

## The Treatment of Maladaptive Shame in Borderline Personality Disorder: A Pilot Study of “Opposite Action”

Shireen L. Rizvi and Marsha M. Linehan, *University of Washington*

*This study sought to pilot test a short-term intervention for maladaptive shame in borderline personality disorder (BPD) based on the skill of “opposite action” from dialectical behavior therapy. Five women with BPD were treated with the intervention using a single-subject, multiple-baseline design. Results indicate that, although state ratings of shame are highly variable, it is possible to reduce shame about a specific event over a short period of time. This was verified by a new shame measure that was created for this study. Results from this study have several implications for the treatment of shame in BPD and other clinical populations. A detailed case example is provided.*

**B**ORDERLINE PERSONALITY DISORDER (BPD) is a severe personality disorder characterized by prominent and pervasive dysregulation of emotion, behavior, and cognition. Of all psychiatric disorders, BPD represents one of the more challenging to mental health professionals (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). It has been theorized that part of the difficulty in treating BPD is due to chronic and extreme feelings of shame experienced by individuals with the disorder (Crowe, 2004, Linehan, 1993). While clinical experience suggests that shame is pervasive within individuals with BPD, it has been sorely understudied. The only study that has empirically studied the phenomenon of shame in BPD, compared to other psychological disorders, demonstrated that shame-proneness is higher in BPD than in individuals with social anxiety or normal controls (Rusch et al., 2005).

BPD is also related to high mortality rates, with up to 10% of individuals ultimately committing suicide (Linehan, Rizvi, Shaw Welch, & Page, 2000), a figure 50 times higher than the rate of suicide in the general population (Work Group on Borderline Personality Disorder, 2001). Interestingly, a number of studies have linked suicidal behavior to shame, suggesting that this emotion may play an important role in the development and maintenance of suicidal behavior. For example, Hastings, Northman, and Tangney (2000) found that proneness to experiencing shame predicted suicide ideation in a sample of college students. Lester (1998) reported that higher levels of shame were associated with higher current suicidality, after controlling for age, gender, and current level of

depression. In a longitudinal study on moral emotions (Tangney & Dearing, 2002), shame-proneness in the fifth grade predicted later suicide attempts by young adulthood. Recent research with BPD individuals found that shame (as measured by both self-report and coding of nonverbal cues) while talking to a clinical interviewer about a recent episode of parasuicide predicted repeated parasuicide in the following 12 months (Brown, 2002).

These findings suggest an association between shame, BPD, and suicidality that warrants attention from treatment developers and providers. However, there has been little empirical work on the treatment of shame in general, and with BPD specifically. Dialectical behavior therapy (DBT; Linehan, 1993a, 1993b) has been found to be an efficacious treatment for BPD in seven controlled trials (Lieb et al., 2004). Although DBT explicitly targets shame in BPD, shame is only one of multiple targets and thus the specific effects on this emotion are not yet known. This study sought to further develop and test the “opposite action” DBT technique as a means of specifically reducing shame in individuals with BPD.

### Treatment of Shame

In the treatment development field, Barlow has written extensively about the mechanisms of treatment for fear disorders. Expanding the work of earlier emotion theorists such as Wolpe and Izard, Barlow (1988) suggested that a crucial function of exposure therapy for anxiety disorders, such as specific and social phobia, is the prevention of natural action tendencies associated with anxiety and promotion of actions incompatible with anxiety. He wrote that the “essential step in the modification of emotional disorders is the direct alteration of associated action tendencies” (p. 313). Cognitive-behavioral interventions for anxiety, or fear, disorders all include this one common element: individuals have to approach

**Cognitive and Behavioral Practice 12, 437–447, 2005**

1077-7229/05/437-447\$1.00/0

Copyright © 2005 by Association for Advancement of Behavior Therapy. All rights of reproduction in any form reserved

 **Continuing Education Quiz located on p. 495.**

the object/situation that is fearful, thus acting counter to (and inhibiting) their prominent urges to avoid.

In DBT, Linehan (1993b, p. 94) articulates this process as a behavioral skill designed to regulate all emotions, not just fear, and named it "opposite-to-emotion action" or "opposite action." The premise behind this strategy is that one can change an unwanted emotion by identifying the current emotion, identifying the urges (action tendencies) associated with the emotion, determining the actions that are opposite to those urges, and then engaging in those opposite actions. Over time, the skill has been expanded further to include an emphasis on opposite action "all the way." Thus, an emphasis is put on not only overt action but also on posture, nonverbal and verbal expressiveness, and concurrent thoughts. The hypothesized agent of change is this *integrated opposite action* of individual when faced with an emotion-eliciting cue. By preventing maladaptive action tendencies and generating new incompatible response patterns, the initial affective response is weakened, and the incompatible response is strengthened.

In developing a specific opposite-action intervention for shame, two modifications were made to the original specification of the procedure. First, the criteria for whether shame was considered justified was expanded to include two criteria: (a) the action or characteristic of the individual violated his or her own "wise mind" moral values, *and/or* (b) the action or characteristic would cause others to reject him or her if they knew about it. If neither of those conditions were true, then the shame was considered to be unjustified. Second, due to the complexity of emotions, the emerging evidence that emotions, including shame, have more than one maladaptive action tendency, and the distinction between justified and unjustified emotions, it was deemed necessary that opposite actions be guided more by the *principles* of cue exposure, response prevention, and opposite action than by a one-size-fits-all approach. There are several identified action tendencies associated with shame. Behaviorally, a person feeling shame experiences the urge to hide, withdraw, disappear (or die), and/or disguise characteristics or behavior. Cognitively, shame is associated with both making a negative appraisal of the situation and blaming the self for what went wrong. In addition, shame often has a cognitive response of preoccupation or rumination with a negative action as well as with negative evaluation of self more generally (Tangney & Dearing, 2002). In some cases, shame is associated with an action tendency to blame others for the event that elicited the emotion (Fischer & Tangney, 1995) and studies have documented a relationship between shame and expressions of hostility toward self and others (Tangney, Wagner, Barlow, Marschall, & Gramzow, 1996; Tangney, Wagner, Fletcher, & Gramzow, 1992). Although withdrawing/hiding and

avoiding are the action tendencies most commonly associated with shame, all action urges would need to be altered if one expects the shame to be reduced (and not reinforced). Thus, various opposite actions were identified for an individual, based on the specific situation and their specific urges in that situation.

The opposite-action procedure tested in this study involves five steps. First, the cues that elicit shame for a particular client are identified. Second, an appraisal is made as to whether shame for that cue is justified or unjustified by the situation. Third, the individual is exposed to the shame cue. Fourth, maladaptive emotion-linked action tendencies are blocked. Finally, actions that are opposite to the emotion-linked action tendencies are elicited and reinforced. The last two steps are influenced by whether the shame is justified or unjustified. For example, if a participant described feeling justified shame over an event (e.g., committing a violent crime in the past) and an urge to hide that event from others for fear of rejection, the opposite action would not involve revealing that event to everyone they knew. It would instead involve revealing that event to the therapist only, working on making amends for the past behavior, and committing to not engage in that behavior again. The case example below provides an illustration for addressing unjustified shame. The intervention was tested with five participants using a single-subject, multiple-baseline design.

## Method

### Participants

Participants were recruited for a treatment study targeting shame by brochures sent to mental health providers, by a Web site announcement, and by describing the study to individuals who telephoned our research clinic looking for treatment options for BPD. Inclusion criteria consisted of a diagnosis of BPD, age between 18 and 60 years, and current suicidality. Suicidality was included as a criterion because of the desire to obtain a severe sample for which shame was expected to be significant. For the purposes of this study, suicidality was operationally defined as an intentional self-injurious act within the past 30 days (with or without the intent to die) and/or current high suicide ideation, including a plan for suicide. In addition, so that an individual therapist would be available to monitor suicidal behavior and provide crisis intervention when necessary, participants were included only if they were in ongoing weekly individual therapy with a non-DBT therapist. Non-DBT orientation of the therapist was chosen to lower the possibility that facets of the experimental intervention would be present in the individual therapy. Exclusion criteria for the study included a current *DSM-IV* diagnosis of mental retardation, substance abuse or dependence, schizophrenia, or another

متن کامل مقاله

دریافت فوری ←

**ISI**Articles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات