrated internal reliability coefficients of α = .89 for both PTSD and DSO items in a U.S. community sample. In the present study, internal reliability was α = .91 for PTSD symptoms and α = .92 for C-PTSD symptoms.

Secondary Outcomes

The Other as Shamer Scale (OAS; Goss et al., 1994). A Spanish version was used (available from the Compassionate Mind Foundation resource page). The OAS is a self-report scale composed of 18 items developed to assess external shame, understood as shame related to the perception of being judged, criticized, or devalued by others. Participants responded to each item on a five-point scale ranging from 0 ("never") to 4 ("almost always"). The scale is structured into three factors: inferiority, emptiness, and mistakes. The total score ranges from 0 to 72, calculated by summing all item responses, with higher scores reflecting greater levels of external shame. In a study with a Mexican population (Ríos-Mercado et al., 2025), the scale demonstrated internal consistency with ω = .96. In the present study, internal reliability was α = .95 for the inferiority factor, α = .87 for the emptiness factor, and α = .91 for the mistakes factor.

The Forms of Self-Criticism and Self-Reassurance Scale (FSCRS; Gilbert et al., 2004). A Spanish version was used (available from the Compassionate Mind Foundation resource page). The FSCRS is a self-report scale composed of 22 items designed to measure self-criticism and self-reassurance by assessing how individuals think and feel about themselves during setbacks. The scale includes three subscales: inadequate self, which captures a sense of personal insufficiency; hated self, which assesses the desire to criticize or harm oneself; and reassured self, which evaluates the ability to self-soothe. Participants respond to items on a five-point scale ranging from 0 ("not at all like me") to 4 ("very much like me"). The self-criticism score is the sum of the inadequate self and hated self-subscales. Internal consistency for the original scale was reported as α = .90 for inadequate self, α = .86 for hated self, and α = .86 for reassured self. In the present study, internal reliability was α = .92 for the inadequate self-subscale, α = .85 for the hated self-subscale, and α = .91 for the reassured self-subscale.

The Compassionate Engagement and Action Scales (CEAS; Gilbert et al., 2017). A Spanish version was used (available from the Compassionate Mind Foundation resource page). The CEAS is a self-report scale composed of three subscales designed to evaluate self-compassion, compassion for others, and compassion from others. Each subscale contains items assessing engagement (the motivation and ability to notice, become sensitive to, and emotionally engage with suffering) and action (the tendency to take helpful steps in response to suffering). Items are rated on a 10-point scale ranging from 1 ("never") to 10 ("always"), with higher scores indicating greater compassion in each domain. In the original validation study, the subscales demonstrated adequate internal consistency, with Cronbach's alpha coefficients of α = .90 for self-compassion, α = .94 for compassion for others, and α = .91 for compassion from others. In

the present study, internal reliability was α = .93, α = .92, and α = .96, respectively.

The Depression Anxiety and Stress Scale (DASS-21) (Antony et al., 1998). The Spanish version by Gurrola-Peña et al. (2006) was used. The DASS-21 consists of 21 items divided into three subscales of seven items each—depression, anxiety, and stress. Each statement is rated on a four-point scale, from "did not apply to me at all" (0) to "applied to me very much, or most of the time" (3), referring to the past week. The instrument allows the evaluation of the three symptom domains both independently and jointly, with higher scores indicating greater severity. In a validation study with a Mexican population conducted by Gurrola-Peña et al. (2006), internal consistency was α = .81 for depression, α = .76 for anxiety, and α = .79 for stress. In the present study, internal reliability estimates were α = .92 for depression, α = .89 for anxiety, and α = .83 for stress.

The Dissociative Experiences Scale (DES-II) (Carlson & Putnam, 1993). The Spanish version by Robles García et al. (2006) was used. The DES–II is a self-report instrument consisting of 28 items designed to assess dissociative experiences—amnesia, depersonalization, derealization, and absorption. Participants indicated the percentage of time (0%–100%) that each experience applied to them. The original study reported an internal consistency of α = .93. In the present study, internal reliability was α = .95.

The Plutchik Suicidal Risk Scale (Plutchik et al., 1989). The Spanish version validated by Rubio et al. (1998) was used. This self-administered instrument consists of 15 items assessing previous suicide attempts, suicidal ideation, and associated risk factors. Each item is answered with "yes" (1) or "no" (0), and the total score ranges from 0 to 15, with a cut-off of 6 or higher indicating suicidal risk. The internal consistency of the original version was α = .84. In the present study, internal reliability was α = .73.

Statistical analysis

To evaluate the primary hypothesis that CFT would demonstrate significant reductions in C-PTSD symptomatology, we conducted a set of repeated measures analysis of variance (RM ANOVA) models. This analytical approach examined within-subject effects of time (pretreatment, posttreatment and 6-month follow-up), within-subject effects of time by treatment group (CFT vs. PE), as well as between subject group effects (CFT vs. PE) regardless of time across all outcome measures. Group and time post-hoc mean comparisons (e.g., pre - follow-up) were conducted using *t* statistics, and Holm's *p* value adjustment for controlling Type I error rate. Effect sizes were evaluated using partial eta squared (η^2_p) for ANOVA results, with values of .01, .06, and .14 representing small, moderate, and large effects, respectively. For post-hoc comparisons we used Cohen's *d* for effect size estimation (.20 = small, .50 = moderate, .80 = large effect). Analyses were computed using JASP Version 0.16.4. Missing data were addressed using an intent-to-treat (ITT) approach with multiple imputation (10 imputations) implemented through the mice package in R Studio Version 1.4.1717C. Additionally, per-protocol (PP) analyses were conducted on participants who completed treatment to assess efficacy under optimal conditions.

Results

Primary outcomes

The primary hypothesis regarding CFT effectiveness was supported by the data. In the CFT group, 16 of 21 participants (76.19%) completed the treatment, with 13 (81.25%) exhibiting symptomatic remission. Meanwhile, in the PE group, 12 out of 20 participants (60%) completed the treatment, with symptomatic remission in 10 (83.33%) of those who completed it.

Confirming our hypothesis of comparable effectiveness, the ITT analysis of variance revealed a significant within-subjects effect of time on C-PTSD symptoms, with non-significant time × treatment group interactions and non-significant group effects (see Table 4). Both CFT and PE demonstrated significant and large reductions in C-PTSD symptomatology: CFT showed a reduction of 14.95 points ($p < .001$, $d = 1.95$) from pre to posttreatment and 16 points from pretreatment to follow-up ($p < .001$, $d = 2.08$). PE showed similar reductions of 17.15 points ($p < .001$, $d = 2.23$) and 17.75 points ($p < .001$, $d = 2.31$) respectively, supporting the hypothesized equivalence between treatments. These results were similar in the per protocol analysis (Table 5).

Secondary outcomes

Partially supporting our hypothesis of superior CFT outcomes in specific domains, the ITT analysis revealed significant within-subjects effects of time on all secondary variables, with some differential patterns between treatments (Table 4).

For shame (OAS scores), contrary to our hypothesis of CFT superiority, both treatments showed large and significant reductions with CFT demonstrating slightly

Table 4. Post hoc between pre, post, and follow-up (intention-to-treat)

Measure	Pre *M (SD)*	Post *M (SD)*	Follow-up *M (SD)*	Effect Size *(d)* Pre-Post	Effect Size *(d)* Pre-Follow up	Effect Size *(d)* Post-Follow up	*F* (2,78) Time	η^2_p Time	*F* (2,78) Time x treat-ment	η^2_p Time x treat-ment	*F* (1, 39) Treat-ment	η^2_p Treat-ment
ITQ							89.63***	0.70	0.33	<.01	0.01	<.001
PE	33.50 (4.03)	16.35 (9.53)	15.75 (8.61)	2.23 (1.13-3.33) ***	2.31 (1.19-3.43) ***	0.08 (0.72-0.88)						
CFT	32.38 (5.01)	17.43 (9.30)	16.38 (7.84)	1.95 (0.92-2.97) ***	2.08 (1.03-3.14) ***	0.14 (0.64-0.92)						
OAS							37.60***	0.49	0.16	<.01	1.27	0.03
PE	48.30 (15.16)	30.45 (15.90)	29.50 (16.91)	1.18 (0.34-2.03) ***	1.24 (0.39-2.10) ***	0.06 (0.68-0.81)						
CFT	45.81 (16.74)	25.05 (12.27)	25.10 (13.22)	1.37 (0.51-2.24) ***	1.37 (0.51-2.23) ***	<.01 (0.73-0.72)						
FSCRS-SC							40.54***	0.51	0.17	<.01	1.68	0.04
PE	39.10 (7.27)	22.60 (13.78)	22.35 (12.39)	1.51 (0.57-2.46) ***	1.53 (0.59-2.48) ***	0.02 (0.77-0.81)						
CFT	34.57 (11.42)	19.71 (10.84)	20.05 (8.55)	1.36 (0.46-2.26) ***	1.33 (0.43-2.23) ***	0.03 (0.80-0.74)						
FSCRS - SR							36.08***	0.48	0.94	0.02	0.58	0.01
PE	10.60 (4.98)	17.00 (6.68)	17.50 (7.10)	1.07 (0.33-1.80) ***	1.15 (0.40-1.90) ***	0.08 (0.72-0.55)						
CFT	12.10 (5.69)	19.24 (5.01)	17.38 (6.27)	1.19 (0.45-1.93) ***	0.88 (0.19-1.57) ***	0.31 (0.32-0.94)						
CEAS – SC							26.11***	0.40	0.31	<.01	3.75	0.09
PE	40.15 (14.20)	62.45 (22.22)	64.00 (20.91)	1.22 (0.26-2.18) ***	1.31 (0.34-2.28) ***	0.08 (0.95-0.78)						
CFT	47.67 (18.04)	72.62 (13.67)	68.43 (18.96)	1.37 (0.40-2.33) ***	1.14 (0.21-2.07)**	0.23 (0.62-1.08)						
CEAS – CO							5.98**	0.13	2.92	0.07	1.04	0.03
PE	78.85 (16.67)	77.40 (15.43)	63.65 (14.76)	0.09 (-0.67-0.84)	0.90 (0.09-1.72)**	0.12 (0.82-1.07)						
CFT	76.38 (20.53)	80.43 (15.60)	75.33 (17.18)	0.24 (0.50-0.98)	0.06 (-0.68-0.80)	0.30 (0.44-1.05)						
CEAS – CR							6.38**	0.14	1.68	0.04	4.34*	0.10
PE	39.20 (22.26)	49.60 (28.55)	43.75 (19.32)	0.44 (0.38-1.26)	0.19 (0.61-1.00)	0.25 (0.56-1.06)						
CFT	42.19 (25.56)	60.57 (20.22)	62.81 (23.48)	0.78 (0.05 -1.61)*	0.88 (0.04-1.72)*	0.10 (0.88-0.69)						
DASS-21 (Dep)							73.46***	0.65	0.80	0.02	1.38	0.03
PE	14.35 (5.49)	5.30 (5.23)	7.05 (5.28)	1.88 (0.87-2.89) ***	1.52 (0.58-2.45) ***	0.36 (1.15-0.43)						
CFT	14.05 (5.01)	2.81 (2.86)	5.90 (4.62)	2.33 (1.23-3.43) ***	1.69 (0.73-2.65) ***	0.64 (1.44-0.15)						
DASS-21 (Anx)							62.49***	0.62	0.66	0.02	0.16	<.01
PE	10.95 (5.84)	3.10 (4.52)	5.05 (3.38)	1.73 (0.76-2.69) ***	1.30 (0.41-2.18)***	0.43 (1.21-0.35)						
CFT	12.43 (5.95)	3.19 (2.87)	4.76 (3.86)	2.03 (1.01-3.05) ***	1.69 (0.74-2.63) ***	0.35 (1.10-0.41)						
DASS-21 (Str)							80.69***	0.67	1.17	0.03	1.75	0.04
PE	15.05 (4.50)	6.85 (5.53)	8.05 (4.30)	2.00 (0.93-3.07) ***	1.71 (0.69-2.72) ***	0.29 (1.13-0.54)						
CFT	15.24 (3.51)	4.76 (2.21)	6.38 (3.94)	2.55 (1.36-3.74) ***	2.16 (1.06-3.25) ***	0.39 (1.22-0.43)						
DES – II							20.61***	0.35	0.20	<.01	0.69	0.02
PE	25.89 (14.06)	16.21 (15.72)	13.34 (10.31)	0.67 (0.04-1.38)*	0.86 (0.13-1.60) **	0.20 (0.48-0.87)						
CFT	24.42 (20.50)	12.02 (14.90)	9.74 (8.17)	0.85 (0.13-1.57)**	1.01 (0.27-1.75) ***	0.16 (0.50-0.82)						

Note. PE: prolonged exposure; CFT: compassion focused therapy; ITQ: International Trauma Questionnaire; OAS: Others as Shamer Scale; FSCRS – SC: Forms of Self-Criticism and Self-Reassurance Scale – Self-Criticism; FSCRS – SR: Forms of Self-Criticism and Self-Reassurance Scale – Self-Reassurance; CEAS – SC: Compassionate Engagement and Action Scales – Self-Compassion; CEAS – CO: Compassionate Engagement and Action Scales – Compassion for Others; CEAS – CR: Compassionate Engagement and Action Scales – Compassion from Others; DASS-21 (Dep): Depression, Anxiety, and Stress Scale – Depression; DASS-21 (Anx): Depression, Anxiety, and Stress Scale – Anxiety; DASS-21 (Str): Depression, Anxiety, and Stress Scale – Stress; DES-II: Dissociative Experiences Scale. * $p < .05$, ** $p < .01$, *** $p < .001$

larger effect sizes (d = 1.37 vs d = 1.18 posttreatment; d = 1.37 vs d = 1.24 at follow-up). CFT showed a reduction of 20.76 points from pre to posttreatment ($p < .001$) and 20.71 points from pretreatment to follow-up ($p <. 001$). PE demonstrated reductions of 17.85 points ($p < .001$) and 18.80 points ($p < .001$) respectively.

For self-criticism (FSCRS), both treatments achieved comparable large reductions, not supporting our hypothesis of CFT advantage. PE showed reductions of 16.50 points from pre to posttreatment ($p < .001$) and 16.75 points from pretreatment to follow-up ($p < .001$). CFT demonstrated reductions of 14.86 points ($p < .001$) and 14.52 points ($p < .001$) respectively. Both treatments achieved substantial and equivalent improvements in self-criticism.

However, supporting our hypothesis of differential compassion outcomes, significant treatment-specific effects emerged. For compassion from others (CEAS-CR), only the CFT group showed significant improvements: CFT demonstrated increases of 18.38 points from pre to posttreatment ($p < .05$) and 20.62 points from pretreatment to follow-up ($p < .05$), while PE showed no significant changes at any time point.

Conversely, for compassion toward others (CEAS-CO), only the PE group showed significant changes, with a pattern of decreased compassion: PE demonstrated decreases of 15.20 points from pretreatment to follow-up ($p < .01$) and 13.75 points from post-treatment to follow-up ($p < .05$), while CFT showed no significant changes, maintaining stable compassion levels throughout treatment.

These contrasting patterns provide support for our hypothesis that CFT offers unique advantages in compassion-related domains, specifically enhancing perceived support from others while preventing the decline in compassion toward others observed with exposure-based treatment.

Discussion

The present study aimed to evaluate the effectiveness of a CFT protocol specifically designed for individuals with C-PTSD using an active control comparison with PE. The results provide strong support for the primary hypothesis that CFT would demonstrate effectiveness comparable to PE for C-PTSD symptom reduction. Both treatments achieved significant and large effect sizes with no significant differences between conditions, directly confirming our predicted equivalence. These results were sustained at six months and are consistent with findings from McLean et al. (2022) and Romaniuk et al. (2023), who evaluated CFT programs for individuals with PTSD associated with childhood sexual abuse and war veterans, respectively.

Moreover, 81.25% of participants who received CFT achieved symptom remission, a percentage higher than the 57% reported in McLean et al. (2022). This may be explained by differences in the population type and implementation format, as McLean et al. (2022) conducted their intervention in group format exclusively with survivors of childhood sexual abuse, while this study used an individual format with participants who experienced diverse traumatic events. The explanation related to format may be supported by Au et al. (2017), who conducted the treatment individually, finding that 9 out of 10 participants no longer met PTSD diagnostic criteria after the treatment.

On the other hand, Vrabel et al. (2024) found no differences between pre and posttest self-reports in individuals with eating disorders and trauma. This can be explained by the eating disorder-focused protocol they used but may also indicate that the presence of these disorders can affect treatment effectiveness for C-PTSD, even though evidence exists for the use of CFT in eating disorders. Future studies could evaluate the protocol's effect on other comorbidities.

Treatment completion rates were higher for CFT (76.2%) compared to PE (60 %). While it has been noted that the average dropout rate in trauma interventions is approximately 18%, Brown et al. (2022) suggest this can increase to 36 % or even 68 % in interventions that directly address traumatic memory, as in the case of PE. Given that CFT does not focus on traumatic memory, this may explain its lower dropout rate.

Beyond posttraumatic symptoms, both treatments showed significant reductions in shame, self-criticism, depression, anxiety, and stress, similar to the results described by Millard et al. (2023) in clinical populations and McLean et al. (2022) in victims of childhood sexual abuse. The secondary hypothesis regarding superior CFT outcomes in compassion, shame, and self-criticism domains received partial support. Contrary to our expectations, CFT did not demonstrate clear superiority over PE in reducing shame or self-criticism. For shame reduction, while both treatments showed substantial improvements, CFT demonstrated slightly larger effect sizes without statistical superiority. For self-criticism, both treatments achieved comparable large reductions, with PE showing slightly larger effect sizes.

The findings suggest that CFT has a similar effect to PE on self-compassion and self-soothing capacity. This contrasts with the meta-analysis by Millard et al. (2023), which found that CFT is more effective than usual treatment in increasing levels of self-compassion

Table 5. Post hoc between pre, post, and follow-up (per-protocol analysis)

Measure	Pre *M (SD)*	Post *M (SD)*	Follow-up *M (SD)*	Effect size *(d)* pre-post	Effect size *(d)* pre-follow up	Effect size *(d)* post-follow up	*F* (2,40) Time	η^2_p Time	*F* (2,40) Time x treatment	η^2_p Time x treatment	*F* (1,20) Treat-ment	η^2_p Treat-ment
ITQ							49.77***	0.71	0.09	<.01	0.12	<.01
PE	34.10 (2.18)	16.90 (12.12)	15.30 (10.27)	1.99 (0.55-3.44)***	2.18 (0.67-3.68)***	0.19 (0.88-1.25)						
CFT	32.17 (4.14)	16.25 (10.09)	14.92 (8.81)	1.84 (0.51-3.17)***	2.00 (0.62-3.38)***	0.15 (0.82-1.13)						
OAS							21.28***	0.52	0.16	<.01	1.11	0.05
PE	47.10 (15.92)	28.60 (15.76)	31.30 (16.26)	1.20 (0.04-2.36)**	1.03 (0.09-2.14)*	0.18 (1.18-0.83)						
CFT	43.50 (18.25)	21.33 (13.33)	25.25 (12.51)	1.44 (0.28-2.60)***	1.18 (0.10-2.27)**	0.25 (1.18-0.67)						
FSCRS-SC							23.21***	0.53	0.56	0.03	3.27	0.13
PE	39.00 (7.71)	24.36 (14.76)	21.27 (15.05)	1.28 (0.05-2.52)**	1.56 (0.25-2.86)***	0.27 (0.81-1.35)						
CFT	32.75 (10.68)	15.00 (8.72)	17.75 (9.74)	1.56 (0.29-2.83)***	1.32 (0.11-2.52)**	0.24 (1.28-0.80)						
FSCRS - SR							17.44***	0.47	0.74	0.04	0.80	0.04
PE	11.30 (5.14)	16.80 (6.65)	17.50 (6.43)	0.91 (0.11-1.93)*	1.02 (0.02-2.07)*	0.12 (1.03-0.80)						
CFT	13.00 (5.83)	20.33 (5.21)	18.17 (6.85)	1.21 (0.18-2.24)***	0.85 (0.08-1.79)*	0.36 (0.50-1.21)						
CEAS – SC							14.92***	0.43	1.52	0.07	3.38	0.14
PE	45.10 (15.39)	56.60 (21.66)	63.70 (20.42)	0.66 (0.46-1.79)	1.07 (0.13-2.27)*	0.41 (1.51-0.69)						
CFT	49.91 (15.63)	75.17 (13.59)	71.91 (17.19)	1.45 (0.24-2.67)***	1.27 (0.10-2.44)**	0.19 (0.81-1.18)						
CEAS – CO							6.70**	0.25	3.22	0.14	0.28	0.01
PE	84.50 (9.20)	75.80 (16.57)	66.40 (15.12)	0.54 (-0.36-1.44)	1.12 (0.10-2.15)**	0.58 (0.33-1.49)						
CFT	79.33 (19.03)	80.83 (15.35)	76.00 (18.29)	0.09 (0.70-0.89)	0.21 (0.59-1.00)	0.30 (0.50-1.11)						
CEAS – CR							2.32	0.10	0.13	<.01	2.30	0.10
PE	39.90 (21.31)	52.50 (27.64)	42.20 (20.46)	0.50 (0.60-1.61)	0.09 (0.98-1.17)	0.41 (0.68-1.50)						
CFT	50.75 (29.15)	63.25 (23.41)	58.25 (25.95)	0.50 (0.51-1.51)	0.30 (0.70-1.29)	0.20 (0.79-1.19)						
DASS-21 (Dep)							42.67***	0.68	1.49	0.07	2.84	0.12
PE	15.90 (4.60)	7.50 (5.91)	7.40 (5.60)	1.73 (0.39-3.07)***	1.75 (0.40-3.10)***	0.02 (1.02-1.06)						
CFT	13.50 (5.30)	2.67 (2.46)	6.33 (4.79)	2.23 (0.77-3.69)***	1.48 (0.27-2.68)***	0.75 (1.78-0.27)						
DASS-21 (Anx)							38.04***	0.66	0.91	0.04	0.05	<.01
PE	12.90 (5.93)	4.900 (5.91)	5.30 (3.97)	1.63 (0.30-2.96)***	1.55 (0.24-2.85)***	0.08 (1.15-0.98)						
CFT	13.50 (6.26)	2.75 (2.49)	5.75 (4.00)	2.19 (0.74-3.64)***	1.58 (0.33-2.82)***	0.61 (1.63-0.41)						
DASS-21 (Str)							42.49***	0.68	0.46	0.02	0.98	0.05
PE	16.10 (4.17)	7.40 (5.87)	8.00 (4.03)	2.05 (0.51-3.60)***	1.91 (0.41-3.41)***	0.14 (1.33-1.04)						
CFT	15.25 (3.96)	4.92 (2.28)	7.50 (4.64)	2.44 (0.83-4.04)***	1.83 (0.43-3.23)***	0.61 (1.73-0.51)						
DES – II							18.50***	0.48	1.86	0.08	3.54	0.15
PE	30.11 (16.51)	17.18 (17.38)	13.00 (9.50)	1.09 (0.04-2.14)**	1.44 (0.29-2.59)***	0.35 (0.56-1.27)						
CFT	18.04 (9.22)	8.15 (8.60)	8.02 (2.31)	0.83 (0.09-1.76)*	0.71 (0.19-1.60)	0.13 (0.96-0.70)						

Note. PE: prolonged exposure; CFT: compassion focused therapy; ITQ: International Trauma Questionnaire; OAS: Others as Shamer Scale; FSCRS – SC: Forms of Self-Criticism and Self-Reassurance Scale – Self-Criticism; FSCRS – SR: Forms of Self-Criticism and Self-Reassurance Scale – Self-Reassurance; CEAS – SC: Compassionate Engagement and Action Scales – Self-Compassion; CEAS – CO: Compassionate Engagement and Action Scales – Compassion for Others; CEAS – CR: Compassionate Engagement and Action Scales – Compassion from Others; DASS-21 (Dep): Depression, Anxiety, and Stress Scale – Depression; DASS-21 (Anx): Depression, Anxiety, and Stress Scale – Anxiety; DASS-21 (Str): Depression, Anxiety, and Stress Scale – Stress; DES-II: Dissociative Experiences Scale

* $p < .05$, ** $p < .01$, *** $p < .001$

and self-soothing. However, this aligns with Hoffart et al. (2015), who proposed self-compassion as a specific mechanism of change in PTSD, suggesting that increased self-compassion is implicated in PE.

However, the hypothesis was strongly supported regarding differential compassion dynamics. As predicted, CFT demonstrated unique benefits in enhancing perceived compassion from others, while PE showed no significant changes in this domain. Conversely, PE was associated with a concerning decrease in compassion for others at follow-up, while CFT maintained stable compassion levels throughout treatment. Considering the small to medium effect size of PTSD treatments on anger (Wells et al., 2024), one possible hypothesis is that anger following trauma processing in the PE group may have led to decreased compassion for others—an effect not observed in the CFT group, as compassion is the proposed mechanism of change in this psychotherapy. This is supported by results for compassion from others, where individuals who received CFT experienced an increase in perceived compassion from others, a change not observed in the PE group.

This study makes several important contributions to the C-PTSD treatment literature. First, it provides randomized controlled trial evidence for individual CFT in formally diagnosed C-PTSD populations, addressing a significant gap identified in recent reviews (Millard et al., 2023). Importantly, this trial employed a design comparing CFT to an active, evidence-based control (PE) rather than a waitlist, and delivered treatment in an individual format—addressing key methodological limitations of prior CFT studies, which have predominantly used observational designs, waitlist controls, or group formats. Second, the finding that CFT demonstrated equivalent effectiveness to PE—a gold-standard trauma treatment—while showing a lower dropout rate (24% vs. 40%) suggests important clinical implications. For individuals who decline or cannot tolerate exposure-based treatments, CFT may offer a viable alternative that addresses core C-PTSD features of shame, self-criticism, and interpersonal difficulties through compassion-focused mechanisms rather than trauma memory processing. Additionally, this study provides evidence that CFT may effectively reduce dissociative symptoms in C-PTSD populations—a variable not previously examined in CFT trials.

The differential effects on compassion measures provide preliminary evidence for CFT's proposed mechanisms of action. The increase in perceived compassion from others in the CFT group, contrasted with decreased compassion for others in the PE group, suggests that CFT may uniquely enhance interpersonal compassion dynamics—a potentially important factor in C-PTSD recovery given the interpersonal nature of complex trauma.

Furthermore, these results contribute to growing evidence supporting the effectiveness of brief, evidence-based interventions delivered via teletherapy to clinically complex populations. The implementation of both CFT and PE through videoconferencing in the present study aligns with recent research demonstrating the viability and effectiveness of remote psychological treatments. Delgado Armada et al. (2023) documented significant symptom reductions and high adherence rates in group cognitive-behavioral therapy via videoconferencing for OCD, while Gordillo et al. (2024) reported increased adoption of teletherapy for depression during the COVID-19 pandemic, particularly for cognitive-behavioral and third-wave approaches. Supporting this broader pattern, Reyes-Ortega et al. (2023) demonstrated that abbreviated dialectical behavior therapy successfully reduced depression, anxiety, stress, and emotion dysregulation in Mexican university students presenting with suicidal ideation and high emotional regulation difficulties. Together, these findings underscore the viability of delivering brief, skills-based psychological interventions to individuals with complex clinical presentations through accessible teletherapy modalities.

Future research should examine several important questions. First, analyzing the impact of traumatic event type and comorbidities on the effectiveness of the evaluated protocol would help determine whether certain trauma histories or psychiatric conditions moderate treatment outcomes. Second, investigating the mechanisms of CFT through mediation analyses focusing on compassion, shame, and emotional regulation pathways would help clarify the theoretical foundations of this approach. Third, longer-term follow-up studies are needed to assess the durability of treatment effects beyond 6 months and determine whether therapeutic gains remain stable over time. Finally, examining treatment moderators would help identify patients who may benefit the most from CFT versus exposure-based approaches, enabling more personalized treatment selection.

Despite these promising findings, several methodological limitations must be acknowledged when interpreting the results. The sample size limits its generalizability, and future studies should employ larger samples while examining the impact of trauma type and comorbidities. The dropout rate of 24% in CFT and 40% in PE may introduce attrition bias, which was addressed through intention-to-treat analysis using

multiple imputations. However, the specific reasons for participant dropout were not systematically recorded, which limits the ability to identify potential patterns of attrition or to distinguish between treatment-related and external causes. Finally, replication by independent research groups is needed to confirm these findings.

This study provides the first randomized controlled trial evidence that individual CFT is an effective treatment for C-PTSD, demonstrating outcomes comparable to PE while potentially offering advantages in treatment retention and interpersonal compassion dynamics. The results support CFT as a viable alternative for individuals who decline or cannot tolerate exposure-based treatments, with unique benefits for rebuilding compassionate relationships with others. The confirmed hypothesis of equivalent effectiveness, combined with superior retention and differential compassion outcomes, positions CFT as an important addition to the C-PTSD treatment repertoire, offering clinicians and patients a theoretically distinct yet equally effective therapeutic option.

Conflicts of interest

The authors have no conflicts of interest to disclose.

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