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Acceptance and Commitment Therapy Group Treatment for Symptoms of Borderline Personality Disorder: A Public Sector Pilot Study

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A pilot study of a brief group-based Acceptance and Commitment Therapy (ACT) intervention (12 two-hour sessions) was conducted with clients of public mental health services meeting four or more criteria for borderline personality disorder (BPD). Participants were randomly assigned to receive the ACT group intervention in addition to their current treatment (ACT+TAU; N=21) or to continue with treatment as usual alone (TAU; N=20). There was significantly more improvement from baseline for the ACT+TAU condition than the TAU condition on the primary outcome variable—self-rated BPD symptoms. The ACT+TAU gain was both clinically and statistically significant. The ACT+TAU condition also had significantly more positive change on anxiety and hopelessness, and on the following ACT consistent process variables: psychological flexibility, emotion regulation skills, mindfulness, and fear of emotions. For all but anxiety, the improvements for the ACT+TAU condition were significant, while the TAU condition had no significant changes on any measure. Follow-up was possible for only a small number of participants. The improvements gained by the ACT+TAU participants were maintained except for fear of emotions. Anxiety continued to improve, becoming significantly different from baseline at follow-up. Examination of mediators found that psychological flexibility, emotion regulation skills and mindfulness, but not less fear of emotions, mediated BPD symptoms. Psychological flexibility and emotion regulation skills also mediated hopelessness. There is a need for a larger trial, for comparison with other established treatments for BPD, and for conducting a trial of a longer intervention. Nonetheless, this pilot study suggests that a brief group-based ACT intervention may be a valuable addition to TAU for people with BPD symptoms in the public sector.

BORDERLINE personality disorder (BPD) is a condition characterized by pervasive affective, cognitive, behavioral, and interpersonal difficulties, and is often associated with marked disability (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). BPD is characterized by difficult feelings (intense and fluctuating negative emotions), problematic behaviors (angry outbursts, acting in potentially self-damaging ways on impulse, deliberate self-harm, and/or frantic efforts to avoid abandonment), unstable and intense interpersonal relationships and/or disturbances in the sense of self (unstable self-image, feelings of emptiness,

dissociation, transient psychosislike symptoms; American Psychiatric Association, 2000). There have been considerable advances in the treatment of this disorder over the last two decades and there is now evidence for the efficacy of several therapies for BPD. These include Dialectical Behavior Therapy (DBT; Linehan, 1993), Mentalization Based Therapy (Bateman & Fonagy, 1999), Transference-Focused Psychotherapy (Clarkin, Kernberg, & Yeomans, 1999), and Schema Therapy (Giesen-Bloo et al., 2006).

Group therapies for BPD symptoms are less resource intensive and have also shown promise (Monroe-Blum & Marziali, 1995; Soler et al., 2009; Wood, Trainor, Rothwell, Moore, & Harrington, 2001), as have group treatments added to treatment as usual (TAU) (Blum, Pfohl, St. John, Monahan, & Black, 2002; Blum et al., 2008; Gratz & Gunderson, 2006). Although ACT is proving to be an effective treatment for a range of disorders (see Twohig, 2012-this issue), there have been no published reports of successful trials of ACT for BPD, other than a group treatment which included ACT interventions by Gratz and Gunderson.

¹ Video patients/clients are portrayed by actors.

Keywords: Acceptance and Commitment Therapy; mediation; borderline personality disorder; treatment; group therapy

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In Gratz and Gunderson's (2006) study, the addition of only 14 sessions of group treatment to TAU had positive effects on self-harm, BPD symptoms, anxiety, and mood. The treatment was based on the role of experiential avoidance and emotion dysfunction in BPD and sought to teach more adaptive ways to respond to emotions. Elements of a number of therapies, including DBT, emotion-focused psychotherapy (Greenberg, 2002), traditional behavior therapy, and ACT, were included. Although there was no mediation analysis included in the study, the authors noted that the six group sessions focusing on ACT content "generated the most enthusiasm from clients during and after treatment, and appear [ed] to be the basis of much of the observed improvements" (Gratz & Gunderson, p. 33).

The symptoms of BPD can be seen as having a similar functional analysis to other disorders successfully treated by means of ACT (Twohig, 2012-this issue), and as possibly benefitting from treatment aiming to increase present-moment awareness, increase acceptance of difficult emotions, facilitate identification of values, and increase committed action on values. From the perspective of ACT, it is not intense negative affects per se that are the problem, it is experiential avoidance (which tends to increase the intensity of the negative experiences), fusion with negative thoughts, and the unhelpful choices the person makes about action—particularly actions that are against the individual's core values. Self-harm and drug or alcohol abuse can be seen as experiential avoidance strategies (Chapman, Gratz, & Brown, 2006; Strosahl, 2004). There is some research supporting the view that BPD symptom severity is related to experiential avoidance (Chapman, Specht, & Cellucci, 2005), and that BPD symptom severity is more strongly related to experiential avoidance than to emotion dysregulation, or difficulties with distress tolerance (Iverson, Follette, Pistorello, & Fruzzetti, 2011). Higher levels of experiential avoidance have been found to be associated with less likelihood of improvement in depression for those with BPD (Berking, Neacsu, Comtois, & Linehan, 2009).

The current study is a report on a pilot of a brief ACT outpatient group treatment to supplement TAU within public sector mental health services. The study was conducted by staff of a specialist public sector mental health service in Victoria, Australia (Spectrum). The group protocol was developed based on 10 years of experience in providing residential and outpatient treatment for people with a diagnosis of BPD. Initially Spectrum's group treatment was based on DBT, then a combination of DBT and ACT, and more recently "Wise Choices," based on ACT alone, the outpatient group treatment which is the subject of this study.

It was hypothesized that participants randomly assigned to receive 12 sessions of outpatient ACT group

treatment in addition to treatment as usual (ACT+TAU condition) would experience (a) significant reductions in BPD symptoms, and (b) improvements in anxiety, depression, stress, and (c) improvements in hopelessness, compared with participants who received TAU only (TAU condition).

A further aim of the study was to investigate the role of possible mediators in any improvements in the above outcome variables. If BPD symptoms are manifestations of experiential avoidance, fusion with negative thoughts, difficulties with present moment awareness, and impulsive action contrary to personal values, then psychological flexibility, mindfulness, less fear of emotions, and skills for dealing with strong emotion would be expected to mediate outcome in successful ACT treatment.

Method

Recruitment, Screening, and Condition Allocation

Potential participants were recruited via referrals from public mental health services to Spectrum. Trained research assistants assessed those referred using the schizophrenia, posttraumatic stress disorder, anxiety disorders, affective disorders, and drug and alcohol disorders scales of the Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 1997) and the BPD scale of the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). All potential participants then had a clinical interview with one of the group leaders. Consistent with the ACT view that there are other multiproblem clients with similar difficulties to those with a *DSM-IV* diagnosis of BPD, groups were open to clients with four or more of the nine BPD *DSM-IV* criteria. Although the current categorical diagnostic system requires five criteria, it is widely recognized that the disorder is better considered as on a dimension of severity (Trull, Widiger, Lynam, & Costa, 2003). The presence of four or more symptoms of BPD for those accepted into the study was supported by the referring clinician, the SCID assessment, and the clinical interview.

Inclusion criteria were (a) four or more criteria of BPD; (b) a registered client of a public sector adult mental health service (c) agreement from the public sector service to arrange an inpatient admission or crisis team visit if required; and (d) any kind of regular contact (at least once in 2 weeks) with a public or private sector clinician, not necessarily for therapy. Both males and females were included, although the number of males referred was small (see Table 1 and Figure 1).

Exclusion criteria were (a) current positive or negative psychotic symptoms other than reactive psychotic symptoms associated with BPD; (b) a significant risk of violent and/or threatening behavior to other participants; (c) intellectual

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