

Treatment of Shame in Borderline Personality Disorder

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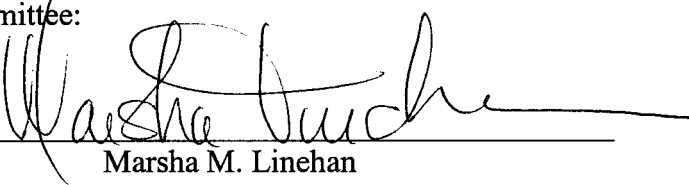
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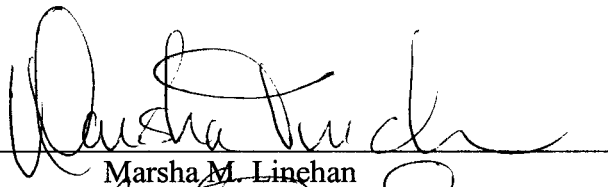
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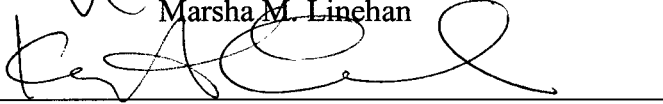


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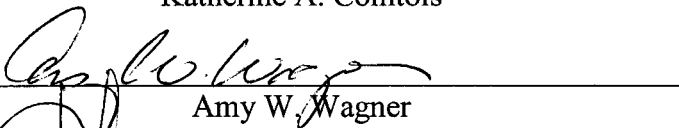
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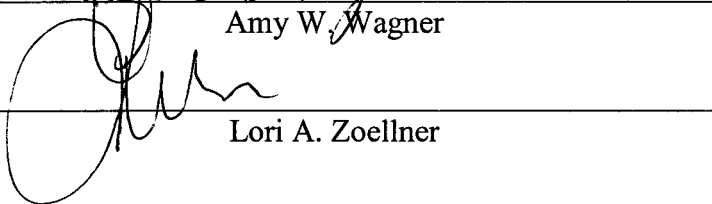
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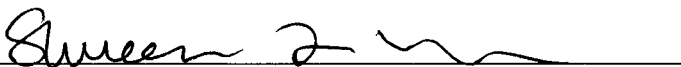
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Abstract

Treatment of Shame in Borderline Personality Disorder

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Research on the emotion of shame has increased dramatically in recent years. Shame has been found to be associated with suicidal behavior, interpersonal difficulties, deficits in problem solving, and problems with other negative affect such as anger and depression. However, despite empirical evidence that the experience of shame is linked to psychopathology, a focus on shame has been largely absent in clinical approaches. Nowhere is this more apparent than in the field of borderline personality disorder (BPD), a disorder proposed to be associated with the presence of intense and chronic levels of shame. This study sought to develop and test a short-term intervention for shame in BPD, using the skill of “Opposite Action,” from Dialectical Behavior Therapy. This skill was expanded upon and developed into a 8-10 week intervention during which clients were exposed to cues that evoked shame, maladaptive responses were blocked, and adaptive, opposite responses were elicited and strengthened. A pilot case was used to further refine the treatment manual and consequently, five clients were treated with the

intervention using a single-subject, multiple baseline design. There were several noteworthy results. First, repeated measurement led to the finding that state ratings of shame are highly variable, independent of any treatment effect. Second, within-session changes in shame indicate that it is possible to reduce shame about a specific event over a short period of time using the technique of opposite action. A shame checklist that was created for this study verified this finding. Scores on the checklist showed a significant reduction in shame intensity by the end of treatment, suggesting that this intervention was successful at reducing shame about specific events that was not necessarily accounted for in the weekly, unstable ratings. Finally, the method for developing the treatment manual was successful in that it produced a short-term intervention, based on empirical principles of behavior change, that was highly acceptable to participants. There were no dropouts during the intervention and rates of overall compliance were extremely high. These findings have several implications for the treatment of shame in BPD and other clinical populations.

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Dedication

I would like to dedicate this work to the six women who trusted in the process and worked so diligently to make changes in their lives. They are a source of inspiration.

INTRODUCTION

Borderline Personality Disorder is a Pervasive, Costly, and Difficult to Treat Problem

Borderline Personality Disorder (BPD) is a severe personality disorder characterized by prominent and pervasive dysregulation of emotion, behavior, and cognition. Current diagnostic criteria for BPD include difficulties with interpersonal relationships, affective instability, problems with anger, problems with self-identity, destructive impulsive behaviors, frantic efforts to avoid abandonment, chronic feelings of emptiness, transient dissociative symptoms and/or paranoid ideation, and suicidal behaviors (American Psychiatric Association, 1994). In order for a diagnosis to be made, at least five of these nine criteria must be present beginning in early adulthood and lasting for several years. The criteria themselves suggest that the problems have to be of a chronic and pervasive nature in order to accurately make the diagnosis of BPD.

Of all psychiatric disorders, BPD represents one of the more challenging to mental health professionals for several reasons. First, individuals with BPD utilize mental health treatment at highly disproportionate rates. Although prevalence rates indicate that 1 to 2% of the general population meet criteria for BPD, it is estimated that between 9 and 40% of high inpatient services utilizers have a diagnosis of BPD (Surber, Winkler, Monteleone, Havassy, Goldfinger, & Hopkin, 1987; Swigar, Astrachan, Levine, Mayfield, & Radovich, 1991). In addition, individuals with BPD receive significantly more individual therapy, group therapy, day treatment, or psychiatric hospitalizations than individuals with major depressive disorder or other personality disorders (Bender et al., 2001). Costs of such services are high. In one study, the total annual cost to treat just

14 BPD clients in a routine community setting was estimated at \$645,000 (Psychiatric Services, 1998).

The longitudinal course of BPD, with and without treatment, is a complex and much studied phenomenon. At the heart of the discussion about the long-term course of BPD is whether it represents a stable, chronic condition or an unstable, episodic one with relapses and remissions. Many studies have shown that rates of remission do not become notable until after at least ten years of naturalistic follow-up, suggesting that remission from BPD is possible but only after a long and steady course (Kullgren, 1992; Links, Heslegrave, & van Reekum, 1998; Paris, Brown, & Nowlis, 1987; Paris & Zweig-Frank, 2001; Pope, Jonas, Hudson, Cohen, & Gunderson, 1983; Stone, 1993). These studies, however, have been plagued by methodological problems, including high attrition rates, lack of formal measures for determining the presence or absence of BPD at follow-up, lack of “blind” diagnostic assessors, and the absence of control groups, which makes conclusions across studies a difficult task. A recent study by Zanarini and colleagues (Zanarini, Frankenburg, Hennen, & Silk, 2003), which attempts to overcome some of these past limitations, suggests that BPD is not as chronic a disorder as previously believed. This study has many strengths, which includes an attrition rate of only 6% and the use of psychometrically sound diagnostic interviews. In a sample of 290 individuals with BPD, initially diagnosed upon admission to an inpatient psychiatric hospital, more than one-third no longer met criteria for BPD two years later. At the six-year follow-up, the rate of remission from BPD was nearly 70%. Also examined were specific symptom patterns over time. Results indicated that symptoms related to impulsivity were the quickest to remit with time, while symptoms of affective disturbance and emotion

dysregulation were the most chronic. It is important to note, however, that even with the encouraging finding of diagnostic remission, the BPD individuals were more likely to have 23 of the 24 symptoms studied than the control individuals which were patients with a diagnosis of another personality disorder. This indicates that individuals with BPD are in no means “cured” with the passage of time, and in fact, functional impairment may remain long after diagnostic criteria are no longer met (Skodol, Siever, Livesley, Gunderson, Pfohl, & Widiger, 2002). This finding is also consistent with the stage model of treatment in Dialectical Behavior Therapy (DBT) which posits that once behavioral control is achieved in treatment with BPD individuals, the next stage is one of “quiet desperation” and misery (Linehan, 1993a).

There have been many promising advances in the treatment of BPD in recent years, but it is clear that there is still much work ahead for determining best methods for treating individuals with BPD, whether BPD symptoms or other comorbid disorders are the primary target. Analyses of outcomes for those who have received inpatient and outpatient treatment-as-usual (TAU) suggest that traditional treatments in the community for BPD are only marginally effective when outcomes are measured two to three years following treatment (Perry & Cooper, 1985; Tucker, Bauer, Wagner, Harlam, et al., 1987). This is also true for treatment of Axis I disorders when BPD is present: a comorbid diagnosis of BPD or BPD features is associated with worse outcomes in the treatment of many Axis I disorders, including major depression (Ilardi, Craighead, & Evans, 1997; Phillips & Nierenberg, 1994; Shea, Pilkonis, Beckham et al., 1990), obsessive-compulsive disorder (Baer, Jenike, Black, Treece, Rosenfeld, & Greist, 1992), bulimia nervosa (Ames-Frankel, Devlin, Walsh, & Strasser, 1992; Coker, Vize, Wade, &

Cooper, 1993), substance abuse (Kosten, Kosten, & Rounsaville, 1989; Verheul, van den Brink, & Hartgers, 1998), and post-traumatic stress disorder (Feeny, Zoellner, & Foa, 2000). In fact, many treatment studies for Axis I disorders exclude individuals with BPD which leads to a lack of evaluation of effective treatments for individuals with BPD as a comorbid diagnosis. In pharmacotherapy trials for BPD, most of which are brief in duration, drop-out rates have been very high (Kelly, Soloff, Cornelius, George, et al., 1992) and compliance has been problematic, with upwards of 50% of clients reporting misuse of their medications and 87% of therapists reporting medication misuse by their clients, including taking other than prescribed dosages or taking an overdose (Waldinger & Frank, 1989). Despite advances in pharmacotherapy (e.g., Cowdry & Gardner, 1988, Soloff, 1994, 1998), it is commonly assumed by experts that some form of psychosocial treatment is necessary to treat BPD effectively.

A final challenge to the successful treatment of BPD is the lethality risk associated with the disorder. BPD is the only DSM-IV diagnosis for which chronic attempts to harm or kill oneself is a criterion.

Suicidal Behaviors and BPD

Many clinicians and researchers believe that parasuicide (both suicide attempts and other intentional, non-fatal, self-injurious behaviors) is the defining feature of BPD. Rates of self-harm among clients diagnosed with BPD range from 69 to 80% (Clarkin, Widiger, Frances, Hurt, & Gilmore, 1983; Cowdry, Pickar, & Davies, 1985; Gunderson, 1984). BPD is also related to high mortality rates with up to 10% of individuals ultimately committing suicide (Linehan, Rizvi, Shaw Welch, & Page, 2000; Paris, 2002).

This figure is 50 times higher than the rate of suicide in the general population (Work Group on Borderline Personality Disorder, 2001). Conversely, BPD individuals constitute from 7% to 38% of all people who suicide (Linehan et al., 2000) and, in one study, 55% of admissions to a hospital for self-injury (Soderberg, 2001). There is some conflicting findings about whether suicidal behavior in BPD is distinctly different from suicidal behavior in other diagnoses. Links and colleagues (Links, Heslegrave, Mitton, van Reekum, & Patrick, 1995) found that, in contrast to suicide attempters with other psychiatric diagnoses, suicidal behavior in BPD tended to be recurrent and did not appear to be related to episodic mood disorder. More recent work by Soloff and others, however, disputes some of these findings. Soloff and colleagues (Soloff, Lynch, Kelly, Malone, & Mann, 2000) compared characteristics of suicide attempts in individuals with BPD, major depression, and BPD plus major depression. They found no differences between BPD and major depression in terms of number of lifetime attempts (covaried for age), level of subjective intent to die, violence of method, or degree of medical damage. However, individuals with the two concurrent disorders, had the greatest number of past suicide attempts and the highest level of objective planning for the attempt(s) (e.g., preparation, premeditation).

There has been limited research on the function of suicidal behavior and the consequences, both positive and negative, that affect the behavior. Many researchers (as well as philosophers) believe that the act of suicide is an attempt to permanently escape from pain. Recurrent suicidal behaviors, then, may provide a less permanent but effective means of reducing pain temporarily. Studies that have examined this possibility have indicated that individuals report a feeling of calmness after their decision to commit

suicide (Strosahl, Chiles, & Linehan, 1992) and that decreasing negative emotions was a primary goal of parasuicide in a sample of BPD women (Brown, Linehan, & Comtois, 2002). Thus, suicidal behavior may function to regulate emotion in the short-term by blocking the experience of negative emotion and inducing a positive response like calmness. There have now been several experimental physiological studies that lend support, beyond self-report data, to the hypothesis that self-injury functions in this way (Doron, Stein, Levine, Abramovitch, Eilat, & Neuman, 1998; Haines, Williams, Brain, & Wilson, 1995; Sachsse, von der Heyde & Heuther, 2002; Shaw Welch, 2003).

The relation of specific emotions to suicide and suicidal behavior within BPD has not been extensively studied. In populations not limited to BPD, anger and hostility have often been identified as factors that discriminate suicide attempters versus non-attemptors in both retrospective (Conte & Plutchik, 1974; Crook, Raskin, & Davis, 1975; Henderson, Eastwood, & Montgomery, 1972; Epstein, Thomas, Shaffer, & Perlin, 1973; Farmer & Creed, 1986; Herpertz, Steinmeyer, Marx, Oidtmann, & Sass, 1995; Lester, 1968; Mann et al., 1999; Myers, McCauley, Calderon, Treder, 1991; Nelson, Nielsen, & Checketts, 1977; Philip, 1968; Vinoda, 1966; Weissman, Fox, & Klerman, 1973) and prospective studies (Angst & Clayton, 1986; Romanov, Hatakka, Keskinen, Laaksonen, Kario, Rose, & Koskenvou, 1994; Paykel & Dienelt, 1971). Furthermore, individuals report that self-injury is a way to express anger (Brown et al., 2002; Herpertz, 1995). The experience of anxiety also appears to diminish following parasuicide. In studies of chronic self-mutilators, individuals typically report the relief of seemingly unbearable anxiety and tension immediately following the self-harm (Favazza & Conterio, 1989; Fulwiler, Forbes, Santangelo, & Folstein, 1997; Gardner & Gardner, 1975; Jones et al.,

1979; Kemperman et al., 1997; Simeon et al., 1992; Simpson, 1975; Wilkins, & Coid, 1991).

The emotion of shame has been far less studied, although clinical lore suggests that shame, i.e., the sense of self as bad and worthless, is linked with self-hatred which often triggers suicidal behavior (e.g., Anderson, 1981; Baumeister, 1990; Linehan, 1993a; Maris, 1981). Shame has also been cited as a reason for both suicide attempts and non-suicidal self-injury (Bennum, 1983; Rosen, 1976; Roy, 1978). As described below, however, there is good reason to believe that shame may play a unique role in the development and maintenance of suicidal behavior. Furthermore, it could be that those individuals who represent high suicide risk and self-harm behavior may be prone to experiencing shame at intense levels on a more chronic basis.

Emotion Dysregulation and BPD: Linehan's Biosocial Theory

Linehan's biosocial theory of BPD posits that the disorder is primarily a dysfunction of the emotion regulation system. From this perspective, BPD criterion behaviors can be seen as either attempts to regulate negative emotions or inexorable consequences of dysregulated emotions. Furthermore, the theory states that this emotion regulation disorder develops over time from the transaction between a biological deficiency in the system and an invalidating environment which often punishes, corrects, or ignores behavior independent of its actual validity. Through interactions with this environment, the individual learns to discount the validity of their own emotional responses and often looks to external cues for information on how to respond. In addition, they learn to form unrealistic goals and expectations for themselves and others. As a consequence of this

learning over time, they tend to oscillate between emotional inhibition (shutting down their own emotional responses) and extreme emotional styles. Furthermore, Linehan theorized that a central problem in individuals with BPD is that their experience of emotions is different than individuals without BPD in three specific domains. First, individuals with BPD have lower thresholds to emotional cues. Second, BPD individuals have higher reactivity to emotional cues, meaning that their responses are more extreme more quickly than other individuals. Third, in BPD, a slower return to baseline following an emotion episode is theorized to be evident. These three characteristics are a result of both the biological deficit and the invalidating environment, as proposed in Linehan's biosocial theory, and inevitably lead to a life filled with intense emotions, interpersonal difficulties, coping problems, and dysfunctional behaviors, which often function (no matter how short-lived) to ease the pain and suffering of such intolerable emotional states.

This theory also provides an explanation for the high prevalence of suicidal behaviors in BPD. Linehan (1981) has conceptualized suicidal behaviors as functioning to regulate emotion. According to Linehan, parasuicide (both suicide attempts and nonsuicidal self-injury) is linked to negative emotions in three specific ways: first, parasuicide leads to an immediate reduction of emotional arousal and thus is negatively reinforced because it diminishes an extremely painful aversive state; second, parasuicide becomes a problem solution for BPD individuals under high emotional arousal, which then serves to impede cognitive processing necessary for more effective, and adaptive, problem solving; and third, parasuicide may be a form of learned self-invalidation triggered specifically by the emotion of shame. The unique characteristics of shame

which may lead to self-invalidation and physical self-punishment will be discussed shortly.

Difficulties in Treating BPD: The Role of Shame

Although recent treatment development advances have led to empirically supported treatments for BPD (e.g., Dialectical Behavior Therapy (DBT); Linehan, 1993a, 1993b), BPD still presents a major public health concern and there remains a critical need for development of effective treatment interventions with this population.

In addition to number of complications that arise in the treatment of BPD mentioned early, individuals with BPD are also notorious for their association with a number of therapy-interfering behaviors and have developed a reputation of being “the virus of psychiatry” (Simmons, 1992). Unfortunately, there has been no empirical research on rates and consequences of therapy-interfering behavior in BPD, however, clinicians’ experiences and case examples abound with a number of behaviors that interfere with therapy and may lead to therapist burn-out, such as storming out of sessions early or not leaving when the session is over, throwing objects, not showing up for appointments or showing up extremely late, not paying for therapy, not doing assigned tasks, or shutting down within session (Linehan, 1993a; Stone, 2000). What accounts for these high rates of therapy-interfering behaviors? We believe that there are two essential problems that make treatment especially difficult for clients with BPD. First, compared to non-BPD individuals, BPD clients appear to have an impaired ability to tolerate distress in an effective manner. Second, individuals with BPD appear to be highly prone to feelings of shame which can be conceptualized as the emotion that

interferes the most with change-oriented treatment. These two problems, lack of functional distress tolerance skills and high frequency and intensity of shame, inevitably lead to problems within a therapy session where often the most difficult aspects of one's life and behaviors are the topic of conversation and analyzed in detail.

The emotion of shame poses a unique problem in psychotherapy. Therapy operates as a forum for discussing intensely personal information with another person, thus exposing internal thoughts and feelings. As Greenberg and Paivio (1997) write, "shame operates everywhere in therapy because clients are constantly concerned about what parts of their inner experience can be revealed and what parts must be hidden" (p.235). In addition, shame is associated with a number of characteristics such as decreased eye contact, slumped and rigid posture, and mental and physical withdrawal (see below) which would interfere with continued and fluid discussion of a topic in therapy. Furthermore, the internal experience of shame is often so aversive that clients may inhibit talking about a problem that is causing them distress in order to avoid experiencing the emotion itself. The end result is that the problem remains unsolved. If this occurs repeatedly, it is easy to see how treatment can fail. Thus, it seems imperative that more systematic work on shame, and the reduction of shame, is crucial within treatment-resistant populations such as BPD.

What is Shame?

A. Definition and Characteristics

The Oxford English Dictionary defines shame as "the painful emotion arising from the consciousness of something dishonouring, ridiculous, or indecorous in one's

own conduct or circumstances . . .” (2000). In psychology, shame is labeled as a “self-conscious emotion” and classified in the same category as guilt, embarrassment, and pride. M. Lewis describes shame as “a highly negative and painful state that also results in the disruption of ongoing behavior, confusion in thought, and inability to speak” (2000, p.629).

There are several 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). This tendency to blame others suggests that anger may be a secondary response to the presence of shame.

Several studies have documented the nonverbal display of shame. Facial expression studies have demonstrated that shame is associated with gaze and head movements downward, lips drawn in with corners of the mouth down, and rigid, slouched, forward-leaning posture (Izard, 1971, 1977). These nonverbal correlates of shame appear to be distinct from facial displays of other emotions such as sadness and embarrassment (Keltner, 1995). In addition, shame has been found to be associated with decreased levels of expressive behavior such as broken or delayed speech and lowered volume while talking (Keltner & Harker, 1998). These characteristics of shame appear to

function to avoid contact with another person by averting one's gaze, closing off one's posture, and not communicating clearly and directly.

B. Distinction between Shame and Guilt

It's important to distinguish between shame and guilt largely because the two are often used interchangeably, and perhaps incorrectly, by researchers, clinicians, and clients. Although both represent constructs of emotional experience, there has been growing evidence that these two emotions are more dissimilar than most believe. Beginning with Helen Block Lewis' (1971) conceptualization, and corroborated by research findings, the key distinction between shame and guilt is whether a person attributes a transgression, or perceived transgression, to a problem with the *self* or a problem with a *behavior*. As H. B. Lewis proposed: "The experience of shame is directly about the *self*, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the *thing* done or undone is the focus" (1971, p.30, emphasis in original). Thus, shame is an experience in which the entire self is viewed as bad while guilt involves a focus on particular misdeeds. Expressed another way, the "distinction is between 'I can't believe that I did *that*' (guilt) and 'I can't believe that *I* did that' (shame)" (Lester, 1997, p.353, emphasis in original). Since H. B. Lewis' distinction, there have been numerous studies to test the differences between shame and guilt and, overall, results have supported this differential focus of evaluation. Moreover, shame and guilt appear to have different action tendencies. While shame (as discussed earlier) is associated with the urge to withdraw, hide, or attack, guilt appears to be associated with urges to repair or make amends for a wrongdoing (Tangney & Dearing, 2002).

These differential urges are clearly demonstrated in a study of young children by Barrett and colleagues (Barrett, Zahn-Wexler, & Cole, 1993). In this study, 2-year olds were put in a situation during which a toy broke while they were alone playing with it and was seemingly caused by the child. The investigators identified two different styles of response to this transgression in the children: an “avoider” style, thought to be representative of shame, and an “amender” style, thought to be representative of guilt. Children in the avoider group tended to avoid the experimenter, were slow to make reparations, and were slow to tell the experimenter about what happened. In contrast, children in the amender group approached the experimenter quickly and attempted to make amends immediately. Although demonstrating an unmistakable difference between two types of response styles, this study has been criticized for its potentially tautological conclusions. For example, Harder (1995) states that the validity of this study hinges upon preceding assumptions of what guilt and shame are and suggests that there may be other reasons for why these differences occur, such as learned active versus passive coping styles. Nonetheless, the results from the Barrett et al. study indicate different styles of responding to a perceived transgression, one that is adaptive and one that is clearly not.

Differences between shame and guilt are also reflected in Tangney’s longitudinal family study of moral emotions. Results from this study indicate that shame proneness in 5th grade predicted later high school suspension, drug use, and suicide attempts (Tangney & Dearing, 2002). Shame prone individuals were also less likely to apply to college or engage in community service. Interestingly, guilt proneness did not appear to be related to maladjustment in any areas. As it turns out, it appears far better overall to experience guilt than shame. Guilt seems to lead to amendment of the problem (usually

immediately) and is less likely to be related to psychopathology. However, despite these important differences between guilt and shame and their relation to psychopathology, there has been, to our knowledge, no rigorous empirical studies of differences between guilt and shame in clinical populations.

Why do we have Shame? Theories on the Function of Shame

As with all emotions, shame can have an adaptive function. Given the many negative associations with shame (described in detail below), there has been some speculation about what role shame serves on both an individual and societal level. The most widely held belief is that shame serves the important function of regulating behavior. That is, because shame is such an aversive experience, individuals will do whatever necessary to avoid feeling shame, and thus will inhibit themselves from behavior that will prompt the emotion in the first place. Shame is thought of as a “moral emotion,” along with guilt and pride, which serves to decrease the probability that a person will commit a moral transgression. Research in this area, however, is surprisingly lacking. There has been no published reports on the relationship between shame and incidence of transgressions. Tangney and Dearing (2002) report some findings from a longitudinal study which addresses the question of whether proneness toward experiencing shame as a child is related to the absence of transgressions later in life. Their findings indicate that not only does shame-proneness *not* predict less transgressions later but that the inverse appears to be true. Specifically, high shame proneness in the 5th grade, as measured by forced choice responses to scenario based problems, predicted greater frequency of high school suspensions and drug use compared to less shame-prone peers when reassessed at ages 18-19. Thus, there has been little evidence that the

presence of shame helps people avoid wrongdoing (although certainly more work in this area is sorely needed). So then why do humans experience shame?

By examining the action tendencies associated with shame, namely the urges to hide or withdraw from others, another possible function of shame emerges. The emotion may function to hide shame-evoking behavior or characteristics from others and, in this manner, may prevent rejection or ostracism. That is, shame may serve a protective effect after-the-fact to keep one in one's community. In a sense, this idea represents the antithesis to the hypothesis described above that shame functions to *prevent* immoral behavior. Instead, shame may function to cover up a transgression that already occurred and cannot be changed. Although, this function makes intuitive sense, interestingly, no one has extensively discussed this aspect of shame.

Evolutionary theorists have tried to determine the function of shame by examining how human displays of shame resemble nonhuman animal patterns and how these patterns relate to social behavior in general. For example, Gilbert and McGuire (1998) theorize that shame developed in social situations to turn off or lessen an attack by another through the process of submissive behaviors on the part of the person experiencing shame. In a similar vein, Keltner and Harker (1998) argue that shame functions to appease others and thus reestablishes social harmony following a transgression. The process by which this occurs follows certain steps according to these authors. First, shame is marked by a distinct nonverbal display by the "transgressor." Second, this display is readily perceived by others. Third, the display of shame functions to reduce anger in others and increase social approach which, in turn, produces social reconciliation. There is some evidence that shame functions in this way. Some

interesting studies with mock jurors (Young, Keltner, & Lingswieler, 1996 cited in Keltner & Harker, 1998) have found that lower sentences are given to defendants displaying shame than to defendants displaying anger or no emotion. Other studies indicate that parents punish children who exhibit a shame response less (Semin & Papadopoulou, 1990, cited in Keltner & Harker, 1998) and that shame displays elicit greater rates of sympathy in others (Keltner, 1995). It appears that shame serves some useful functions, at least part of the time. These evolutionary theories, however, have thus far failed to offer perspectives on how the experience of shame can go awry or how shame becomes pathological.

Tomkins (1987) has posited that shame is cued by situations in which pleasure is interrupted and that shame can only occur after a positive emotion, such as interest or excitement, has been activated. Shame then serves to inhibit these positive affects. Unfortunately, Tomkins did not discriminate between the emotions of shame and guilt in this proposition and there is no empirical basis for his claims. Furthermore, although one can easily make the claim that shame does interrupt positive affect, it is far more difficult to argue that shame is the only emotional consequence to the disruption of pleasure or interest. Expanding upon the work of affect theorists such as Tomkins, Schore (1998), from an attachment perspective, postulates that shame emerges in toddlerhood and functions to socialize the child to societal norms. During this developmental stage, the role of the mother (or primary caregiver) changes from that of complete caregiver during infancy to one of “socializing agent” whose primary responsibility is to teach the child to inhibit many behaviors (e.g., tantrums, unrestricted exploration, “unacceptable” behaviors) that the child finds pleasurable. According to Schore, the process by which

this occurs includes a shame transaction. He theorizes that a child learns from infancy that behavior is often followed by direct eye contact and exchange of positive affect with the mother. As the child grows, s/he expects, based on this previous learning, to be “attuned” with the mother whenever s/he engages in activity that is inherently pleasurable. However, when the child engages in such a activity that is disapproved of by the caregiver, a different transaction occurs:

“Despite an excited expectation of a psychobiologically attuned shared positive excitement and joy, the infant unexpectedly encounters a facially expressed affective misattunement. The ensuing break in an anticipated visual-affective communication triggers a sudden shock-induced deflation of positive affect, and the infant is thus propelled into a state which he or she cannot yet autoregulate. Shame represents this rapid state transition from a preexisting positive state to a negative state.” (Schore, 1998, p.65)

From a behavioral perspective, Schore’s position can be conceptualized as follows: Because this “misattunement” between mother and child is aversive to the child, it functions to punish the behavior that immediately precedes this dyadic interaction. Shame thus becomes associated with this misattunement and becomes classically conditioned with “bad” behaviors, or behaviors that are unacceptable to the primary caregiver. The “reattunement” occurs when the behavior stops. Specifically,

“the child’s facial display, postural collapse, and gaze aversion act as nonverbal signals of his or her internal distress state. If the caregiver is sensitive, responsive, and emotionally approachable, especially if she [sic] reinitiates and reenters into mutual gaze visual affect regulating transaction, the dyad is

psychobiologically reattuned, shame is metabolized and regulated, and the attachment bond is reestablished. The key to this is the caregiver's capacity to monitor and regulate her own affect." (p.67)

This passage provides some clues as to how difficulties regulating shame can occur. According to this theory, problems would arise if the caregiver is not able to regulate his/her own affect, if the caregiver is unaware of the nonverbal signals of distress displayed by the child, and/or if the reattunement does not occur following a rupture. Although not yet researched, it is possible that these problems occur more frequently in the early development years of children who later go on to develop BPD.

Although Schore provides a theory for the development of shame and the role that shame plays in childhood, many questions remain about how shame continues to function through all developmental stages and into adulthood. This is a deeply understudied field of examination that would inform researchers about the potential origins of emotion dysregulation and psychopathology.

Measurement of Shame

Despite the fact that the emotion of shame has been talked about for decades in psychological theory, it has only been subject to measurement in recent years. As such, there is still much work needed to develop a body of measures with sound psychometric properties that can be easily compared to one another. A number of problems, unique to the study of shame in particular, add to the difficulties with measurement. For one, depending on the mode of information gathering (e.g., interview or self-report), either the interviewers or the participants themselves are required to reliably distinguish shame

from other similar constructs such as guilt, embarrassment, or low self-esteem. This is a complicated task as, colloquially, these words are often used interchangeably.

(Incidentally, many existing measurements fail to do this themselves as will be elaborated upon shortly.) In addition, the nature of shame may make its measurement exceedingly complex. Shame and the events which prompt it are often not talked about (and especially not talked about with strangers, as researchers invariably are) and this must be taken into account when attempting to measure it. For example, developing an interview to ask people to describe their experiences of shame (and shameful events) may not be practical or valid. With that in mind, many measurement developers have had to use creative strategies for getting the information that they desire.

Existing measures of shame can be loosely classified into trait measures (i.e., global measures of proneness to experience shame) and state measures (i.e., measures of the current level and intensity of shame). The trait based measures, such as the Personal Feelings Questionnaire (PFQ; Harder & Lewis, 1987), the Test of Self-Conscious Affect (TOSCA; Tangney, Wagner, & Gramzow, 1989), the Internalized Shame Scale (ISS; Cook, 1987), the Other As Shamer Scale (OAS; Goss, Gilbert, & Allan, 1994), and the Revised Shame-Guilt Scale (RSGS; Hoblitzelle, 1987) are intended to be relatively stable measurements. Scores on these instruments indicate a variety of different phenomenon, depending on the measure: how often a person feels shame (as in the PFQ), how likely they are to respond to various situations with a shame-like response (TOSCA), the frequency with which they have particular shame thoughts or feelings (ISS), beliefs about how others evaluate them (OAS), or how well shame words describe them (RSGS). In contrast, state based measures are designed to determine how much shame an individual

is feeling *in any given moment*. A valid and reliable instrument would be able to detect even small changes or shifts in different levels of shame and could be used to measure treatment effects or as a manipulation check for shame induction research.

Unfortunately, there are far fewer state measures than trait measures for assessing shame and none of them have been tested for their ability to detect these small changes over time. Existing measures designed specifically to primarily assess state shame include the State Shame and Guilt Scale (SSGS; Marschall, Sanftner, & Tangney, 1994) and the Experiential Shame Scale (ESS; Turner, 1998). Other measures have shame items which can be clustered to make a separate shame scale, such as the Positive and Negative Affect Schedule (PANAS; Watson & Clark, 1988) and the Differential Emotions Scale (DES; Izard, 1977). Problems with these latter two measures include lack of discrimination between shame and other constructs such as embarrassment and guilt. The ESS attempts to circumvent some of the problems associated with the measurement of shame by purposely lowering the “face validity” of the measure and attending to physical correlates (e.g., flushing) and behavioral urges (e.g., avoidance, hiding). The SSGS includes five statements designed to address the experience of shame in the moment, for example “I want to sink in the floor and disappear” and “I feel like I am a bad person.” Unfortunately, none of these measures have been subject to rigorous examination of their psychometric properties generally (save for the PANAS) or their construct validity for the phenomenon of shame specifically.

Empirical Work on Shame/Problems associated with Shame

Although research on shame has increased dramatically in recent years, most of the studies have focused on nonclinical samples. There is a paucity of empirical research on shame in samples with psychopathology and even these are difficult to compare because of differences in measurement. Further, to our knowledge, there has been no published data-driven reports on shame in BPD. With these limitations in mind, there does appear to be some evidence that shame is related to psychological distress and interpersonal difficulties. This evidence sheds some light on the potentially crucial link between shame and BPD.

A. Shame and Suicidal Behavior

Suicide can be conceptualized as the ultimate form of hiding or disappearing. Case examples and publicity abound for incidents of individuals committing suicide following public exposure of a serious transgression. Completed suicides, though, often leave us with more questions than answers as it is very difficult to determine the causes of suicide post-mortem. Thus, the role of shame is often more inferred than known in suicide. That leaves examination of individuals who engage in suicidal behavior (suicide attempts as well as nonsuicidal self-injury) and who report suicide ideation as both sources of information for the relationship between shame and suicidal behavior and as proxies for the determining the relationship between shame and suicide.

There have been a few studies, using nonclinical samples, that have documented a link between shame and suicidal behaviors. Hastings, Northman, and Tangney (2000) found that proneness to experience shame, as measured by the TOSCA, predicted suicide ideation in a sample of college students. In another study of college students, Lester

(1998) found that higher levels of shame were associated with higher current suicidality, after controlling for age, gender, and current level of depression. In this study, suicidality was defined as the score on the single suicide item on the BDI and questions about whether they had ever considered, threatened, or attempted suicide. In Tangney's longitudinal study on moral emotions (Tangney & Dearing, 2002), shame-proneness on the TOSCA in the 5th grade predicted later suicide attempts by young adulthood.

For borderline personality disorder, Linehan proposes that shame contributes to suicidal behavior (1981,1993a). Because the experience of shame itself is aversive, the self-reflection and analysis necessary for problem solving may be avoided which, in turn, leads to an absence of problem solving and generation of new behavior so that a repetition of problem situations and problematic behavior occurs. Moreover, Linehan theorizes that the combination of shame, self-invalidation, self-hatred, and self-contempt contribute to self-punishment actions such as parasuicide or suicidal ideation. Recent research with BPD individuals in Linehan's clinic found that shame while talking to a clinical interviewer about a recent episode of parasuicide (as measured by both self-report and coding of nonverbal cues) predicted repeated parasuicide in the following 12 months (Brown et al., 2002). This finding lends evidence to Linehan's theory as it illustrates that shame may be interfering with developing alternative methods of coping.

B. Shame and Problem Solving

This link between shame and problem solving or coping methods has not received much empirical attention. However, given what we currently know about shame, it makes sense that the experience of shame would have an impact on approaching and solving a problem. The action tendencies of shame, which include withdrawing and

hiding, run counter to solving problems. Furthermore, the experience of shame is such that the self is determined to be globally bad or inferior. Given this perspective (as opposed to the perspective that something was wrong with a particular behavior or deed), rectifying the situation becomes nearly impossible. As Leith and Baumeister (1998) write, “[It] would be futile to focus on remedying one particular misdeed if the core problem is that the entire self is riddled with inadequacies . . . The only responses that seem to minimize the subjective distress of shame are to ignore the problem [or] to avoid other people” (p.4). Thus, it becomes exceedingly difficult to solve problems in an adaptive manner when the strongest urges experienced are to avoid and ignore rather than approach and attempt to solve the problem.

In a study of depressed and nondepressed college students, Strack and colleagues (Strack, Blaney, Ganellen, & Coyne, 1985) found that greater self-focus and lower expectancy for success were associated with poorer performance on a problem solving task. In addition, problem solving deficits among the depressed sample could be overcome by decreasing the level of self-focus. Although this one study does not provide clear evidence for an association between shame and impaired problem solving, it does suggest that self-focus, which is a byproduct of the shame experience, interferes with performance. Clearly, more work in this area is needed.

C. Shame and Empathy

This self-focus, or preoccupation with the self, that occurs with shame may also have an effect on interpersonal aspects of the situation that evokes shame. Specifically, this high degree of self-focus can limit the ability to see things from another person’s perspective and thus create interpersonal strife. A study by Tangney and colleagues

(Tangney, Marschall, Rosenberg, Barlow, & Wagner, 1994 as cited in Tangney & Dearing, 2002) demonstrated that, when describing shame-inducing events (as opposed to guilt-inducing events), participants were less likely to express empathy for others involved in the situation. In another study, a measure of shame proneness was not related to the ability to have a shift in perspective (i.e., to describe the event from another person's point of view; Leith & Baumeister, 1998). This was in contrast to guilt proneness which was significantly correlated with perspective taking. These results held up even after accounting for levels of self-esteem. Moreover, an interesting study determined that, when induced to feel shame in a laboratory setting, subjects were less likely to feel empathy for a disabled student in an apparently unrelated task following the shame induction (Marschall, 1996 as cited in Tangney & Dearing, 2002). Collectively, these studies suggest that there is a direct link between the experience of shame and decreased levels of empathy and interpersonal connectedness.

If, as we propose, shame is frequently occurring in individuals with BPD at high levels of intensity, it is easy to see how it could contribute to their interpersonal difficulties. If they are chronically over-focused on their self or their behaviors, it would be exceedingly difficult for them to maintain intimate, reciprocal relationships or even be fully present in a conversation with someone.

D. Shame and Other Emotions/Psychopathology

Part of the difficulty in assessing the relationship between shame and other emotions is attributable to methodological problems that exist in such research. First, as discussed earlier, up until recently, there was often a failure to discriminate between shame and guilt (and sometimes a failure to discriminate between shame and other

constructs such as embarrassment or low self-esteem). Second, many studies have relied on correlations between scores on different self-report questionnaires to document a link between two emotions, or between an emotion and a measure of psychopathology. Although these studies offer useful information, it is important to remember that they provide only evidence for an association between shame and distress. The causal pathways are as of yet unknown. Finally, there are a number of problems that exist with the measurement of shame (as discussed previously). These problems often make results from varying studies both difficult to compare and interpret.

In terms of what we do know about shame's relationship with other emotions, there is a growing body of evidence that individuals who are prone to feeling shame are also more prone to the experience of anger and more likely to do unconstructive things with anger, such as "letting off steam," direct and indirect aggression, resentment, and suspicion (Tangney, Wagner, Fletcher, & Gramzow, 1992; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). This association was in contrast to guilt-proneness (after factoring out co-existing shame proneness) which showed only a modest correlation with anger arousal among children, and no relation to anger arousal among adolescents and adults. In addition, guilt proneness was significantly positively correlated with constructive responses to anger, such as discussing the matter of conflict directly with the target of anger. Thus, it appears that, at least in nonclinical populations, anger and shame are directly linked. Moreover, shame tends to be related to destructive, rather than constructive, responses to anger.

As previously stated, there is a dearth of research on the relationship of shame to psychopathology in general, and BPD specifically. Numerous studies have used

questionnaires to document correlations between shame and depression (Allan, Gilbert, & Goss, 1994; Andrews, Qian, & Valentine, 2002; Tangney, Wagner, & Gramzow, 1992), but less is known about the relationship between shame and other forms of psychopathology. In large samples of college students, using measures of shame-proneness (TOSCA), the Beck Depression Inventory (BDI), and the Symptom Checklist 90 (SCL-90), shame-proneness was significantly correlated with depression, obsessive-compulsive behaviors, paranoid ideation, and anxiety (Tangney & Dearing, 2002). In a rare study examining shame in a psychiatric sample (Averill, Diefenbach, Stanley, Breckenridge, & Lusby, 2002), shame, as measured by two self-report questionnaires, was significantly associated with depression scores on the BDI and all subscales of the SCL-90 in adults admitted to an acute-care psychiatric hospital. While these studies give us an indication that shame and psychopathology are linked, we do not yet have a clear understanding of the precise role that shame plays in specific mental disorders.

Longitudinal studies are scarce but Andrews and colleagues (Andrews, Brewin, Rose, & Kirk, 2000) have demonstrated that shame predicts PTSD six months following a trauma, after controlling for gender, education level, degree of injury, and symptomatology at one month post-trauma. Similarly, a recent study of victims of childhood sexual abuse, demonstrated that level of shame predicted PTSD symptomatology one year after discovery of abuse after controlling for adjustment at time of discovery, age, gender, and abuse severity (Feiring, Taska, & Lewis, 2002). An interesting additional finding in this study was that individuals that demonstrated a decrease in levels of shame between the two timepoints (time of discovery and one year

follow-up) also demonstrated improvement in all other psychological adjustment domains, namely depressive symptoms, level of self-esteem, and PTSD symptoms.

E. Summary of Research on Shame

In summary, results from the growing body of research indicate that shame is associated with suicidality, may impede problem solving, is related to decreases in empathy for others, is correlated with anger, depression, and other forms of psychopathology, and potentially mediates maladjustment following childhood sexual abuse and other forms of trauma. Together, these findings suggest a powerful negative effect of shame, or association between shame and maladjustment, that requires attention from treatment developers and providers.

Treatment of Shame

A. Non-behavioral Treatment Models

The treatment of pathological, or dysfunctional, shame has been largely overlooked in treatment models and manuals. This is true both in general and in regards to the treatment of BPD specifically. At best, shame has been discussed in passing and often clinicians have failed to discriminate between shame and guilt. This is largely the case in psychoanalytic and psychodynamic models of treatment. More modern psychologists (e.g., Nathanson, M. Lewis) have noted that shame is conspicuously absent in the writings of Freud. Guilt was more predominant in Freud's theories and was believed to be the cause of many forms of psychopathology through the constant battle between the id and the superego. Unfortunately this tendency to ignore shame is also found in more recent work on treatment for BPD, by Otto Kernberg, the leading

psychodynamic treatment developer for borderline personality disorder, and colleagues.

In their book, *Psychodynamic Psychotherapy for Borderline Personality Disorder* (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989), neither “shame” nor “emotion” is listed in the index. Guilt is mentioned sporadically and without clear definition. This lack of attention to shame is perhaps indicative of both the historical precedence of not viewing shame as particularly noteworthy until only recent years, and the psychoanalytic emphasis on anger, often to the exclusion of other emotions, as a key component of psychopathology in BPD.

The most detailed attention to the treatment of shame can be found in Greenberg’s *Emotion Focused Psychotherapy*. Greenberg (2002) differentiates between adaptive and maladaptive shame. He writes that adaptive shame functions to “protects one’s privacy while also keeping one connected to one’s community” (p.145). Shame, or any emotion, is maladaptive when it “is an old, familiar, disorganizing feeling that recurs across time, situations, and relationships . . . [and is always] difficult, deep, and distressing” (p.177) and leads one to feel diminished or worthless. In terms of treating intense negative emotions, Greenberg speaks of “emotion coaching” in which a therapist evokes the emotion in-session so that it is able to be transformed. He advocates the experiential nature of this process and hypothesizes that it is only in the process of experience that one can fully integrate new, adaptive information. In this model, the process by which the therapist helps transform unhealthy emotions includes challenging the client’s negative cognitions explicitly and/or getting the client to experientially activate a more healthy emotional response (labeled an “opposing emotion”). This latter step can be done through directed imagery, for example, focusing on another feeling such as love or joy

and when it was last experienced, or using self-talk and having a new, healthy feeling “talk” to the current unhealthy one.

Greenberg and Paivio (1997) write about using an emotion focused approach specifically with shame. They classify problems related to shame into four categories which include, shame from violating one’s own standards or values, shame stemming from childhood abuse, shame from being socially rejected, and shame as a secondary response to chronic self-critical thoughts. This classification is somewhat similar to the notion of justified and unjustified shame described in detail below. They suggest different strategies depending on the type of shame experienced. With regards to shame over violating a standard or value, Greenberg and Paivio suggest that first, a “safe” therapeutic environment in which the client can talk about shameful behavior must be provided by the therapist. Then, the therapist attempts to shift “overgeneralized shame and self-condemnation to regrets about the behavior or mistake and mobilize a desire to make amends” (p.241). This approach is compatible with Tangney and Dearing’s suggestion (2002) for treating shame. They advocate attempting to move the client from feelings of shame to more adaptive feelings of guilt so that the individual is motivated to act in an effective manner rather than withdraw.

B. Cognitive-Behavioral Models

Unfortunately, cognitive-behavioral models have also been previously remiss in attending to the emotion of shame in treatment. Writings on the topic have been sparse and usually blended with other emotions. Beck and colleagues’ landmark description of cognitive therapy (Beck, Rush, Shaw, & Emery, 1979) suggests that the therapist tell the client that shame is partially “self-created” through cognitions and that the client should

adopt an “antishame philosophy” by openly acknowledging shameful events rather than hiding them. Works by Dryden on shame in rational-emotive behavior therapy (REBT) include the hypothesis that individuals experiencing shame are more likely to form inferences overestimating the shamefulness of what is revealed, the chances that people will care about what is revealed, the amount of disapproval others will show, and the duration of any disapproval (1995). In other words, in this model, shame is associated with dysfunctional thought distortion. The strategy for dealing with this in REBT, is to pairs “unhealthy” shame with “healthy” disappointment through the process of confrontation and cognitive restructuring.

Despite some of these theoretical writings and guidelines for treatment interventions of shame, there has been no empirical work on any of these strategies. It is interesting that the models have a great deal in common with regards to hypotheses about shame and how to treat it. Yet, there is no evidence about whether any of these procedures, when applied systematically, would demonstrate a reduction in shame. Furthermore, to the best of our knowledge, there has been no writings detailing the step-by-step treatment of maladaptive shame that clinicians may try to emulate. The present study represents an effort to provide such a model, using a cognitive-behavioral technique and a key element in DBT, called “Opposite Action.”

C. Opposite Action as Treatment Model

The strategy of Opposite Action has its origins in the earliest forms of behavior therapy. Wolpe, considered the first behavior therapist, developed and applied the principle of “reciprocal inhibition” as a mechanism for behavior change, initially with respect to fear. Wolpe (1995) described reciprocal inhibition as follows: “When a

response antagonistic to anxiety can be made to occur in the presence of anxiety-evoking stimuli and in consequence effects a complete or partial suppression of the anxiety response, the bond between stimuli and the anxiety response is weakened” (p.24). The first clinical application of this idea to humans occurred with anxious individuals and was labeled “systematic desensitization” (Wolpe, 1954, 1990). In this early procedure, individuals were given instructions on how to induce relaxation and states of calmness and then gradually introduced to anxiety-provoking situations. Over repeated exposure to cues which elicited anxiety, individuals were instructed to relax and, thus, systematic desensitization “pits the calmness of relaxation against the imagined anxiety situations” (Wolpe, 1995, p.33). The main tenet behind reciprocal inhibition is that it is impossible to feel two incompatible emotional responses concurrently. Thus, one response (the more adaptive one) can become strengthened and the other response (the maladaptive one) can become weakened by repeated exposure to the cue, inhibition of the “old” maladaptive response, and dragging out of the “new” adaptive response.

Wolpe’s work laid the foundation for future behavior theorists to apply these principles to a host of clinical problems. Reciprocal inhibition is also at the heart of exposure treatments, the most empirically supported treatments for anxiety disorders. In this field, Barlow has written extensively about the mechanisms of exposure treatment. Although he does not use the term “reciprocal inhibition,” it is clear that the principle is the same. Barlow (1988) suggested that the crucial function of exposure therapy for anxiety disorders, such as specific and social phobia, was 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” (1988, p.313). Other earlier emotion theorists had come to similar conclusions. For example, Izard stated that treatment for anxiety disorders involves “the individual learn[ing] to act his way into a new feeling” (cited in Barlow, 1988, p. 410). Cognitive behavioral interventions for anxiety, or fear, disorders all include this one common element: individuals have to approach the object/situation that is fearful, thus acting counter to (and inhibiting) their prominent urges to avoid.

Successful treatments for other maladaptive emotions such as sadness and anger, also have these elements of reciprocal inhibition in that they encourage action that is incompatible with actions associated with the emotion. For example, treatments for depression (sadness), such as Cognitive Therapy (Beck et al., 1979) and Behavioral Activation (BA; Martell, Addis, & Jacobson, 2003), often require that the individual galvanize him/herself to engage in activities that give them a sense of mastery or pleasure. This engagement runs counter to the urges associated with depression, such as withdrawal, fatigue, and shutting down. Similarly, treatments for anger (e.g., Kassinove & Tafrate, 2002) focus on asking the individual to work on perspective shifting and increasing gentleness and forgiveness for the person or situation at which they are feeling anger. These strategies also require the individual to act counter to the urges associated with anger (attack physically or verbally).

In Dialectical Behavior Therapy (DBT), Linehan articulated this process as a behavioral skill designed to regulate all emotions. She named this skill “opposite-to-emotion action” or “opposite action.” The premise behind this strategy is that one can change a negative emotion, currently perceived as distressing and/or unwanted, by identifying the current emotion, identifying the urge (action tendency) associated with the

present emotion, determining the action that is opposite to that urge, and then engaging in that opposite action. She writes that the key ingredient to emotion change is “nonreinforced exposure to events that prompt fear, sorrow, guilt, shame, and anger, as well as simultaneous blocking or reversal of automatic, maladaptive emotional action and expressive tendencies. The emphasis is on both exposure and acting differently” (1993a, p.344). Stated another way, the key steps to opposite action include presenting cues that elicit a conditioned affective response, the absence of reinforcement for the affective response, blocking of maladaptive coping responses (action tendencies), and alternative, opposite, responses are elicited and reinforced. Compatible with Wolpe, Barlow, Izard, and others, the hypothesized agent of change is this *action* of individual when faced with an emotion-eliciting cue. By counteracting maladaptive action tendencies and generating new behaviors, the initial affective response is reduced.

DBT has had promising results overall in the treatment of individuals with BPD and other severe mental health problems (see Rizvi & Linehan, 2001, for a review of DBT’s efficacy). However, specific strategies in DBT have not yet been subject to rigorous study. The aim of the current study is to examine the efficacy of the strategy of Opposite Action, specifically with regards to its application to the emotion shame.

Targeting Shame through Opposite Action

The application of opposite action to the emotion of shame specifically is described briefly in the DBT skills manual (Linehan, 1993b, p. 94). In that manual, shame and guilt are grouped together and the opposite action for both is considered the same. The strategy of opposite action for shame and guilt is dependent on whether the emotion is considered to be “justified” or “unjustified.” The defining characteristic of

unjustified shame is whether the behavior or activity that elicits shame “fits one’s wise mind values.” In other words, if the behavior or activity engaged in by the individual is something that is consistent with one’s moral belief system, then it is not justified to feel shame about it. However, if an individual engages in a behavior or has a characteristic that does not fit their own moral value system, then the shame is considered justified.

In the current study, the DBT skill of opposite action for shame was modified in two main ways; however, neither modification changed the central premise of getting the individual to act in opposition to their urges. First, the notion of justified versus unjustified shame was elaborated upon to make it more concrete for the individual to determine. Specifically, shame was considered “justified” if at least one of two criteria were met: whether the action or characteristic of the individual violated their own moral values and whether the action or characteristic would legitimately cause others to reject him/her if they knew about it. These two criteria became questions that individuals could ask themselves to determine whether their shame was justified in that context. If neither of those conditions were true, then the shame was considered to be unjustified. Second, due to the complexity of shame, the emerging evidence that shame has more than one maladaptive action tendency (e.g, withdraw, avoid, attack others, attack self), and the distinction between justified and unjustified shame, it was deemed necessary that opposite action be based more on the *principles* of cue exposure, response prevention, and opposite action than on a “one size fits all” approach. Thus, various “opposite actions” were identified for an individual, based on the specific situation and their specific urges in that situation.

For the present study, this idea was elaborated and detailed more explicitly. Ultimately, the primary goal of this treatment was to reduce shame and thereby reduce associated dysfunctional behavior, such as suicidal behaviors. The opposite action procedure involved 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. 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. Specific examples and instructions for doing this intervention are detailed in the treatment manual (Appendix A). As previously mentioned, there has been no systematic exploration of this, or any, strategy for reducing shame.

The Current Study: Aims and Hypotheses

This study sought to explicitly develop and test an intervention designed to reduce shame in individuals with BPD. The opposite action intervention, described partially above and in much fuller detail below, was developed using basic emotion theory and research on shame, and further improved through work with a pilot participant. Then, the intervention was tested with five participants using a single-subject, multiple baseline design.

A multiple baseline across subjects design was chosen over a group comparison design for several reasons. First, this study seeks to develop and evaluate a new treatment that has not previously been subject to empirical study. As such, a single-

subject design allows for a careful examination of behavioral change over a set period of time. A multiple-baseline design (with the intervention occurring at different start points for participants) can demonstrate the effect of an intervention by showing that behavior change occurs when (and only when) the intervention is put into place. Second, limitations of the group comparison approach (i.e., comparing a group who received the intervention with a group who did not receive the intervention) are numerous, though often overlooked (Barlow & Hersen, 1984). Problems include the obfuscation of individual variability as well as the consideration of between-group differences only. A single subject design, such as multiple baseline across subjects, allows for careful examination of both between-subject *and* within-subject factors. Given the highly heterogeneous make-up of the individuals with BPD, a multiple baseline design allows for exploration of individual clinical outcome. Third, as a pilot study, much data can be obtained from a single subject methodology and the design fosters the measurement of several target behaviors simultaneously. Finally, information gleaned from this study will be able to inform future clinical studies and, if successful, could be easily translated to a controlled clinical trial. Since shame has been sorely overlooked in psychopathology more generally and specifically with BPD, a small-scale pilot study with this population seemed both achievable and necessary.

This study had two primary aims. The first aim was to develop a short-term, protocol-driven intervention which directly targets the experience of shame in BPD individuals that is consistent with the DBT framework, using a pilot subject. The second aim was to evaluate outcomes of this treatment with several BPD individuals. A multiple baseline, single subject design was employed to determine the efficacy of the proposed

treatment. Individuals with BPD, including a pilot subject, were treated with an 8-10 week intervention which directly exposed them to cues that evoke shame. All participants were also in a concurrent weekly DBT skills group so that a multiple baseline across individuals design could be employed and to provide a context whereby weekly measurements of shame could be collected in a reliable manner. Participants started the exposure intervention at different time points, with the design allowing for control of individual differences in history and progress. The first hypothesis was that the experience of shame will decrease as a result of the opposite action intervention. That is, individuals would have lower ratings of shame during the exposure intervention and following the intervention as compared to their baseline ratings. Second, it was hypothesized that suicidal urges will decrease as a result of the intervention. Given the lack of other treatment interventions for shame specifically, it was unclear how an intervention designed to reduce shame may impact the presence and intensity of other emotions, including guilt, pride, and other affect. Thus, these emotions were also examined over time.

Information gathered from an intervention targeting shame has implications for future research and treatment of BPD. First, if shame and suicidal behavior are causally linked, then parsimonious interventions for shame will lead to a reduction in rates of parasuicide. Furthermore, the experience of shame is proposed to interfere with problem solving in general and the ability to express oneself about shame-producing events. Both of these things are necessary for effective therapy. Thus, targeting shame in BPD may lead to better treatment success rates, in general, as it may remove major impediments to successful therapy with this difficult-to-treat population.

METHOD

Procedural Overview

The procedures for the current study had two separate phases. The first phase included the development of the treatment manual. During this phase, a draft of the treatment manual was written, based on DBT principles of opposite action, basic research on shame, and assumptions about the clinical course of dealing with this emotion. The draft was then tested on one pilot case and modifications were made, as necessary, as treatment progressed with this case. The second phase included the examination of the treatment manual on five participants. Using a multiple baseline design, the shame intervention was introduced at different time points for participants and the effects of the intervention on levels of shame and other variables of interest were measured on a weekly basis.

Participants

The pilot participant as well as the five experimental participants were recruited in the same manner. Three primary methods of recruitment were used. First, individuals who called the Behavioral Research and Therapy Clinics (BRTC) looking for treatment options for BPD were told about the study, and if they were interested or wanted more information, they were encouraged to call the study investigator. Second, brochures were mailed to psychiatrists, psychologists, and community mental health workers in the Seattle area. In these brochures, clinicians were asked to contact the study investigator if

they had clients who met our inclusion criteria. Third, the study description was posted on the BRTC clinic website.

Inclusion and exclusion criteria are displayed in Table 1. Inclusion criteria consisted of a diagnosis of BPD, age between 18 and 60 years, and current suicidality. For the purposes of this study, suicidality was operationally defined as a parasuicidal act within the past 30 days (with or without the intent to die) and/or current high suicide ideation, including a plan for suicide. The latter was determined to be present if the participant answered yes to the following questions: “In the past month, have you been thinking a lot about death or suicide?” and “Do you have a plan for how you would kill yourself?” The plan had to be elaborated and considered to be both credible and lethal if implemented in order for it to be considered meeting the inclusion criteria. In addition, participants were included only if they were in ongoing weekly individual therapy. The reason for this criteria was the following: often clients with BPD have repeated serious life crises in addition to the high level of suicidality specifically chosen for this study. The current study design did not allow for crises or suicidal behavior to be addressed because it would have detracted from the main mission of the study. For that reason, it was decided that participants should be in ongoing non-DBT oriented therapy so that these issues would be attended to by another treatment provider. 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. Furthermore, the primary therapist for each client was required to complete both a statement acknowledging that their client was in the treatment study as well as a crisis plan indicating that they would take clinical responsibility for the client and address any crises and suicide risk.

Exclusion criteria for the study included a current DSM-IV diagnosis of mental retardation, substance abuse or dependence, schizophrenia, or another psychotic disorder. All participants gave informed consent prior to their participation.

Table 1. Inclusion and exclusion criteria

Inclusion
<ul style="list-style-type: none"> • Age: 18 - 60 years
<ul style="list-style-type: none"> • DSM-IV Diagnosis: Borderline Personality Disorder
<ul style="list-style-type: none"> • Current Suicidality: Presence of suicidality, including either a parasuicide act within past 30 days and/or suicide ideation with suicide plan
<ul style="list-style-type: none"> • Current involvement in non-DBT individual therapy
Exclusion
<ul style="list-style-type: none"> • Present DSM-IV diagnosis of Mental Retardation, Cognitive Impairment Disorder, Substance Abuse or Dependence, Schizophrenia or Other Psychotic Disorder
<ul style="list-style-type: none"> • Needs priority treatment for other debilitating problems (e.g., severe anorexia nervosa, severe dissociative identity disorder)

Inclusion and exclusion criteria were initially assessed through a phone screen. Participants who appeared eligible based on the phone screen were invited to the clinic for an intake assessment to further assess appropriateness for the study. The intake assessment consisted of the following instruments:

1. International Personality Disorder Examination, BPD Section only (IPDE; Loranger, 1995). The IPDE is the most widely established measure of personality disorders currently available. Only the BPD section of this lengthy interview was administered in order to determine if the participant met the primary inclusion criteria of a diagnosis of BPD.
2. Structured Clinical Interview for DSM-IV, Axis I (SCID-I; First et al., 1995) and Axis II (SCID-II; First et al., 1996) served as the primary instruments for obtaining

comorbid Axis I and Axis II diagnoses. The BPD section of the SCID-II was used as a confirmatory measure of the BPD diagnosis provided by the IPDE.

3. Demographic Data Schedule (DDS; Linehan, 1982) obtained a wide range of demographic data in a self-report form.
4. Lifetime Parasuicide Count (LPC; Linehan & Comtois, 1996) is a self-report measure that was developed as a very brief survey of past parasuicidal acts and categorizes them into suicide attempts and non-suicidal acts.
5. Parasuicide History Interview (PHI; Linehan, Brown, Heard, Wagner, & Comtois, 2004) measured the topography, intent, medical severity, social context, precipitating and concurrent events, and outcomes of parasuicidal behavior during a target time period. During the intake assessment, the PHI was completed up to three times on the most recent episode of parasuicide, the most severe medically treated in the past year, and the most severe medically treated lifetime.

Phase I Methods: Development and modification of the treatment manual

Development of the treatment manual

In essence, the development of the treatment manual consisted of extracting an element of DBT, expanding upon it, and then testing this element as a “stand alone” treatment. However, it is impossible to completely separate out this element from DBT as a whole and, in practice, the intervention was developed in the context of other common DBT strategies, such as validation and commitment (Linehan, 1993a, 1993b). In addition, the primary investigator received intensive training in DBT and this training was instrumental in both the development and execution of this current study. Thus,

other DBT strategies have been interwoven into the structured intervention. The initial draft of the manual was structurally based on the format of other similar existing (and effective) treatments, namely Prolonged Exposure Therapy for PTSD (PE; Foa & Rothbaum, 1998) and treatments for anxiety disorders, such as social anxiety disorder and panic disorder (Craske & Barlow, 2000; Hope, Heimberg, Juster, & Turk, 2000). These treatments have similar structural elements which include an emphasis on providing a thorough and convincing rationale before beginning any difficult therapeutic tasks, organizing the treatment around principles of exposure to cues/topics and blocking of maladaptive action urges such as avoidance, and often audiotaping the treatment sessions for the client to take home and listen to during the week in between sessions. Furthermore, these treatments are all short-term, usually ten sessions or less, and have detailed steps about how each session should be structured. These treatment manuals then served as a guide for the format of the current intervention. For the shame intervention, there were initially eight weekly sessions of approximately 90 minutes in length. This decision was open to modification based on the experience of treating the pilot client. The manual also specified the outcome measurements be collected before and after each session.

The first session was developed with the idea that client “buy in” and commitment to the treatment was the primary goal. Thus, the manual was written with an emphasis on providing a rationale through didactic information about shame and the effects of shame. Use of the DBT strategies of orienting, providing didactics, validation, and commitment were prominent throughout this first session. In terms of didactics, information was written into the first session of the manual in order to bring the client

“up-to-date” on research findings on shame and allow them to start to consider shame as an emotion to address specifically. Basic research on shame, as discussed previously in the introduction, was utilized to detail some common effects of the shame experience, including verbal and nonverbal signals, urges, and behaviors. The well-documented correlations of shame with psychopathology were presented as a means of showing that shame is maladaptive in certain circumstances or at certain levels of intensity.

Furthermore, the topic of justified versus unjustified shame was introduced. The first session also included basic orientation to the intervention, including number and length of sessions, a description of the procedure of the opposite action technique, as well as asking for commitment from the client to the process of the intervention. It was also necessary to get a sense of which events or personal characteristics served as the primary shame cues for the individuals in the treatment. Thus, a Shame Checklist was developed (see below) and administered during the first session. Finally, an introduction to the role of homework in the intervention was presented and the assignment between the first and second session was formulated as listening to the audiotape of the session at least once, and reading a handout which summarized the critical elements of the intervention.

The second session was written to begin with time to explore the client’s reactions to the first session and review of the homework. It was thought that, if the client did not have a positive reaction to the first session or if they did not complete their homework, that these problems would need to be addressed immediately so as to prevent drop-out or lack of commitment to the process. Next, the Subject Units of Distress Scale, or SUDS, was presented to the client as a simple method for determining level of distress throughout the sessions. The manual included instructions for developing anchor points

for SUDS, which is a 0-100 scale, so that the client could better understand and use the scale appropriately. The client was also taught to use a shame scale in a similar manner, on a 0-100 scale, when prompted throughout the sessions. The second session also included instructions for beginning the opposite action procedure. The DBT principles of cue exposure, response prevention, and opposite action guided this activity. Initially, before the first client was treated, the procedure consisted of the following: discussion of the cue that evoked shame, assessment of urges associated with that cue, and extraction of the action associated with the opposite of those urges. For example, if the urge was to withdraw and not discuss the situation, the client would be encouraged to talk about the situation over and over until shame was reduced substantially. However, prior to treating the pilot case, it was unclear exactly how this procedure would evolve and there was room initially in the treatment manual to stray from this early conceptualization of the protocol. Homework would be determined at the end of the session and would be based on continuing to use opposite action in contexts outside of therapy.

The third through penultimate session were all structured the same. The session would begin with a review of the homework. The majority of each session would be comprised of the opposite action procedure, which ultimately followed a cue exposure, response prevention, opposite action model. Finally, the last session was written to be a wrap-up and review session during which all topics that were covered in the previous weeks were evaluated. See Table 2 for a description of the initial components of the treatment manual.

Table 2. Initial components in draft manual.

Session	Components
1	<ul style="list-style-type: none"> • Presentation of basic research on shame • Introduction to topic of justified versus unjustified shame • Overview of entire intervention • Completion of the Shame Checklist • Assignment of homework
2	<ul style="list-style-type: none"> • Reactions to previous section • Review of homework • Introduction to SUDS and Shame Scale • Beginning of Opposite Action intervention
3 – 7	<ul style="list-style-type: none"> • Review of homework • Opposite Action Intervention • Assignment of homework
8	<ul style="list-style-type: none"> • Review of homework • Review of all situations covered in previous weeks • Wrap-up and goodbye

Development of the Shame Checklist

Before treatment began with the pilot case, it was important to have a method of determining shame cues that was not overly intrusive, because it would be given early in the intervention, was exhaustive and open to multiple experiences, and could be administered in a short amount of time. For all of these reasons, it was determined that a questionnaire would be an easier method for gathering this information than an interview. A “Shame Checklist” was developed in order to fulfill such a need (see Appendix B). Items on the checklist came from the following sources: literature on shame, characteristics associated with borderline personality disorder that were believed to elicit shame (e.g., “making a suicide attempt”, “losing control in front of others”), and clinicians’ responses to a request for situations that have elicited shame in their clients. This latter method entailed providing nine members of a DBT consultation team with a questionnaire, asking them to list out situations that they have seen in their clinical work

(or own personal experience) to elicit shame. Confidentiality was assured, even in this informal process, so that clinicians could feel that their own answers to the questions would not be publicly linked to them in the future. Thus, the items reflect both research and clinical experience for the prompting events for shame.

The final version of the checklist consists of 98 situations or characteristics that were hypothesized to elicit shame in some people. Instructions for the checklist had two parts. First, individuals were asked to read through the items and circle any items that they had ever experienced in their life. They were then instructed to go back over the items that they had circled, and rate them on a scale of 0-100, indicating their *present* level of shame for that situation. In order for the most accurate information to be obtained, it was decided that individuals would complete this instrument on their own, without the therapist in the room with them. It was believed that this would allow the client to be the most candid while completing the questionnaire. As specified earlier, the checklist was initially devised to be administered toward the end of the first session.

The pilot case: Evolution of the treatment manual

The first person to call for more information about the study met all eligibility criteria for the study (see below) and was enrolled as the pilot case on which the treatment manual was further refined. This individual was a 42-year-old Asian American woman who was unemployed at the time of entry into the study. She had a number of comorbid Axis I and II disorders, including major depression, social anxiety disorder, specific phobia (snakes), posttraumatic stress disorder, and obsessive compulsive and paranoid personality disorders. She also had a lifetime history of bulimia nervosa. In

terms of suicidal behavior, she had a history of one lifetime serious suicide attempt and approximately 150 episodes of non-suicidal self-injury, including several episodes in the weeks prior to starting the study. This client was very compliant with attendance and promptness at sessions. During the assessments, she reported being very nervous about doing any work on her shame because she was afraid of disclosing personal information about herself to anyone, including her own individual therapist, but she also was committed to the process and to the study requirements.

All sessions were videotaped and reviewed on a weekly basis with a DBT expert. This allowed for careful examination of the process of the intervention and to ensure that all changes to the manual were recorded and added. The treatment manual guidelines for the first session required very few modifications as a result of the first session with the pilot case. The organizational structure of some of the information that was presented was changed to help with the flow of the session. The pilot participant also completed the Shame Checklist and her experience verified that this was a useful method of obtaining shame cues. She reported a mean level of shame intensity, on the Shame Checklist, as 76.5 for the endorsed items. As the opposite action procedure was introduced and begun with the pilot participant, however, it became clear that more information was needed in the manual for how to conduct the treatment. Essentially, there were three primary modifications and enhancements that occurred during the pilot case.

The first modification concerned the conceptualization of opposite action. In the draft manual, opposite action was based on the theoretical idea that all one had to do to reduce shame was to take the research findings on urges associated with shame (i.e.,

withdraw, hide) and do the opposite of that (reveal, expose). However, it became apparent very early on in the treatment of the pilot case that the opposite action for shame cannot be determined theoretically. That is, it was not sufficient to have a set of a priori rules about the urges associated with shame and a fixed set of actions considered to be the opposite of those urges. Instead, the determination of the opposite action had to be based on minute analysis of the specific cue and the client's actual reactions to that cue. This analysis had to include several sources of information, including behavioral urges, cognitions, body language, and actual behavior. The inquiry could be guided by the theoretical foundations of this project, but the theory could not be used as a stand-alone model for the intervention. While working on a specific shame cue with this pilot participant (the major shame cue with an intensity of 100) and analyzing the videotape of the therapeutic interaction, it was evident that, in addition to determining the behavioral urges, it was also necessary to examine the other components of the emotional experience. The end result is that opposite action was conceived of as a process that had to be engaged in "all the way," with all components of the emotion (urges, thoughts, behaviors) attended to. This notion of "all the way" participation in opposite action was something that was embraced by the participants.

The second modification involved the development of a structure for doing the opposite action intervention. The need for such a structure became clear as the first case was being treated, and five steps were specifically outlined. These steps became: 1) determine the cue that elicits shame, 2) make an appraisal as to whether the shame is justified or unjustified, 3) expose the client to the cue, 4) block maladaptive actions and urges, and 5) elicit and reinforce opposite (adaptive) actions. Although these steps were

entirely consistent with the proposed model for change, it wasn't until the first client was seen that it became clear that a step-by-step guide was necessary. The treatment was summarized to the client in the following manner: "In terms of shame, opposite action will look different depending on the situation and depending on whether the shame is justified or not. The first step will be to determine what the cues are for shame. Then we have to determine whether the shame is justified or unjustified in various situations. Once we do these things, we then have to find out what your urges are – what you feel like doing when you are faced with these cues and have you engage in the opposite behavior of those urges." Thus, the pilot case provided an opportunity to expand the manual in areas that had previously been insufficient.

Treatment proceeded with the pilot case in this manner until we neared the end of the proposed eight weeks and the need for the third modification became apparent. Due to the needs of the client and the sensitivity of the subject matter being discussed, it seemed premature to end the intervention after just eight sessions, especially since we were still working on a very difficult and taxing shame cue. Thus, it was decided to extend the treatment for two more weeks. The intervention was then modified to have some flexibility in its duration. Based on clinical judgment and client need, the intervention could be extended to nine or ten sessions.

By the end of the intervention with the pilot case, the treatment manual was considered finalized and ready for the five experimental participants. The treatment manual, in its entirety, is included in Appendix A.

Phase II Methods: Analysis of the effectiveness of the treatment

For the experimental participants, the intake assessment was also considered to be the start of the baseline period for those who were eligible for the study and thus, a number of outcome measurements were also administered. (See outcome measures section below.) If the participant met all eligibility requirements at the end of the pre-treatment appointment and signed statements and crisis plans were received from their individual therapist, they were considered to be enrolled in the study. The five experimental participants were enrolled into the study on a rolling basis and each received both DBT skills group and the shame intervention. Each of these components are detailed below and the randomization procedure for determining different baseline lengths is described.

DBT Group Skills Training

All participants received six months of DBT skills training in addition to the experimental intervention. There were two primary reasons for including the skills training. First, it was initially thought that clients would not volunteer for the opposite action intervention for shame by itself. Thus, the addition of the skills group was perceived to be a motivational factor for participating in the research study. Second, due to the nature of the multiple baseline design, it was imperative that data be collected on a weekly basis. It was unlikely that clients with BPD would complete weekly measurements on their own without a structure in place for obtaining the data. The skills group met every week and group did not begin until each participant had completed their questionnaires. The group was conducted by two leaders, a post-doctoral fellow and an

advanced graduate student in clinical psychology. Each client was enrolled in the group for a total of 24 weeks, the length of time required to go through each module in its entirety.

The function of DBT skills training is to teach the individual with BPD specific behavioral skills which s/he presumably lacks and which are viewed, at least theoretically, as important for the amelioration of suicidal behavioral patterns. The treatment manual for DBT skills training (Linehan, 1993b) is extremely structured and gives session-by-session guidelines on content and formatting of information and practice exercises. DBT skills training is didactically focused with a heavy emphasis on skill training procedures, including modeling, instructions, behavioral rehearsal, feedback and coaching, as well as homework assignments. In standard DBT skills training, there are four group skill modules targeting 1) mindfulness, 2) interpersonal effectiveness, 3) emotion regulation, and 4) distress tolerance.

Mindfulness skills teach methods for controlling attention and being aware of the present moment. Interpersonal effectiveness training is a regimen of skills for maximizing effectiveness in interpersonal conflict situations. Emotion regulation training teaches a range of behavioral and cognitive strategies for reducing unwanted emotional responses as well as urges to self-harm, and it focuses primarily on teaching group members how to identify and describe emotions, avoid situations and cues associated with ineffective behavior, and increase positive emotions. Distress tolerance training teaches a number of “delay of gratification” and self-soothing techniques aimed at surviving crises without attempting suicide or engaging in other dysfunctional behavior. In addition, the distress tolerance module teaches strategies for reality acceptance as a

means of accepting the current moment “as is” as opposed to engaging in dysfunctional behaviors in an attempt to “reject reality.” Opposite Action, as a skill for regulation emotions including shame, was excluded from the skills group because this skill forms the context of the current study.

Opposite Action Intervention

The duration of the opposite action treatment was 8-10 sessions with the sessions scheduled to occur on a weekly basis. Sessions were approximately 90 – 120 minutes each. The treatment manual described above and in the results section (and included in Appendix A) was followed for each of the clients. During these appointments, each participant was systematically exposed to cues associated with shame with the aim of reducing the level of shame experienced by the participant as well as the dysfunctional behaviors that co-occur with shame. All of the shame intervention sessions were conducted by the study investigator (SLR). Each session was audiotaped for the client to listen to for homework as well as videotaped (for the investigator).

Outcome Measures

The following instruments were used as outcome measures.

1. State Shame and Guilt Scale (SSGS; Marschall et al., 1994) was completed on a weekly basis at the beginning of each group, in addition to before and after each opposite action session, and at each assessment. The SSGS has three subscales designed to assess shame, guilt, and pride in the moment. The subscales yield a score on a 5-25 scale with a higher score indicating greater amounts of that emotion in the moment.

2. Positive and Negative Affect Scale (PANAS; Watson & Clark, 1988), a state-based measure, was completed by the participants on a weekly basis at the beginning of group, in addition to before and after each opposite action session, and at each assessment. The PANAS has two subscales, positive affect and negative affect, and asks participants to complete it about how they are feeling in that one moment. The subscales are computed on a 10 to 50 scale with higher scores indicating greater levels of each affect in the moment.
3. The Positive Feelings Questionnaire (PFQ; Harder, 1990) has a guilt subscale and a shame subscale and is designed to be a measure tapping more “traitlike” forms of these emotions. The PFQ was administered at each assessment period. Scores range from 0 to 40 on the shame subscale, and from 0 to 24 on the guilt subscale, with a higher score indicating greater amounts of shame or guilt, respectively.
4. A Daily Diary Card was used as a monitoring system and required participants to rate their level of urges to commit suicide and other variables including shame, urges to self-harm, presence of any self-harm behaviors, and other negative emotions such as fear, sadness, and anxiety on cards to be filled out at the end of each day. Diary cards were collected weekly at each group and special emphasis was made by the group leaders to ensure that diary cards were filled out completely. So as not to be overly influenced by sporadic extreme values (of either a low or high value), median values of urges to commit suicide for the week were computed and yielded a score between 0 and 5 with a higher score indicating higher urges.
5. Suicidal Behavior Questionnaire (SBQ; Linehan, 1981) is a brief questionnaire which assesses less overt forms of suicidal behaviors, such as suicide threats and suicidal

ideation. This measure was included to assess suicidal behaviors other than overt parasuicidal behaviors. The SBQ was administered at each assessment period. For the current study, there were three variables of interest. First, the SBQ asks a series of questions about how often the individual thought of killing themselves over various timeframes. These questions were pooled into one variable which was used as an index of recent suicide ideation (named "Recent SI"). This variable was scored on a 0-4 range, with 0 indicating no suicide ideation and 4 indicating high frequency of suicide ideation. Second, participants were asked how likely they would consider the possibility of killing themselves within the next month ("Future SI"). Third, there is a question which asks how likely it is that the participant will attempt suicide within the next month ("Future SA"). These latter two questions are also scored on a 0-4 scale with 0 indicating "no chance at all" and 4 indicating "very likely."

Assessment procedure

There were four formal assessment sessions in addition to the weekly measurement collected. The first assessment session (intake) was the most thorough and included in-depth interviews to assess baseline symptomatology and inclusion/exclusion criteria. There was also an assessment immediately prior to beginning the shame intervention (pre-shame intervention) and immediately following the last intervention session (post-shame intervention). Finally, all participants were asked to complete an assessment eight-weeks following their last intervention session (8-week followup). These three assessments included the following measures: PANAS, SSGS, PFQ, and SBQ. The post-shame intervention and 8-week followup assessments were conducted by

a trained clinical assessor who was blind to treatment progress and content of the shame intervention sessions. The measurements completed and collected weekly were the SSGS, PANAS, and diary card. See Figure 1 for a visual illustration of the sequence and timing of the assessments and measurements.

Randomization Procedure

Because each of the three DBT skills modules are taught over a period of eight weeks, a natural baseline length was provided by participation in the group. Upon entry to the study, each of the participants were randomly assigned to Cohort 1, 2, or 3. These cohort numbers corresponded to the time point in which they were to receive the opposite action treatment. Those individuals assigned to Cohort 1 were scheduled to start the intervention at the time of their entry into the skills group. Those individuals assigned to Cohort 2 were scheduled to have the intervention during their second module of skills (the middle eight weeks of their treatment). Finally, those in Cohort 3 were scheduled to have the intervention coincide with their third module in the last eight weeks of their skills group. This design allowed for conclusions to be drawn about the efficacy of the opposite action treatment while controlling for any possible benefit from the skills group, the passage of time, or time in therapy.

Analysis Plan

In light of the hypotheses of this study, the primary outcome variables of interest were the weekly measures of the shame scale on the SSGS and weekly averages of urges to commit suicide on the daily diary card. These variables were plotted in graphical form for the length of the study for each participant. Because the SSGS was also administered

before and after each individual session, shame scores were plotted for each of these points as well. Additionally, other variables measured on a weekly basis, such as the other two scales of the SSGS and the PANAS positive and negative affect scores were similarly plotted. Finally, pre-post data will be presented to show the overall effect of the intervention. Specifically, scores on the four measures given at the pre and post shame intervention assessment periods will be presented. Because this is a study investigating the effects of a new intervention, it is worthwhile to examine overall effects, despite the small number of participants.

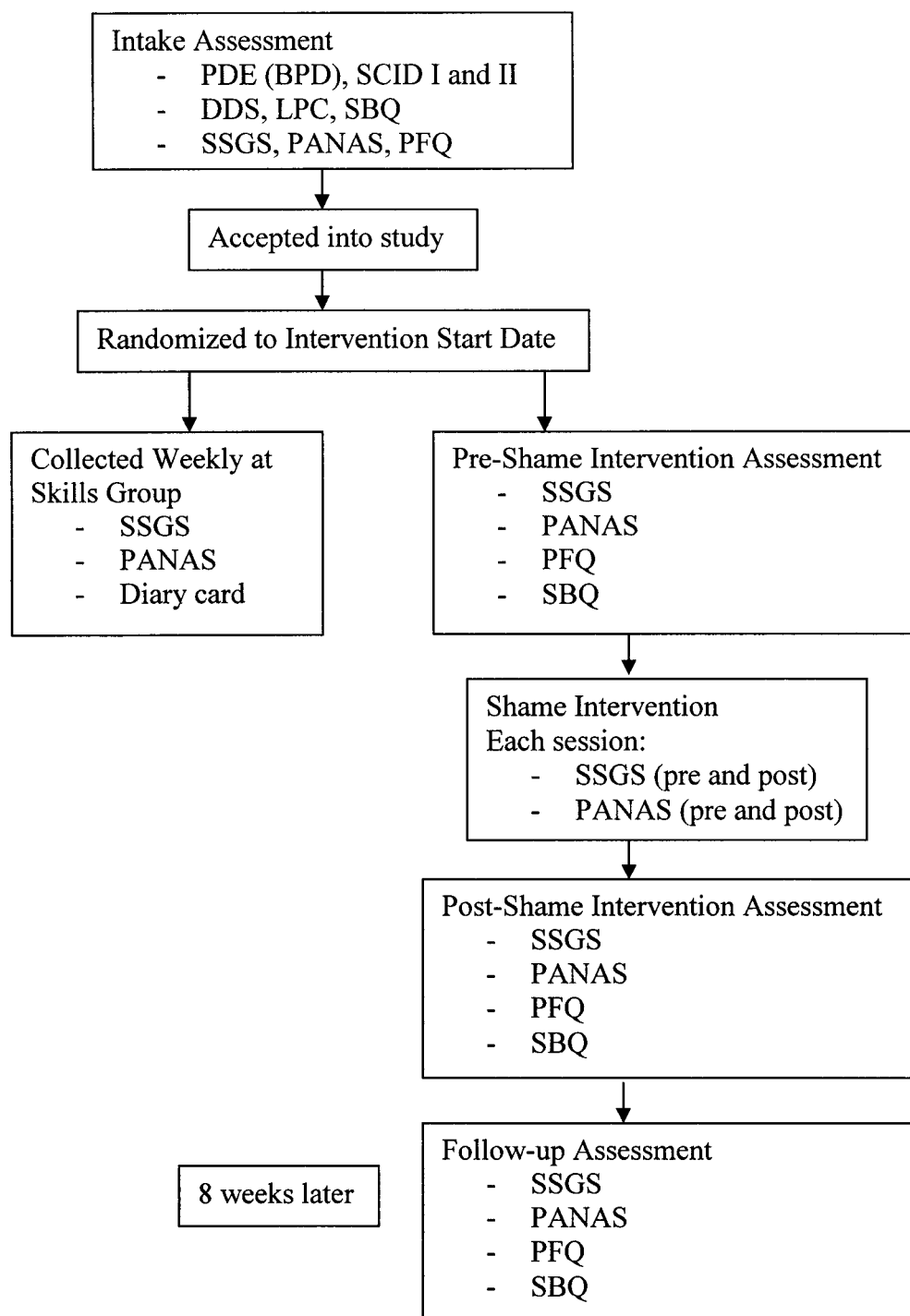


Figure 1. Sequence of assessments for experimental participants

Note: PDE=Personality Disorder Examination; SCID=Structured Clinical Interview for DSM-IV; DDS=Demographic Data Schedule; LPC=Lifetime Parasuicide Count; SBQ=Suicidal Behavior Questionnaire; SSGS=State Shame and Guilt Scale; PANAS=Positive and Negative Affect Scale; PFQ=Personal Feelings Questionnaire

RESULTS

Participants

A total of 27 calls were received from individuals interested in receiving the treatment or hearing more about the study. Of these, 5 declined participation over the phone: two never called back, one said the study involved too much time, one wanted skills group only, and one stated that she was “not ready.” Sixteen people were excluded from the study (11 during the phone screen, 5 during an interview) for the following reasons: current substance dependence (n=1), no primary therapist (n=4), absence of suicidality (n=4), subthreshold BPD (n=4), and presence of a psychotic disorder (n=3). Six individuals were accepted in the study and started attending the skills group. One person dropped out before the shame intervention was applied because she entered intensive treatment for a substance dependence relapse. Therefore, five people attended a first session of the shame intervention and are included in all further analyses.

All participants were women and met criteria for BPD as assessed by both the IPDE and the SCID-II. Although men were not excluded from the study, only one male called for more information and he was excluded because he did not meet full criteria for BPD. Table 3 provides a summary of demographics and information about psychopathology for the five participants. Despite some obvious similarities (i.e., females meeting criteria for BPD), this was a remarkably heterogenous group. As shown in the table, the sample had high rates of comorbidity. Number of lifetime parasuicide events ranged from 5 to 423 (median: 49.5). Four of the participants had made at least

one serious suicide attempt at some point in their life. Two of these four (Clients #2 and #3) had made a suicide attempt within 8 weeks of entering the study.

Table 3. Demographic information and comorbidity for experimental participants.

	Client #1	Client #2	Client #3	Client #4	Client #5
Age	23	55	23	39	39
Ethnicity	Caucasian	Caucasian	Arab American	Caucasian	Caucasian
Education Level	Some college	College degree	College degree	Masters degree	College degree
Employment Status	Student	Un-employed	Full-time	Un-employed	Full-time
# BPD criteria (IPDE)	5	5	8	6	6
Current Axis I Disorders	MDD, Agoraphobia, Social Phobia, PTSD, GAD	MDD, Agoraphobia, Social phobia, GAD	Specific phobia, GAD	Dysthymia, Social phobia	MDD
Lifetime Axis I Disorders	Anorexia, OCD, Alcohol dependence	-	MDD	MDD, Agoraphobia	-
Other Axis II disorders	Paranoid	Avoidant	Histrionic	OCPD, Avoidant	-
# of Lifetime Parasuicides	5	30	423	69	20
# of Suicide Attempts	3	3	1	0	0

Note: Only full threshold diagnoses are included here. MDD = Major Depressive Disorder; PTSD = Posttraumatic Stress Disorder; GAD = Generalized Anxiety Disorder; OCD = Obsessive Compulsive Disorder; OCPD = Obsessive Compulsive Personality Disorder

Single subject design: Randomization, missing data, and baselines

Results of the randomization yielded two participants in Cohort 1 (clients #1 and #2), two participants in Cohort 2 (clients #3 and #5), and one participant in Cohort 3

(client #4). However, due mostly to difficulties with scheduling, the timing of the intervention did not correspond exactly with the timing of the three group modules. For example, the two participants randomized to Cohort 2 began the shame intervention in their 10th and 11th week of the study, and not the 8th as planned. Three of the five clients also had to miss certain weeks, due to scheduling conflicts, and did not finish within eight weeks. Furthermore, because some participants had nine or ten sessions, this naturally carried over into a greater number of weeks. All five participant finished the entire treatment (both six months of the DBT skills group and the shame intervention) and attended the post-shame intervention assessment. One participant (Client #3) did not return for the follow-up assessment despite numerous attempts to get in contact with her.

For the most part, there was very little missing data over the course of the study. Attendance rates at the weekly groups were high with a total attendance rate of 85% across subjects and a range of attendance from 64% to 100%. This allowed for prompt collection of the daily diary cards and for completion of the weekly SSGS and PANAS questionnaires. One participant, Client #3, was the most sporadic with attendance and thus, there are less weekly measurements available for her. Additionally, most of the participants were very compliant with completing their diary cards; completion rates ranged from 82% to 100% of all variables, when Client #3 is omitted. This client completed only about 42% of her diary card and despite attempts to get her to complete it more fully, the level of completion stayed stable over the course of the study. Thus, her graphs have the most “holes” in the plotted lines.

By viewing graphs on each of the clients’ data, it became clear that their levels of shame (and everything else that was measured) were not stable at all. To illustrate this

point, two figures are included. Figure 2 shows one of the clients' shame ratings as measured on her diary card over the first 50 days of her involvement in the study. For comparison, Figure 3 shows that same client's ratings of sadness over the first 50 days. What is clear from these figures is that this clients' experience of her emotions changed dramatically from day to day. All the other clients in the study exhibited similar trends. The first rule in multiple baseline designs is that a stable baseline is required before an intervention should be applied, so that interpretation of the effects of the intervention is possible. Obviously, in this case, there was no stable baseline for any of the clients. Despite this palpable setback, the study was continued because it was a test of a pilot intervention and it was believed that there was still much information to be gained.

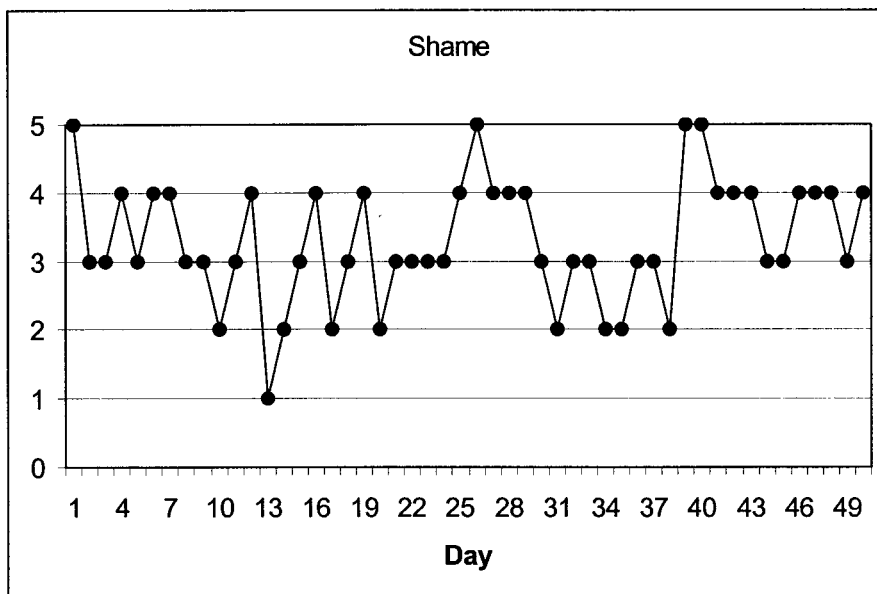


Figure 2. Sample client's shame ratings over first 50 days.

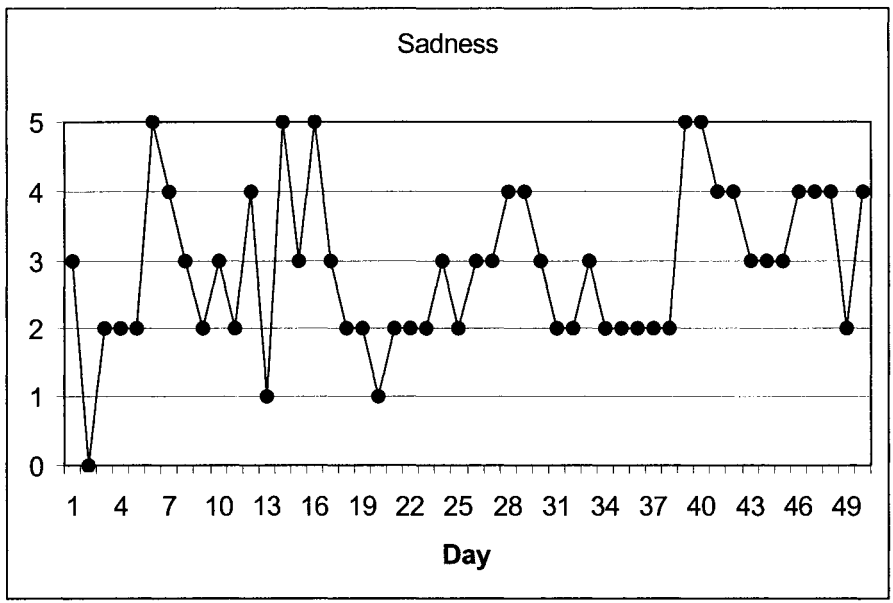


Figure 3. Sample client's sadness ratings over first 50 days.

Shame

Figures 4 through 8 display the weekly SSGS shame subscale scores for each of the five participants respectively. These data were collected at the weekly skills group. Dotted lines indicate the data that was collected while the participant was also engaged in the shame intervention. Solid lines indicate data collected while the participant was not in the shame intervention, either prior to receiving the intervention or the weeks following the intervention, depending on their randomization.

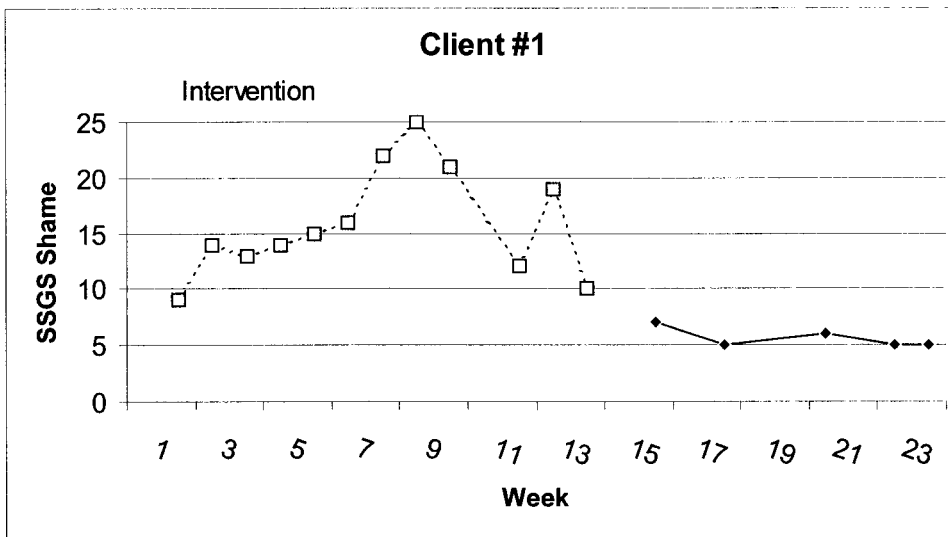


Figure 4. Client #1 Weekly SSGS Shame.

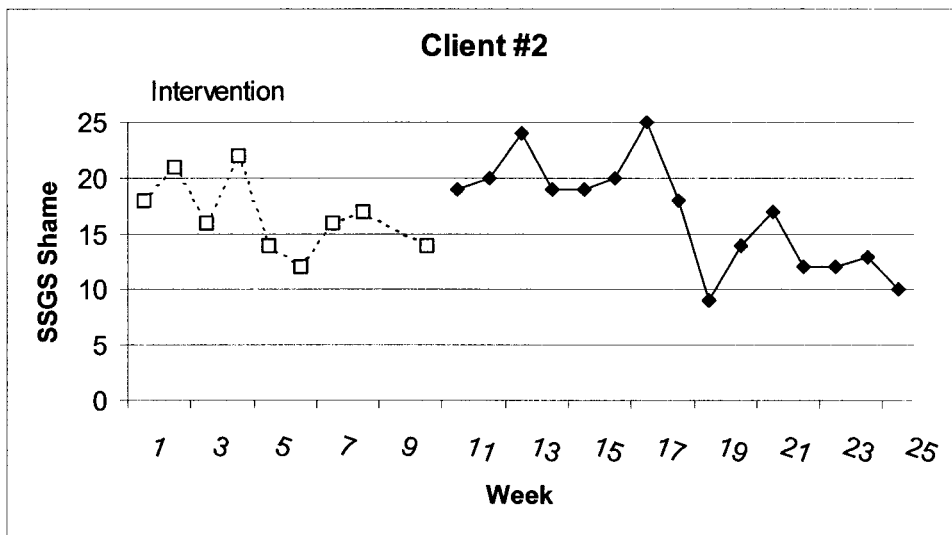


Figure 5. Client #2 Weekly SSGS Shame.

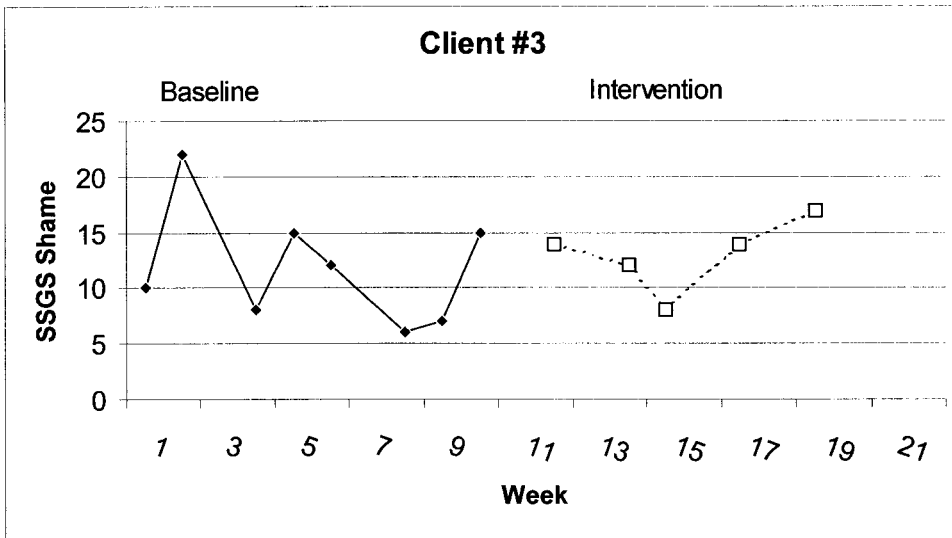


Figure 6. Client #3 Weekly SSGS Shame.

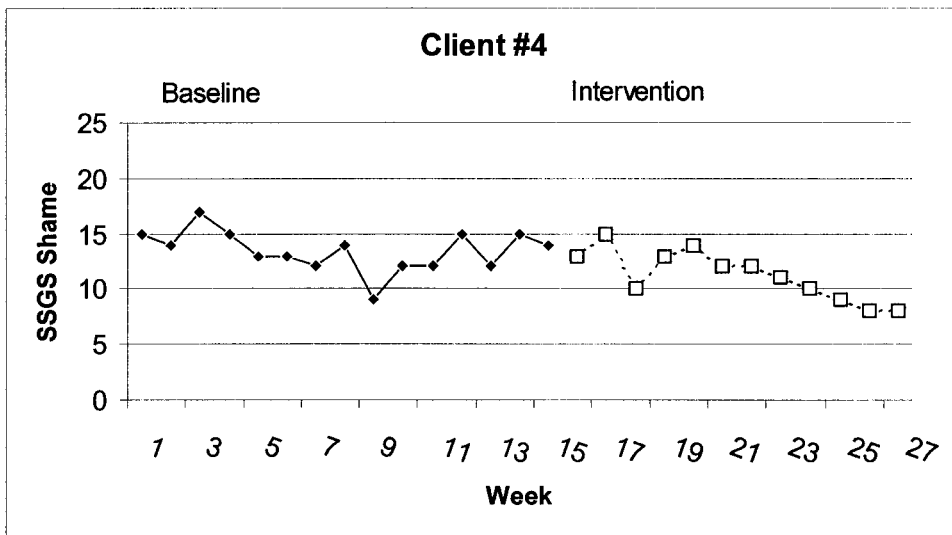


Figure 7. Client #4 Weekly SSGS Shame.

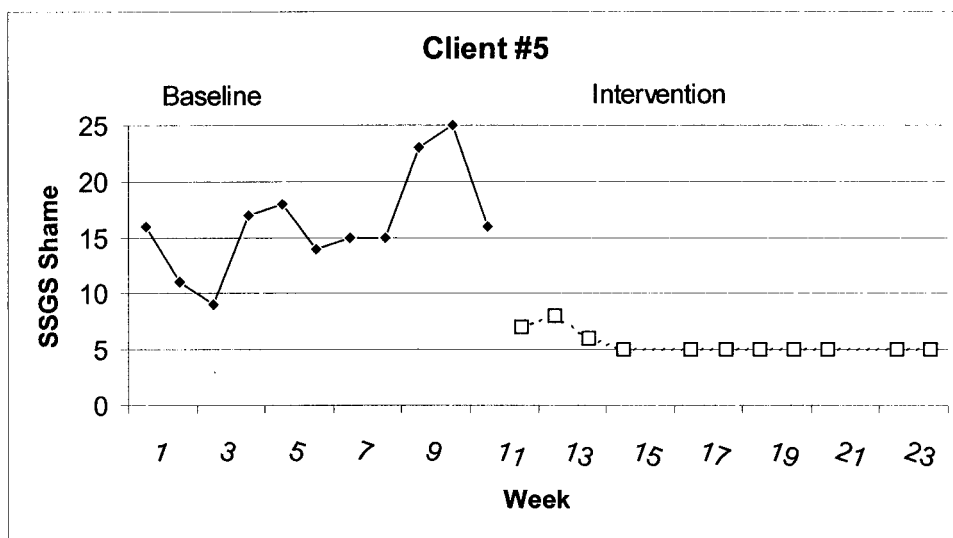


Figure 8. Client #5 Weekly SSGS Shame.

As demonstrated in the graphs, the lack of stable shame scores during the baseline phases makes interpretation of the intervention scores very difficult. Client #1 exhibited changes in shame scores during the intervention phase with shame scores reaching their highest levels at week 8. Interestingly, her shame scores post-intervention were reduced to 7 or less (5 is the lowest possible score on this scale). Client #2 had a reduction in shame by the end of the study but this was several weeks after finishing the shame intervention sessions. Client #3 had the least overall reduction in shame and had highly variable scores throughout the study. The scores of client #4 indicate a fairly steady level with slight decreases over time during the intervention, culminating in a 7 point difference between the first week and the last week in the study. Finally, client #5 showed a dramatic decrease in shame at the first opposite action session and her scores remained at the lowest possible level from week 14 until the end of the study.

The SSGS was also administered at the beginning and end of each opposite action intervention session in order to get a sense of within session changes as a result of the procedure. Figures 9 through 13 demonstrate the SSGS shame scores during the intervention sessions for each client.

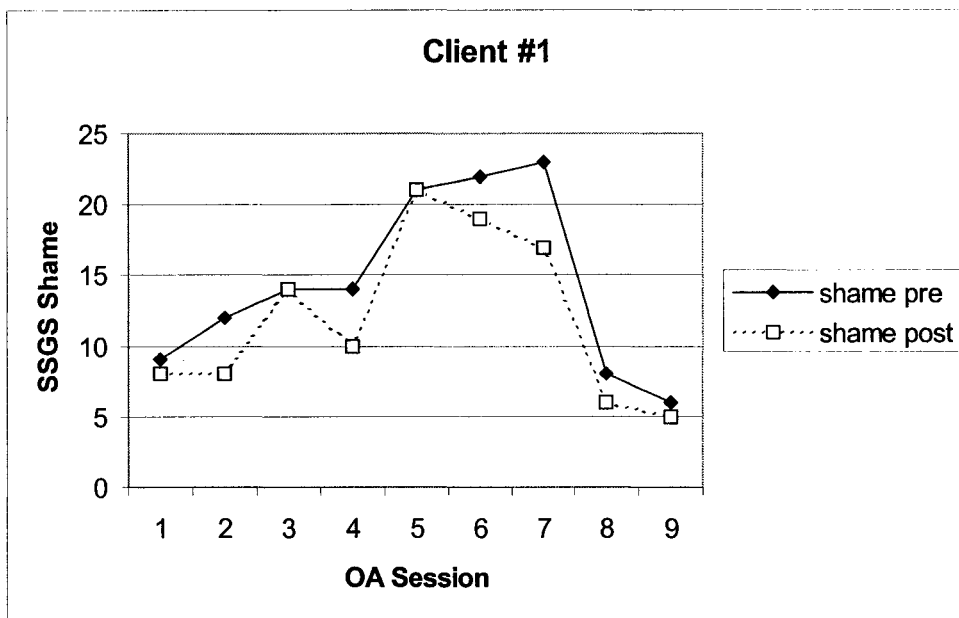


Figure 9. Client #1 Opposite Action Sessions, SSGS Shame.

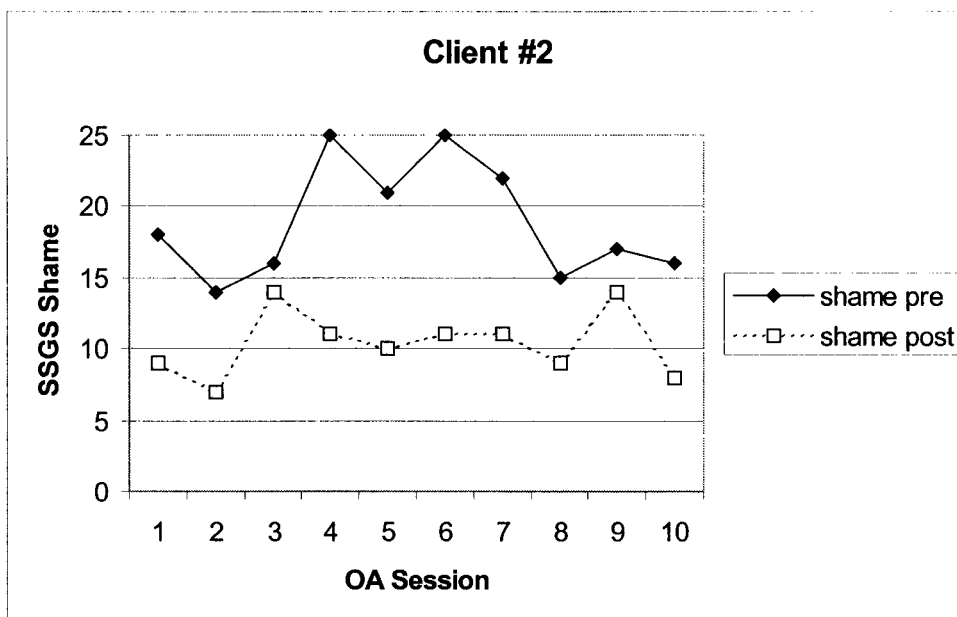


Figure 10. Client #2 Opposite Action Sessions, SSGS Shame.

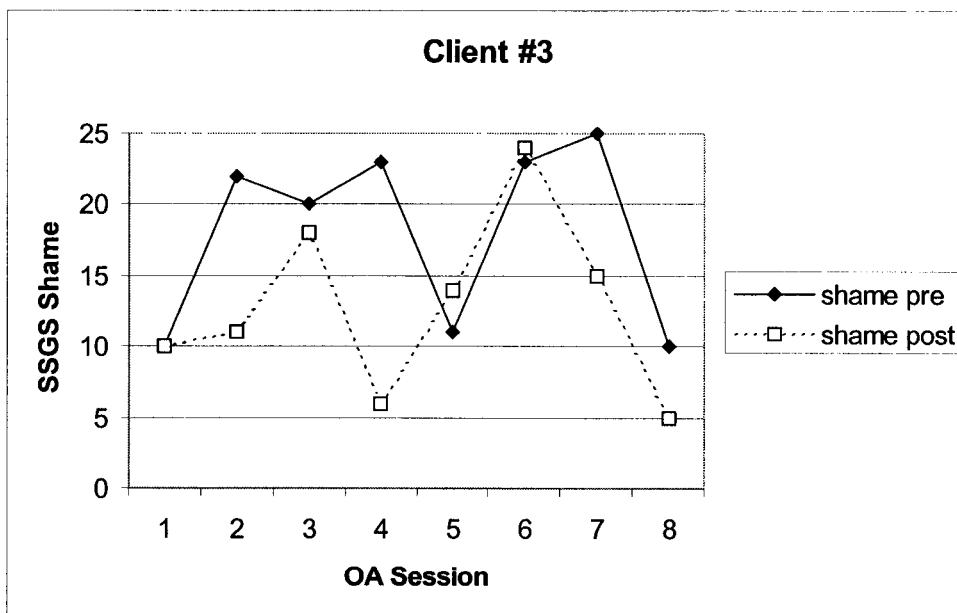


Figure 11. Client #3 Opposite Action Sessions, SSGS Shame.

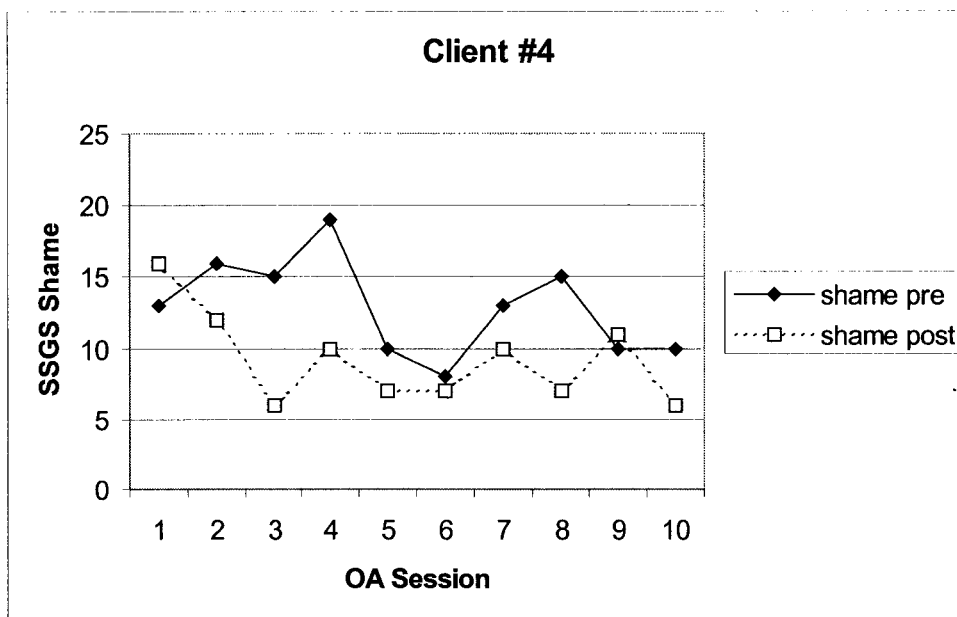


Figure 12. Client #4 Opposite Action Sessions, SSGS Shame.

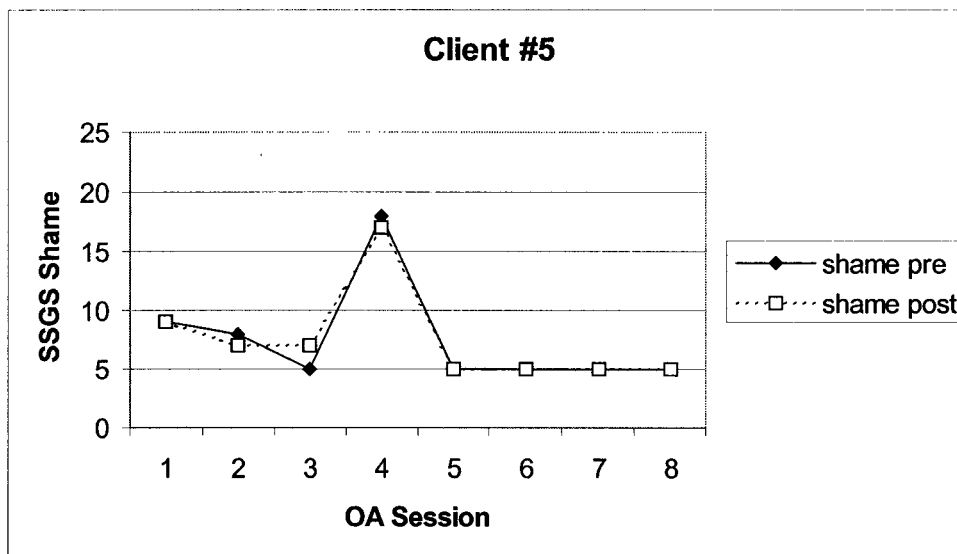


Figure 13. Client #5 Opposite Action Sessions, SSGS Shame.

For the most part, these figures indicate that shame at the end of the session was less than, or equal to, pre-session shame. Across all participants, 89% of the sessions had a decrease in shame or the same score at the end of the session. This result is most

striking in Client #2 who had the greatest difference between pre-session and post-session scores, but all clients more or less exhibited similar patterns. In Client #5, her scores flattened out at the lowest possible score starting at session 5 and thus there is little to compare for pre and post session. The average shame score at pre-session was 14.5; at post-session, this average fell to 10.4. These results can also be broken down by client. Client #1's average shame score went from 14.3 at pre-session to 12.0 at post-session. For client #2, the difference was 18.9 to 10.4. Client #3's difference was 18.0 to 12.9 and client #4 was 12.9 to 9.2. Client #5 had no difference in pre- and post-session average scores (7.5).

If the treatment had no effect, then one would expect that for one-third of the sessions the scores would go down, for one-third scores would increase, and for one-third scores would remain the same. A chi-square "goodness of fit" test was executed to determine if the probability that the decrease in shame across 32 of the 45 sessions could be attributed to chance. Results indicate that the observed values are significantly different than what one could expect to happen through chance alone, $\chi^2(2) = 29.2$, $p < .001$.

Urges to commit suicide

Urges to commit suicide were measured on the diary card which participants were instructed to complete on a daily basis. Figures 14 through 18 show the median values of these urges over time for each of the participants. Again, the dotted lines indicate the values during the period that they were receiving the shame intervention.

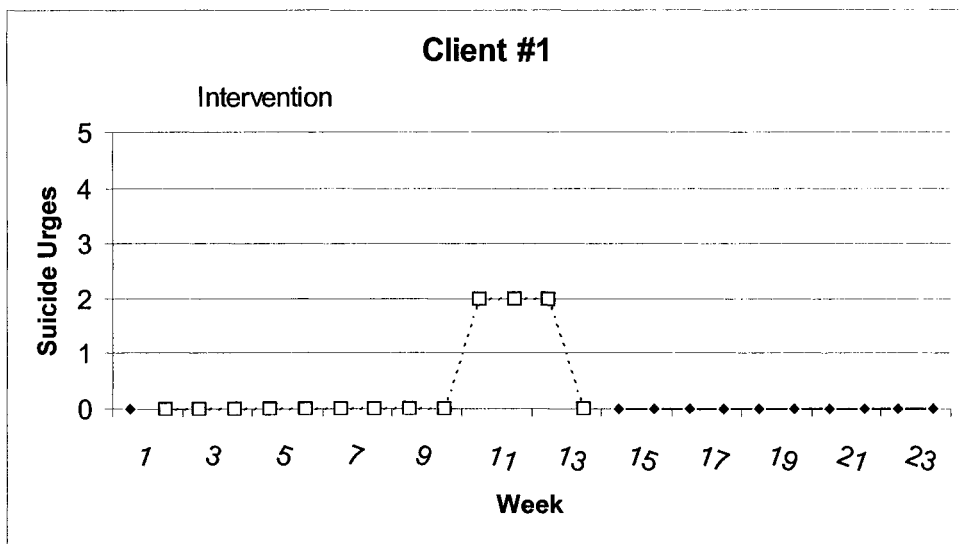


Figure 14. Client #1 Median suicide urges over time.

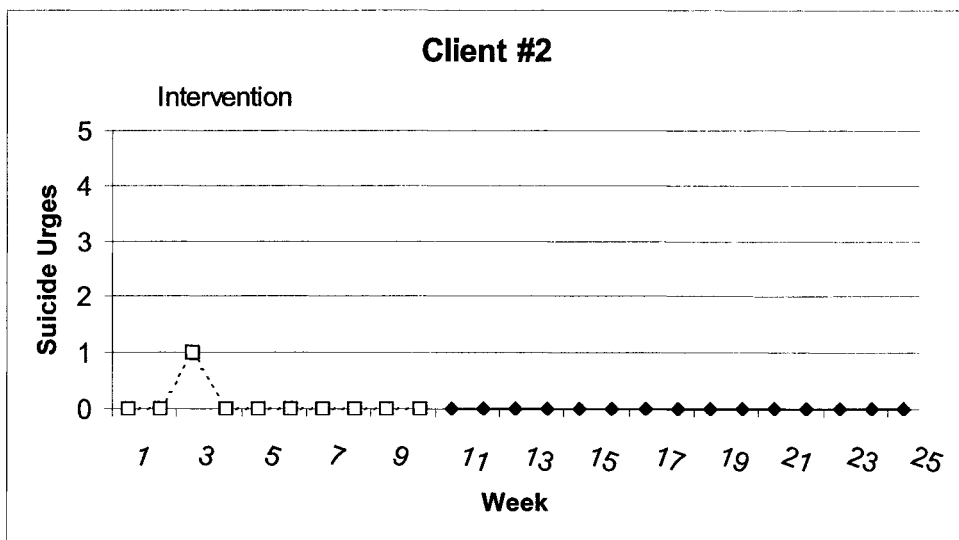


Figure 15. Client #2 Median suicide urges over time.

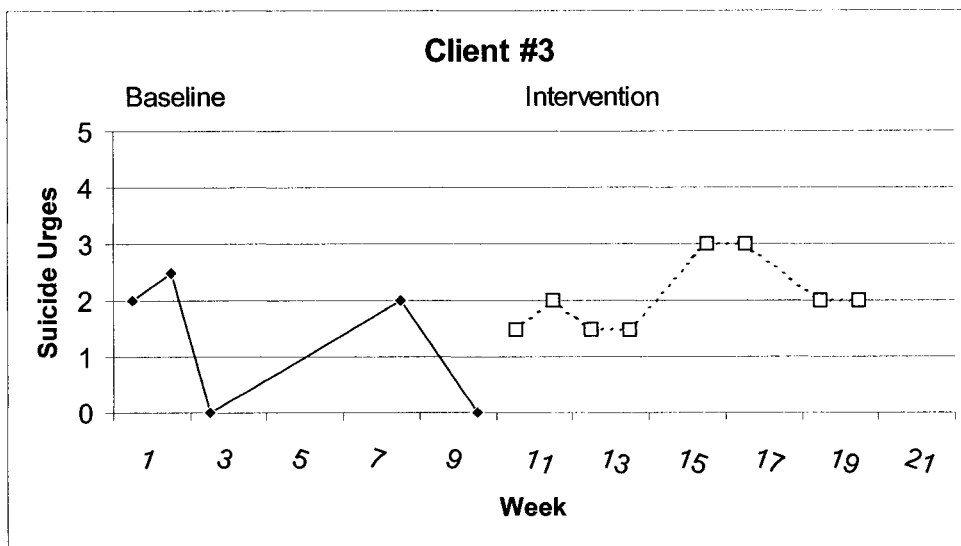


Figure 16. Client #3 Median suicide urges over time.

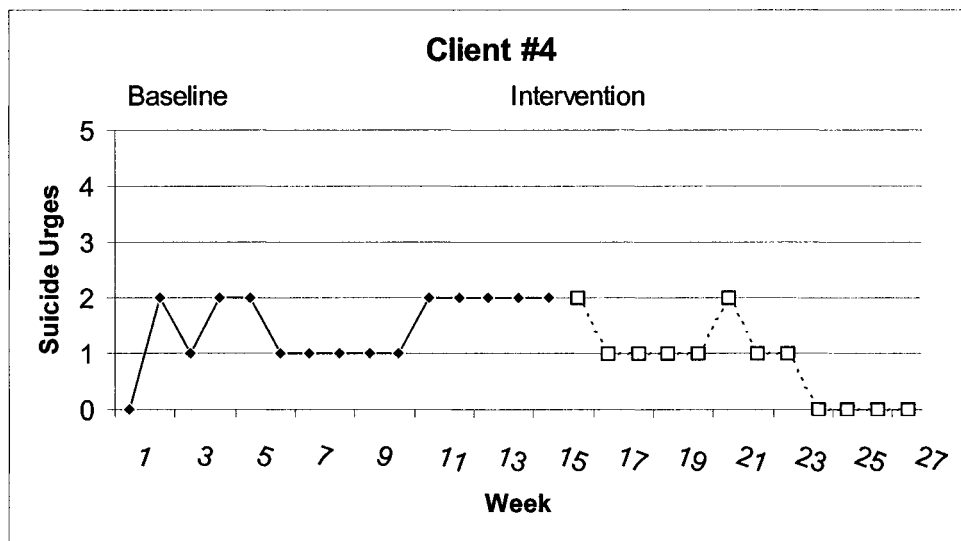


Figure 17. Client #4 Median suicide urges over time.

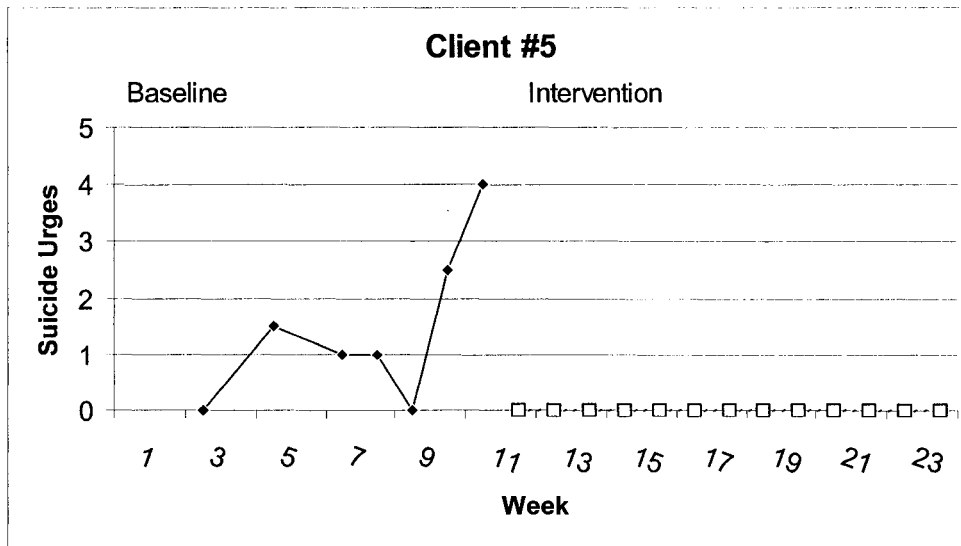


Figure 18. Client #5 Median suicide urges over time.

With the exception of client #3, all participants finished their last few weeks of group with zero urges to commit suicide. Although most of them began the study at relatively low levels of such urges, this is notable given the fact that these individuals were selected because of high levels of suicidality.

In terms of suicidal behavior during the study, there were no suicide attempts made by any participant during the length of the study. However, there were a number of identified self-harm episodes over the course of the study. Table 4 displays the number and method of self-harm episodes for each participant. Interestingly, although not targeted specifically, the rate of self-harm episodes was relatively infrequent and also remarkably low in terms of lethality of method and potential damage to the self. Given the relative low base rate of this phenomenon generally, though, these results are difficult to interpret.

Table 4. Self-harm episodes during course of study.

	Client #1	Client #2	Client #3	Client #4	Client #5
# Episodes during Intervention	2	0	2	4	0
# Episodes during Follow-up	0	1	ND	1	0
Method	Hit self on legs	Scratched self	Scratched self	Head banging	-

Note: ND=no data available

Associated variables

The following figures include graphs for each participant on the following four variables: SSGS Guilt scale, SSGS Pride scale, PANAS positive affect scale, and PANAS negative affect scale. Each of these variables are designed to be measurements of state emotion, i.e. emotions felt in the current moment when completing the questionnaire. For the SSGS Pride scale and the PANAS positive affect scale, higher scores indicate better, more positive, feelings in the moment.

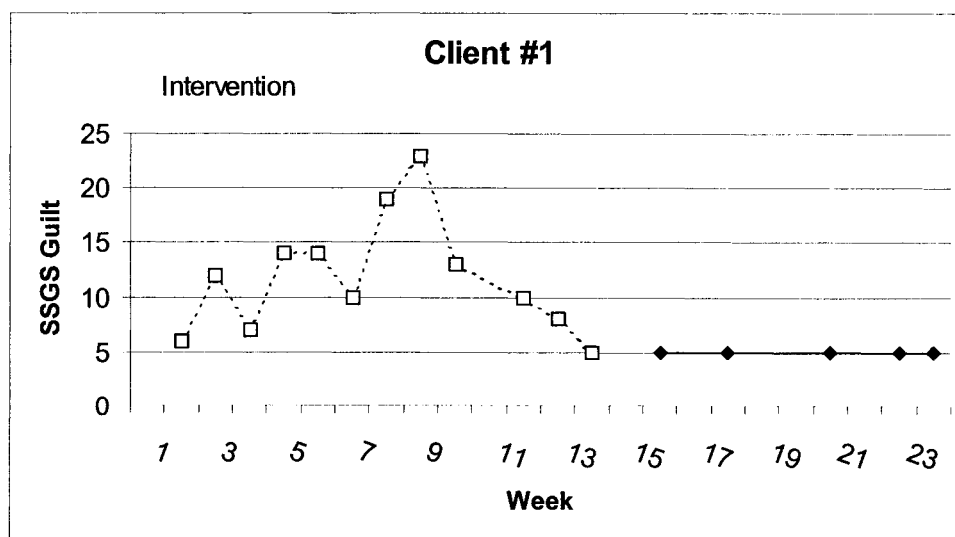


Figure 19. Client #1 Weekly SSGS Guilt.

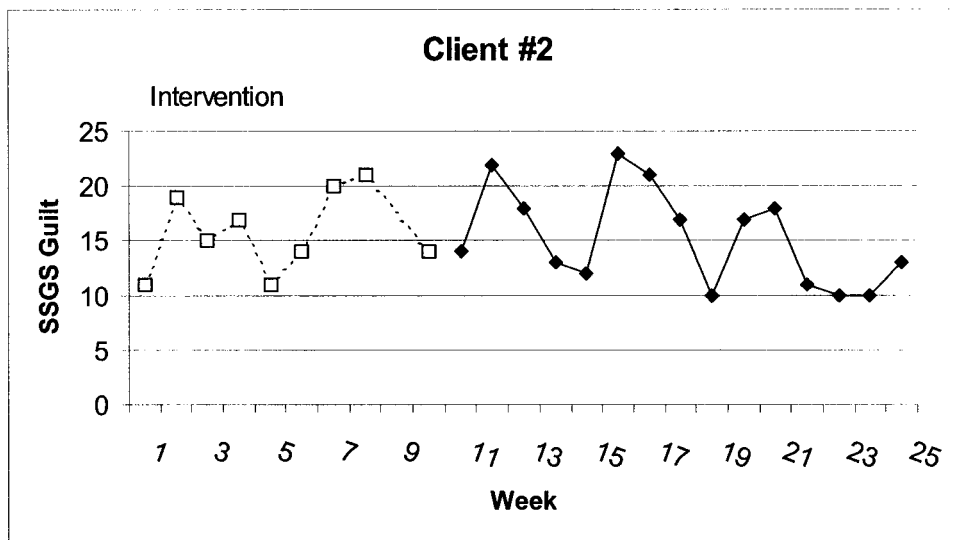


Figure 20. Client #2 Weekly SSGS Guilt.

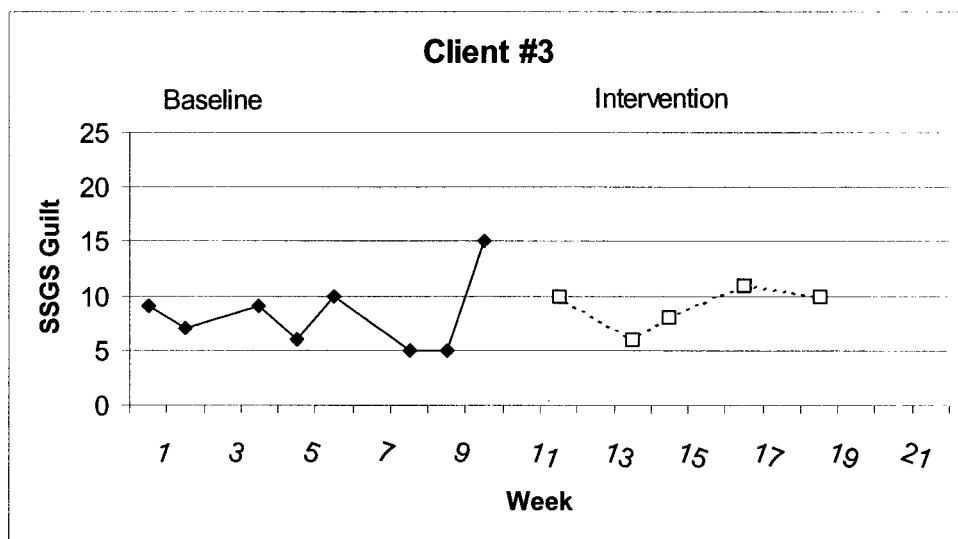


Figure 21. Client #3 Weekly SSGS Guilt.

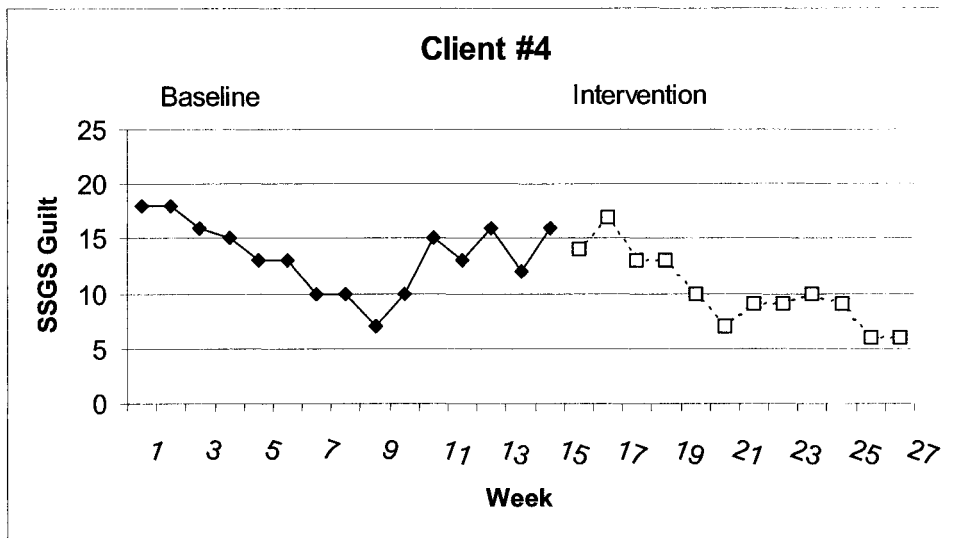


Figure 22. Client #4 Weekly SSGS Guilt.

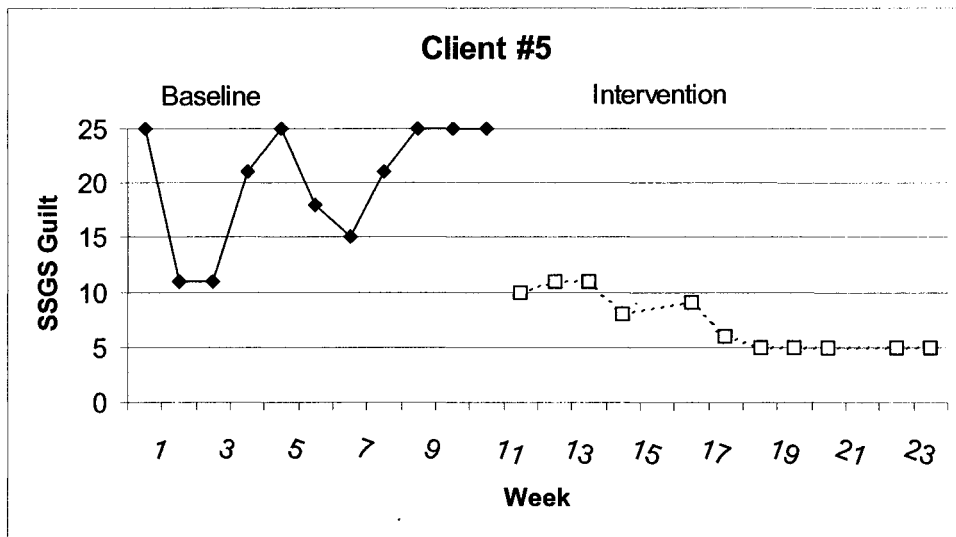


Figure 23. Client #5 Weekly SSGS Guilt.

As shown in the graphs, clients #1, 4, and 5 all had a notable decrease in guilt ratings over the course of the study. For client #1, this began during the shame intervention and was then maintained during the follow-up phase. Clients #4 and 5 had

the decrease occur within the intervention period. With the exception of week 9, client #3's guilt scores had a somewhat restricted, and stable, range both during the baseline and intervention phases. The guilt scores for client #2 showed an unstable pattern throughout the study.

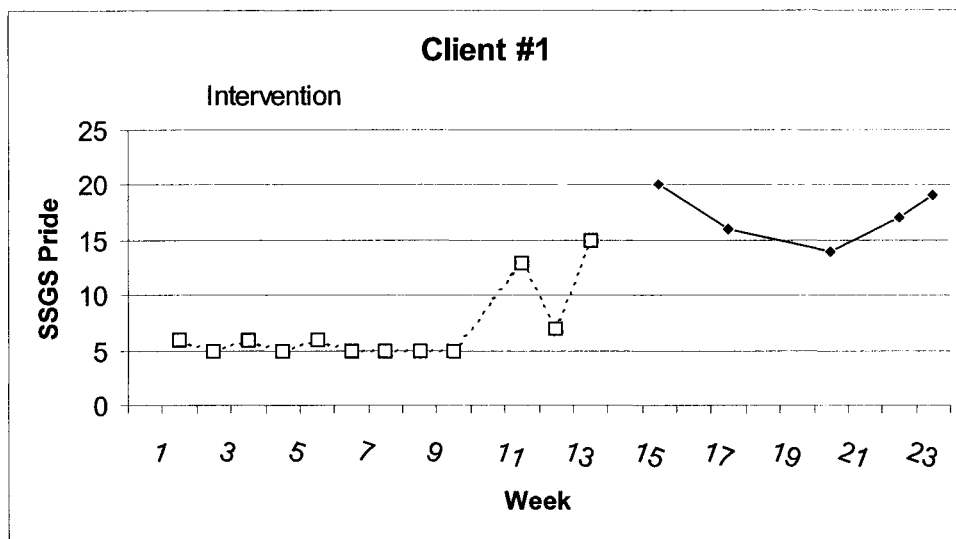


Figure 24. Client #1 Weekly SSGS Pride.

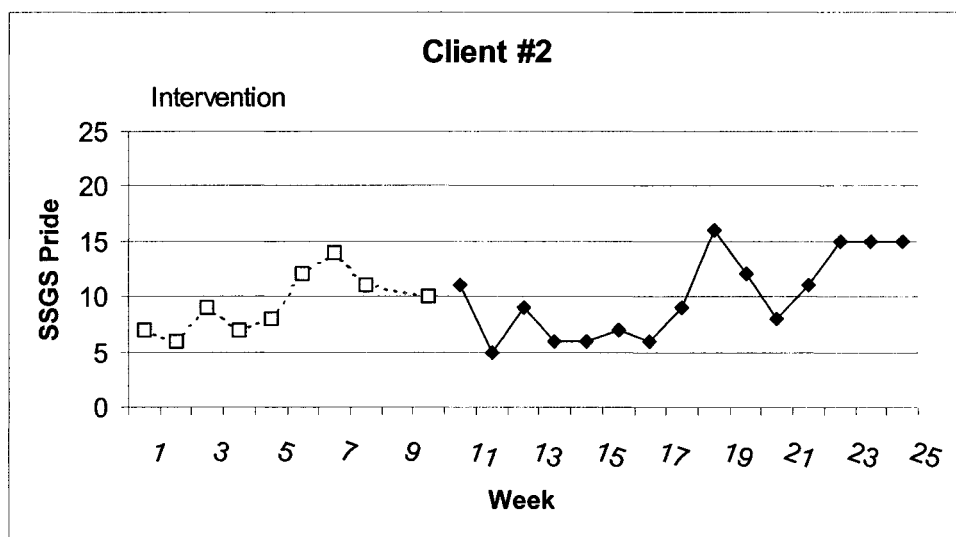


Figure 25. Client #2 Weekly SSGS Pride.

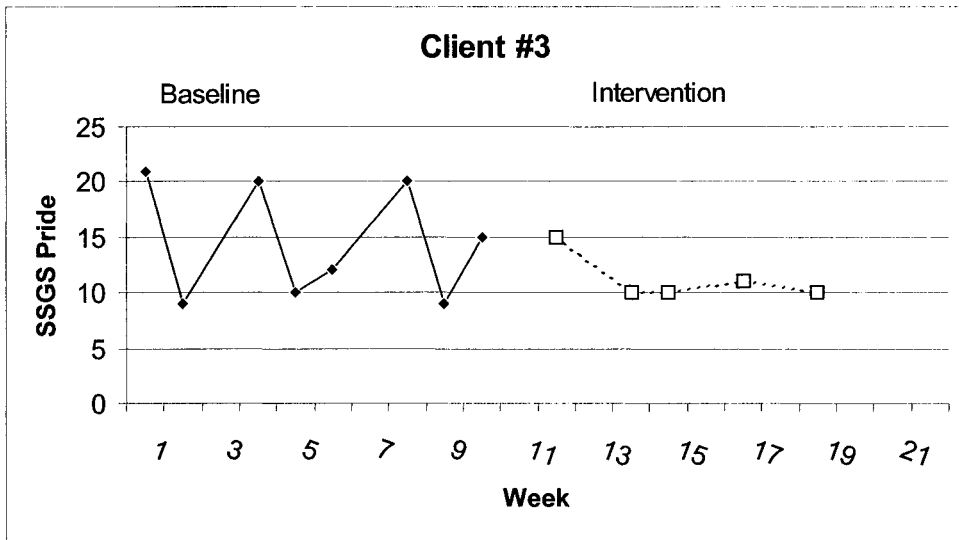


Figure 26. Client #3 Weekly SSGS Pride.

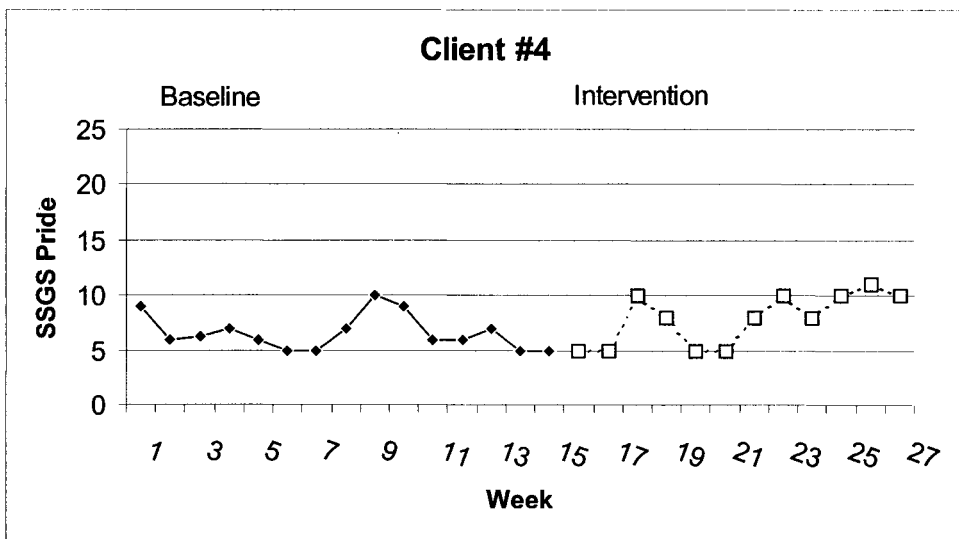


Figure 27. Client #4 Weekly SSGS Pride.

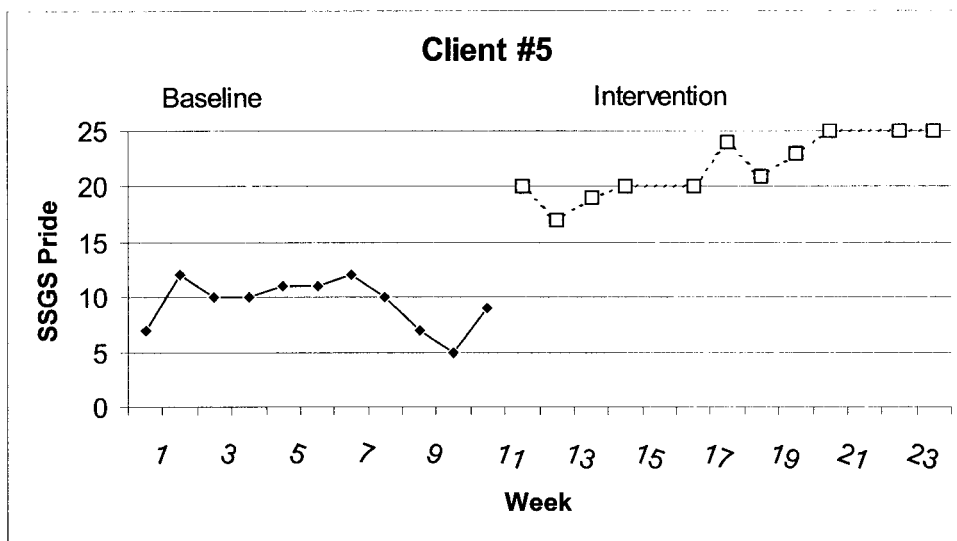


Figure 28. Client #5 Weekly SSGS Pride.

The study participants had variable responses to items assessing pride throughout the study, with one client showing a restricted range of response throughout the study (client #4), and others displaying a rise in pride during the intervention phase (e.g., clients #1, 2, and 5). Client #3 had more inconsistent responses during the baseline, with more than a 10-point difference between sessions.

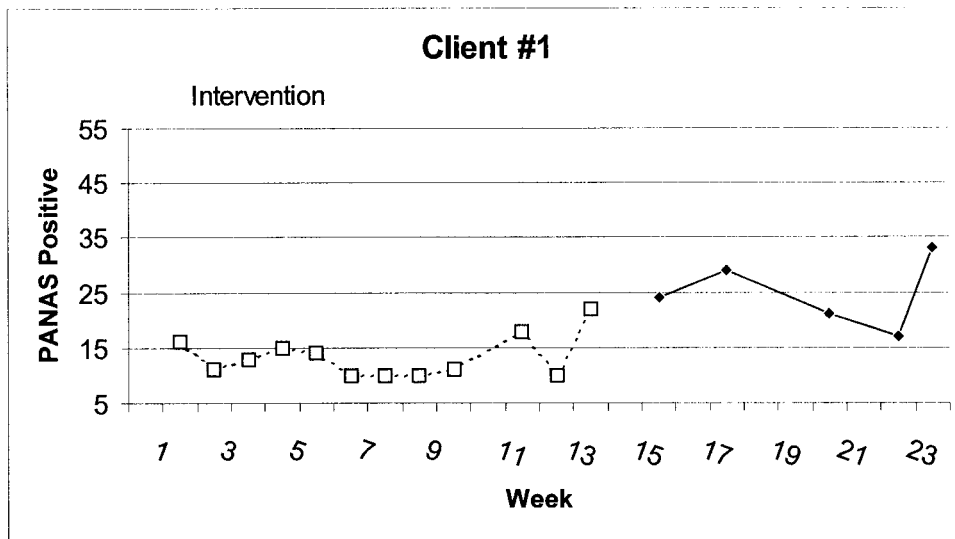


Figure 29. Client #1 Weekly PANAS Positive Affect.

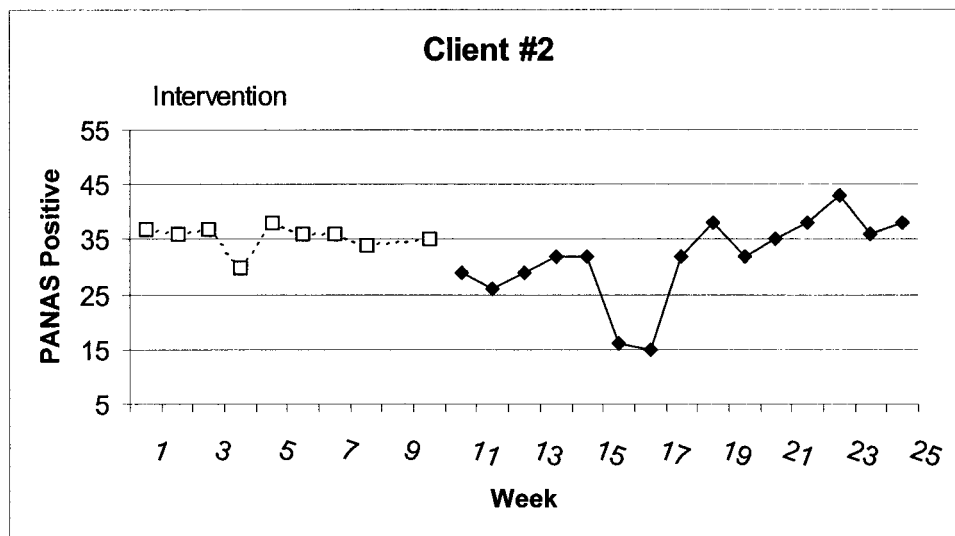


Figure 30. Client #2 Weekly PANAS Positive Affect.

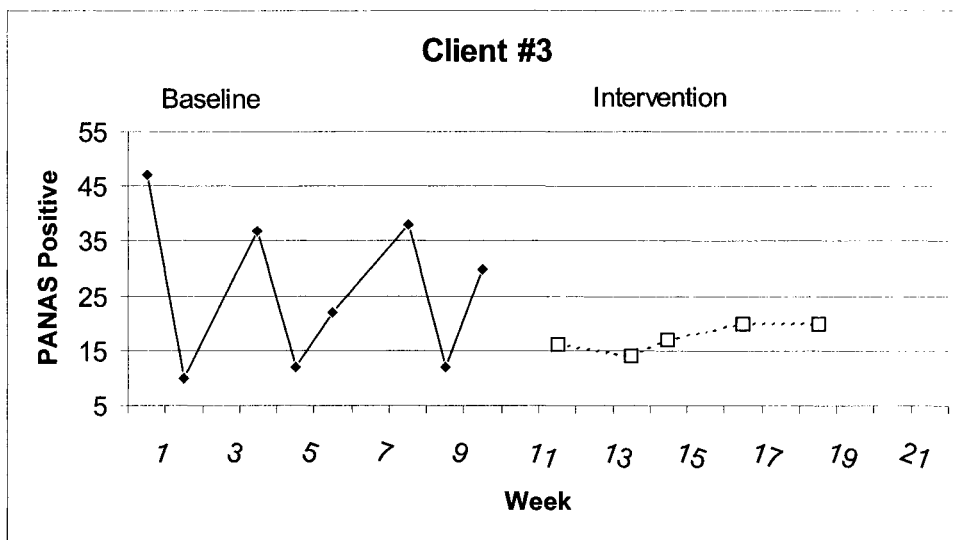


Figure 31. Client #3 Weekly PANAS Positive Affect.

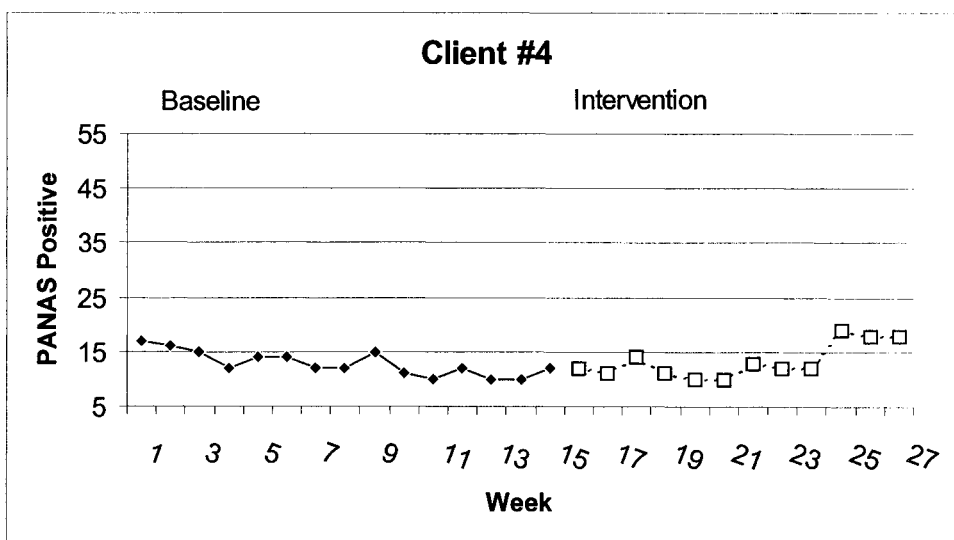


Figure 32. Client #4 Weekly PANAS Positive Affect.

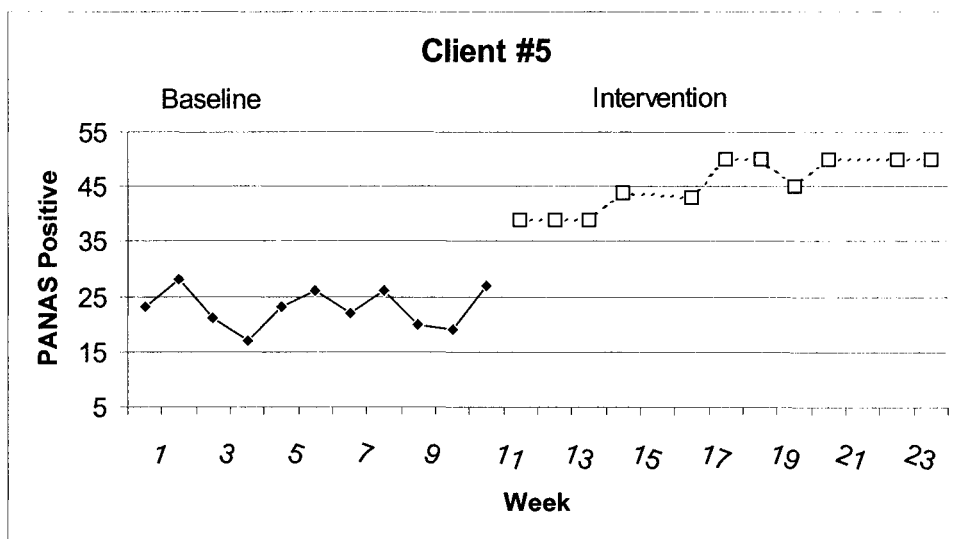


Figure 33. Client #5 Weekly PANAS Positive Affect.

The positive affect subscale of the PANAS showed little change for all participants during the course of the intervention (dotted lines). There was also wide amounts of variability between clients. For example, client #4 exhibited low levels of positive affect throughout the study. Other participants (#2, #3) had a full range of positive scores throughout, though not necessarily with any sense of pattern. Client #5's scores followed the most consistent pattern, with positive affect increasing at week 11 and staying at high levels until the end of the study.

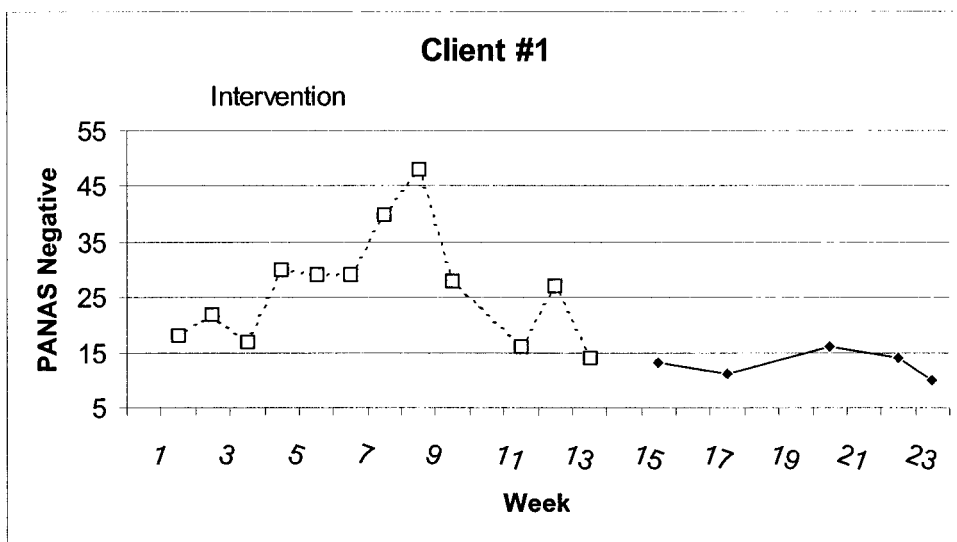


Figure 34. Client #1 Weekly PANAS Negative Affect.

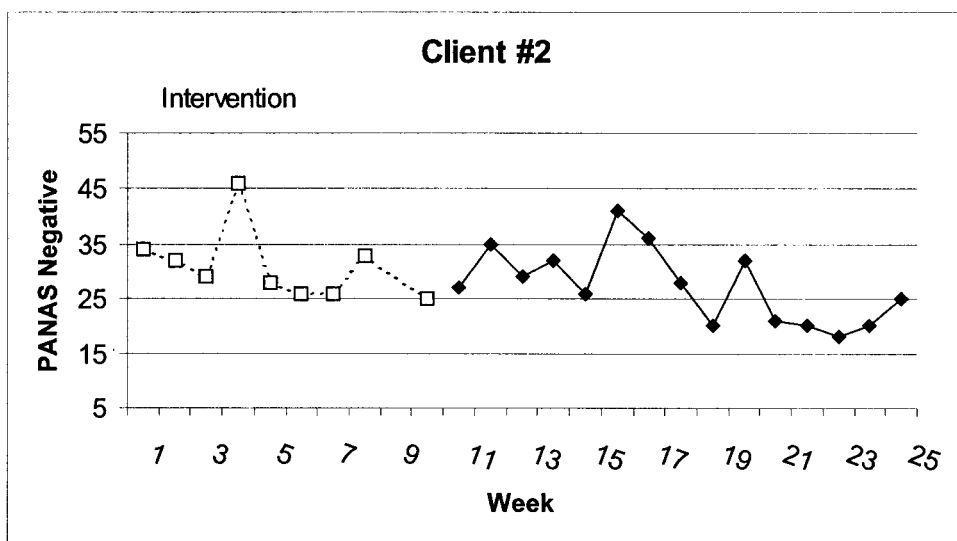


Figure 35. Client #2 Weekly PANAS Negative Affect.

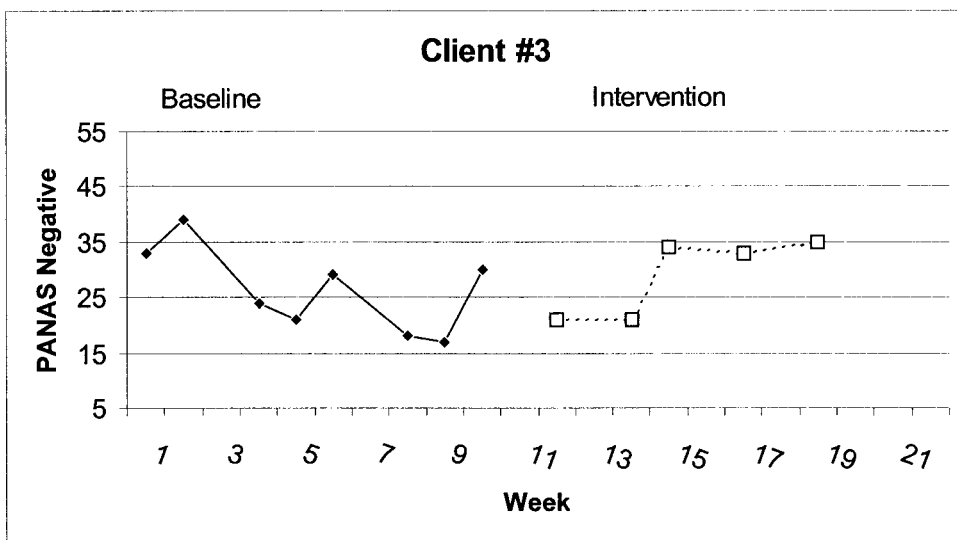


Figure 36. Client #3 Weekly PANAS Negative Affect.

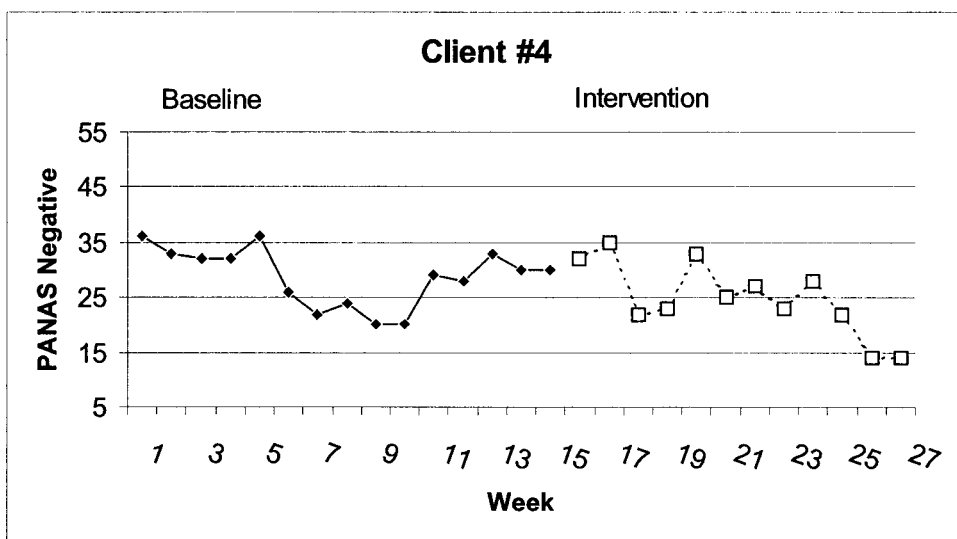


Figure 37. Client #4 Weekly PANAS Negative Affect.

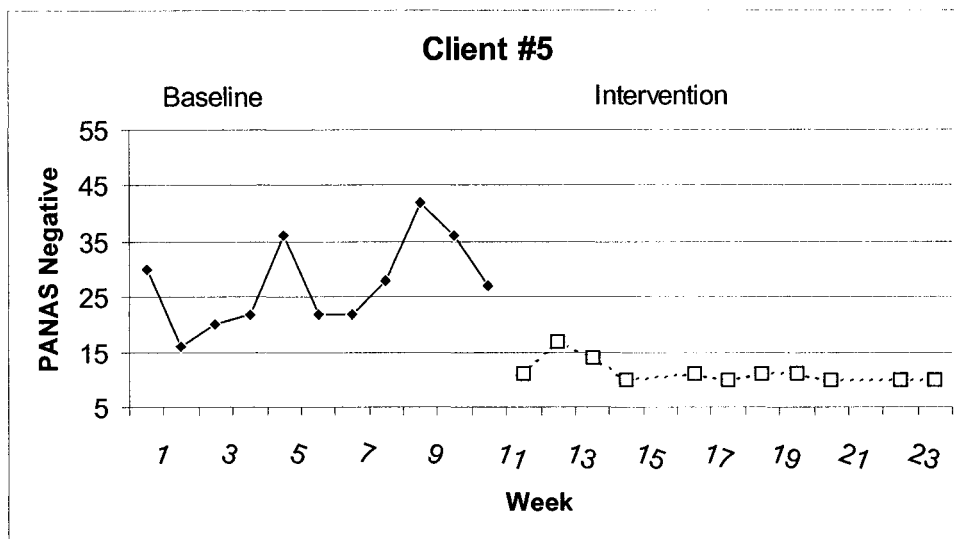


Figure 38. Client #5 Weekly PANAS Negative Affect.

Negative affect was also incredibly variable over time and across participants. Clients #1, 4, and 5 ended the study with lower ratings of negative affect. Client #2 also appeared to have a linear trend downward with a slight rebound during the last two weeks of the study. Client #3 had less data points than the others but appeared to have higher ratings of negative affect at the end of the study. This is difficult to interpret, especially in light of her highly variable scores during the baseline phase.

Pre-post intervention differences

Table 5 indicates the assessment scores for all relevant outcome variables. Not including the SBQ, the differences in scores between the pre-shame intervention assessment and post-shame intervention assessment were all in the intended direction with three exceptions. Client #3 had slightly lower pride (by one point) at post-treatment as well as higher negative affect on the PANAS. Client #2 had the same SSGS guilt

score at both timepoints. These gains were maintained somewhat at follow-up. There were slight regressions on some items but nothing remarkable.

The SBQ is more difficult to analyze visually because of the low variability of scores. For example, on the item measuring the likelihood of future suicide attempts (Future SA), all clients, save for #3, indicated that there was zero likelihood throughout the study. The measure of recent suicidal ideation showed a decrease for clients #2, 4, and 5. Client #3 exhibited an increase in suicide ideation at the post-shame intervention assessment while client #1 indicated no change (however, her scores were very low at the beginning). The measure of likelihood of future suicidal ideation stayed the same for all participants over time, with the exception of client #5 who indicated zero likelihood by the post-shame intervention assessment and client #4 who indicated an increase in likelihood at the follow-up assessment.

T-tests were computed, comparing pre-intervention to post-intervention scores for all the outcome variables listed in Table 5. The shame scale on the SSGS was significantly different ($t(4) = 2.90, p < .05$). There were trends for two other variables: the PFQ shame scale ($t(4) = 2.43, p < .10$) and the pride scale on the SSGS ($t(4) = 2.21, p < .10$). Obviously, given the small sample size, these findings are limited in their scope but still noteworthy.

Table 5. Pre-post shame intervention data for experimental participants.

	Client #1	Client #2	Client #3	Client #4	Client #5
SSGS Shame					
Pre	10	20	9	12	16
Post	5	16	7	10	5
Follow-up	5	17	-	9	5
SSGS Guilt					
Pre	7	21	6	12	25
Post	5	16	5	8	5
Follow-up	5	16	-	9	5
SSGS Pride*					
Pre	9	6	16	8	12
Post	20	12	15	9	25
Follow-up	17	12	-	9	25
PANAS Pos*					
Pre	15	35	26	12	28
Post	28	36	29	15	50
Follow-up	25	31	-	13	49
PANAS Neg					
Pre	17	29	18	24	27
Post	10	21	28	23	10
Follow-up	12	27	-	25	10
PFQ Shame					
Pre	15	23	21	21	27
Post	13	20	14	16	9
Follow-up	11	21	-	16	6
PFQ Guilt					
Pre	11	15	14	13	20
Post	7	15	9	11	5
Follow-up	4	14	-	13	4
SBQ Recent SI					
Pre	.25	1.50	1.25	1.25	2
Post	.25	.25	2.25	0	0
Follow-up	0	.25	-	2	0
SBQ Future SI					
Pre	0	0	2	2	3
Post	0	0	2	2	0
Follow-up	0	0	-	4	0
SBQ Future SA					
Pre	0	0	2	0	0
Post	0	0	2	0	0
Follow-up	0	0	-	0	0

Note: SSGS=State Shame and Guilt Scale, PANAS=Positive and Negative Affect Scale, PFQ=Personal Feelings Questionnaire, SBQ=Suicidal Behaviors Questionnaire

* Higher scores = better outcome

Finally, intensity scores for each of the items on the shame checklist were averaged and compared from the first session to the last session. Figure 39 indicates the change in average intensity scores for these two timepoints. Each client indicated a lessening of average shame intensity by at least 20 points. Across clients, the average intensity at the first session was 66.4 and at the last session was 29.3. This difference was significant, $t(4) = 6.75, p < .01$.

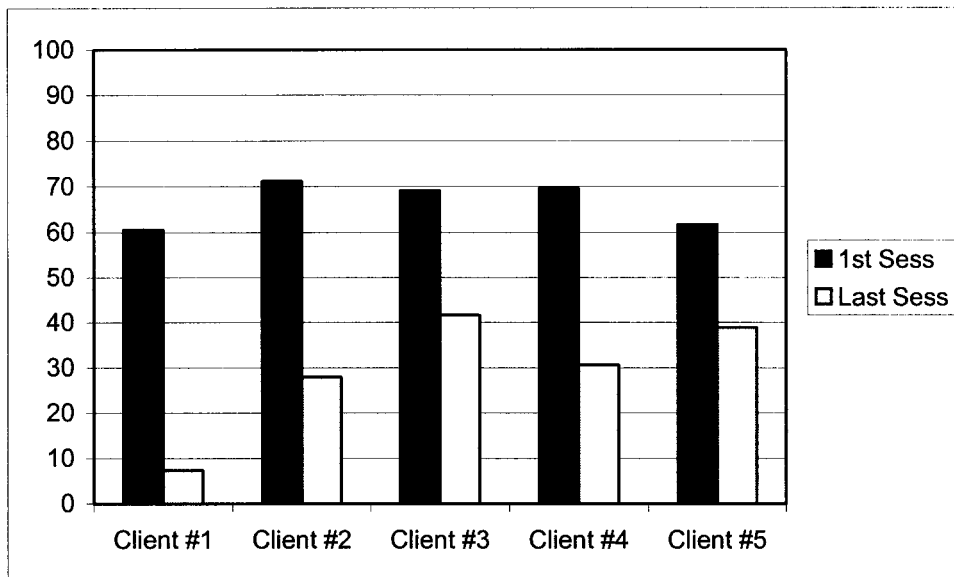


Figure 39. Shame checklist scores at first and last intervention session.

DISCUSSION

There were several key findings from this study that contribute to a better understanding of the emotion shame and methods for reducing shame, and have implications for further treatment development. The idea to study the application of opposite action to reduce shame initially led to a formulation of the nature of adaptive and maladaptive effects of shame and possible mechanisms for changing shame and its negative consequences. This knowledge was then written into a treatment manual that, when applied, demonstrated several results. First, unrelated to the intervention itself, it became clear that state ratings of shame are highly variable. This created difficulties because the overall effects of the intervention could not be adequately assessed. In addition, due to these variable ratings, a stable baseline was not achieved which posed an obstacle for the use and interpretation of the multiple baseline methodology. Second, independent of this lack of stable measurement over time, the within-session changes in shame indicate that it is possible to reduce shame about a specific event within a short period of time using the technique of opposite action. The shame checklist that was created for this study verified this finding. Scores on the checklist showed a significant reduction in shame intensity by the end of treatment, suggesting, in conjunction with the within-session changes, that this intervention was successful at reducing shame about *specific* events that was not necessarily accounted for in the weekly, unstable ratings. Finally, the method for developing the treatment manual was successful in that it produced a short-term intervention, based on empirical principles of behavior change, that was highly acceptable to participants. Each of these findings will be discussed in detail below.

Variability in Shame Ratings: Measurement Problems versus “True” Inconsistency

Results indicate that shame ratings were highly variable over time, regardless of phase. That is, shame scores vacillated throughout the study for nearly every participant across the baseline, intervention, and post-intervention phases. There are several possible explanations for this high level of variability found in the weekly measures. The first explanation could be that the measure itself was faulty. The decision to utilize the SSGS as the primary outcome measure of shame was based on a number of factors. It was designed as a state measure, which meant that it could be more sensitive to change since it asked for levels of shame *in the moment* as opposed to other instruments such as the Personal Feelings Questionnaire (PFQ) and Internalized Shame Scale (ISS) which ask participants to rate how frequently they experience various characteristics of shame. When deciding what measure to use for the current study, Harder (personal communication) advised against using his measure, the PFQ, because he indicated that it was not sensitive to change over a short period of time and was not designed to be used as a repeated measure. The SSGS is also short (15 items) which made it easy to administer on a frequent basis. Finally, the SSGS overcomes some of the difficulties with other measures by discriminating shame from guilt, and using some of the urges associated with shame as items (e.g., “I want to sink into the floor and disappear”) so that it is not dependent on the participant to distinguish various emotions.

Whether the SSGS was the best measure to use to reliably measure changes in shame over time is subject to debate. Despite its advantages, it soon became clear that although participants were reporting decreases in shame over the specific events that were targeted in each session, this lessening of shame was not being reflected in the

weekly SSGS scores. The problem appears to be that, in the SSGS, shame was measured as the experience in the current moment and not yoked to any specific event or context. Participants completed the SSGS at the beginning of their skills group each week. They were not instructed to think about any specific event when they filled it out and their scores may have been indicative of any number of things, including shame about being part of a therapy group, shame about their homework experiences, or shame about any number of events that may have occurred in the course of a day. Alternatively, they might not have felt very much shame because none of these situations were a source of concern for them at the time. It is also plausible that the SSGS is not appropriate for repeated administration. Test-retest reliability on this or any other shame measure is completely absent in the literature. Moreover, there have been no studies that have examined changes in shame on such a frequent basis. This deficiency in psychometric research, and lack of models, added to the difficulty in choosing an appropriate measure for this study.

If the sole reason for high variability is measurement error, then a possible conclusion is that shame is, or can be, a stable emotion, but the instrument itself is not a reliable method for assessing that information. However, another explanation for the variability in responses over time is that scores on the SSGS represent an accurate reflection of natural shifts in emotion from day-to-day and week-to-week. If this is the case, then it would be impossible to obtain a stable baseline using any measure of current emotion state. The best way to test this hypothesis in the future is to give a battery of instruments to a sample on a weekly (or daily) basis and assess constancy of responses. Alternatively, given the nature of BPD and its defining characteristics of emotional

lability and impulsivity, it is plausible that the difficulties in obtaining a stable baseline are attributable to the nature of BPD itself. Perhaps the only characteristic that is “stable” in BPD is instability. This view has been expressed historically by Schmideberg (1959 as cited in Paris, 2002) who called the course of BPD “stably unstable.” Ultimately, what is needed to address this question of stability is a control group without BPD to determine how these measures compare week to week in other populations. This will help answer the question of whether the diagnosis of BPD itself contributes to the highly variable scores on weekly measures.

Because of the high variability across time and phase, the multiple baseline data were difficult to interpret. Multiple baseline approaches are used to evaluate the effects of an intervention by showing that change occurs when, and only when, an intervention is introduced. Continuous measurement starting during a baseline period is necessary and the idea is that the baseline is intended to represent the level of outcome in the immediate future if the intervention was not introduced. This predictive function is difficult to interpret in cases such as this one, when the baseline phase is highly variable. As a general rule in multiple-baseline approaches, the more variable the data are in the baseline phase, the harder it is to draw conclusions about the effects of the intervention (Kazdin, 2001). Thus, it is difficult to ascertain whether the intervention had any effect, using these weekly measures.

There have been a number of statistical analyses proposed to overcome some of the subjectivity in interpreting results in single-subject designs. The most prevalent of these methods, time-series analyses (see Gottman, 1981), is often used to confirm the results displayed in graphs. While these tests are intended to add some objectivity to the

analysis of the results, they often have criteria that make them difficult to implement in applied research including studies like this one. The biggest impediment to using time-series analyses, for example, is that it is recommended that 50 or more observations are obtained in order to overcome its inflated risk of Type I error (Crosbie, 1993).

Furthermore, some have argued against the use of statistical criteria in single-subject applied research because the goal of such research is to evaluate new interventions (Baer, 1977; Michael, 1974). As such, graphical analysis, which is largely a non-sensitive means of assessing change, will call attention to only marked and obvious effects. In this light, statistical analyses places the threshold lower for evaluating the effects of an intervention and may detect small changes that are not replicable (Kazdin, 1984).

Weekly Changes over Time: A Test of the Hypotheses

Graphical analysis for all the weekly measures of the outcome variables indicate no obvious effects of the intervention across *all* of the experimental participants. Rather, over time, the intervention appeared to have a positive impact on two of the participants (#1 and #5), a slight impact on clients #2 and 4, and virtually no effect on client #3.

There are many possible explanations for the lack of strong findings in support of the treatment, two of which have been discussed in detail above. First, the measurement of shame was rife with problems which led to a difficulty in measuring change reliably in shame on a weekly basis. Second, the extreme variability in responses during all of the phases, including the baseline phase makes drawing of conclusions about the intervention's effectiveness tenuous at best. It is possible that an emotion such as shame which has both trait and state components is not a good candidate for a single subject

design in which obtaining a stable baseline prior to intervention is imperative.

Furthermore, another criteria for evaluating change in a single subject design is what is called a “change in level” when the intervention is added. Change in level refers to an abrupt change at the point when the intervention was applied. It should be clear, given the nature of shame, that it is highly unlikely that any intervention would lead to an *abrupt* change in level of shame. Last, it is of course plausible that the treatment in itself was not effective, even with consideration of these other factors.

Because the study was designed using single-subject multiple baseline methodology, the original hypotheses were to be tested using graphical analyses of the two key outcome variables: shame and urges to suicide. The first hypothesis of the study was that the experience of shame would decrease as a result of the opposite action intervention. This would be reflected in lower ratings of shame during the exposure intervention, and following the intervention, as compared to their baseline ratings. Comparison of the weekly SSGS shame ratings are difficult to interpret, especially in light of the lack of stable baseline prior to the intervention. Shame scores were highly variable over time for all of the participants and it is difficult to determine an intervention effect because there does not appear to be a pattern to their scores. Moreover, as just discussed, it is unlikely that the SSGS was the best measure to detect effects of the intervention. Therefore, in this domain, the results are inconclusive.

The second hypothesis was that suicidal urges would decrease as a result of the intervention. Suicidal ideation as measured by the diary card was relatively low across all the participants, with only one client having a score greater than 3 during any week. With the exception of one client, all clients ended the study with at least four weeks of no

suicide urges. However, two of these clients had no suicide urges at all, except for one week (client #2) and three weeks (client #1) during the opposite action intervention. A similar problem of lack of stable baseline was present with regards to suicide urges and the relative low base rates of suicidal urges overall makes interpretation of whether the intervention had any effect exceedingly difficult. Given these problems with interpreting the effects on the intervention on suicidal urges, pre-post differences on the SBQ were also used as a test of this hypothesis. Scores on the SBQ scale designed to measure recent suicidal ideation indicated a decrease for three of the participants, with two participants stating that they had no recent suicidal ideation at the end of the intervention. One client showed no change in suicidal ideation over time, however her scores were very low at intake. One client had an increase in recent suicidal ideation on the SBQ. This latter client was also the one which showed virtually no effect of the intervention and who had unstable response patterns throughout.

Shame Reduction Within the Opposite Action Sessions

Differences were found between pre-session and post-session scores of shame, independent of the lack of stable measurement. For 89% of the sessions, shame was reduced or at the same level at the end. Thirty-two of the total 45 sessions resulted in a decrease in shame and this result was significant greater than one would expect occur by chance. In order to understand the implications of this, it is important to note the context with which the individuals were completing this measure. Starting at the second session, the clients knew that they were going to be exposed to cues that evoked shame and that they would have to reveal (at least to the therapist) intimate details of each experience.

The SSGS, designed to measure shame in the current moment, in this context may have picked up on the feelings of shame most relevant to the topic about to be discussed (at the beginning of the session) and the topic that was just addressed (at the end of the session). In this sense, the SSGS may reflect a true estimate of the shift in amount of shame about the specific cue that was the target of the opposite action intervention. This improvement, however, was not maintained when participants were asked to complete the measure again at their weekly skills group.

Shame Checklist

The Shame Checklist was originally devised for the current study as a measure of potential shame cues for each participant. The idea was that this measure could then be used to create a hierarchy of shame events and help organize the sessions. The Shame Checklist was administered at the end of the first session so that these cues could be identified and levels of intensity about each event could be rated. The checklist was re-administered at the end of the final opposite action session. Results from the checklist are striking. The average reduction in shame intensity was more than 37 points on a 0-100 scale and this change was significant. Although there has yet to be research on the reliability and validity of this measure, it is possible that the checklist is a stronger indicator of positive effects of the intervention. The shame checklist may have captured the context specificity of shame in a way that the weekly measurements did not. It appears that “free floating shame” (weekly measures) does not change substantially with this intervention but event specific shame (as measured by the shame checklist and

indicated through discussion with the participants during each session) does have the potential for change through this targeted intervention.

Pre-Post Intervention Differences

Analysis of pre-post assessment differences indicate that, in spite of the small sample size, shame on the SSGS was significantly lower at the post-treatment assessment. Furthermore, there was a trend for shame, as measured by the PFQ, to be lower at post-treatment and the SSGS pride subscale to be higher. The significant finding on the SSGS is interesting, in light of the variable weekly ratings. As mentioned earlier, there has been no research on using the SSGS as a frequently given measure (e.g., weekly) and it's plausible that it is a measure that is more sensitive to change when given less often. Furthermore, the administration of the measure on a weekly basis, though consistent with a single subject design, may lead to the inability to "see the forest through the trees." Adding assessments before and after the completion of the intervention allows for the bigger picture to be examined. Clearly, a control group would be needed to draw inferences about the effectiveness of the treatment; yet, the fact that a significant difference was found in the primary outcome variable is noteworthy. Moreover, a trend for significance in a second measure of shame adds to the strength of the difference. The fact that pride showed a trend for significance is also important. Through discussions with the clients during the intervention, it was clear that they were developing pride for not only enduring this difficult therapeutic task but also for their newfound skills in dealing with a previously incapacitating emotion.

Acceptability of Treatment to Participants

Of note is the manner with which all of the participants embraced this treatment. Given the chaotic nature of these clients' lives and high dropout rates in other studies, it is remarkable that there were no treatment dropouts and no unplanned missed sessions. All participants, in the first session, identified shame as a problem in their lives and all accepted willingly the rationale for why reducing shame is important. All but one of the participants indicated that they would have preferred the sessions to continue at the end of the study. Furthermore, all the clients were consistent with appointments, collaborative in working on the problem, and, for the most part, extremely compliant with their homework. It is likely that certain elements of the treatment contributed to the high compliance rates and overall lack of therapy-interfering behaviors. First, beginning with the first session, much emphasis was placed on orienting the client to the rationale and, by way of this method, commitment to the process of reducing shame was achieved. This emphasis was made using standard DBT strategies such as providing didactic information, getting commitment through such methods as identifying the pros and cons and playing devil's advocate, and validating the difficulty of the task ahead while pushing for change so that their lives would improve. In terms of the presentation of didactic information, it was believed that the client would benefit as much as the investigator (if not more) from knowing basic research findings on the topic of shame and this information was incorporated into the sessions, especially during the first two when rationale was most emphasized. Second, because of the constant check-in to ensure that homework and measures were completed in a timely manner, the clients were reinforced for doing their work and this behavior was thereby strengthened. One of the basic tenets

in cognitive-behavioral therapy is that if you assign homework, it is imperative to review it during the next session so that its utility is made clear and the behavior that is targeted through homework practice is reinforced and strengthened (see, for example, Goldfried & Davison, 1994). Each opposite action session began with a quick inspection of the diary card to ensure its completeness as well as a review of each of their individualized homework assignments. At the beginning of each DBT skills group, all clients were asked to hand in their completed diary cards, and if not complete, were expected to spend a few minutes finishing them. Third, and perhaps most important, due to the extremely intimate nature of shame, the fact that participants were opening up and revealing deeply personal details about their lives to the therapist, most likely engendered an attachment to the therapist and contributed to their desire to continue to come in. Efforts were made by the therapist to be nonjudgmental and validating throughout the sessions; this was verified and strengthened by the review of videotapes with a DBT expert.

A second possible explanation for the high level of engagement in this therapy is that high levels of shame, which is associated with a fear of rejection by others, actually draws a person into therapy because therapy represents a situation with an empathic other who (hopefully) is not rejecting. In this sense, individuals with high levels of shame may be more likely to engage in therapy because it provides a context where they can be accepted and feel like they are overcoming problems that typically lead to thoughts that they are a bad person or a failure. It is just as possible, however, that shame, which is associated with the urges of hiding and withdrawing, is related to treatment *noncompliance* because individuals who experience a lot of shame would not want to expose themselves to rejection or talk about things that make them bad. In order to test

this hypothesis and get a sense of whether the level of compliance obtained in this study is noteworthy within this population, a comparison sample was examined. Specifically, a treatment study in our laboratory sought to examine the effects of psychosocial treatments in a sample remarkably similar to the current study. Suicidal individuals diagnosed with BPD, and all female, were recruited and enrolled in various year-long psychosocial treatments. Each of these participants completed a PFQ at their intake assessment. The ten individuals who scored the highest on the shame scale of the PFQ were analyzed. Of these 10, seven dropped out of treatment. This is in contrast to an overall dropout rate of 36% in the entire sample. A Fisher's Exact Test was computed to compare these two samples and the results were significant at $p < .05$. This suggests that high levels of shame alone do not account for high treatment retention and, in fact, the opposite may be true.

The rate of retention and compliance found in this study begs the question: What is the critical ingredient for treatment retention with this population or with this type of intervention? Another case of 100% treatment retention with a BPD sample can be found in Linehan and colleagues' treatment study for individuals with BPD and opiate dependence (Linehan, Dimeff, Reynolds, et al., 2002). In this study, all twelve individuals assigned to a comprehensive validation condition completed the year long study. The authors propose that the emphasis on validation, with the absence of direct targeting of behavioral change, was one of the essential components for keeping the clients in treatment. This is an interesting hypothesis especially in light of the findings from the current study. In this study, although validation was a part of the overall intervention, the primary emphasis was on behavioral change, in the context of discussing

deeply personal and painful topics. This suggests that high treatment retention rates are possible even with very short-term change-oriented treatments. More work is needed to determine the differential impact of validation and change on both treatment compliance and effectiveness.

Development of the Treatment Manual

The treatment development aspect of the study was successful in that a “user friendly” and final draft of the manual was produced within a relatively short period of time. The method used for developing the treatment manual involved the following procedures: extracting and expanding upon the opposite action strategy from DBT targeting shame, using other empirically supported treatments as a model for the structural elements of the intervention, utilizing information from basic research on shame to guide the intervention, and dissecting videotapes of each session with the pilot participant to ensure that all active ingredients of the treatment were incorporated into the manual to be replicated with the experimental participants. The sessions with the pilot participant led to modifications to the design and implementation of the treatment. The most essential modification involved the deviation from a “one size fits all” approach to the urges and opposite actions associated with shame. It became clear early on in the treatment of the pilot case, that shame was associated with a multitude of urges and behaviors. Although these urges and behaviors were all consistent with the shame experience (i.e., were associated with hiding, avoiding, and self-hatred), it was not sufficient to have the client engage in the opposite behaviors of revealing, given the nature of the shame cues. Rather, it became important to analyze in detail, all

components of the shame experience which involved breaking down various aspects such as behaviors, urges, cognitions, and other emotions. This analysis then led to a formulation of what opposite action could be in each individual case and became conceptualized as engaging in opposite action “all the way” by targeting each and every aspect of the emotion. This method led to the formation of a principle-driven manual, included in the Appendix, which was not deviated from for the experimental participants.

Summary: Was the Treatment Effective?

To answer the question of whether this intervention was successful at reducing shame in suicidal individuals with BPD, all of these sources of information must be considered. The strongest finding in support of positive effects of the intervention was established by the shame checklist, which measured intensity of shame in response to specific situations or characteristics that the participants have experienced in their lifetime. Levels of intensity of situation-specific shame were dramatically different at the last session compared to the first session. In addition, scores of shame measured at the beginning and end of each opposite action session show that, for the vast majority of the sessions, shame was much lower at the end of the session. Pre-post intervention comparisons indicated that changes in the outcome variables were largely in the intended direction across all clients, yet not always noteworthy in size of the difference. Of course, given the lack of a control group, it is also impossible to know whether these changes were due to chance. Graphs demonstrating changes on a week-to-week basis for each of the primary outcome variables do not lend strong support for the intervention. However, there are a multitude of explanations for why this was the case that do not

necessarily cast doubt on the intervention on the whole. Finally, the high level of compliance demonstrated by all the participants throughout the intervention should not be overlooked. The reputation of clients with BPD is that they are notoriously bad with treatment follow-through in terms of both attendance and participation during the session (Linehan, 1993; Stone, 2000). This study demonstrated that, with a small sample and a very intensely personal intervention, a high level of compliance is possible.

Future Directions

First and foremost, this study highlights the immense need for work on the measurement of shame. Specifically, measures that are sensitive to clinical change, can be used as repeated measures, and can differentiate between a global sense of shame and shame about specific events are necessary in order to not only better understand the emotion itself but also be able to test the effects of any intervention. The Shame Checklist, devised for this study, has potential for fulfilling some of these needs. Further research is needed to obtain reliability and validity information on this measure.

More basic research on shame in BPD is also necessary to further refine treatment strategies for this often dysfunctional emotion. Replicating studies from nonclinical samples would be necessary to determine whether shame does uniquely contribute to the psychopathology of BPD. For example, is the presence of shame related to interpersonal difficulties in BPD, by way of reduction in empathy, as is found in college student samples? Or is shame a precursor to angry outbursts that inevitably lead to problems in relationships or in maintaining steady employment? Laboratory studies that focus on the effects of shame are sorely needed, especially in clinical samples. Also, there has been

some limited research on the relationship between shame, suicide ideation, and suicidal behavior. This research all suggests that a relationship exists between shame and suicidal thoughts and behaviors in nonclinical populations. However, there has not been work systematically documenting the link between shame and suicide in different clinical samples. It would be valuable to learn whether the relationship between shame and suicide is stronger in, say BPD, as opposed to depression or schizophrenia, two other disorders with high rates of suicide. It is possible that this research is the key to the development of more successful suicide prevention efforts.

One of the strongest findings from this study was the treatment retention and compliance rates. Further research is needed to explore each of the elements which are hypothesized to have contributed to the high compliance rates in the current study. For example, it would be interesting to learn whether nonjudgmental stance, in the absence of rationale and homework review, would produce the same compliance rates.

Alternatively, perhaps rationale is the most important aspect and if participants can hear a credible reason to change a certain behavior, other elements of the treatment are less important in producing the same compliance rates. These elements converged in the present study to produce near-perfect attendance rates, dedication to the treatment assignments, and follow-through despite the extreme difficulty of the task.

Finally, although the findings from the current study were not strong in their support of the short-term opposite action intervention, the intervention itself warrants further examination. As discussed, design flaws and measurement problems may have obscured the possible “true” effects of the intervention. The level of compliance and the overall enthusiasm for this intervention, from both the clients as well as treatment

providers who have learned of this work, highlights the need for a shame intervention that is empirically supported and easy to disseminate. The opposite action strategy holds promise for being such an intervention. Future research is needed to first address the measurement and design issues and then apply the intervention in a rigorous manner so that its effects can be determined. If, in future studies, the intervention leads to significant reductions in shame compared to a control group, then it will have many potential uses. First, it could be used as a stand-alone treatment when excessive and/or maladaptive shame is the number one target of therapy. It could also be used in conjunction with other treatments in order to reduce shame so that a major impediment to therapy can be systematically addressed.

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Appendix A

Opposite Action for Shame Treatment Manual

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I. Introduction/Overview

This manual was developed for a short-term (8 to 10 week) intervention designed to reduce shame in suicidal individuals with Borderline Personality Disorder (BPD). As such, it describes a procedure, using principles of behavior therapy, called “Opposite Action.” Opposite Action was described by Linehan (1993a) and is categorized as an Emotion Regulation skill in the Dialectical Behavior Therapy (DBT) Skills Training Manual (Linehan, 1993b). Opposite Action is highly compatible with exposure treatments for anxiety disorders and broadly encompasses the same principles.

In a nutshell, the opposite action intervention involves the following steps:

1. Identify cues that elicit shame
2. Make appraisal as to whether shame is justified or unjustified
3. Expose to cue that elicits shame
4. Block dysfunctional behaviors
5. Elicit opposite, functional behaviors

A complete and thorough assessment is necessary so that the shame cues are carefully determined and urges associated with that cue are elicited. Shame will not be reduced if the cue and the urges are not properly identified.

This shame intervention promotes adherence to the *principles* of opposite action, and does not advocate a rigid approach. Rather, much emphasis is placed on flexibility and creativity of the approach. Furthermore, it is important to monitor the progression of treatment. Videotaping sessions is recommended so that sessions can be reviewed. Behaviors associated with shame can often be quite subtle; thus, having a videotape of the session, or an observer, can aid in the development of appropriate opposite actions.

This manual includes a session-by-session outline which provides detailed information about the structure of each session. This outline is followed by general information on the topics of justified and unjustified shame, troubleshooting various problems that may arise in the process of conducting this intervention, and miscellaneous points to consider.

II. Session by Session Outline

Session 1

Materials Needed for Session 1

1. Audiotape for session (to give to client)
2. Shame Checklist
3. Handout for Session 1
4. Pre and post-session questionnaires

Agenda for the session:

1. Present overview of treatment
2. Provide rationale of treatment
3. Get commitment/troubleshoot
4. Information gathering - Assess shame cues
5. Introduce treatment measurement/assessment
6. Assign homework

1. Overview of Treatment

Introduce client to treatment program s/he will receive:

- 8 to 10 week intervention designed to reduce shame
- Meet once a week for 60-120 minutes each time
- Focus of treatment will be shame and difficulty coping with the emotion (e.g. high avoidance of emotion, high avoidance of shame cues, dysfunctional behaviors as a result of emotion, etc)
- Intervention is different from individual therapy; although something that happened during the week may become a topic of conversation, this intervention is designed solely to reduce shame. It is important that client continue to have

regular individual therapy or case management so that other events/problems (e.g., suicidal behavior) can be discussed directly.

- Audiotape sessions to listen to 1x each week
- All sessions will also be videotaped for purposes of supervision, adherence, and training

2. Treatment Rationale

(The following script can be used to guide the session.)

- Introduce client to rationale for treatment

“In this treatment, we are going to work together to reduce your experience of shame and the difficulties in your life that are associated with the experience of shame. You may be asking yourself why reducing shame is important. I’d like to spend some time talking to you about what we know about shame and why we believe reducing shame will help you in your life.”

“First, do you think that shame causes a problem for you? In what way(s)?”

Use client’s responses to guide dialogue about the following ways in which shame can be problematic (cite research evidence where applicable). Be as Socratic/conversational as possible here and engage client rather than lecture to him/her:

- the experience itself is extremely painful and aversive (“What does shame feel like to you?”)
- may result in decreases in problem solving ability (“How is your ability to think about/solve problems affected when you are experiencing shame?”)
- can result in decreases in empathy for others; affects interpersonal relationships (“When you feel shame, how does this affect how you interact with or get along with others?”)

- may increase desire to commit suicide or harm yourself (“Are you more or less suicidal when you are experiencing shame?”)
- may lead to other problematic behavior in order to diminish the emotion. This problematic behavior may take the form of avoidance. (“Do you do anything that you later regret in order to try to get rid of the feeling of shame? Or do you avoid doing anything that is important to do because you’re trying to get rid of shame?”)

“It’s important to also talk about why we experience shame at all, that is, what the adaptive function of shame is.

“All emotions serve functions and we have all emotions for a reason. For example, people feel fear when they are threatened by something, people feel anger when a goal is being blocked, etc. When do you think people are most likely to feel shame?”

- Allow time for client to come up with cues for shame; after they finish or if they are unable to come up with any, say:

“Usually, when you are feeling shame, you are comparing some aspect of yourself or your behavior to a standard, either your own or someone else’s and feeling like you do not live up to that standard. For example, you may compare your behavior or some quality of yourself to your own values or your own morals. Or you may compare your behavior or some quality of yourself to other people’s standards. As a result, you often have thoughts like you are a bad person or a failure, or you may think and fear that others will reject you. Does this sound like what you experience?”

“One reason for why we might have shame at all is to keep us from doing something, or doing something *again*, that would cause others to reject us. We may inhibit (or block) ourselves from doing certain things or exposing certain aspects of ourselves so that we don’t have to feel shame later. Or shame may function to stop us in the midst of doing something bad. In this regard, the threat of shame acts as a preventive measure. Can you

think of examples in your own life where this seems true? Have you stopped yourself from doing something or talking about something because you didn't want to feel shame?"

- Allow time for client to come up with situations where shame played a role in the inhibition of behavior

"Shame may also operate to have us hide something bad that we did from other people. The reason for this is that if we told other people about something very egregious that we did, it is likely that these people would reject us and think less of us. Thus, shame may be in the picture as a cue to us to not tell other people about what happened. Have there been times when shame has done this for you?"

- Allow time for client to come up with situations where shame operated to have them conceal a behavior/characteristic from other people

"Similar to this aspect of not telling somebody about something bad that you did, shame may cue us to remove ourselves from people that may judge us, following a transgression or the exposure of something personal. When you feel shame, what do you generally feel like doing?"

- Work with client to understand that the action urge associated with shame is to *withdraw* or *hide*

"This withdrawing or hiding can often serve a useful purpose by keeping us away from others who would judge us for what we did."

"In addition, studies that have looked at what happens to people when they experience shame show that someone who is feeling shame often looks and behaves in a way that seems appeasing, or pacifying, to other people. For example, an interesting study found

that when a person on trial shows the nonverbal display of shame, they are more likely to get a lighter sentence than someone who does not look like they are feeling shame. Results from this study and others have led many scientists to believe that shame functions to appease others and reestablishes social harmony following a transgression. For example, if you did something that wronged another person and later experienced and expressed shame about it, it's more likely that the person will forgive you than if you did not experience shame. Do you think has been true for you?"

- Allow time for client to come up with situations where the expression of shame affected how others related to them [Note: In individuals with BPD, it is quite possible that they have not had a positive experience with the expression of shame. This may be due to qualities of the environment of which they are a part, or skills deficits in interpersonal functioning. If client is unable to come up with their own personal experiences then therapist can use self-disclosure as modeling or talk about "celebrity" confessions that fit this mold.]
- SUM UP presumed adaptive functions of shame:

"So we think that shame has 4 functions.

1. works to prevent us from engaging in or continuing behaviors that cause shame
2. works to have us hide something egregious that we did
3. works to have us remove ourselves from others that might evaluate us
4. works to appease others and reestablish social harmony following a transgression

"These functions of shame are also related to the biggest fear that is associated with shame – the fear of being rejected by others. Does this fear sound familiar to you?"

"I'd now like to distinguish between two different categories of shame. When you experience shame in a situation in which there is a real danger of getting rejected by other people in the situation (or people who find out about the situation), we call it justified

shame. It makes sense that you would experience shame in that situation and it's likely that the experience of shame, even though it's painful, will help you make amends with the other person(s). Another time when shame is justified is when your behavior really does violate your own standards. Again, it makes sense that you would experience shame then and the experience of shame may function to both have you hide what you did to prevent you from being rejected and from engaging in that behavior again.

“Sometimes, however, your experience of shame gets out of whack and you may experience shame in situations where it's not useful or adaptive. There may be lots of times when you may feel shame even when there is no risk of getting kicked out by your reference group.”

“Therapy may be a good example. Do you feel shame when you talk to your therapist? Do you think shame is justified in those situations? What are some other times when you feel shame when you think it's not justified (e.g., when there is little or no risk of getting rejected)?”

- Allow time for client to come up with examples of nonjustified shame [Note: keep in mind that some clients *have* had the experience of being rejected by a therapist; be careful not to assume that shame is *always* unjustified in therapy situations.]

“In addition, sometimes even when shame is justified (that is, someone may reject you for something you did), the shame experience may be so extreme that it is no longer useful or helpful. For example, often the experience of shame is associated with a desire to hide or withdraw. At its extreme, you become unable to solve problems if you are withdrawn. Furthermore, if you find that you are experiencing shame *all* the time, then it's problematic. (Experiencing *any* emotion *all* the time is a problem.)

“Finally, people have trouble with shame when they engage in behaviors that are problematic either as a result of shame or to try to ward off the feeling of shame. Are there particular things that you do when you are feeling shame that get you into trouble? What about certain behaviors that you do to try to prevent yourself from feeling shame at all?”

- Allow time for client to come up with examples of dysfunctional behaviors related to shame

“So to sum up, people can have problems with shame for a variety of different reasons.

1. unjustified shame: shame occurring when it is not warranted by the situation
2. extreme shame (even when justified)
3. chronic shame (even when justified)
4. dysfunctional behaviors as result of shame or to avoid shame (rather than functional, appeasing behaviors)

“Given all these problems with shame, it makes sense that we would want to figure out how to change it, right? Now that I’ve talked about shame, can you think of some reasons for why reducing shame is important? How would your life be different if you didn’t experience so much shame?”

- Allow time for client to come up with own reasons why reducing shame is vital

“Now lets talk about *how* to reduce shame. How we’re going to approach the emotion of shame is very similar to how behavioral therapies focus on decreasing the emotion of fear. Imagine a person who has a severe fear of spiders. In order to manage this fear, this person avoids all places where they might see spiders; they don’t go to the attic of their house, they don’t go hiking or camping, etc. In addition, since their avoidance doesn’t work 100% of the time, they sometimes come in contact with a spider. Whenever this happens, this person engages in all sorts of problematic behaviors: they run out of the

room (no matter what is taking place), they rant and rave, they call up a friend no matter what time of night to get them to come over and ‘dispose’ of the spider, etc. Now imagine that this person is going to reduce their fear of spiders. What steps do you think the person would need to engage in order to become less afraid?”

- Use client’s responses to guide dialogue here. Make sure to touch upon issue of repeated exposures to cue (spider) and not engaging in avoidance behaviors. Also talk about how in treatments for phobias what is needed is *repeated and prolonged exposures* and, in fact, the person begins to approach the spider (opposite action)
- It may be useful to use other examples here especially if client has trouble relating to spider phobia example. Other possibilities include: being thrown off a horse (and overcoming fear by getting back on it); being in a car accident (and getting over fear of another accident by driving again), etc.

“When the person approaches, rather than avoids, the spider, we call this ‘opposite action’ because they are acting in opposition to the urge associated with the emotion, in this case, fear. When the person experiences fear, the ‘natural’ urge is to avoid. However, by continuing to avoid, the person never gets over their fear – they will always be afraid every time they see a spider. In order to get over the fear, the person has to constantly use opposite action; by approaching rather than avoiding, they are going to slowly reduce their fear. [Note: Therapist can use drawing of desensitization/habituation over time to illustrate this point if necessary.]

“But remember now the distinction between justified and unjustified emotions. What if rather than a relatively harmless spider, it was a poisonous funnel web spider? Approaching the spider would not be a good idea. So it’s not always in your best interest to reduce fear when it’s justified. This is true for shame as well. We’re not trying to get

rid of shame altogether, but rather to reduce the amount of shame you feel, especially when it's unjustified, and the problems that go along with it for you.

“In terms of shame, opposite action will look different depending on the situation and depending on whether the shame is justified or not. The first step will be to determine what the cues are for shame. In other words, we have to find out what your spiders are and where you are likely to run into spiders. Then we have to determine whether the shame is justified or unjustified in various situations. Once we do these things, we then have to find out what your urges are – what you feel like doing when you are faced with spiders and have you engage in the opposite behavior of those urges.”

- At this point, it is very important to make sure that the client understands the rationale. If possible, have client have repeat back rationale and correct any misunderstandings

“At minimum, this treatment will have you talk about what you feel ashamed of in an environment that won't kick you out.”

3. Get commitment/troubleshoot

- Get client to commit to this intervention, in terms of both regular attendance as well as commitment to the process (throwing self in despite difficulty of task, doing homework, etc.)
- Use standard DBT commitment strategies (Linehan, 1993, Chapter X)
 - o foot-in-the-door; door-in-the-face; pros and cons; devil's advocate
 - o Examples: “This is going to be difficult and intense. Are you sure you want to do this? Why?”; “When you experience shame, you want to hide. Thus, it's almost paradoxical to ask you to talk about it continually with me over the next 8 weeks. Are you sure you're up to it?”

4. Information Gathering – Assess Shame Cues

“In the next part of this session, I’d like to gather some information from you regarding experiences in which you have felt a lot of shame. Every person is different in terms of when they feel shame. There are no right or wrong answers here. In order for this treatment to work, we need to make sure we are targeting the right things.”

- Give shame checklist and introduce as follows:

“Given the nature of shame that we talked about earlier, it is often incredibly difficult to talk about situations in which you have felt shame. It may be easier at first to do it on paper. This is a list of situations and behaviors that may be related to shame for you. What I’d like you to do is read this list and circle any items that you have experienced. For all the items that are circled, please rate the intensity of your shame on a 0-100 scale (100 being highest intensity). If you experienced something but didn’t feel any shame about it, then please write a ‘0’. If there are other situations/behaviors that come to mind that are *not* on the list, please add them at the end. Do you have any questions?”

- Make sure client understand the rating system and, if necessary, establish anchor points with them before they complete the checklist.
- Leave the room while they complete the shame checklist. When done, look over form briefly to ensure that it was filled out correctly.
- Tell the client that we will be using this checklist in future sessions

5. Introduce Treatment Measurement

- Would have already started daily monitoring to establish baseline
- Emphasize importance of making daily ratings

- Troubleshoot any problems with doing this

6. Assign homework

- Listen to tape of this session 1x; troubleshoot – do you anticipate any trouble doing this?
- (Give Handout to client) Read handout at least once; make notes as necessary
- Diary card to fill out every day; Give several copies of diary cards and instructions for completing them; troubleshoot

Session 2

Materials Needed for Session 2

1. Completed Shame Checklist from Session 1
2. Audiotape for session (to give to client)
3. Therapist Exposure Recording Form
4. Exposure Homework Recording Form
5. Pre and post-session questionnaires

Agenda:

1. Review daily ratings
2. Review homework
3. Reaction to last week
4. Present agenda
5. (Briefly) Review treatment rationale
6. Introduction to SUDS
7. Begin exposure treatment
8. Assign homework

1. Review daily ratings

- Collect and review diary card ratings
- If not completed, have client complete in session (work with client to get most accurate ratings possible). Also troubleshoot to solve problem.

2. Review homework

- Assess whether client listened to audiotape

- If didn't do it, do brief assessment and problem solve for next time; reiterate rationale
- Inquire about experience of listening to tape; for some clients, listening to the tape may have been a shame experience in itself – assess whether this was the case and use as possible example. Find out what they did in response to shame, if anything.
- Assess whether client read handout from previous session. Answer any questions that may have arisen from reading the handout.

3. Reaction to last week

- Ask client about any reaction to last week's session

4. Present agenda of session

“What we're going to do today is the following: first, we'll review the rationale for the opposite action procedure that we'll be doing over the next seven weeks. Then we'll talk some about how we're going to monitor your progress during the sessions and then we'll start the opposite action treatment. Any questions?”

5. Review treatment rationale

- Make sure client understands rationale for treatment; review again as necessary
- Specifically, make sure client understands FIVE main elements to procedure:
 1. IDENTIFY shame cues
 2. DETERMINE whether shame is justified or unjustified
 3. EXPOSE to shame cue
 4. BLOCK maladaptive behavior
 5. Do OPPOSITE ACTION
- These steps will be figured out collaboratively

6. Introduction to SUDS

- The following is excerpted and adapted from Treating the Trauma of Rape: Cognitive-behavioral therapy for PTSD (Foa & Rothbaum, 1998)

“In order to find out how much discomfort certain situations cause you, we need to use a scale that you and I are both familiar with. We call this the SUDS scale which stands for Subjective Units of Discomfort. It's a 0 to 100 scale. A SUDS rating of 100 indicates that you are extremely upset, like the most you have ever been in your life, and 0 indicates no discomfort at all, or complete relaxation. Usually when people say they have a SUDS of 100, they may be experiencing physical reactions, such as sweaty palms, palpitations, difficulty breathing, feelings of dizziness, and anxiety. How much discomfort are you feeling now as we are talking?” (p.147)

- Work with the client to identify SUDS anchor points at 0, 25, 50, 75, & 100, and other points in between if necessary. Refer to these anchor points when you ask for SUDS ratings until the client becomes familiar with this system.

0 =

25 =

50 =

75 =

100 =

“We are going to be using SUDS ratings to monitor your progress during the exposures to shame cues. We will use this scale during exposure exercises to monitor change in your levels of discomfort. In addition to the SUDS scale, I will also be asking you to rate your feelings of shame, also on a 0 to 100 scale.”

7. Begin opposite action treatment (Therapist: have completed checklist with you)

“Last week we started talking about situations or behaviors that elicit shame. We also talked about how we’re going to reduce shame, namely by having you talk about what causes shame, blocking dysfunctional behaviors, and having you engage in opposite, more functional, behaviors. It’s likely that we are going to learn over time what these dysfunctional and functional behaviors are; that is, what we do in a few weeks might look different from what we do today.

- For first run, pick a situation for which they gave a mid-range shame rating (e.g. 30 – 60 range)

“To start with, I want you to tell me about the situation(s) that you gave a midlevel intensity rating [list situations]. [Orient:] While you tell me, I’m periodically going to be asking you to rate your SUDS level as well as your level of shame on the 0 to 100 scale that we just talked about. Can you start by telling me all about the specific situation that you were thinking of?”

- Strategy for doing the opposite action treatment; Use the following steps
 1. Have client tell the story once through so that you get most of the details (get SUDS and shame ratings, minimally at beginning and end of the telling)
 2. Use a whiteboard/writing pad to analyze the components of the shame experience. This should include: prompting event, emotion, thoughts, urges, actual behaviors.
 3. Determine whether shame is justified or unjustified. Work with the client so that they agree with your determination. [Note: See section on justified versus unjustified shame, p. 147.]
 4. Using this analysis, determine the opposite action behavior. If it’s possible to engage in this behavior during the session, repeat story over and over with the client doing opposite action. If opposite action is only possible outside the

session, then use exposure to practice imaginal rehearsal of engaging in opposite behavior, or use role-plays. Also, assign relevant homework.

- Get SUDS and shame ratings at start and monitor throughout (i.e. ask for SUDS ratings and shame ratings approximately every 5 minutes, or before and after each telling of the story, using Therapist Opposite Action Recording Form)
- Use at least 30-60 minutes of the session to do this. If client gets through all of story prior to 30 minutes, have him/her repeat the story, using opposite action until the full length of time has passed.
- Notes: Think shaping as you do this. It's possible that during the first exposure simply talking about the event/behavior is opposite action. Later, other opposite actions such as direct eye contact, more confident voicetone, comedy, correction/overcorrection etc. can be introduced. The first few times will most likely be the most difficult for the client. It's likely that at first, the story/stories will be broken up, not fluid, and accompanied by lots of avoidance behaviors. Maintain steady pressure on the client to continue while validating the difficulty of the task. Remember to repeat rationale whenever necessary to get client to continue and cheerlead.
- It is highly preferable that the client not end the opposite action session with a high SUDS rating. Treatment sessions should be planned so that there will be sufficient time at the end of the session to evaluate the client's level of distress. It is very important to leave a few minutes at the end of the session for a "winddown." It is also helpful to orient the client to the possibility that s/he may feel temporarily more upset after some sessions. Also, that each reaction, no matter how difficult, reflects the beginning of the emotional processing of the shame experience and is a step toward progress. (Adapted from Foa & Rothbaum, 1998, p158.)

8. Assign homework

- Continue daily ratings
- Listen to tape of session at least once during week; Use Opposite Action Homework Recording Form to record SUDS ratings
- Continue with opposite action practice regarding situation discussed in session (for example, this might entail telling other people story (if unjustified) with pride, or repairing behavior (if justified). Use Opposite Action Homework Recording Form to record SUDS ratings.

Sessions 3 – 9 (2nd to last session)

Materials Needed for Sessions 3 – 9

1. Audiotape for session (to give to client)
2. Therapist Opposite Action Recording Form
3. Opposite Action Homework Recording Form
4. Pre and post-session questionnaires

Agenda:

1. Review daily ratings
2. Review homework
3. Opposite Action Treatment
4. Assign homework

Sessions 3 through 9 follow essentially the same format and consist of multiple exposures to shame cues, generation and activation of opposite action behaviors, and discussion. The necessity of accurate assessment cannot be overstated. If shame does not appear to be decreasing, it is often necessary to step back and make sure that the cues have been properly identified and that the urges that go along with those cues have been stated explicitly. The Therapist Opposite Action Recording Form should be used throughout the sessions to collect data on level of shame and SUDS. This is especially important to do when conducting opposite action exercises because clients often are quite adept at masking their distress. Without asking directly about it, the therapist can be misled into believing that the experience is quite easy and may miss important problem areas.

Early in treatment, it may be necessary for the therapist to come up with opposite actions for the clients to use. By the 4th or 5th session, the client should be encouraged to generate their own opposite action practice. As such, they are learning to become their own therapist with regards to overcoming dysfunctional shame.

Also by the 5th session (at the latest), the highest rated shame cues should be targeted to allow for enough time to process this experience. Many clients will have multiple highly rated items. The idea is that, especially with repeated practice, what is targeted in session should generalize to other situations/cues that elicit shame. Thus, homework practice could consist of continuing a particular situation that was discussed in session *as well as* developing opposite actions for other areas in their life that were not directly targeted in session. Homework review time can be spent discussing both types of homework so that client gets feedback as to their implementation.

The following examples are provided in order to demonstrate different opposite action treatments. (Note: examples are modified to protect the confidentiality of the clients.)

JR was a 25-year old woman who, in the 2nd session reported that the most recent time she had felt a moderate to high level of shame (70 on the Shame Checklist) was when a friend got mad at her. Details of the event included the friend becoming drunk at a bar and then demanding her car keys from JR. JR refused to give the keys to her friend who then became belligerent and physically shoved JR and insulted her in front of many patrons at the bar. In this case, the cue was determined to be the insult that the friend yelled at her. The thoughts that JR had included "I'm a bad friend," "I'm a stick-in-the-mud for demanding the keys from my friend," "I'm boring and if I were a more fun person, everyone would like me (including this friend) [and therefore, I would never get into arguments]." Her urges were to avoid the friend, avoid going to the bar again, and to think about suicide (e.g., "I'm unloveable and therefore life is hopeless"). Her actual behavior during the time was to avoid making eye contact with anyone and since that time, she had actually avoided going to the bar and had not talked to her friend. The therapist with JR's input detailed the various components of this shame experience on an easel. The cue, thoughts, urges, and actual behavior were all written down. Once they were written, the therapist asked JR if the shame was justified, reminding her that for shame to be considered justified, one of two criteria must be met: 1) behavior violated

JR's own moral values, and/or 2) behavior is something that would cause others to reject her. JR thought about it for a moment and then stated that she believed the shame was unjustified. This in itself, appeared to have quite an effect on JR which she later described as an "a-ha moment" when she realized she didn't have to feel shame over her own behavior that night. We talked about what opposite action would be, namely the opposite of her urges, thoughts, and behaviors, and came up with the following behaviors to practice: telling other friends about what happened that night, calling up her friend and talking directly about the events of that night, going to the bar, and having more "wise" thoughts about the event, such as "Preventing a friend from driving drunk is very important to me. A decent friend is one who protects the safety of friends and others." We also practiced, in session, her telling me the story a few times. Shame over talking about it in session went from 60 during the 1st telling to 30 by the last time. At the next session, JR reported much success over doing her opposite action for homework.

Commentary: This was a relatively straightforward case of unjustified shame that had serious consequences on the client's life. It was not too difficult to work with the client to see it as unjustified and the process by which this was done turned out to be extremely therapeutic in its own right. That is, seeing for herself that the shame was unjustified and that she did "the right thing" in the situation had an immediate effect on her level of shame. The opposite action process involved accurately defining the urges and directly behaving in ways that were opposite of those urges.

CK was a 45-year old single woman who had stopped her work as a bank teller several years ago after being hospitalized for severe depression and suicidality. For the past couple of years, she had been existing off her savings account (quickly depleting) and disability payments from the state. Being on disability had been a chronic source of shame for her (and thus, served as the cue for the shame experience). Her urges when she thought about being on disability or when otherwise presented with the cue (through conversations with people, receiving the check in the mail, etc.) were to contemplate suicide (conceived as "escape behavior") and also to avoid all aspects of her previous

work life. She participated in this avoidance by making occasional suicide attempts and, as an example, discontinuing walking in a favorite park because she knew that other women from work went there frequently. She also avoided doing a number of things which gave her a sense of productivity and exposed her to others such as gardening and participating in church groups because she felt like a bad person (and thus undeserving of doing things that gave her joy) and because she didn't want to engage in conversation with anyone who might ask her about her occupation. As a result, her life had become increasingly isolated and pleasureless. CK had quite a bit of difficulty telling the therapist about these shame experiences with a shame score of 80 while talking about it the first time. After writing it up on an easel, the therapist asked whether CK believed the shame to be justified or unjustified. CK responded that she believed it was justified shame because it violated her own moral values to not be contributing in a productive way to society (by working) and to be taking money through disability. However, it was also important to note that although the shame was justified, having extreme shame in session was detrimental as it prevented problem solving and brainstorming. Thus the therapist worked with CK to reduce shame in session by having CK repeat the facts of the experience over and over to the therapist while paying attention to the therapist's verbal and nonverbal indication of acceptance, nonjudgmental style, and non-rejection. CK showed a reduction in shame level to 25 by the 6th time talking through it. The therapist, in collaboration with CK, decided that the opposite action for the justified aspect of the shame experience involved the notions of "acceptance" and "repair." In terms of acceptance, a number of DBT skills were employed so that CK could radically accept the fact that her life is as it is now and that there is nothing that she can do to change the past. She could also find reasons for how she ended up where she was; to recognize how everything is caused; and to find meaning in her experience. Other homework assignments included looking for jobs so that she could earn money on her own. Finally, the behavior of avoidance was directly targeted. Again, although the shame was considered to be justified because it violated her own values, an assessment of the avoidance indicated that it did nothing to fix the situation. Thus, other opposite action assignments included walking through the park that she previously enjoyed, beginning

gardening, and regularly attending church and social functions. We also practiced in session ways in which she could respond to direct questioning about her line of work.

Commentary: This is a more complicated example because it has elements of both justified and unjustified shame. It is difficult to argue with a client's moral values and the therapist is encouraged to avoid getting into this debate at all costs. This example is an important illustration of the necessity of distinguishing between justified and unjustified shame and the difference in opposite actions that depends on this distinction. Once a shame experience occurs that is justified in nature, an opposite action of acceptance and repair is in order. This opposite action runs counter to the urges experienced by the client. Most often, in these cases, the client having had such an experience is convinced that they are a bad person and/or are flawed in some substantial way. The urges which are compatible with this cognitive distortion are often, though this might seem paradoxical, to engage in behavior that "adds proof" to the cognitive process that they are bad. Thus the client often gets stuck in a quagmire of "badness" while engaging in very few behaviors that would help them get out of it. In these cases, the therapist has to validate the pain of the experience but also stress the necessity of moving past it. This is done through acceptance and repair. Repair can be in the form of repairing to self and/or repairing to others whom were harmed. (See section on justified shame, p.X) In the example above, the repair of moving towards getting a job would help CK with both – she would repair harm to others (society as whole) by becoming a "productive member" and she would repair harm to herself by beginning to treat herself as a respectable human being.

Final Session (8, 9, or 10)

Materials Needed for Final Session

1. Audiotape for session (to give to client)
2. Therapist Opposite Action Recording Form
3. (Blank) Shame Checklist
4. Pre and post-session questionnaires

Agenda:

1. Review daily ratings
2. Review homework
3. Opposite Action Treatment
4. Give shame checklist again
5. Wrap-up

1. Review daily ratings

- Collect and review diary card ratings
- If not completed, have client complete in session (work with client to get most accurate ratings possible).

2. Review homework

- Review last homework assignment. Pay special attention to difficulties with homework as this may be last chance for feedback regarding OA implementation.

3. Exposure Treatment

[Note to therapist: Prior to session, review the client's treatment notes and make a list of all the situations that served as shame cues over the past 7-9 weeks.]

- Review all the situations that were covered during the past sessions
- Have client practice opposite action for as many of these situations as possible in session

4. Give Shame Checklist Again

[Note to therapist: Prior to session, review the client's initial Shame Checklist from Session 1 and circle the same numbers they previously circled on a new form.]

“At the start of treatment, eight (nine, ten) weeks ago, you filled out a checklist regarding situations that may have elicited shame. I'm going to ask you to now complete the same checklist again. This time, I circled the items that you circled that last time you filled it out. Circled items indicate situations that you have ever experienced. I want you to go through this checklist and rate the level of shame you feel about each of the circled items. If a situation that you experienced is not circled, feel free to circle it yourself and rate it appropriately.”

[Therapist: Again, leave the room so that client has privacy while completing this form.]

5. Wrap-up

- Inquire as to how this intervention has or hasn't been helpful
- Ask about what did they learned from this intervention
- Discuss future steps; steps that they can take on their own to continue this OA work, steps for work in future therapy
- Praise them for all the hard work they've done. Remind them that since shame is such a powerful emotion, everything they've done (no matter how small) was a step forward to decreasing the emotion of shame and the problems with which it is associated
- Say goodbye

III. Justified versus Unjustified Shame

Classifying shame as justified or unjustified shame can often be a complicated process. Specifically, shame is considered “justified” if at least one of two criteria are met: whether the action or characteristic of the individual violates their own moral values and whether the action or characteristic would legitimately cause others to reject him/her if they knew about it. These two criteria can be used as questions that individuals can ask themselves to determine whether their shame is justified in that context. If neither of those conditions are true, then the shame is considered to be unjustified.

Determining whether shame is justified or not is very similar to “cognitive appraisal” strategies in anxiety disorder treatments. An individual is asked to appraise a situation to determine whether it does indeed pose a real threat to the self. If it doesn’t, then the situation is something to approach. If it does, it makes sense to avoid the situation when possible.

Of course, many situations have components of both justified and unjustified shame. For example, a client may feel shame about their self-harm behavior. Certainly, this is a behavior that would cause some other people to reject them if they knew about it. However, even if shame is justified in some places or in certain situations, often it is unjustified in therapy because the therapist is nonrejecting. It is also important to get shame down in therapy so that effective problem solving can occur.

For unjustified shame, many times clients will at first have difficulty seeing their shame as unjustified. In these cases, it is very important to remember to validate the shame experience (unjustified \neq bad, immoral; it happened for a reason) while pointing out that there was little risk of rejection, or did not violate moral values.

IV. Troubleshooting

The following are a list of potential problems that might arise during the course of the shame intervention. Recommended strategies for dealing with such problems are provided. More detail about many of these strategies can be found in Linehan (1993a).

1. Client wants to quit treatment altogether

Strategies:

- give client sense of control over process
- weigh pros and cons
- contingency clarification
- link to goals

2. Client keeps “quitting”, e.g., pulling back or withdrawing during session, doing OA only halfway, not doing homework

Strategies:

- validate difficulty of task
- reinforce even the most miniscule of progress
- contingency clarification
- highlight consequences of succeeding/reducing shame
- cheerlead

3. Therapist gets stuck; gets in battle with client; client and therapist become polarized

Strategies:

- dialectical strategies
- make sure have cues properly assessed and whether it is justified or not;
- link reducing shame to their goals

4. Obstacles to engaging in opposite action are present

Strategies:

- do fine grained analysis of steps in OA and when peak shame occurs – determine what is happening during that peak moment (usually lack of participation, doing it only “half way”; interpretations of another person’s behaviors/thoughts, fear)

5. Intervention is not working (shame and SUDS ratings are not decreasing within or across sessions)

Strategies:

- make sure you have the right cue and whether it’s been properly classified as justified or unjustified
- make sure OA is being done *all the way*
- make sure practice is prolonged (rule of thumb: continue to do it until SUDS and shame ratings are reduced by at least 50%)
- determine if safety behaviors are present and remove, determine obstacles (see “4” above)

V. Miscellaneous Points to Consider

1. Confidentiality

Given the nature of shame and of this client population, it is likely that you will hear things that are of a deeply personal nature. It is important that the client trust that this information will not be revealed to others when it's not necessary to do so. Even though you may have consent from clients to show videos, talk on a team, or consult with others, the therapist should always use discretion about what to reveal to others. At all times, the welfare of client should be the utmost priority.

2. Therapist self-disclosure and feedback

As described in detail throughout the treatment, in shame there is great fear that one will be rejected for revealing something difficult. In actuality, there are a number of things that people do that would lead to such rejection. Therefore, the therapist has to maintain a grasp of social convention and not "fall into the pool" with the client by either believing that they would get rejected (when it's likely they would not) or by pressuring the client to reveal something that actually would lead to others' rejection. Furthermore, it is important to not reassure the client excessively which often serves as a "safety cue" and prevents the acquisition of new knowledge (same as in other exposure treatments). It is the therapist's job throughout the treatment to provide realistic and natural feedback.

3. Role of therapist regulating own emotions

The therapist must take special care to remain aware of their own emotional reaction to both the disclosure of the clients and to maladaptive behaviors exhibited by them. Supervision and a consultation team are often helpful tools to deal with one's own emotions.

4. Client attachment to therapist

During the course of this short intervention, clients are asked to reveal incredibly intimate details about themselves, many of which they haven't shared with anyone else. Given this level of intimacy, it is highly likely that they will feel very close to the therapist very quickly. It is incredibly important to remind clients from the very first session that this is short term treatment. This can be done making statements that highlight this fact such as "We have only X weeks left" or "This is our X of Y sessions," etc. At the end of the intervention, it may be helpful to tell the client that even though this is the end of treatment, you, as the therapist, do not cease to exist and that you will continue to think of them.

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Appendix B: Shame Checklist

Instructions: This is a list of situations and behaviors that may be related to the experience of shame for you. First, read through the list and circle the number to the left of any items that you have experienced. Next, for all the items that are circled, please rate the intensity of your shame *now, as you think about it*, on a 0-100 scale (0 being absolutely no shame, 100 being highest intensity). If there are other situations/behaviors that come to mind that are *not* on the list, please add them at the end.

Rate 0-100	Circle	A time when I . . .
_____	1.	Was laughed at in front of others
_____	2.	Was reprimanded/criticized in front of others
_____	3.	Was “talked down to”
_____	4.	Was rejected
_____	5.	Saw someone who was present when I was out-of-control
_____	6.	Was caught in a lie
_____	7.	Talked about/thought about past abuse that I committed
_____	8.	Was not good at something
_____	9.	Was around someone who was “better” at something than I am
_____	10.	Saw the DSM-IV
_____	11.	Thought about having Borderline Personality Disorder
_____	12.	Made a suicide attempt or harmed myself on purpose
_____	13.	Talked about a suicide attempt or time when I harmed myself
_____	14.	Threatened to kill myself
_____	15.	Yelled or screamed in public
_____	16.	Lost something important
_____	17.	Had sex with someone when I didn’t want to
_____	18.	Forced/coerced someone to have sex with me
_____	19.	Had an affair/was unfaithful
_____	20.	Was sexually harrassed
_____	21.	Cried at work
_____	22.	Cried in front of others
_____	23.	Was out of control
_____	24.	Didn’t know the answer to a question I felt I should know
_____	25.	Teased in front of others
_____	26.	Was caught saying negative things about others
_____	27.	Ate unhealthy or high fat food
_____	28.	Stayed in bed during the day
_____	29.	Missed a therapy session(s)
_____	30.	Missed an important appointment
_____	31.	Was praised for something I didn’t do
_____	32.	Was sexually promiscuous

Rate 0-100	Circle	A time when I . . .
_____	33.	Was the only one getting drunk at a party
_____	34.	Didn't live up to a really important standard of mine
_____	35.	Didn't live up to others' standards
_____	36.	Told a lie
_____	37.	Broke a promise
_____	38.	Broke a moral code
_____	39.	Was late for a meeting
_____	40.	Binged and/or purged
_____	41.	Didn't meet a deadline
_____	42.	Wasn't able to meet a person's expectations
_____	43.	Knew someone talked badly about me behind my back
_____	44.	Knew someone was mad at me
_____	45.	Had something personal exposed to a group of people
_____	46.	Gained weight
_____	47.	Lost weight
_____	48.	Received a compliment
_____	49.	Found out someone I cared for didn't feel the same way
_____	50.	Was turned down for a date/request to spend time with someone
_____	51.	Was poor
_____	52.	Was slow to learn something
_____	53.	Avoided something you have to do
_____	54.	Hurt someone emotionally
_____	55.	Hurt someone physically
_____	56.	Was abused sexually
_____	57.	Felt unable to change
_____	58.	Saw a picture of myself/saw myself in mirror
_____	59.	Was in the hospital
_____	60.	Hurt an animal
_____	61.	Was afraid to do something
_____	62.	Was a bad parent
_____	63.	Was a bad son/daughter to your parents
_____	64.	Failed at work
_____	65.	Lost a friendship
_____	66.	Had fantasies of being helpless/a baby/a victim
_____	67.	Had fantasies of violence
_____	68.	Had sexual/kinky fantasies
_____	69.	Had sex with a partner of a friend
_____	70.	Betrayed a friend
_____	71.	Was betrayed by someone I love
_____	72.	Evaded taxes/other payments
_____	73.	Had road rage
_____	74.	Hated a family member

Rate 0-100	Circle	A time when I . . .
_____	75.	Watched/listened to myself on tape
_____	76.	Was poor as child
_____	77.	Had fantasies about someone dying or being dead
_____	78.	Shoplifted/stole something
_____	79.	Had an abortion
_____	80.	Had a private aspect of myself exposed
_____	81.	Other: _____
_____	82.	Other: _____
_____	83.	Other: _____

Rate 0-100	Circle	
_____	84.	Being a mental patient
_____	85.	Not being in an intimate relationship
_____	86.	Not being married
_____	87.	Not having children
_____	88.	Being gay/lesbian
_____	89.	Thinking I am too fat/too thin/too tall/too short
_____	90.	Feeling unattractive
_____	91.	Being in treatment for mental disorder
_____	92.	Thinking about your race/ethnicity
_____	93.	Not having good career
_____	94.	Not having nice place to live
_____	95.	Going to group therapy
_____	96.	Being alone more than others
_____	97.	Being adopted
_____	98.	Particular physical characteristic; describe: _____

Shireen Leila Rizvi
Curriculum Vitae

EDUCATION

- 2004 Ph.D., University of Washington, Seattle, WA: Clinical Psychology
- 2003-04 Boston Consortium in Clinical Psychology, VA Healthcare System,
Boston, MA: Psychology Intern
- 2001 M.S., University of Washington, Seattle, WA: Clinical Psychology
- 1996 B.A., Wesleyan University, Middletown, CT: Psychology

HONORS AND AWARDS

- 2002 Society for a Science of Clinical Psychology (SSCP) Dissertation Grant
Award
- 2002 University of Washington, Department of Psychology, Dissertation
Research Award
- 2002 Society for Psychotherapy Research, Student Travel Award
- 1996 Graduated with High Honors from Wesleyan University
- 1996 Holzberg Fellowship, Wesleyan University

GRANTS

“Treatment of shame in borderline personality disorder.” National Institute of Mental Health, National Research Service Award (F31), Individual Pre-Doctoral Fellowship, July 2002 – December 2003.

PROFESSIONAL AFFILIATIONS

Association for the Advancement of Behavior Therapy
Society for a Science of Clinical Psychology
Society for Psychotherapy Research

RESEARCH EXPERIENCE

- 2002-present **Investigator**, Treatment of Shame in Borderline Personality Disorder, Behavioral Research and Therapy Clinics, University of Washington
- 2000-03 **Research Assistant**, Treatments for Depression Study, Center for Clinical Research, University of Washington; Principal Investigators: Neil Jacobson, Steve Hollon, Keith Dobson, David Dunner
- 2000-03 **Clinical Assessor**, Treatment of Depression in Parents: Impact on Children Study, Seattle Children's Hospital, University of Washington; Principal Investigator: Elizabeth McCauley
- 1998-00 **Research Assistant**, Treatment of Parasuicidal Behavior in Borderline Personality Disorder, Behavioral Research and Therapy Clinics, University of Washington; Principal Investigator: Marsha Linehan
- 1996-98 **Research Assistant**, Treatment Studies for Eating Disorders, Department of Psychiatry, Stanford University; Principal Investigators: Stewart Agras, Christy Telch
- 1995-96 **Research Assistant**, New England Women's Health Project, Wesleyan University; Principal Investigator: Ruth Striegel-Moore

PUBLICATIONS

Rizvi, S.L., & Linehan, M.M. (2001). Dialectical Behavior Therapy for personality disorders. *Current Psychiatry Reports*, 3, 64-69.

Dimeff, L.A., Rizvi, S.L., Brown, M., & Linehan, M.M. (2000). Dialectical Behavior Therapy for substance abuse: A pilot application to methamphetamine-dependent women with borderline personality disorder. *Cognitive Behavioral Practice*, 7, 457-468.

Linehan, M.M., Rizvi, S.L., Shaw Welch, S., & Page, B. (2000). Psychiatric aspects of suicidal behaviour: Personality disorders. In K. Hawton & K. van Heeringen (eds.), *International handbook of suicide and attempted suicide*, (pp. 147-178). United Kingdom: John Wiley & Sons.

Rizvi, S.L., Peterson, C.B., Crowe, S.J., & Agras, W.S. (2000). Test-retest reliability of the Eating Disorder Examination. *International Journal of Eating Disorders*, 28, 311-316.

Stice, E., Telch, C.F., & Rizvi, S.L. (2000). A psychometric evaluation of the Eating Disorder Diagnostic Screen: A brief self-report measure for anorexia, bulimia, and binge eating disorder. *Psychological Assessment, 12*, 123-131.

Rizvi, S.L., Stice, E.M., & Agras, W.S. (1999). Natural history of disordered eating attitudes and behaviors over a 6-year period. *International Journal of Eating Disorders, 26*, 406-413.

PRESENTATIONS, WORKSHOPS, AND POSTERS

Rizvi, S.L., Dimidjian, S., Dobson, K., Hollon, S., Schmaling, K., Kohlenberg, R.K., & Dunner, D. (2004, May). Prediction of treatment response: The Treatments for Depression Study. In S.D. Hollon (Chair), *Behavioral activation, cognitive therapy, and medication for major depression*. Symposium to be conducted at the annual meeting of the American Psychiatric Association, New York, NY.

Rizvi, S.L. (2003, November). *Using Opposite Action to Treat Maladaptive Shame in DBT*. Workshop presented at the 8th annual meeting of the International Society for the Investigation and Teaching of Dialectical Behavior Therapy, Boston, MA.

Dobson, K., Dimidjian, S., Hollon, S., Schmaling, K., Kohlenberg, R.J., Rizvi, S.L., & Dunner, D. (2003, November). Behavioral activation, cognitive therapy, and antidepressant medication in the treatment of major depression: Follow-up phase outcomes. In S.D. Hollon (Chair), *Behavioral activation, cognitive therapy, and antidepressant medication in the treatment of major depression*. Symposium conducted at the annual meeting of the Association for the Advancement of Behavior Therapy, Boston, MA.

Rizvi, S.L., Dimidjian, S., Nomensen, K., & Kohlenberg, R.J. (2002, November). Client expectations and early engagement in the Treatments for Depression Study. In S. Dimidjian (Chair), *What can process research contribute to our knowledge of treatments for depression? New findings and future directions*. Symposium conducted at the annual meeting of the Association for the Advancement of Behavior Therapy, Reno, NV.

Reynolds, S.K., Rizvi, S.L., Sayrs, J.H.R., & Linehan, M.M. (2002, November). The University of Washington treatment study for borderline personality disorder: Therapist training and characteristics. In S.K. Reynolds (Chair), *The University of Washington treatment study for borderline personality disorder: DBT versus nonbehavioral treatment by experts in the community*. Symposium conducted at the annual meeting of the Association for the Advancement of Behavior Therapy, Reno, NV.

Rizvi, S.L., & Shaw Welch, S. (2002, November). *Has behavior therapy sold out? A look at the relationship between convention, ethics, efficacy, and practice*. Chaired panel conducted at the annual meeting of the Association for the Advancement of Behavior Therapy, Reno, NV.

Rizvi, S.L., Lindenboim, N., & Linehan, M.M. (2002, June). Treating borderline personality disorder: Therapist burnout, expectancies, and alliance. In S.L. Rizvi (Chair), *The University of Washington treatment studies for borderline personality disorder*. Panel presented at the annual meeting of the Society for Psychotherapy Research, Santa Barbara, CA.

Rizvi, S.L., & Linehan, M.M. (2002, May). *Treatment of shame in borderline personality disorder: A pilot study*. Poster presented at the NIMH conference, New Directions in Borderline Personality II, Minneapolis, MN.

Rizvi, S.L., & Shaw Welch, S. (2001, November). *Preserving the future of empirically supported treatments: Issues in training graduate students*. Chaired symposium conducted at the 35th annual meeting of the Association for the Advancement of Behavior Therapy, Philadelphia, PA.

Rizvi, S.L., Comtois, K.A., & Linehan, M.M. (2001, November). *Characteristics and predictors of treatment expectancies in women with borderline personality disorder*. Poster presented at the annual meeting of the Association of the Advancement of Behavior Therapy, Philadelphia, PA.

Rizvi, S.L., Dimidjian, S., & Dobson, K. (2000, November). Whom do we enroll in clinical trials? In K. Dobson (Chair), *The University of Washington Treatments for Depression Study: Design, subject, assessment, and treatment evaluation considerations*. Symposium conducted at the annual meeting of the Association of the Advancement of Behavior Therapy, New Orleans, LA.

Rizvi, S.L., Reynolds, S.K., Comtois, K.A., & Linehan, M.M. (2000, November). *Therapeutic alliance in the treatment of borderline personality disorder*. Poster presented at the annual meeting of the Association for the Advancement of Behavior Therapy, New Orleans, LA.

Rizvi, S.L., Stice, E.M., & Agras, W.S. (1998, April). *Natural history of disordered eating attitudes and behaviors over a 6-year period*. Poster presented at the International Conference on Eating Disorders, New York, NY.

TEACHING EXPERIENCE

2004, Mar **Intensive Training in Dialectical Behavior Therapy**, Trainer,
Behavioral Tech, LLC, Auckland, New Zealand

- 2004, Mar **Skills Training in Dialectical Behavior Therapy**, Trainer, Behavioral Tech, LLC, Cleveland, OH
- 2003, Feb **Skills Training in Dialectical Behavior Therapy**, Trainer, Behavioral Tech, LLC, Seattle, WA
- 2000 to present ***Eating Disorder Examination and Structured Clinical Interviews for DSM-IV (SCID-I and SCID-II)***, Trainer, Various locations.
- 2000, Sum **Fundamentals of Psychological Research**, Teaching Assistant, University of Washington
- 2000, Spr **Fundamentals of Psychological Research**, Teaching Assistant, University of Washington
- 1996, Spr **Psychological Statistics**, Teaching Assistant, Wesleyan University

CLINICAL EXPERIENCE

- 2003-04 **Clinical Psychology Intern**, VA Healthcare System, Boston, MA
(Primary emphasis: PTSD)
- 1999-03 **Dialectical Behavior Therapy Research Therapist**, Behavioral Research and Therapy Clinics, Department of Psychology, University of Washington (Primary emphasis: Borderline Personality Disorder, suicidal behaviors)
- 2001-03 **Dialectical Behavior Therapy Skills Group Leader**, Behavioral Research and Therapy Clinics, Department of Psychology, University of Washington (Primary emphasis: Borderline Personality Disorder, suicidal behaviors)
- 2001-03 **Prolonged Exposure Research Therapist**, Department of Psychology, University of Washington (Primary emphasis: PTSD)
- 2001-01 **Cognitive Therapy Research Therapist**, Center for Clinical Research, University of Washington (Primary emphasis: Major Depression)
- 2000 **Group Co-Therapist**, Private Practice, Seattle, WA (Primary emphasis: Social Anxiety Disorder)
- 1999-02 **Staff Therapist**, Psychological Services Training Center, Department of Psychology, University of Washington (Varied clinical populations)

SPECIALIZED CLINICAL TRAINING

- 1998-03 **Dialectical Behavior Therapy:** Weekly seminar on fundamentals of dialectical behavior therapy; behavioral theory, behavioral assessment, mindfulness. Instructor: Marsha Linehan, Ph.D.
- 2003 **Mindfulness-Based Cognitive Therapy:** Two day workshop.
Instructor: Zindel Segal, Ph.D.
- 2001 **Diagnosis and Treatment for Anxiety and Panic Disorder:** Two day workshop. Instructors: David Barlow, Ph.D., and David Spiegel, M.D.
- 2001 **Effective Treatment for OCD and PTSD:** Two day workshop.
Instructor: Edna Foa, Ph.D.
- 2000-01 **Cognitive Therapy Treatment Group:** Weekly didactic and consultation group with emphasis on treatment for depression.
Instructor and primary supervisor: Sandra Coffman, Ph.D.
- 1999 **Assessment and Treatment of Suicidal Behaviors:** Three day workshop. Instructor: Marsha Linehan, Ph.D.
- 1998-00 **Functional Analytic Psychotherapy Research Group:** One-year weekly seminar on treatment of depression; conducted 30-session individual therapy case as part of a series of single-case research designs. Instructors and supervisors: Robert Kohlenberg, Ph.D., and Mavis Tsai, Ph.D.