Available online at www.sciencedirect.com

ScienceDirect

Behavior Therapy 48 (2017) 207–221

Behavior Therapy

www.elsevier.com/locate/bt

Compassion-Based Therapy for Trauma-Related Shame and Posttraumatic Stress: Initial Evaluation Using a Multiple Baseline Design

Teresa M. Au
Center for Anxiety and Related Disorders, Boston University
VA Boston Healthcare System

Shannon Sauer-Zavala
Center for Anxiety and Related Disorders, Boston University

Matthew W. King
VA Boston Healthcare System
Boston University School of Medicine

Nicola Petrocchi
Center for Anxiety and Related Disorders, Boston University
John Cabot University

David H. Barlow
Center for Anxiety and Related Disorders, Boston University

Brett T. Litz
VA Boston Healthcare System
Boston University School of Medicine
Massachusetts Veterans Epidemiological Research and Information Center

Accumulating research suggests that shame can strongly contribute to the development and maintenance of posttraumatic stress disorder (PTSD). Interventions that promote self-compassion have shown promise for reducing shame related to various clinical problems, but this approach has not been systematically evaluated for traumatized individuals. The aim of this study was to develop a brief compassion-based therapy and assess its efficacy for reducing trauma-related shame and PTSD symptoms. Using a multiple baseline experimental design, the intervention was evaluated in a community sample of trauma-exposed adults (*N* = 10) with elevated trauma-related shame and PTSD symptoms. Participants completed weekly assessments during a 2-, 4-, or 6-week baseline phase and a 6-week treatment phase, and at 2 and 4 weeks after the intervention. By the end of treatment, 9 of 10 participants demonstrated reliable decreases in PTSD symptom severity,

The authors wish to acknowledge Dr. Frank Dibert for providing clinical supervision; Dr. Lizabeth Roemer for providing consultation on study design and feedback on a previous version of the manuscript; and Rebecca Lubin, Carol Hundert, and Mia Tankersley for assisting with adherence ratings. This study was supported by a Clara Mayo Memorial Fellowship Award to T. M. Au.

Address correspondence to Teresa M Au., Boston University, 648 Beacon St., 6th Fl., Boston, MA 02215; e-mail: tau@bu.edu.

0005-7894/© 2016 Association for Behavioral and Cognitive Therapies. Published by Elsevier Ltd. All rights reserved.

while 8 of 10 participants showed reliable reductions in shame. These improvements were maintained at 2- and 4-week follow-up. The intervention was also associated with improvements in self-compassion and self-blame. Participants reported high levels of satisfaction with the intervention. Results suggest that the intervention may be useful as either a stand-alone treatment or as a supplement to other treatments.

Keywords: trauma; posttraumatic stress disorder; shame; compassion; single-case experimental design

There is growing recognition that shame can strongly contribute to the development and maintenance of PTSD, yet little is known about effective interventions for reducing shame in this context (Candea & Szentagotai, 2013; La Bash & Papa, 2014). Shame refers to the affective experience of feeling intrinsically defective, socially undesirable, and inadequate (Lewis, 1971). It is associated with global negative self-evaluations (i.e., "I am a bad person"), withdrawal, and poor health outcomes (Dickerson, Gruenewald, & Kemeny, 2004). After trauma, shame is commonplace; for instance, individuals who have experienced childhood physical abuse report higher levels of shame than nonabused individuals (Keene & Epps, 2016). Shame is especially prevalent among people with PTSD; in a study of 1,522 adults with histories of interpersonal trauma, 62% of those with assault-related PTSD reported experiencing trauma-related shame, and shame was a stronger predictor of PTSD than fear (Badour, Resnick, & Kilpatrick, 2015). Accordingly, the revised PTSD criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013) no longer require "intense fear, helplessness, or horror" at the time of the traumatic event (Criterion A2 of *DSM-IV-TR*; APA, 2000) and now recognize common posttraumatic changes in cognitions and mood, including negative self-evaluation, distorted self-blame, and shame. Across a variety of populations and types of trauma, shame has been found to persist over time and to consistently predict greater PTSD symptom severity (reviewed in La Bash & Papa, 2014). For example, in a longitudinal study of sexually abused adolescents, higher abuse-related shame at the time of the abuse discovery was associated with persistent shame and increased PTSD symptoms 6 years later (Feiring & Taska, 2005).

For individuals with PTSD and elevated shame, treatments that focus on reducing shame may aid recovery. According to cognitive theory, PTSD develops from and is maintained by the perception of ongoing threat (Ehlers & Clark, 2000). While fear gives rise to perceived external threats (e.g., "the world is unsafe"), shame can fuel a sense of internal threat (e.g., seeing oneself as damaged, inadequate, incapable). Initially, shame may temporarily act as an adaptive response to interpersonal trauma, akin to submissive behavior in animals that preserves group membership and decreases the likelihood of continued aggression from others (Dickerson et al., 2004). However, trauma survivors frequently continue to attack themselves with self-criticism and blame themselves for the trauma long after the external threat has ceased (Lee, Scragg, & Turner, 2001). Lee et al. (2001) theorize that new, maladaptive shame schemas may then replace a previously positive self-identity, or alternatively, pretrauma shame schemas (e.g., "I'm weak") may be activated and exacerbated. The resultant shame may further maintain PTSD symptoms by motivating avoidant behaviors, such as isolating. PTSD that is maintained by fear and perceived external threat may be more responsive to exposure therapy, whereas PTSD maintained by shame may respond less well to such treatments and warrant an alternative approach (Lee et al., 2001). Neglecting to address shame may interfere with the efficacy of PTSD treatment (e.g., Pitman et al., 1991). Conversely, decreases in shame prospectively predict reductions in PTSD symptoms, suggesting that treatments that target shame may alleviate shame-based PTSD (Feiring & Taska, 2005; Øktedalen, Hoffart, & Langkaas, 2015).

Only a small handful of studies have evaluated the efficacy of interventions for reducing shame in any disorder (Gilbert & Procter, 2006; Luoma, Kohlenberg, Hayes, & Fletcher, 2012; Rizvi & Linehan, 2005). These studies have provided encouraging evidence that relatively brief interventions can reduce shame; for instance, in an addictions treatment program, a 6-hour mindfulness- and acceptance-based intervention produced small pre- to posttreatment reductions in shame (within-subjects Cohen's $d = .26$) that grew by the 4-month follow-up (within-subjects Cohen's $d = .66$; Luoma et al., 2012). However, there is no consensus on the most effective ways to directly target and reduce shame (Candea & Szentagotai, 2013).

One promising approach for alleviating shame in PTSD may be to build self-compassion. Compassion involves being mindfully aware of suffering, seeing the shared humanity of the person experiencing suffering, and responding with kindness, warmth, and goodwill *because* of their suffering (Neff, 2003). For individuals with PTSD and high

Download English Version:

https://daneshyari.com/en/article/5038098

Download Persian Version:

https://daneshyari.com/article/5038098

Daneshyari.com