



The impact of experiential avoidance on the reduction of depression in treatment for borderline personality disorder

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ABSTRACT

Background: Reducing symptoms of depression is an important target in the treatment of borderline personality disorder (BPD). Although current treatments for BPD are effective in reducing depression, the average post-treatment level of depression remains high.

Aim: To test whether experiential avoidance (EA) impedes the reduction of depression during treatment for BPD.

Method: EA and depression were assessed in 81 clients at baseline and 4-month intervals during 1 year of therapy. Simple correlations, hierarchical linear modeling, and latent difference score models were used to investigate the association between self-reports of EA and both self-reports and observer-based ratings of depression.

Results: EA was positively associated with greater severity of depression at all points of assessment, and changes in EA were positively associated with changes in depression. Moreover, EA significantly predicted less subsequent reduction in depression whereas no such effect was found for depression on subsequent EA.

Conclusion: The findings are consistent with the hypothesis that EA impedes the reduction of depression in the treatment of BPD and should thus be considered an important treatment target.

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Strong evidence suggests that depression is a common experience among individuals meeting criteria for borderline personality disorder (BPD). For example, in carefully controlled studies, comorbidity rates between BPD and current mood disorder range between 31 and 61% for major depressive disorder (MDD) and between 12 and 24% for dysthymia (Comtois, Cowley, Dunner, & Roy-Byrne, 1999; Skodol et al., 1999; Zimmerman & Mattia, 1999). Moreover, up to 83% of individuals suffering from BPD report a history of MDD, up to 39% report a history of dysthymia (Zanarini et al., 1998), and 37% meet criteria for depressive personality disorder (Grilo, Sanislow, & McGlashan, 2002). Additionally, individuals meeting criteria for both BPD and MDD exhibit greater severity of depression in self-reports than individuals with MDD but without BPD (e.g., Abela, Payne, & Moussaly, 2006; Stanley & Wilson, 2006). Finally, individuals with BPD often suffer from

depressive symptoms even when they do not meet full criteria for any affective disorder. For example, chronic dysphoric mood states, negative self-evaluations, and feelings of hopelessness and helplessness are commonly found in individuals suffering from BPD (Gunderson & Phillips, 1991; Hooley, 2007; Trull, 2001; Zittel-Conklin & Westen, 2005). These findings imply that reducing the suffering associated with depressive symptoms is an important way of reducing the suffering of BPD individuals.

Fortunately, the results of major outcome-studies of the past decade indicate that today's treatments for BPD are effective in reducing depression (Bateman & Fonagy, 1999; Bohus et al., 2004, 2000; Brown, Newman, Charlesworth, Crits-Christoph, & Beck, 2004; Koons et al., 2001; Kröger et al., 2006; Linehan et al., 2006; Turner, 2000). Pre-post effect sizes (Cohen's *d*) in these studies range from 0.54 to 2.1 (*Mdn* = 1.1) for the Beck Depression Inventory (BDI), and from 0.17 to 2.55 (*Mdn* = 0.93) for the Hamilton Rating Scale for Depression (HRSD). However, these studies also demonstrate a significant post-treatment level of depression, with mean values ranging between *M* = 13.4–25.1 for the BDI (*Mdn* = 20.9) and *M* = 7.5–19.1 for the HRSD (*Mdn* = 14.0). In fact, most of these studies report post-treatment mean depression scores corresponding to moderate or even severe levels of

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depression. Thus, even after carefully conducted state-of-the-art BPD-treatments, a great amount of depression-related suffering remains in these patients. Considering that residual symptoms of depression are known to be important predictors of relapse after treatment for unipolar depression (Judd et al., 1998) and that residual depressive symptoms are likely to trigger more typical symptoms of BPD (which have been conceptualized as dysfunctional attempts to avoid aversive inner experiences; Linehan, 1993a), it can be concluded that there is a considerable need to identify factors impeding the reduction of depression during treatment for BPD.

Evidence-based maintaining factors for depression include: a depressogenic attributional style (Abramson, Metalsky, & Alloy, 1989), hopelessness (Beck, Weissman, Lester, & Trexler, 1974), low self-esteem (Brown & Harris, 1978), dysfunctional attitudes (Beck, 1967) and rumination (Nolen-Hoeksema, 1991). All these factors are significantly associated with BPD (Abela et al., 2006). Another concept that is currently discussed as a putative risk-factor for the development and maintenance of depression is the general tendency to react towards aversive experiences with avoidance-oriented response patterns (e.g., Hayes, Beevers, Feldman, Laurenceau, & Perlman, 2005; Ottenbreit & Dobson, 2004). These response tendencies are thought to lead to: loss of reinforcement (Ferster, 1973; Jacobson, Martell, & Dimidjian, 2001), rumination (Cribb, Moulds, & Carter, 2006), impaired emotional processing (Borkovec, Ray, & Stoeber, 1998), increased negative cognitions (Abramowitz, Tolin, & Street, 2001; Wegner & Zanakos, 1994; Wenzlaff & Bates, 1998) and emotions (Campbell-Sills, Barlow, Brown, & Hofmann, 2006; Eifert & Heffner, 2003; Feldner, Zvolensky, Eifert, & Spira, 2003; Feldner, Zvolensky, Stickle, Bonn-Miller, & Leen-Feldner, 2006; Levitt, Brown, Orsillo, & Barlow, 2004), and consequently to depression.

Hayes, Wilson, Gifford, Follette, and Strosahl (1996) have proposed the term of *experiential avoidance* (EA) to summarize a broad range of potentially problematic behaviors that individuals apply in order to avoid aversive experiences. According to Hayes et al. (2004, p. 554), EA is “a phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, images, behavioral predispositions) and takes steps to alter the form or frequency of these experiences or the contexts that occasion them, even when these forms of avoidance cause behavioral harm.” In order to measure EA, Hayes et al. (2004) developed the *Acceptance and Actions Questionnaire* (AAQ), a self-report measure that assesses constructs considered as important indicators of EA. The total score of the AAQ has been demonstrated to be strongly associated with self-report measures of depression (for a review see Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Moreover, two longitudinal studies in non-clinical samples provide further preliminary support for the assumed causal effect of EA on depression (Bond & Bunce, 2003; Kashdan, Barrios, Forsyth, & Steger, 2006). However, due to the striking lack of more rigorous tests of causal effects in clinical populations, it is unclear whether EA is a cause or merely a consequence of depression.

Several findings suggest that EA might be particularly important for the maintenance of depression in BPD: first, BPD individuals report more frequently avoidance-oriented response patterns in coping inventories (Bijttebier & Vertommen, 1999; Kruegelbach, McCormick, Schulz, & Gruenreich, 1993; Vollrath, Alnaes, & Torgersen, 1998) and in the AAQ (Rusch et al., 2006) than do normal controls or patients suffering from social phobia, respectively. Second, both symptoms of BPD and symptoms of other mental disorders often co-occurring with BPD (such as posttraumatic stress disorder; Zanarini et al., 1998) are associated with EA (Chapman, Gratz, & Brown, 2006; Chapman, Specht, & Cellucci, 2005; Marx &

Sloan, 2005). Third, the tendency to suppress negative thoughts was shown to moderate the effect of negative affect on borderline characteristics (Rosenthal, Cheavens, Lejuez, & Lynch, 2005). However, at this point no study has explicitly investigated the association between EA and depression in individuals treated for BPD.

Given that a) the reduction of depression is an important target in the treatment for BPD, b) there is a need to improve the effects of BPD treatments on depression, and c) EA has repeatedly been demonstrated to be associated both with depression and BPD, the aim of this study is to clarify whether EA impedes the reduction of depression during treatment for BPD by testing the following hypotheses:

1. EA is significantly associated with higher levels of depression before, during and after treatment for BPD.
2. The reduction of EA during treatment for BPD is significantly associated with a greater reduction of depression.
3. The level of EA predicts subsequent reduction of depression during treatment for BPD, whereas the level of depression does not predict subsequent changes in EA.

Methods

Participants

Levels of EA and depression were assessed in 81 female outpatients during 1 year of treatment for BPD. Assessment took place at baseline and at 4-month intervals during the treatment. All subjects were participants in a randomized controlled trial in which dialectical behavioral therapy (DBT; Linehan, 1993a, 1993b) was compared to treatment by community experts (TBE; Linehan et al., 2006). Of the 101 participants in the intent-to-treat sample of this study, the current study included the 81 individuals who completed the Acceptance and Action Questionnaire at least once during the first year of treatment¹. Participants were diagnosed with BPD based on both the International Personality Disorders Examination (IPDE; Loranger, 1995) and the Structured Clinical Interview for DSM-IV Axis I Personality Disorders (SCID-I; First, Spitzer, Gibbons, Williams, & Benjamin, 1996). Participants were enrolled if they had a recent and chronic history of non-suicidal self-injury or suicide attempts (i.e. two or more episodes in the previous 5 years, with one episode occurring in the previous 8 weeks). All participants gave informed consent prior to participation in the studies, and all procedures were approved by the University of Washington review board. Participants were between 18 and 44 years of age ($M = 28.90$, $SD = 7.47$); 75.6% earned below \$15,000 per year; 40.7% had some college education; 14.8% were college graduates. The majority of the sample (86.4%) was Caucasian; 61.7% had never been married, and 14.8% were currently married. Most participants (95%) qualified for other Axis I disorders: approximately 50% had two or three other Axis I diagnoses, with the most common being anxiety disorders (80.3%), major depressive disorder (77.8%) and substance abuse disorder (25.9%); about one third (32.8%) were diagnosed with an Axis II disorder other than BPD. Participants had between 0 and 151 lifetime suicide attempts ($Mdn = 3$, $Q_1 = 1$, $Q_3 = 7$) and between 2 and 301 lifetime episodes of self-injury ($Mdn = 26$, $Q_1 = 11$; $Q_3 = 68$). All participants in the study received psychotherapeutic treatment for BPD. About

¹ Since the AAQ was not yet available when the Linehan et al. (2006) study began in 1994, a significant number of missing values (36, 27, 23, and 13 of the $N = 101$ intent-to-treat sample at t1, t2, t3, and t4, respectively) were due to the AAQ not being part of the assessment battery.

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