Not Drowning, Making Waves: ACT for BPD & SUD

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Background

While population surveys reveal that around 1-2% of the general population meet criteria for Borderline Personality Disorder (BPD) (Lenzenweger, Lane, Loranger, & Kessler, 2007), up to 65% of substance users in treatment meet criteria for BPD (Trull, Sher, Minks-Brown, Durbin, & Burr, 2000). Such figures are concerning, as clients with co-occurring Substance Use Disorder (SUD) and BPD present considerable challenges for Alcohol and Other Drug (AOD) treatment services, given their association with greater levels of psychosocial impairment, psychopathology, substance use, unsafe injecting, self-harm and suicidal behaviour (Bowden-Jones, et al., 2004). Treatment studies also highlight that clients with co-occurring SUD and BPD have higher rates of relapse, treatment noncompliance and poorer outcomes than those with either diagnosis alone (Ball, 2007; Gregory, et al., 2008), while SUD significantly reduces the likelihood of clinical remission of BPD (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2004).

A recent systematic review of the literature investigating current treatment options for co-occurring SUD and BPD examined RCTs of psychosocial interventions and found that there is currently insufficient evidence to recommend a 'best practice' model of treatment (Pennay, et al., 2011). Moreover, all effective psychosocial treatment options were unlikely to be implemented with fidelity in community AOD treatment settings due to the long-term and resource intensive nature of the intervention, and the specialist training required of staff. This highlights a significant need for further examination of treatment options for BPD and SUD which are adaptable to the real life clinical setting.

These observations, along with the fact that these clients may represent the majority of AOD treatment seekers, prompted Turning Point Alcohol and Drug Centre to implement ***Making Waves***, a project funded by the Department of Health and Ageing that aims to increase the capacity of the AOD sector to deliver evidence-based treatment to clients with co-occurring BPD and SUD. The current poster outlines an exploratory pilot of Acceptance and Commitment Therapy (ACT) with clients with BPD and SUD which determines the feasibility of implementing ACT informed treatment into AOD treatment services and whether client outcomes improve after receiving ACT. Technology transfer took the form of a training workshop combined with ongoing coaching, and client-based clinical reviews and role plays of ACT techniques in a group supervision model to minimise implementation errors.

Aim

The aim of ***Making Waves*** was to implement ACT for BPD and SUD in a community AOD treatment service with minimal implementation errors to improve client outcomes.

Method

Implementation model: Systematic implementation methods were informed by the Consolidated Framework for Research Implementation (CFRI) (Damschroder & Hagedorn, 2011; see Figure 5).

Clinician training and coaching: Sixteen clinicians from across two services (Turning Point and Eastern Drug and Alcohol Service) underwent 40 hours of staff training and consultation in ACT from a Spectrum consultant consisting of attendance at a 1-day workshop and 90-minute group supervision sessions held fortnightly. They implemented a 12-session ACT treatment developed by Spectrum, a specialist public sector service for people with BPD symptoms which is described in the treatment manual, ***Wise Choices*** (Morton & Shaw, 2012; available from www.spectrumbpd.com.au).

Client intervention: Once written informed consent was obtained, clients completed baseline measures in the areas of: borderline symptoms (BEST); feelings of hopelessness (BHS); drug and alcohol use (ATOP); quality of life (WHOQoL); emotion regulation (DERS); acceptance and values-based action (AAQ-II); and treatment engagement, motivation, and readiness (TCU scales). Clients received 12 sessions of ACT-consistent treatment, from ***Wise Choices*** (Morton & Shaw, 2012). Measures were re-administered after the 6th and 12th session. Comparison between the three time points were conducted through paired-sample *t*-tests as an indication of treatment outcomes.

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Results

Client demographics

Fifteen clients completed evaluation measures at three time points. Most of the sample (n = 14; 93%) were women. Ages ranged from 21 to 52 years (M = 30.5; SD = 8.5). Most participants (n = 9; 60%) had not previously attended AOD treatment. Initially, 21 individuals consented to participte, with 2 (9.5%) participants withdrawing after completing the baseline measures, and 4 (19%) withdrawing after 6 sessions.

Client outcomes

The 15 clients who completed the 12 sessions maintained high levels of treatment satisfaction and counselling rapport (Figure 4) with a statistically significant increase in treatment participation from Time 1 to Time 3 ($t(14) = 3.41$, $p < .05$). Scores range from 10 to 50 with higher scores indicating greater participation, satisfaction and counselling rapport. Across all time points alcohol was the most frequently reported substance (87%), followed by amphetamine type stimulants (53%), heroin and other opiates (47%), cannabis (47%), and benzodiazepines (40%) (Figure 1). A clinically significant reduction in the frequency of alcohol and BZD use was observed with the average number of days used during the last 4 weeks decreasing from Time 1 to Time 3. A statistically significant decrease in cannabis use was observed ($t(14) = -2.16$, $p < .05$). The group mean score on the Acceptance and Avoidance Questionnaire (AAQ-II) decreased from Time 1 to Time 3 ($t(14) = -5.18$, $p < .001$), indicating a statistically significant reduction in psychological inflexibility and experiential avoidance and an increase in the application of ACT-related skills (Figure 2). BEST composite scores ranged from 12 to 72, with higher scores indicating an increase in borderline symptoms. A reduction in BPD symptoms between Time 1 and 3 was observed ($t(14) = -2.56$, $p < .05$; See Figure 3) bringing the pilot sample BEST scores within 1 SD of 'normal' functioning as estimated by Gratz and Gunderson (2006).

Clinician demographics

Particpating clinicians were all AOD clinicians (N = 16) working in specialst AOD treatment settings. Of the particpants 4 were men (25%) and 12 were women (75%). Seven (44%) clinicians had no previous formal ACT training. At the time of interview, most clinicians (n = 11; 69%) had been attending the fortnightly consultation groups for between one and six months. The remaining clinicians (n = 5; 31%) had been attending for 12 months.

Clinician outcomes

Clinician outcomes included increased confidence in implementing ACT ($t(15) = 5.86$, $p < .001$) and increased likelihood that they will continue to use ACT and recommend this treatment approach to colleagues (see Figure 6). Qualitative results indicated that clinicians found ACT useful with complex client presentations and the techniques were a 'good fit' within an AOD setting.

Qualitative clinician outcomes

"Most important to me was the practical application of ACT strategies using specific client examples. It was also beneficial to have the opportunity to role-play ACT approaches and explore the more practical elements."

"...It is the first time I have seen ACT applied to highly complex clients who represent our key demographic and manuals don't typically do that. When you are dealing with psychopathology, it is a different kettle of fish, but ACT can be applied most effectively which is highlighted in the consultation sessions."

Conclusion

ACT is a feasible intervention for AOD services in treatment of clients with complex psychosocial needs if implemented using methods informed by evidence for technology transfer. ACT offers an alternative treatment to CBT and DBT within this setting.

References

Ball, S. (2007). Comparing individual therapies for personality disordered opioid dependent patients. Journal of Personality Disorders, 21, 305-321.
Bowden-Jones, O., Iqbal, M.Z., Tyrer, P., Seivewright, N., Cooper, S., Judd, A., et al. (2004). Prevalence of personality disorder in alcohol and drug services and associated comorbidity. *Addiction, 99*, 1306-1314.
Damschroder, L.J., & Hagedorn, H.J. (2011). A guiding framework and approach for implementation research in substance use disorders treatment. *Psychology of Addictive Behaviors, 25*, 194-205.
Gratz, K.L., & Gunderson, J.G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behavior Therapy, 37*, 25-35.
Gregory, R.J., Chlebowski, S., Kang, D., Remen, A.L., Soderberg, M.G., Stepkovitch, J., et al. (2008). A controlled trial of psychodynamic psychotherapy for co-occurring borderline personality disorder and alcohol use disorder. *Psychotherapy: Theory, Research, Practice, Training, 45*, 28-41.
Lenzenweger, M.F., Lane, M.C., Loranger, A.W., & Kessler, R.C. (2007). DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biological Psychiatry, 62*, 553-564.
Morton, J., & Shaw, L. (2012). *Wise Choices: acceptance and commitment therapy groups for people with borderline personality disorder*. Melbourne, Victoria: Australian Postgraduate Medicine.
Pennay, A., Cameron, J., Reichert, T., Strickland, H., Lee, N.K., Hall, K., & Lubman, D. (2011). A systematic review of interventions for co-occurring substance use disorder and borderline personality disorder. *Journal of Substance Abuse Treatment, 41*, 363-73.
Trull, T.J., Sher, K.J., Minks-Brown, C., Durbin, J., & Burr, R. (2000). Borderline personality disorder and substance use disorders: A review and integration. *Clinical Psychology Review, 20*, 235-253.
Zanarini, M.C., Frankenburg, F.R., Hennen, J., Reich, D.B., & Silk, K.R. (2004). Axis I comorbidity in patients with borderline personality disorder: 6-year follow-up and prediction of time to remission. *American Journal of Psychiatry, 161*, 2108-2114.

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Figure 1: Client Substance Use ATOP (N = 15)

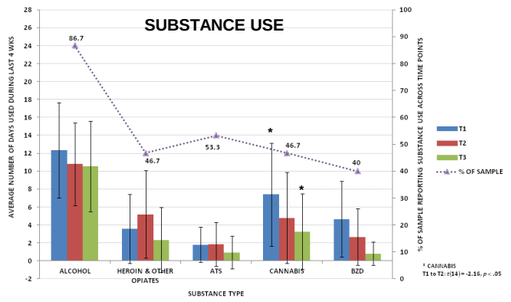


Figure 2: Acceptance and Avoidance (AAQ-II)

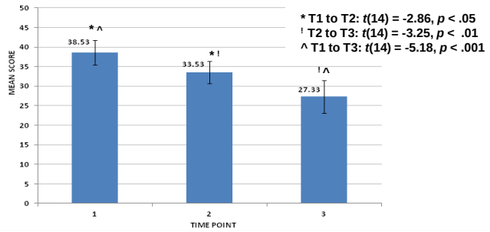


Figure 3: Borderline Symptoms Over Time (BEST) (N = 15)

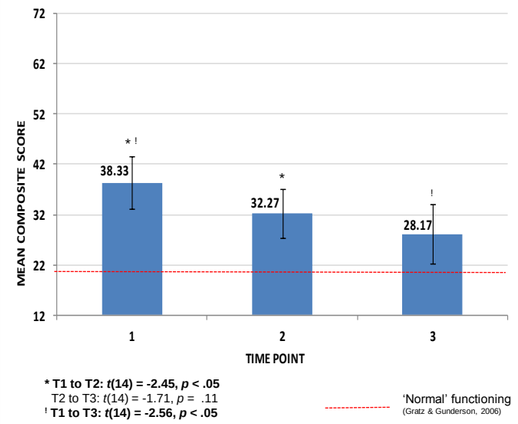


Figure 4: Treatment Engagement and Counselling Rapport (TCU scales) (N = 15)

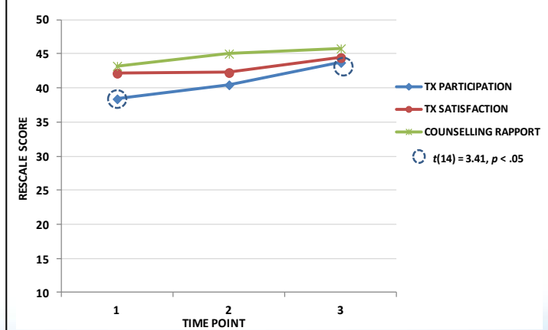
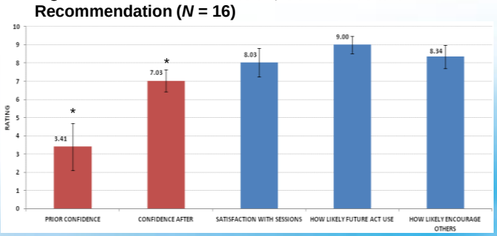


Figure 5: Implementation Model

Figure 6: Clinician Satisfaction, Confidence and Recommendation (N = 16)



* $t(15) = 5.86$, $p < .001$

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