WISE CHOICES

Acceptance and commitment therapy groups for people with borderline personality disorder

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Published 2012 by Australian Postgraduate Medicine.
and for a reduced price and training and workshops.

spectrumbpd.com.au
Chapter 1

Introduction

The Wise Choices group program was developed to address the treatment needs of people with symptoms of borderline personality disorder (BPD). The Wise Choices group program consists of three series:

1. **Introduction to Wise Choices:** Ten structured psycho-educational sessions introducing basic acceptance and commitment therapy (ACT) skills. The sessions cover:
   - the cost of struggling to avoid difficult thoughts and feelings (experiential avoidance)
   - an introduction to acceptance and mindfulness skills, including 'defusing' or 'unhooking from' unhelpful thoughts
   - awareness of values and taking small steps to act on values
   - awareness of 'choice points' – occasions when there is a strong urge to act against values
   - use of mindfulness and acceptance skills to address obstacles to action based on values.

2. **Wise Choices in relationships:** Ten structured psycho-educational sessions providing opportunities for group members to practise applying ACT skills to building better relationships. They cover:
   - relationship values and obstacles to acting in line with values in relationships
   - relationship skills (such as making conversation, resolving conflict and setting limits)
   - use of acceptance and mindfulness skills to address difficult thoughts and feelings that arise in the course of practising relationship skills or in relationships more generally.

3. **Values in action:** Twenty or more semistructured group sessions providing opportunities to further develop and refine mindfulness and acceptance skills, and apply them to the pursuit of values-based living. The sessions gradually become less structured with increasing use of role plays and exploration of process within the group.

The treatment and principles underlying Wise Choices are very similar to standard ACT treatment. Consequently, we expect that the Wise Choices group treatment manual will be suitable for a broad range of presenting problems and readily adaptable for clinicians working in a variety of group-therapy settings, including inpatient and outpatient mental health settings, residential programs and private psychotherapy. Variations on Wise Choices group treatment have been piloted in an adolescent inpatient unit, an adolescent day program, a women's prison and a community health service. An individual therapy version is currently the subject of a pilot study in two drug and alcohol services.

These three group series can be run one after another as a closed group that runs over the course of a year or longer. Alternatively, a service may choose to run Series 1 and 2 in an alternating sequence, with group members attending each series as many times as needed until they are ready for the less structured and more intensive work of the Series 3 groups. In this case, Series 3 would be run as an
ongoing open group with slow turnover of membership. The Series 1 sessions can readily be adapted for use as an open group that has some new participants each session – for example, in an inpatient setting.

**Acceptance and commitment therapy**
ACT is referred to as 'act', consistent with the view that it is the actions we choose to take, more than our thoughts or feelings, which make a difference in our lives. ACT is a functional contextualist psychological treatment approach which aims to increase psychological flexibility (see box below).

**Functional contextual psychology:**
- aims to develop a coherent and progressive science of human action that addresses the challenges of the human condition, and assists individuals, and humankind more generally, to live full, rich and meaningful lives
- considers the whole person, as an integrated organism, within a historical and situational context (Hayes et al. 1999)
- makes use of the pragmatic test of truth, asking ‘is this useful in this context?’ rather than ‘does this correspond to reality?’ (Biglan & Hayes 1996)
- focuses both theory and research on the practical aim of increasing our ability to interpret, predict and influence human behaviour with precision, scope and depth (Hayes et al. 2012)
- includes a theory of language (relational frame theory, Torneke 2010), which explores the unique contribution of language to human achievement and human suffering.

ACT applies techniques consistent with functional contextual theory and research with a view to reducing human suffering, and facilitating the deep sense of meaning and vitality that comes from values-based living.

What does functional contextualism mean for our treatment of people with symptoms of BPD? One important implication is that a person's thoughts, feelings and behaviour all occur within a context, and are best understood by considering their function within that context. Thus, for example, two instances of self-harm may look similar, but serve different functions. Self-harm can be used to manage painful thoughts or feelings, with the physical pain providing a distraction from emotional pain; it can be used to elicit care or prevent a partner from leaving; and it can be used to stimulate a rush of pain-numbing endorphins. Conversely, an instance of self-harm and an instance of drug use may appear different in form and yet serve a similar function – avoiding painful thoughts and feelings. Examination of the function of symptoms, and their relationship with a person’s history and current context, is likely to be of more relevance to treatment planning than diagnostic categories based on the form of the behaviour.

Another implication is that we are called upon to make our theorising practical. The pragmatic truth criterion orients us to developing and testing techniques that make a difference, and explaining what we are doing in ways that can be understood and replicated by others. We are interested not just in whether what we do produces a change but also in the processes that bring the change about.

Both ACT and relational frame theory (RFT) argue that language is at the root of human suffering through its capacity to lock us into rule-based responding and to bring past hurts, future worries and

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3 www.contextualpsychology.org/acbs
imagined catastrophes into the present moment. From this perspective, we are all in the same boat – clinicians, clients with anxiety or depression symptoms, clients with BPD symptoms, and others. We all experience the unavoidable pain of living. We all tend to grasp onto pleasure and avoid pain. We also all have both the advantages and the suffering that come with language. ACT takes the view that it is not negative feelings and thoughts per se that are the problem; rather, the difficulty is experiential avoidance, fusion with negative thoughts, and the unhelpful choices a person makes about action – particularly actions that are against the individual’s core values.

Many Eastern traditions have cultural practices designed to change people’s relationship with language and troublesome emotions, but these traditions are weak in Western culture. Instead, we have an emphasis on analysis, control and elimination of difficult thoughts and feelings, which is replicated in many forms of therapy. From the perspective of ACT, trying to address problems caused by our relationship with language by arguing with, or challenging, the content of language is like fighting fire with fire. ACT uses mindfulness and acceptance strategies to change our relationship with language, rather than changing the content of our thoughts.

In ACT, experiential exercises and metaphors are used to help us contact ‘self-as-context’ – the spacious, content-free perspective from which we observe and experience – and to help us recognise that we contain our thoughts and feelings, but are more than the sum of them. If our thoughts and feelings are like clouds in the sky, we are the sky. The approach aims to improve our capacity to be fully present and to chart a flexible course through moment-to-moment reality, choosing actions that are consistent with heartfelt values.

Spectrum’s treatment is designed to suit people with severe difficulties. Clinicians working with group members who begin with greater mindfulness and acceptance skills and better relationship skills may find their group members are able to move to a less structured and more experiential format faster, while covering the same content. The treatment manual is designed to be used by clinicians who are already using ACT, so we provide only this brief introduction to ACT before discussing BPD. If you are not familiar with ACT, we suggest you start with reading one of the introductions to ACT listed in ‘Further reading and references’.

Acceptance and Commitment Therapy

Accept your feelings and thoughts and be present
Choose action that is in line with your values
Take action

Remember, it’s what you do that counts!

Borderline personality disorder – the diagnosis

The box below gives the official definition of BPD from the Diagnostic and Statistical Manual of Mental Disorders (4th edition, text revision; DSM-IV-TR). According to the DSM-IV-TR, BPD is a condition characterised by:

- difficult feelings – intense and fluctuating negative emotions, sometimes including fears of abandonment
• problematic behaviours (impulsive acts, unwise choices) – angry outbursts, acting in potentially self-damaging ways on impulse, deliberate self-harm, or clingy or changeable ways of relating to others
• a range of other disturbances – unstable self-image, feelings of emptiness, dissociation, transient psychosis-like symptoms.

Borderline personality disorder
A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. frantic efforts to avoid real or imagined abandonment
2. a pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation
3. identity disturbance: markedly and persistently unstable self-image or sense of self
4. impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)
5. recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour
6. affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. chronic feelings of emptiness
8. inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9. transient, stress-related paranoid ideation or severe dissociative symptoms.


However, the criteria can be met in a number of ways, with different combinations of five or more of the nine criteria. Thus, people who meet the criteria for the diagnosis can be quite different from each other. The personalities of those who meet the criteria for the disorder can vary across the full range of personality types – shy, gregarious, dependent, aloof, suspicious, over-controlled or impulsive. Not all BPD clients self-harm; some use drugs and alcohol to dull their pain, whereas others gamble, shoplift, overeat, starve or purge. Those who meet the criteria for the diagnosis may struggle with depression, anxiety or obsessional thinking. Frequently, they meet the criteria for one or more other personality disorder diagnoses as well as those for BPD. These problems with the BPD diagnosis illustrate the problems associated with efforts to distill the complexity of human suffering into categories based on the form of the symptoms, rather than the function.

It has been suggested that ‘emotional dysregulation disorder’ or ‘complex posttraumatic stress disorder’ may be better descriptions of BPD (Herman 1997, Bernstein et al. 2007). Strosahl (2004) has argued for the use of the alternative term ‘multiproblem client’. Spectrum clients have suggested the term ‘hard life syndrome’, which has the advantage of including consideration of historical context rather than only problem behaviour or symptoms. Where possible, we will use the term ‘person with
symptoms of BPD to help us connect with clinicians reading this book who use the term 'BPD', while embracing the implication that the 'symptoms of BPD' are transient and the 'person' is primary. Where this is too cumbersome, we will use 'client', 'group member' or 'participant'.

What use, if any, is the BPD diagnosis, and what is the point of a treatment manual designed for this diagnostic group? We believe that what makes people with symptoms of BPD different – and more challenging to treat – is their typical early history of severe trauma, loss or deprivation. The aim of Wise Choices group treatment is to assist those who experience ongoing and severe suffering as an aftermath of childhood adversity.

Some researchers and clinicians have postulated that a sensitive or impulsive temperament contributes to the development of BPD symptoms. However, in the public sector, it is rare to see clients with severe symptoms of BPD who do not report a history of severe childhood adversity, often including sexual abuse or disrupted attachment relationships with primary carers. Although it is theoretically possible that someone could display BPD symptoms purely as a result of a sensitive temperament, having grown up in an environment that an outside observer would describe as benign, this is not something we have come across in our work.

We tend to give people with symptoms of BPD the benefit of the doubt. If they are having difficulty with intense emotions and dark thoughts, and having trouble forming positive relationships, we assume that, if we knew everything that they had experienced, then what they are thinking, feeling and doing would make perfect sense to us. Or, to put it another way, if we had walked down the path that this person has taken in their life, we would likely have ended in the same place. We will never know a person's entire history – there isn't enough time to tell it. There may be important parts that the person can't remember and has never been told – for example, maltreatment while very young. Fortunately, knowledge of the aetiology of a person's symptoms is not required for ACT treatment. The roots of current thoughts, feelings and behaviour are seen as infinitely complex and as including the whole of the person's natural endowments and history. The focus of the treatment is on the thoughts, feelings and choices that are found in the person's present experience, without a need to reconstruct the person's history.

Does this mean that the client's parents are to blame? Blaming parents makes no more sense than blaming the person with BPD symptoms. Sometimes a child suffers great adversity despite the best efforts of the parents – long periods of hospitalisation while very young, frightening or painful physical symptoms, or abuse by someone outside the family, which the child has been pressured into keeping secret from their parents.

If the client's parents have been physically or emotionally abusive, emotionally distant, preoccupied with alcohol or drug dependence, or depressed and disengaged, we assume it is because they themselves have had hard lives. We prefer to start from the assumption that no one would behave badly towards their children if they were in a position to behave well. If we take a judgmental stance regarding the parents of our clients, what will we say when our clients tell us of the problems they are having in raising their own children? This is not the same as condoning abuse or allowing it to continue. If our clients are still being abused we will work with them to establish safety. If they are harming their children then we will work with them to ensure their children are safe.

4 Although our Wise Choices groups are open to men as well as women, the majority of group members have been female. Rather than using 'he/she', or just 'she', when referring to group members, we have opted to use 'they', even when talking about a single person.
Borderline personality disorder and childhood adversity

ACT treatment does not focus on events of the past. Nonetheless, a perspective that includes the notion of childhood adversity can help make sense of some of the particular treatment needs of those with BPD symptoms, as outlined in the following sections. It may also assist clinicians to maintain compassion and patience for these clients through tough times.

Repeated early trauma or deprivation

Repeated early trauma has more complex and profound effects than a later one-off trauma (Herman 1997). Following a one-off trauma as an adult, a range of posttraumatic symptoms may be experienced. These include numbing, intense re-experiencing (flashbacks), nightmares and an urge to avoid reminders of the trauma. Repeated trauma in adulthood – for example, in situations such as war, imprisonment or domestic violence – is likely to be associated with the above symptoms and, in addition, chronic feelings of anger towards others or self-hatred. Those experiencing repeated trauma in childhood often suffer all of these effects, plus the additional difficulties that are associated with interference with early development (Briere 1992; Morton et al. 1994).

Childhood deprivation can have similar after-effects to childhood trauma. A baby who is repeatedly left to cry when hungry, or left alone for long periods, is experiencing what is felt to be a life or death situation. The absence of an adult, on whom the baby is dependent for survival, triggers much the same intensity of emotion as the presence of a dangerous person.

Whether initial responses to a one-off trauma become consolidated into posttraumatic stress disorder depends in part on whether the person continues to expose themselves to reminders of painful past experiences. It seems that, for those who have suffered trauma in adulthood, efforts to avoid the experience of thoughts and feelings related to the trauma may increase the likelihood of ongoing difficulties. Willingness to accept the experience of trauma-related thoughts and feelings seems to allow these to dissipate over time (Walser & Westrup 2007).

The unfortunate situation of those who have suffered severe childhood adversity is that, in addition to having a greater load of pain to process, they may also lack some of the emotion awareness and emotion tolerance skills that would assist with moving on from the after-effects of trauma. They may have developed a habit of experiential avoidance, turning outswards to avoid their inner world of painful thoughts, feelings and bodily sensations. Their capacity to trust and attach to others may have been damaged, thus limiting their ability to seek, and make use of, the assistance of others. They may avoid close relationships, or turn away from other people altogether. Before they can begin to deal with the aftermath of childhood adversity and move on, many of them will need to develop greater mindfulness and acceptance skills, and better relationships.

Alert for danger, primed for action

In a dangerous place, it is adaptive to be constantly on the alert for danger, and primed to take strong action immediately when under threat. Survival instincts organised around 'flight–fight–freeze' are activated: fight if you can win, run if you can get away and freeze if survival depends on staying hidden. In such situations, our attention is narrowed to focus on potential danger and possible means of defending ourselves or escaping. Neutral and positive aspects of our environment are ignored – there is no use stopping to smell the tropical flowers while being chased by a tiger. After long periods in a dangerous situation, these patterns become habitual.

Many of the difficulties experienced by people who have a history of trauma or deprivation are linked to these patterns. They scan the environment for danger – a frown or a sudden movement – and they
are primed to fight, flee or freeze without much time to consider what would be the wisest course of action. The quick responses that were adaptive in a dangerous context become liabilities in less dangerous situations.

The involuntary 'play dead' response is even more frightening than 'flight–fight–freeze' responses. This reflex is occasionally experienced by people in situations where it seems that painful death is imminent and escape is impossible (Nijenhuis et al. 1998). Like the mouse in the mouth of the cat, the person's muscles go slack and they find themselves unable to run or fight back. The survivor of trauma may subsequently blame themselves for their inaction. If a similar response is triggered in later situations of danger, then the person will be unable to defend themselves.

We all have difficulty holding our attention in one spot – this is apparent when we first try practising mindfulness. However, for some people with BPD symptoms, this difficulty is so severe that it has been termed 'stimulus entrapment' (Meares 1992). Their attention seems to be pulled from one potentially dangerous outside stimulus to another, with little capacity to hold their attention where they choose. For example, while attempting to study in a library, the person's attention may be irresistibly drawn to vengeful thoughts about an argument with a neighbour, dark thoughts about study being a waste of time, critical self-judgements such as 'I'm dumb, I always fail,' or memories of sexual abuse triggered by a man standing uncomfortably close. It may be difficult to attend to neutral stimuli, such as work or study, or to positive stimuli, such as pleasurable activities. Relaxation training, body awareness exercises or even mindfulness of the breath may trigger trauma-related sensations and emotions for some people.

Over-arousal and under-arousal

Those who have suffered severe and prolonged trauma or deprivation in early life may display one, or both, of two opposite constellations of emotional arousal:

- periods of over-arousal and intense trauma-related emotion that appear to signal that aspects of the current environment are potentially life-threatening and must be attended to (as described in the previous section)
- periods of under-arousal, in which emotion and body awareness are blocked and attention to outside stimuli may also be blunted, resulting in an experience of emptiness, 'unreality' or boredom.

Blocking physical and emotional experiences can, in extreme situations, be adaptive. Many people with BPD symptoms have practised hiding their emotional responses to survive. They may have learned that it is no use crying while you are being beaten, or that it is better to hide disagreement than risk an angry counter-attack. They understandably have become experts at ignoring or dampening down their surging emotional responses to a myriad of trauma-related triggers.

Many people with a history of severe childhood abuse or neglect spend some time in a state of partial dissociation (a severe and involuntary form of experiential avoidance), in which they are aware of only a dulled-down version of sights and sounds, and have little contact with their own bodily experience or emotions. Some experience periods of absence or 'blinking out', which may involve a complete, or close to complete, cutting off from present reality. For example, someone whose childhood has included extreme violence from their father may be unable (not just unwilling) to stay present even at the mention of the word 'anger': 'Maybe you were angry?,' '... What did you say?'; 'I said maybe you were angry', '... What did you say?'
Some types of dissociation appear to be quite deep, in the sense that little or no contact with present reality is maintained, whereas others are less deep or may involve elements of voluntary choice. For example, a person may voluntarily choose to partially dissociate by staring at the floor and taking themselves to an imaginary ‘safe place’ that was used to cope with childhood abuse. However, it is possible that thoughts of the childhood ‘safe place’ will elicit flashbacks of childhood abuse, and the person will then experience an involuntary slide into a state where their contact with present reality is limited.

These largely involuntary experiences need to be distinguished from voluntary choices to avoid difficult thoughts or feelings, such as deciding to take drugs or have an alcoholic drink, or choosing to ‘tune out’ and think of other things. They require a related but somewhat different treatment approach.

**Harsh judgements of self and others**

People diagnosed with BPD have often developed the habit of judging self and others harshly. These habits of mind may include:

- pre-emptive judgemental attacks against others who might otherwise strike the first blow: 'I don't care what you think of me because you’re an idiot anyway'
- tit-for-tat judging: 'It doesn't matter that I was rude to you because you were rude to me'
- attempts to control one’s own behaviour via adherence to perfectionistic standards: ‘I must get this perfect, or bad things will happen,’ ‘No use criticising if you’re not perfect yourself’
- self-blame as a way of protecting against overwhelming fear and helplessness ‘It’s too frightening to think that my parent hates me and might kill me, and that there is nothing I can do. Blaming myself means that the outcome is in my control – if I try harder, everything will be all right.’

If these ways of thinking have served helpful functions in the past, they will not be let go of lightly. In our experience, cognitive challenge strategies, even the ‘cheerleading’ used in dialectical behaviour therapy (Linehan 1993a), can trigger anxiety, anger or ‘spacing out’. Efforts to challenge harsh self-judgements may be experienced as an attack on the person's 'life raft', and may come across as misguided, or even malicious. Encouragement to use the ACT technique, defusion, to ‘unhook’ from these thoughts may also be experienced as a threat and will need to be approached cautiously, step by step, conveying respect for the function these thoughts have served in the past.

**Toxic self-attributions**

An outward-turning, danger-focused stance, together with intense engagement with harsh self-judgements, and the use of self-blame as a survival strategy, readily leads to a 'self-as-content' formed from a network of toxic self-attributions (e.g. 'I was born evil,' 'I deserve to be punished,' 'I'm the worst borderline this service has ever seen,' 'I'm destined to kill myself' and 'The world would be a better place without me'). Not only are these self-attributions very harsh, they are often experienced as 'who I am'. This is referred to in ACT as 'self-as-content' – an experience of 'self' as identical with the contents of experience rather than as the context within which the flow of inner experience occurs. This experience of oneself as the context of experience is sometimes referred to as 'self-as-context' or 'observing self'.

In ACT and RFT, the development of 'self-as-context' is seen as a function of the learning of 'deictic framing'. A definition from the Contextual Psychology website is provided in the following box.
Deictic relations seem to be a particularly important family of relational frames that may be critical for perspective-taking. An example is the three frames of I and YOU, HERE and THERE, and NOW and THEN. These frames ... do not appear to have any formal or nonarbitrary counterparts. [The frame of] coordination, for instance, is based on formal identity or sameness, and 'bigger than' is based on relative size. In contrast, [deictic] frames that depend on perspective cannot be traced to formal dimensions in the environment at all; instead, the relationship between the individual and other events serves as the constant variable upon which these frames are based.5

Many people with BPD symptoms lack ready access to an experience of 'self-as-context'. It is unclear whether the capacity for observing self-perspective is underdeveloped, whether access is not readily available, or whether it is avoided. It has been suggested that a lack of emotionally attuned back-and-forth responding with a parent may hamper the development of a self that observes the flow of experience (Meares 1992). Fortunately, the question of how this difficulty arose is not important for treatment and there are exercises which can be used to help people contact the observing self. This shift from a sense of self that consists of painful thoughts and feelings and bad memories, to a sense of self that is spacious and without content, within which thoughts and memories come and go, can make an enormous difference to those who have experienced trauma (Walser & Westrup 2007).

Difficulty shifting perspectives

People with a history of childhood adversity may have difficulty reflecting on their own thoughts and feelings, and even more difficulty in reflecting on the thoughts and feelings of others. They may have difficulty in 'holding their thoughts lightly' and may tend to see thoughts as 'facts' about the outside world. They may have difficulty shifting from their own perspective on a situation to that of the other person, or assume that only one true perspective exists – their own (for example, 'I know that you hate me'). These difficulties have been described as difficulties in mentalization and are the primary focus of mentalization-based therapy (Bateman & Fonagy 2004). From the perspective of ACT and RFT, they are manifestations of limited psychological flexibility. Being in a safe context, and noticing that it is safe, can help increase flexibility and is probably a prerequisite for building perspective shifting capability. Practice in a safe context may help overcome habits of rigidity. The Series 2 groups include several exercises designed for this purpose.

Impulsive action

The diagnostic criteria for BPD include several that relate to self-defeating action. Often, unwise actions occur on impulse, without the person reflecting on their options or even noticing that a choice has been made. Difficulty holding painful thoughts and feelings in awareness, and tolerating discomfort, can result in a tendency to make unwise choices that provide short-term relief. Intense 'flight-fight-freeze' responses, where fast action is felt to be essential for survival, may also contribute to impulsive action. An important part of Wise Choices group program is helping group members identify the 'choice points' that arise when difficult thoughts and feelings are strong, and there is temptation to take action that is not in line with values.

Anxiety-provoking high-risk behaviour

Clinicians are often better acquainted with the treatment of acute suicidality and self-harm than they are with the treatment of chronic suicidality and self-harm. While restrictive forms of treatment such as compulsory inpatient treatment may be appropriate during a short-lived crisis, self-harm
or suicidality that has become a chronic coping strategy requires a different approach. In the case of chronic suicidality or self-harm, escalating efforts to control the client often result in an increased level of risk. Long hospital stays can derail work, study and relationships, and are highly stigmatising.

The intensity of the distress experienced by people with symptoms of BPD readily elicits strong emotional reactions from others and so does some of their high-risk behaviour – particularly self-harm. As described earlier, self-harm may serve a wide range of functions. Although self-harm has short-term benefits, it can have major negative consequences for physical health and close relationships. The responses of clinicians to self-harm can range from compassion through to helplessness, fear, anger and disgust. Clinicians may feel a strong impulse to attempt to control the person's actions and may put pressure on them to stop their self-harm. For the client, self-harm is generally seen as the solution, not the problem, and the efforts of the clinician are likely to be met with overt or covert resistance.

Effective treatment requires an individualised treatment strategy based on assessment of both short-term and long-term risk. This approach requires a careful assessment of the patterns of chronic and acute self-harm, and a treatment plan that provides support to clinicians taking short-term risks in the service of long-term gain. For more on this approach, see Beatson et al. (2010) and Chiles and Strosahl (2005).

Unfortunately, treatment services may unintentionally set up a system which requires clients to self-harm in order to obtain services. Those who seek assistance before they self-harm may be told that their difficulties are not severe enough to access services. Having self-harmed to the threshold required for access to services, the client may then be ‘required’ to continue self-harming, or even to escalate self-harm, in order to maintain access to treatment (Morton et al. 1994). It is very difficult to treat self-harm within a context that requires it.

**Severe interpersonal difficulties**

Many aspects of human interactions can trigger intense emotion for those who have suffered childhood adversity. Typically, people with BPD symptoms have severe relationship difficulties, ranging from efforts to withdraw from others to intense dependence. People with a history of childhood adversity will usually lean towards one of these positions. However, some oscillate agonisingly between the two extremes, experiencing discomfort with both closeness and distance – relationships are experienced as either too close (triggering fears of engulfment) or too distant (triggering fears of abandonment). Intense and changeable emotions create difficulties in charting a course through relationships with self and with others. For someone who was neglected as a child, an apparently minor event, such as a cancelled therapy session, might trigger intense fears and distress from childhood associated with loss or absence of parents, including terror that basic needs will not be met.

Self-harm may be used to elicit care, or to prevent a loved one from leaving – a strategy which may be effective in the short term, but which does terrible damage to relationships over the long term. A typical unhelpful cycle is one in which the person makes a desperate appeal for help with suicidality or self-harm. The other person feels pressured to offer too much, gradually becomes more and more resentful, yet holds back from expressing this out of fear of provoking self-harm or suicide. Eventually, the relationship blows up in some way, thus heightening the client's fear of rejection and desperation. And then the cycle begins again with someone else.
**Remoteness from values**

Impulsive actions and an understandable preoccupation with short-term survival have sometimes resulted in people with BPD symptoms straying far from their values. As they start to reflect on values, they may be assailed by intense guilt and shame. Identifying values, or indeed desires, may expose people with BPD symptoms to the painful gap between what they want for themselves and the lives they currently lead. With limited capacity to 'make space' for painful feelings, they may be tempted to immediately push away the grief over lost time and lost opportunities, or to launch into anger and blame towards those who have stood in the way of a happier life. It is quite a leap to step out of the comfort zone of 'I don't know' or 'It doesn't matter' into the pain of caring.

People with BPD symptoms may have difficulty identifying their values. If they have learned to tune out awareness of body and emotions and to focus relentlessly outwards, it can make it difficult to know what they want or what they value. They may have learned to turn away from awareness of their hopes and desires to protect themselves from disappointment and despair.

**Assessment and case formulation – an ACT perspective**

Assessment of a client's treatment needs from an ACT perspective differs from standard psychiatric history-taking in many ways. There is more emphasis on understanding what is important to the person, and symptoms are examined in the light of how they serve to provide short-term relief and long-term suffering. Difficult thoughts and feelings are not seen as the target of treatment. Rather, it is the relationship of the person to these difficult thoughts and feelings that is of interest. Assessment may include taking a history, but the focus of this history is not so much on places and dates as on the light the history sheds on current patterns of coping.

In the Wise Choices group program, we come back time and time again to a diagram we call the 'avoidance loop' or 'emotional avoidance detour', which illustrates the person's valued direction in life, the situations that trigger difficult thoughts and feelings, and a way that the person avoids these difficult inner experiences. As well as providing an ongoing unifying theme for the Wise Choices treatment program, a diagram based on this metaphor readily lends itself to a way of summarising an assessment of group members' key issues from an ACT perspective. We also find this approach helpful when we provide consultation and training to staff at other services. Assessment is similar whether or not the person meets the criteria for BPD.

The idea for the avoidance loop diagram came from a delightful illustration by Ciarrochi and Mercer (2006). It is reproduced, with permission, below.
The Wise Choices ACT assessment diagram also makes reference to the 'passengers on the bus' metaphor (adapted from Hayes et al. 1999). The box below contains the handout from Session 1 of the Wise Choices groups, which introduces the metaphor.

**Passengers on the bus**

Imagine you've been driving a bus called 'My Life' and the road you've decided to take is towards a full, rich and meaningful life. As you drive along, you pick up passengers – memories, emotions, thoughts, and so on. Some of the passengers you like – friendly ones, funny ones and supportive ones. You hope they will sit up the front, near you. Some passengers you don't like at all. If only these passengers had taken another bus!

Sometimes difficult passengers come up the front of the bus and start trying to get you to go a different way:

-'You've got to turn left!' 
-'You've got to turn right!' 
-'That way is too hard, go this way'

If you do what they say and turn the bus in the direction they want to go, they quieten down and you might feel better for a while. However, giving in to them means you are driving your 'life bus' in a direction you don't really want to go. You can end up focusing on how to keep these difficult passengers quiet and completely lose your way. After a while, you are likely to feel worse.

Naturally, you would really like the difficult passengers to get off the bus, but because they are your thoughts, feelings and memories, there is no way to get rid of them. Even turning around to argue with them distracts you from driving where you want to go. In the end, to have the life you want, you will need to find ways to take all the passengers – the likeable and difficult ones – along for the ride. You will need to find a way to stop making deals with them, which turn control of the bus over to them.

*Can you find a way to drive your bus in a direction that makes your heart glad?*
The components of the metaphor can be illustrated in a diagram, shown below.

**ACT assessment summary**

Values:

What are the short-term benefits?

Feel better for a while

The experiential avoidance loop
- impulsive action, aggression,
- self-harm, substance use,
- social withdrawal, etc

...then feel worse

What are the costs?

Below, we describe each of the components in turn and explain how we operationalise them in practice as part of an ACT understanding of a client's issues.

'Driving the life bus towards a full, rich and meaningful life'

What are the person's values? What makes their heart glad? How aware are they of their values and how much does awareness of values guide action?

Many forms of therapy focus predominantly on problems. One of the great advantages of ACT is a shift to focusing primarily on values, and only secondarily on how impulsive action or experiential avoidance can result in a turning away from values. A discussion of values can open up a new perspective. It can help both clinician and client refocus on what a full, rich and meaningful life would look like for this person, rather than all the ways they are stuck or engaged in self-defeating strategies. Action on heartfelt values can provide a source of vitality and motivation to endure the pain that comes with doing things differently.

A focus on values is quite different from a focus on goals, particularly for people who see themselves as having failed to reach traditional goals in study, work and relationships. Many long-term clients of mental health services have felt pressured to meet goals that are actually the clinician's goals, or those...
of family members, rather than their own (such as giving up drug use, finding a job, or ‘graduating’ from the service). Whereas setting goals leaves the person in a state of endlessly striving for something that may be out of reach, identifying a value provides a direction that can be lived in small ways every day.

‘Choice points’
Which internal and external contexts tend to trigger difficult thoughts and feelings? How are choices for action made: does the person generally make a conscious choice, act on impulse or operate on ‘automatic pilot’? Can the person notice the point at which they make a choice and the thoughts, feelings and values that influence that choice?

‘Difficult passengers’
What are the difficult thoughts, feelings, memories, urges and body sensations that typically trigger unwise actions or experiential avoidance?

‘Being bossed around by difficult passengers, making deals with difficult passengers’
What are the typical methods the person uses for experiential avoidance when difficult thoughts and feelings are strong? What are their typical ‘avoidance loops’? Self-harm? Using drugs or alcohol? Withdrawal from social contact? What are the unhelpful actions that occur as a result of acting on the urges associated with strong emotions? Physical or verbal aggression? Self-harm? Clinginess or demandiness that causes relationship stress?

‘Feel better for a while, then feel worse’
A person would not be making an unhelpful choice over and over for no benefit. What are the short-term benefits of ‘turning off track’? What are the long-term costs? How is making this choice working for the person?

‘Taking the difficult passengers with you’
What mindfulness and acceptance skills does the person already have to notice difficult thoughts and feelings without acting on them? Are they able to use these skills to take action based on values even when emotions are strong? Are they willing to ‘make space for’ difficult thoughts and feelings? How much do they struggle to change difficult thoughts and feelings? What have they tried that works? Is the person familiar with yoga, meditation, martial arts, singing, dancing, art work, or any other activity that may include components of mindfulness or acceptance strategies? Are they able to adapt and apply these skills when difficult thoughts and feelings are triggered? What have they tried that doesn’t work?

What capacity does the person have to make use of the help of others at times of crisis? What can others do to help? What might others do that doesn’t help?

Summary
People with BPD symptoms have generally experienced more suffering than the rest of us. Their struggles are otherwise similar. They may need a more gentle start to treatment in which acceptance, mindfulness and relationship skills are practised in relatively unthreatening contexts before work
with emotionally charged material is attempted. An understanding of the person’s values, and of the difficult thoughts and feelings that trigger action against their values, can provide a focus for treatment.

**Structure of the book**

The remaining chapters of **Part A** provide an overview of Wise Choices group treatment:

- **Chapter 2** describes the use of a graduated approach to treatment for those with a history of severe childhood adversity.
- **Chapter 3** discusses the management of group dynamics and other group process issues.
- **Chapter 4** looks at the practicalities of setting up and running Wise Choices groups.

**Part B** describes the 10 group sessions of Series 1, ‘Wise Choices’, including an overview of a typical session and detailed session outlines.

**Part C** describes the 10 sessions of Series 2, ‘Wise Choices in relationships’, including an overview of a typical session and briefer session outlines.

**Part D** provides guidelines for running Series 3, ‘Values in action’ – 20 or more sessions of less-structured group treatment.

**Part E** consists of all of the handouts used in Series 1 and 2 and some sample handouts for Series 3 group sessions.

A CD with printable copies of the handouts is at the back of the book.