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Opposite Action Intervention for Shame and Self-hatred

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This is the second article in a series of articles on the latest developments relevant to Borderline Personality Disorder (BPD) and Dialectical Behavior Therapy (DBT). The first article reviewed the latest treatment research on DBT. This article will discuss strategies of exposure and *opposite action* for reducing self-invalidation, dysfunctional shame, and self-hatred.

One of the central premises of DBT is that emotion dysregulation and self-invalidation are at the core of BPD. Shame and self-directed anger, the emotions most closely tied to self-invalidation, trigger many dysfunctional BPD behaviors. Shame is indirectly related to other problems, in that, shame often interferes with effectively solving problems. Shame is conceptualized as a self-conscious emotion that involves judging the self as globally bad, a strong urge to hide, and painful ruminative self-awareness.

BPD individuals face the dialectical dilemma of desperately seeking to escape all forms of distress (i.e., they are "emotion-phobic") while at the same time actively increasing their distress through self-punishment and other self-defeating behaviors. They actively avoid shame-eliciting situations and also actively increase their shame by seeking to verify their beliefs that they deserve to suffer. There is considerable research indicating that self-verification is a very strong human motive, such that people who hate themselves often prefer negative feedback (that confirms their negative self-views) over praise. This apparently contradictory process is best illustrated by deliberate self-harm, which BPD individuals report is a very effective form of self-punishment, emotional escape, and a way to get more social support. As a result, the BPD individual feels better *and* worse.

If a functional analysis reveals that shame plays an important role in the patient's problem, the primary task of the DBT therapist is to reduce shame by reversing shame behaviors – by stopping behaviors that function to avoid shame and behaviors that increase shame. The intervention is called *Opposite Action for Shame* (Rizvi & Linehan, 2005) and was originally described by Marsha Linehan and categorized as an emotion regulation skill in the DBT skills training manual (Linehan, 1993). *Opposite Action* is based on the behavioral principles of non-reinforced exposure (extinction) and emotional processing, processes that are highly effective in reading fear and avoidance responses in anxiety disorders.

As an exposure-based therapy, the first step is to do a thorough functional analysis, which involves identifying the specific areas of shame (e.g., body image vs. sexual behaviors), and for each, identifying the triggers and situations that elicit shame, the avoidant and self-punitive behaviors, and deciding the extent to which the shame is justified or unjustified. Shame is justified if there is a *real* danger of getting rejected by others, or the behavior violates the patient's true morals values; that is, there is a *real* problem that needs to be fixed. Shame is *un*justified if there is little to no risk of rejection *and* the behavior does not violate the patient's standards or morals. Most patients begin by stating that all their shame is justified, but the reality is that most of the shame for most patients is largely unjustified.

Because Opposite Action is an extremely aversive form of therapy (as are all forms of exposure therapy), the next step is to enhance the patient's motivation for treatment, using strategies of motivational enhancement similar to those used by Miller and Rollnick (1991). To that end, the therapist and patient thoroughly discusses how shame interferes with the client's life goals, and the Opposite Action procedures and rationale. The client must make a well-informed decision after thoroughly considering the advantages and disadvantages. No pressure is exerted on the patient to undergo treatment; instead a collaborative and Socratic approach is used and the therapist emphasizes the patient's freedom to choose treatment whatever treatment they believe will help them achieve their most important goals. The patient's doubts are considered seriously, and the therapist even takes the position of the devil's advocate.

Generally, treatment for unjustified shame includes repeated exposure to the shame triggers while blocking maladaptive behaviors (response prevention) and eliciting and strengthening opposite responses. Exposure is accomplished by having the patient repeatedly and for prolonged periods: 1) disclose detailed factual personal information that was previously concealed, 2) engage in previously avoided behaviors, 3) reveal physical characteristics that were previously hidden, and 4) approach social situations that were previously avoided. In vivo exposure, imaginal exposure, and role-play simulations are all utilized to elicit shame. Response prevention entails stopping vague responses, switching of topics, euphemisms, mumbling, judgments, self-blame, blame of others, anger, distraction, eye gaze avoidance, and escape. As with other forms of exposure therapy, it is not likely that therapy will be effective if the shame triggers and behaviors are not adequately identified and incorporated into exposure activities. By acting opposite to shame, patients actively approach their avoided situations and learn they will not be truly rejected and clarify that their behaviors are not truly immoral. Furthermore, by acting opposite patients practice verbal and non-verbal responses that are contrary to shame. They practice describing and validating themselves in a confident voice with direct eye contact. The self-persuasion can be very powerful as they act their way into feeling more comfortable and self-confident. Generalization is achieved through listening to audio-taped sessions, and in vivo opposite action homework and phone calls.

The most common examples involve sexuality and body image. For example, a previous patient was ashamed of her attraction to woman, sexual pain, and anal sex. She also believed that her sexual deviancies were immoral according to Christianity. Her shame behaviors were dissociation and self-harm as self-punishment for perceived transgressions. She had secretly explored her interest in erotic lesbian photography, lesbian love stories, and painful sex toys, but largely avoided these out of shame. A lot of therapy time was spent having the patient non-judgmentally describe her sexual interests in detail, while she acted non-ashamed and described all the ways they "make sense." She also read lesbian love stories in sessions, validated that lesbian interest is normal and acceptable, and that her interest in sexual pain and anal sex make sense given her history of sexual abuse. Although the patient's interest in sexual pain and anal sex may have arisen from her history of sexual abuse, we determined that the interests were ego-syntonic and were things she wanted to pursue from "wise-mind." Therefore, her homework assignments included: reading the books and looking at the pictures at home while masturbating, asking the priest at the local "gay-friendly" church about the acceptability of her sexual interest and behavior, telling her husband about her interest in women and asking him for anal sex when she desires it, and purchasing and using a painful sex toy, regularly doing nice things for herself that she felt she did not deserve, and validating herself. This same patient also often felt shamed any time she received negative feedback from others, therefore she practiced asking for, listening to, and validating feedback from others, and having genuine discussions about what she can

improve. When patients hide their bodies therapy involves having them show their bodies to others in a variety of settings until they become more comfortable.

For justified shame, the problem is conceptualized as problematic *behaviors* rather than a bad *self*. The therapist helps the patient fix the problematic behaviors and damage to relationships (e.g., apologizing, making amends, and restitution) so that they believe they have "paid their debt." In addition, sometimes patients need to practice describing their transgressions or flaws in a nonjudgmental manner and validating themselves regarding how the problem developed, and accepting their mistakes. This distinction between justified and unjustified shame is crucial for treatment since it would make shame worse if a patient repeated avoided behaviors and approached avoided situations and ended up getting humiliated, ostracized, and judged as immoral.

In the next article in this series we will describe the latest DBT emotion regulation skills.