Research Project Portfolio

University of Nottingham

School of Medicine

Division of Psychiatry and Applied Psychology

Doctorate in Clinical Psychology

2023

Acceptance and commitment therapy for people experiencing multiple disadvantage and emotionally unstable personality disorder: Adapting a manual through consultation

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Submitted in part fulfilment of the requirements for the

Doctorate in Clinical Psychology

Acknowledgements

I would like to express my deepest appreciation to my research supervisors Dr Anna Tickle and Dr Danielle De Boos. You have been calm and encouraging throughout this process, which I appreciated as a trainee who had not been to university for some time, and when the original research plan became unattainable. It has been a privilege to have worked with both of you on this project and to learn so much about qualitative research processes. I will miss working with you both. I am extremely grateful to the research and academic tutors, as well as the Service User and Carer Advisory Panel at the University of Nottingham for their valuable feedback throughout the research process. It has been extremely valuable to have had such expertise guiding the project.

The first year of training marked an emergence from lockdown due to the Covid-19 pandemic. It was also during the first year that I married my husband Tom, who has been unwavering in his patience, support, and encouragement every step of the way. If we can survive home-working, a pandemic, and a doctorate, I think we can do anything! I look forward to supporting him in the same way throughout his own degree. A very special thanks to my mum, dad, brother, and grandad, who have been incredibly understanding and supportive throughout my training. They have shown a keen interest in every part of my research, and my original inspiration for working with marginalised populations was always my mum. I am also incredibly grateful to my best friend Naomi for her endless words of encouragement and guidance.

Finally, I would like to thank all of the staff, managers, and people with lived experience at Framework who made recruitment to the study possible. Individuals facing multiple disadvantage continue to be marginalised by society across health and social care sectors, and I hope this will improve in the future. I feel privileged to have had the opportunity to conduct my research in an area which I feel so passionately about and hope to contribute further in the future.

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Thesis Abstract

Background: Of the estimated 289,000 people facing homelessness in the UK, 42.6% experience mental health and substance misuse difficulties, and 36.6% have a diagnosis of Emotionally Unstable Personality Disorder (EUPD). National guidance recommends psychological therapies for the treatment of EUPD; however, individuals who also misuse substances and face homelessness are often excluded by services due to inappropriate modes of delivery. Current guidance recommends that individuals receive support for what they feel are their priority needs; however, this is not always enacted. Previous research has shown that consulting with People With Lived Experience (PWLE) can be valuable in shaping services to maximise delivery to such marginalised populations. Another barrier to accessing therapies is that they are often delivered by specialist professionals such as Clinical Psychologists, of which there is a national shortage. In addition, the services supporting this population of people predominantly rely on professionals without specialist therapeutic training. The evidence-base is limited regarding the effectiveness of therapies for this population; however, Acceptance and Commitment Therapy (ACT) has been shown to be effective in individuals who misuse substances, and individuals diagnosed with EUPD. ACT posits that mental health difficulties can be avoided through developing 'psychological flexibility' and can be delivered by professionals without specialist training; however, no tailored ACT interventions exist for this population.

Study Aims: Identify existing ACT interventions that could be adapted for this population, consult with professionals and PWLE regarding required adaptations, and develop a draft manual for this population.

Method: Literature was reviewed to identify existing ACT interventions related to the target population in adherence with manual development guidance. A rating measure was developed to assess existing interventions' strengths and inadequacies, and to encapsulate a range of needs related to the target population. Four relevant professionals and two PWLE each attended two semi-structured interviews and provided quantitative and qualitative data regarding the existing interventions. Quantitative analysis was conducted to dictate the order of excerpts and identify significant differences between first and second interview data to assess for conformity bias. Framework analysis was used to analyse qualitative data and three main themes were identified: acceptability,

facilitators, and barriers. Data was interpreted by mapping the range and nature of responses, identifying key dimensions, identifying associations, formulating explanations, and developing strategies for the adapted manual.

Results: Excerpts with higher rating measure scores were selected to present in participant interviews. Forty-one excerpts across five manuals were identified in the literature. There were no significant differences between first and second interview scores. All 41 excerpts were included within the adapted manual.

Discussion: This study was a first attempt at consulting with professionals and PWLE to develop an adapted ACT manualised intervention. It provides clinical and research opportunities related to this population and it can be delivered by non-psychologists. Future research is required to explore the feasibility, effectiveness, and acceptability of the adapted manual, and to evaluate whether the intervention improves psychological flexibility and quality of life and reduces EUPD symptoms and substance misuse. Limitations include sample characteristics, which limit generalisability.

Statement of Contribution

Hannah Holland was responsible for the planning and designing of the research, gaining ethical approval, writing the review of the literature, consultation with professionals and people with lived experience, recruitment, data collection, data analysis, and the write up of the research.

Dr Anna Tickle provided support as the first research supervisor on the design of the research, ethical approval processes, data analysis, and the write-up, as well as recruiting participants.

Dr Danielle de Boos provided support as the second research supervisor on the study and provided feedback on the shaping of the study, and data analysis.

Research Tutors at the University of Nottingham provided support throughout the programme regarding the design of the study.

Richard Galloway provided support in the recruitment of people with lived experience.

Journal Paper

Formatted in preparation for submission to the 'International Journal of Mental Health and Addiction' *(see Appendix A for journal submission guidelines).*

Acceptance and commitment therapy for people experiencing multiple disadvantage and emotionally unstable personality disorder: Adapting a manual through consultation

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Abstract

Background: Individuals diagnosed with Emotionally Unstable Personality Disorder who misuse substances and face homelessness are often excluded from services. Psychological interventions are often inappropriate for this population, few are coproduced, and there is a limited number of psychologists to deliver them. Acceptance and Commitment Therapy (ACT) focuses on improving wellbeing and does not require delivery by psychologists. **Aims:** Identify existing ACT interventions and develop an adapted manual through consultation. **Methods:** The literature was searched for existing interventions. Six professionals and people with lived experience provided quantitative and qualitative data during serial interviews, and Framework Analysis was used. **Results:** Forty-one interventions were identified across five existing manuals. An adapted manual was developed. **Discussion:** This study contributes an intervention which can delivered by non-psychologists. Limitations of serial interviewing and the sample should be considered. Future research is required to continue adapting this intervention.

Key words: Substance, personality disorder, homelessness, ACT, consultation.

Literature Review

Emotionally Unstable Personality Disorder (EUPD) is characterised by severe affect instability, identity, relationship difficulties, and behavioural dysregulation (American Psychiatric Association [APA], 2013*) [see 1.1 in extended for diagnostic criteria for EUPD].* The UK prevalence of individuals with an EUPD diagnosis is 0.7%-2.0%, with 20% of psychiatric inpatients and 10-30% of outpatients meeting diagnostic criteria (National Institute for Health and Care Excellence [NICE], 2009). EUPD is mostly diagnosed among women (75%); although estimates vary, with most studies focusing on treatment-seeking females (Tadić et al., 2009). Despite controversy surrounding the diagnostic label (Lamb et al., 2018), as current clinical guidance is founded upon diagnoses, the term 'EUPD' will be used here. Evidence suggests EUPD is caused by an interaction between genetic vulnerability and an invalidating childhood environment (Chapman et al., 2022) *[see 1.2 in extended for further information regarding the aetiology of EUPD].* NICE (2009) guidance recommends psychological treatment of EUPD, particularly where comorbidities exist.

Approximately 58,000 people in the UK experience combined homelessness, substance misuse and mental health difficulties annually, known as 'Multiple Disadvantage (MD)' (Fulfilling Lives, 2020). Individuals experiencing 'homelessness' are defined as individuals sleeping rough, living in unaffordable, temporary, or harmful accommodation, facing eviction, squatting, or at risk of violence at home (Royal College of Nursing, 2021). In the UK, approximately 289,000 people experience homelessness (Fitzpatrick et al., 2021), 42.6% of whom experience substance misuse and mental health difficulties (Mental Health Foundation, 2021). Childhood trauma and relationship difficulties can precipitate homelessness (Fitzpatrick et al., 2012) and are associated with EUPD (APA, 2013). Approximately 36.6% of people experiencing homelessness in the US have an EUPD diagnosis (Whitbeck et al., 2015); although generalisability to UK populations is limited.

Substance misuse involves "the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage" (NICE, 2019). Approximately 78% of individuals diagnosed with EUPD misuse substances (Tomko et al., 2014). One reason for this could be a desire to alleviate distress (Vest & Tragesser, 2020); although this study only focused on alcohol, cannabis, and opioids *[see 1.3 in*

extended for further information regarding EUPD and substance misuse comorbidity]. Substance misuse rates are high among individuals facing homelessness, contributing to 32% of deaths in England in 2017 compared with 1% of the general population (Advisory Council on the Misuse of Drugs, 2019). Individuals misusing substances were found to be seven times more likely to become homeless, and to misuse substances to cope with homelessness, maintaining both factors (Single Homeless Project, 2017). There is, therefore, a need for effective interventions for this population.

Treating such individuals is difficult as they are frequently excluded from services (Fulfilling Lives, 2020) despite contrary guidance (NICE, 2016). This population are more likely to lead lifestyles that are described as chaotic (Reid, 2009) which do not 'fit' with traditional service delivery (e.g., rigid appointment times). Current guidance recommends individuals receive support for the difficulties they prioritise (e.g., mental health), particularly for those facing homelessness (NICE, 2016; Public Health England [PHE], 2017). This supports the Five Year Forward View (Mental Health Taskforce, 2016), and Department of Health (DoH; 2002) guidance recommending person-centred mental healthcare for individuals who misuse substances. Coproduced guidance provides specific recommendations to improve care quality, reflecting the value of consulting with People With Lived Experience (PWLE) in service design (Making Every Adult Matter [MEAM] Coalition, 2015). However, collaboration with PWLE is inadequate due to lack of commissioning and resources (Fulfilling Lives, 2020), despite guidance (NICE, 2022) *[see 1.4 in extended for further information regarding coproduction].* Recommendations include professionals developing trusting relationships and exploring risk factors for disengagement (e.g., modes of delivery, difficult experiences, literacy, ineffective communication) (DoH, 2017). For individuals misusing substances, guidance recommends competently delivered evidence-based treatments which acknowledge mental health and trauma difficulties (NICE, 2022). Barriers to delivering treatment include a lack of specialist professionals, such as Clinical Psychologists (Association of Clinical Psychologists [ACP], 2020) and existing interventions which assume resources (e.g., psychologists) or service aims (e.g., substance misuse reduction). Services supporting individuals with MD predominantly rely on non-specialist professionals (Fulfilling Lives, 2020), therefore require interventions tailored to individuals and services.

Research regarding the effects of psychological interventions for this population is lacking. For individuals diagnosed with EUPD, Dialectical Behaviour Therapy (DBT) has been shown to significantly reduce self-harm and suicidal behaviour (Hedges' *g*=.68) through improving emotion regulation (Panos et al., 2014). Mentalisation-Based Therapy has been shown to significantly reduce psychiatric symptoms (*d*=1.06-1.42) (Bales et al., 2015). General Psychiatric Management (GPM) has been found to be as effective as DBT in reducing EUPD symptomatology (McMain et al., 2009). However, evidence is based on few studies, in which self-report measures and confounding variables increase the risk of bias. There is a further lack of research for those diagnosed with EUPD who misuse substances. However, a narrative review (Holland & Tickle, 2023) demonstrated favourable results regarding the effectiveness of psychological therapies in individuals diagnosed with EUPD who misuse substances. For samples including participants who did and did not misuse substances, DBT significantly reduced self-harming behaviours where treatment-as-usual did not. GPM was found to lead to larger improvements in EUPD symptomatology in those misusing substances (*d*=.58) than those who did not (*d*=-.04) (McMain et al., 2009). Conclusions must be drawn cautiously, however, due to methodological heterogeneity and quality across studies. There is a significant gap in the literature, clinical practice, and service delivery for a coproduced psychological intervention that does not require specialist professionals for this population.

Acceptance and Commitment Therapy (ACT) states that psychological distress is not avoidable but mental health difficulties are (Hayes et al., 1999) *[see 1.5 in extended for further information regarding the theoretical underpinnings of ACT, 1.6 for further information regarding epistemology, and 1.7 for further information regarding the ACT theory of psychopathology].* Attempts to avoid distress through 'experiential avoidance' (e.g., substance misuse), can cause more difficulties (e.g., homelessness), high levels of which have been associated with fulfilling more EUPD diagnostic criteria (Chapman et al., 2006). This occurs due to reduced 'psychological flexibility', which is characterised by fusing with unhelpful thoughts, avoiding distress, focusing on the past or future rather than the present, lack of direction, passivity, and limited awareness of internal processes (Hayes et al., 2006). Research demonstrates that the severity of poor mental health and experiential avoidance has an interactive effect on substance misuse (Sloan et al., 2017) which can increase the risk of emotion dysregulation (Luoma et al., 2008).

Compared to Cognitive-Behavioural Therapy (CBT), drug counselling, and self-help, ACT is presented as a promising intervention for reducing experiential avoidance (*d*=.84).

ACT aims to increase 'psychological flexibility', which describes "the ability to contact the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends" (Hayes et al., 2006, p. 7). This can be done by developing skills in six core processes: cognitive defusion, acceptance, present moment awareness, values, committed action, and self-as-context (Hayes et al., 2006). 'Experiential avoidance' occurs "when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioural predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them" (Hayes et al., 1996, p. 4). Both biosocial theory (Linehan, 1993) and Chapman et al. (2006) suggest that experiential avoidance is more likely in individuals diagnosed with EUPD due to a heightened sense of intense emotions, and a lack of ability to regulate emotions and tolerate distress. When distressed, they are more likely to become fused with thoughts about avoiding such emotions and engage in behaviours to reduce distress in the short-term (e.g., substance misuse) but which do not align with their values (Zurita Ona, 2020). 'Values' are "chosen qualities of purposive action that can never be obtained as an object but can be instantiated moment by moment" (Hayes et al., 2006, p. 8). This is a particularly important skill to develop for individuals diagnosed with EUPD, who often have difficulties in regulating their emotions (Zurita Ona, 2020). Values can motivate helpful behaviours and facilitate acceptance despite the experience of painful emotions or stimuli (Hayes et al., 1999). Alongside the five other ACT processes, this would allow individuals diagnosed with EUPD to notice their experiences, accept them, and take steps towards their values without engaging in experiential avoidance. This would involve accepting, rather than avoiding, their internal processes, and engaging in behaviours that align with their personal life values (e.g., family, compassion, knowledge, etc.) without succumbing to their urges to misuse substances to avoid distress. Identifying personal values can provide the motivation to commit to developing psychological flexibility, which may reduce avoidance strategies (e.g., substance misuse) *[see 1.8 in extended for further information regarding the ACT process]*.

ACT research regarding people experiencing MD is sparse; although Murthy et al. (2020) proposed that experiential avoidance can maintain the cyclical nature of mental ill-health and homelessness. Studies involving participants who misuse substances have found ACT to be as effective as CBT in reducing experiential avoidance (González-Menéndez et al., 2014) and psychological inflexibility (Maia et al., 2021). However, generalisability is limited as not all participants had EUPD diagnoses. Piri et al. (2020) found that both schema therapy and ACT were effective in reducing EUPD symptoms in individuals diagnosed with EUPD compared to a no-treatment control group. A manual developed by Luoma et al. (2005) significantly improved mental health (*d*=.49) in people misusing substances. Another by Meyer et al. (2018) found that ACT significantly reduced alcohol-related outcomes and improved quality of life (*d*=.65, and .50, respectively). ACT has been shown to be as effective as DBT for individuals diagnosed with EUPD (Reyes-Ortega et al., 2020) and has demonstrated significant effects in improving EUPD symptomatology, psychological flexibility, and experiential avoidance (Cosham, 2013). However, the use of self-report measures, small samples, and heterogeneity in therapy format across studies jeopardise the reliability of findings and may introduce bias *[see 1.9 in extended for a more in-depth review of existing literature]*.

ACT, which can be delivered by professionals without expertise in the delivery of psychological therapies (e.g., Clinical Psychologists), may be as effective as therapies which require such expertise for delivery (e.g., DBT). Therefore, it may be a practical approach for services without clinically trained professionals, such as services supporting individuals facing MD (Homeless Link, 2017). Indeed, a review by Arnold et al. (2022) found that ACT interventions can be successfully delivered by a range of professionals to effectively address psychological distress. There is a clear need for evidence regarding an ACT intervention which aims to improve mental health for the target population. No specific ACT interventions exist for people diagnosed with EUPD who misuse substances and face homelessness, for whom flexible and coproduced approaches would be advantageous. ACT is likely to be effective, as reducing experiential avoidance (e.g., reduced substance misuse to avoid difficult emotions) could reduce psychological distress and improve emotional regulation. As discussed, individuals diagnosed with EUPD are more likely to be psychologically inflexible due to the nature of EUPD. This is related to emotion regulation difficulties and a lack of

ability to tolerate distress (APA, 2013), which can lead to an increased likelihood of avoidance of such discomfort (Chapman et al., 2006). It also relates to the increased likelihood of individuals within the population to become fused with unhelpful thoughts (e.g., Zurita Ona, 2020), which can also lead to experiential avoidance (e.g., Firouzjaei et al., 2020). In addition, an unstable sense of identity may inhibit individuals with a diagnosis of EUPD to only view themselves from one perspective in a judgemental manner. Although transdiagnostic, the existing range of difficulty-specific ACT manuals suggests a need to tailor to different populations. Accordant with guidance, an adapted ACT manual would provide a psychological treatment for this population. To address this gap in the literature, this study aimed to:

1. Identify existing manualised ACT interventions that could be used with individuals facing MD and diagnosed with EUPD to increase psychological flexibility and quality of life, and reduce symptoms associated with EUPD and experiential avoidance (e.g., substance misuse),
2. Consult with professionals and PWLE regarding the accessibility and relevance of existing interventions and whether they require adaptations for the target population,
3. Develop a draft manual for professionals without specialist therapeutic or mental health training to use with the target population.

Method

Epistemology

A pragmatic position was adopted to ensure the most effective methodology was used to address the research aims (Maarouf, 2019).

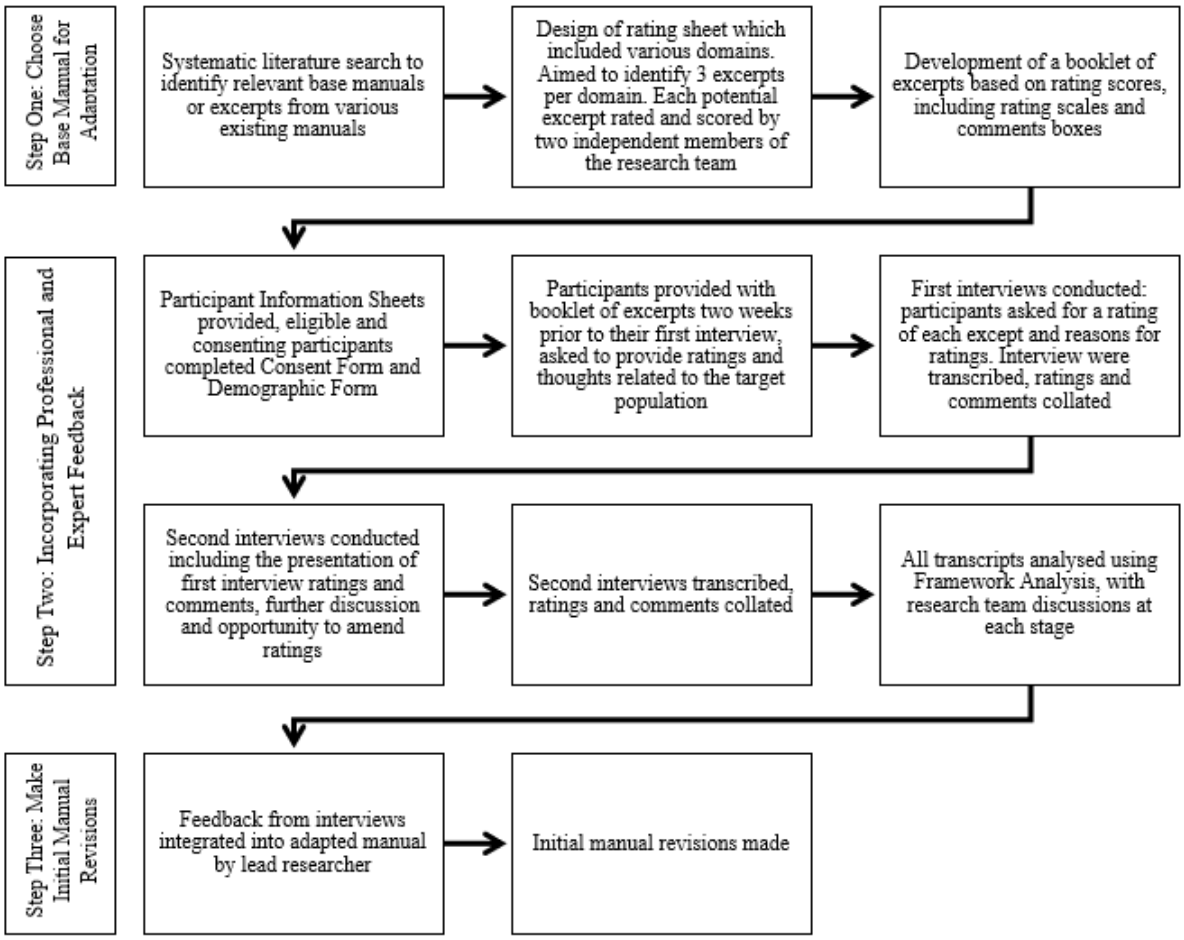
Design

The development of an adapted manual was grounded in Goldstein et al.'s (2012) guidance, which has been shown to be useful in developing manuals in various mental health fields (e.g., Akter et al., 2020; Bryl & Goodill, 2020; Goldstein et al., 2012). This guidance emphasises the importance of adapting existing manuals for populations with shared characteristics of the target population, particularly where existing manuals have empirical support. Goldstein et al.'s (2012) guidance involves a

total of nine steps, as illustrated in Figure 1. The current research focused on the first three steps, which involved identifying existing manuals which can be adapted for the target population, incorporating professional and expert feedback, and making initial manual revisions.

Figure 1

Visual Depiction of the Procedure



Note. The steps this study included across the first three stages of manual development as per Goldstein et al. (2012).

Step One: Choose a Base Manual for Adaptation

Goldstein et al. (2012) identified that manualised interventions for specific target populations may not exist, and existing manuals are often criticised on the basis that they do not apply to varied populations (Carrol & Nuro, 2002). As the current research focused on both EUPD and substance misuse, it was anticipated that there would be a

lack of existing manualised interventions to use as a single base manual. Previous manual adaptation studies have incorporated several existing resources into an adapted manual to ensure relevance for the target population, with promising results (e.g., Akter et al., 2020). Therefore, the researchers were open to considering parts of more than one existing manual in the adaptation process.

Manualised interventions have also been criticised for a lack of flexibility in implementation which fails to take the diversity of specific populations into consideration (e.g., Carrol & Nuro, 2002). For instance, existing manuals which use symbols and pictures may be widely applicable to adults with a moderate learning disability. However, for individuals within the target population, the level of ability to understand and engage with particular formats is largely unknown and likely to vary. Therefore, the researchers aimed to identify more than one excerpt for each domain derived from the rating scale (e.g., 'Values', 'Personality Disorder', etc.).

As per Goldstein et al. (2012), a systematic literature review was conducted to identify existing manualised interventions and determine whether they could be adapted for the target population. The stage of research for those interventions was explored along with the theoretical foundation and mechanisms of action for compatibility with the target population *[see 2.1 in extended for further information regarding the identification of existing interventions]*. Those excerpts identified as potentially adaptable for the target population were reviewed through the development of a rating measure (Figure S1 in supplementary material). Excerpts with higher scores were included in a booklet of excerpts presented to participants during Step Two.

Step Two: Incorporating Professional and Expert Feedback

Feedback was then gathered from the target population and professionals working with that population about the content and structure of interventions identified in Step One as per Goldstein et al. (2012) *[see 2.2 of extended for further information regarding gathering information from professionals and experts]*. An explanatory mixed-methods sequential design was used. Quantitative data was gathered during semi-structured interviews by using a rating scale designed by the researchers. This allowed participants to provide a quantitative response which indicated how helpful they thought each excerpt was and enabled the researchers to measure conformity bias

between first and second interview responses. In-depth qualitative data were gathered via ratings and serial semi-structured interviews (Schoonenboom & Johnson, 2017).

Serial interviewing involves more than one interview with each participant and was appropriate for the current research due to time restrictions and discussions about complex issues. They provide opportunities for in-depth discussions regarding participants' perceptions and experiences, which they may not have considered before understanding the perceptions of other participants (Read, 2018). Previous research has shown that more than one interview can help to gathered detailed information, allowing researchers to understand participants more fully (e.g., Spradley, 1979; Fujii, 2018). This was important for the current research, as the researchers anticipated that participants were unlikely to have considered ACT manuals for EUPD and substance misuse before.

Step Three: Make Initial Manual Revisions

In accordance with guidance by Goldstein et al. (2012), initial adaptations of existing interventions were made, including changes to both the content and structure of the original interventions. Data analysis in Step Two informed the decisions made in manual adaptation *[see 2.3 of extended for further information regarding content and structural changes according to Goldstein et al. (2012)]*.

Procedure

Step One: Choose a Base Manual for Adaptation

Systematic Literature Review. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines provided a framework for the development of the review protocol (Page et al., 2021). The databases PsycINFO, Embase, Google Scholar, and the ACBS website were systematically searched between February 2022 and October 2023. No date limit was set. Free-text terms were used with all databases. Broad search terms and multiple alternatives were used to increase the likelihood of identifying relevant manuals (see Figure S2). Following the identification of potentially relevant manuals, duplicates were removed. Titles and abstracts were assessed by one reviewer. Full texts of the manuals were obtained, and inclusion criteria were applied.

Eligibility Criteria. Manuals were considered for inclusion if they:

1. Were for individuals diagnosed with EUPD/BPD and/or individuals who misused substances,
2. Used ACT as the psychological approach.

Manuals were excluded if they:

1. Were intended solely to reduce substance misuse,
2. Were not based on ACT,
3. Did not focus on interventions,
4. Did not focus on either EUPD or substance misuse.

Rating Measure. In accordance with guidance by Goldstein et al. (2012), empirical support, appropriate theoretical foundations, and adaptability were incorporated into a rating measure (Figure S1) designed by the researchers. Goldstein et al. (2012) also emphasised the importance of measuring existing interventions' strengths and inadequacies relative to the theory being used. The researchers therefore incorporated ACT principles (e.g., 'Values') into the rating measure, inspired by the Acceptance and Commitment Therapy-Fidelity Measure (ACT-FM) (O'Neill et al., 2019) *[see 2.4 in extended for further information regarding the ACT-FM]*. Existing literature was also considered in order to identify any additional factors which related to the target population that should be added into the rating measure.

Identifying Appropriate Excerpts. All relevant excerpts across existing manuals were identified and rated on a Likert scale of 0 (not mentioned) to 3 (explicitly addressed in detail) in relation to various domains. Higher scores reflected greater utility for adaptation. The researchers aimed to gather three excerpts per domain, and more if there were a range of excerpts relevant to varying needs (e.g., physical mobility). For domains wherein all manuals offered excerpts which scored a '3' (e.g., "A focus on clarifying an individual's values"), the three excerpts from manuals with the highest scores for empirical support were used. Two independent reviewers analysed and rated exercises for each existing manual and a discussion was had to explore and make decisions about any differences. Exercises with a score of '3' were included in a booklet of excerpts that would be presented to participants during Step Two. If there were less than three excerpts scoring '3', excerpts scoring '2' were considered, to provide options

during Step Two. Where less than three excerpts scored ‘2’ or ‘3’, excerpts scoring ‘1’ were considered.

All identified existing manuals were read by the lead researcher and all excerpts relevant to each domain were noted. These excerpts were then screened using the following criteria. Excerpts were retained if they included:

- A clear rationale was provided as to why the exercise was useful,
- An experiential element,
- Information to help facilitators understand important aspects of the therapy,
- Clear, simple examples,
- Information which was easily transferable to other populations,
- Comprehensive instructions,
- A script for facilitators to use,
- Accessible language,
- A visual tool.

Excerpts were excluded if they:

- Only aimed to reduce substance misuse,
- Only included information, which was not for use with the client,
- Included language that would unlikely be understood by facilitators/clients,
- Included academic and/or complex language throughout,
- Were very brief, and would require further information for facilitators and/or clients to understand,
- Included abstract concepts throughout,
- Used American terminology throughout and were therefore less relatable.
- Relied on a group format.

Identifying Empirical Support. For those domains included within the rating measure pertaining to empirical evidence, studies related to each identified manual were identified on PsycINFO and/or Embase. Studies which had cited those studies already found were also searched for. For manuals for which no studies were found on either database, the lead researcher contacted the manual authors to enquire about studies related to their manuals. All research relating to each existing manual was reviewed by

the lead researcher, who provided scores in the appropriate domains of the rating measure (Figure S1).

Ensuring Adaptability. The rating measure (Figure S1) also considered other factors related to adaptability. The rating measure (Figure S1) also considered other factors related to adaptability, as per Goldstein et al. (2012). Factors relevant to the adapted manual included:

- Suitability for individual administration to adult clients and coproduction, as the adapted manual was aimed at facilitation with individual adults,
- The inclusion of in-session and between-session tasks, as is usual in ACT,
- Suitability for administration by professionals without specialist therapeutic or mental health training,
- Consideration of potential distress in relation to trauma, as individuals with a diagnosis of EUPD are more likely than the general population to have experienced trauma,
- Relevant adaptations and accessibility of the language used, as the target population was likely to be diverse in terms of cognitive ability and neurological differences.

Step Two: Incorporating Professional and Expert Feedback

Recruitment. Purposive typical case sampling was used to recruit "typical" members of the target population (Onwuegbuzie & Collins, 2007). Professionals and PWLE were recruited via managers from services which support people facing MD. They provided potential participants with Participant Information Sheets (Appendices B and C). Those interested were asked to contact the lead researcher by telephone or email for more information. If eligible and willing to participate, potential participants completed a Consent Form (Appendix D) and demographics questionnaire (Appendix E) *[see 2.5 in extended for further information regarding participants, and 2.6 for further information regarding recruitment and participation]*.

Inclusion/Exclusion Criteria. 'Professionals' were required to be health service workers without ACT expertise (e.g., substance misuse practitioners). PWLE were required to have lived experience of MD and EUPD. Participants needed to be over the age of 18 and be able to read, speak, and write in English to ensure appropriate levels of

verbal fluency and comprehension and transcription. Exclusion criteria included acute mental health crisis or being high risk to themselves or others.

Sample Size. The researchers aimed to recruit between six and ten participants (three to five professionals and three to five PWLE) as per 'information power' guidelines (Malterud et al., 2016). This was based on the study's narrow aim (perceptions of existing interventions), dense specificity (participants recruited from the target population), and established theory (ACT). Strong interview dialogue was predicted due to interviewer skills and participant communication.

Data Collection. Participants were given two weeks to review a booklet of 41 existing excerpts and rate each on a Likert scale of 1 to 10 (1=not helpful at all, 10=very helpful), noting their perceptions related to the target population (Figure S3). Participants were then invited to their first face-to-face or remote audio-visual interview with the lead researcher where they were systematically guided through the booklet and asked for their ratings *[see 2.7 in extended for more information regarding interview format]*. Semi-structured open-ended interview questions were asked related to each rating (e.g., "Why did you respond with _?") with the researcher steering discussions to obtain data relevant to the research aims (Willig, 2009) *[see 2.8 in extended for further information regarding semi-structured interviews and other data collection methods considered]*. Ratings and comments were collated (Figure S4) to indicate participants' perceptions of excerpts and to illustrate individual ratings as well as rating means for professionals, PWLE, and the whole sample, to highlight the majority views (e.g., of required adaptations). Four weeks later, ratings and comments from the first interviews were presented to each participant within a second interview (example: Figure S5). Participants were given the opportunity to provide further comments and amend their original ratings. Ratings and comments from the second interviews were then collated *[see 2.9 for information regarding ethical approval and 2.10 for further information regarding epistemology]*. All participants were provided with a debrief letter offering support (Appendices F and G).

Data Analysis. Excerpt ratings were used as indicators of participants' perceptions and were enriched by qualitative data. Qualitative data was used to dictate the order of domains, and second interview mean ratings across the whole sample were used to dictate the order of excerpts within each domain. If quantitative and qualitative

data both demonstrated significant issues with an excerpt in relation to the target population, an alternative exercise would be considered that used the same mechanism. The aim was to incorporate all feedback consistent with participants' experience prior to feasibility testing (Goldstein et al., 2012). Interviews were audio-recorded and transcribed by the University of Nottingham (UoN) Automated Transcription Service. Framework Analysis (FA) (Ritchie & Spencer, 1994) enabled theme development and data comparison across cases and was appropriate based on the researchers' comprehensive prior understanding of the research topic. FA is appropriate for research with specific questions, limited timeframes, and a priori issues such as barriers to interventions for people experiencing MD (Srivastava & Thomson, 2009). It has been used successfully in healthcare research (Gerrish et al., 2004) and adapting manuals for marginalised populations (Marlow et al., 2022) *[see 2.11 in extended for further information regarding FA and other methods of analysis considered and 2.12 for considerations regarding conformity bias]*.

Familiarisation. Excel spreadsheets were created for each interview of each participant. The lead researcher immersed themselves in written and audio-recorded transcripts, noting key thoughts and ideas regarding each of the 41 booklet excerpts.

Identifying a Thematic Framework. The lead researcher reviewed their research notes and identified key concepts across the data. Concepts were categorised into domains to create the thematic framework, each with subthemes.

Indexing. The lead researcher systematically applied the thematic framework to all interview transcripts by noting index reference numbers in the right-hand margins of each transcript.

Charting. To understand the data as a whole across all transcripts, the lead researcher considered the range of attitudes and experiences for each subtheme. Original transcript data was arranged according to the relevant thematic reference. As a thematic approach (Ritchie & Spencer, 1994) was adopted, separate charts were developed for each domain and entries were made for all participants.

Mapping and Interpretation. The lead researcher interpreted the data as a whole by mapping the range and nature of the data, identifying associations, providing explanations, and developing strategies (Ritchie & Spencer, 1994), as these were

relevant to the original research *[see 2.13 in extended for further discussion of this decision – i.e. why not defining concepts/creating typologies]*.

Range and Nature. The range and nature of responses within each subtheme were explored to identify the nature of participants' responses and any polarities.

Key Dimensions. By reviewing this information, key dimensions were developed relevant to each domain, as well as the specific subthemes within them.

Associations. The lead researcher analysed associations between responses across participants, including explicitly expressed and implicit connections identified through the review process to highlight polarities or disagreements. In such instances, participant type (professional, PWLE) and the nature of responses were identified to consider the distribution of views (e.g., PWLE felt x and professionals felt y).

Explanations. Associations were used to formulate explanations of the data.

Developing Strategies. The researchers considered how data could be incorporated into an adapted manual. Explanations were reviewed and related strategies were identified, through explicit suggestions within the data, or deriving implicit connected strategies from the data.

Step Three: Make Initial Manual Revisions The researchers considered the generalisability of interview data to the target population and its consistency with research, theory, and practicalities (e.g., treatment duration, environmental considerations, available resources) (Goldstein et al., 2012). Excerpts with higher ratings were prioritised within their relative domain *[see 2.14 in extended for further information regarding the safeguarding of rigour and quality]*.

Results

Step One: Choose a Base Manual for Adaptation

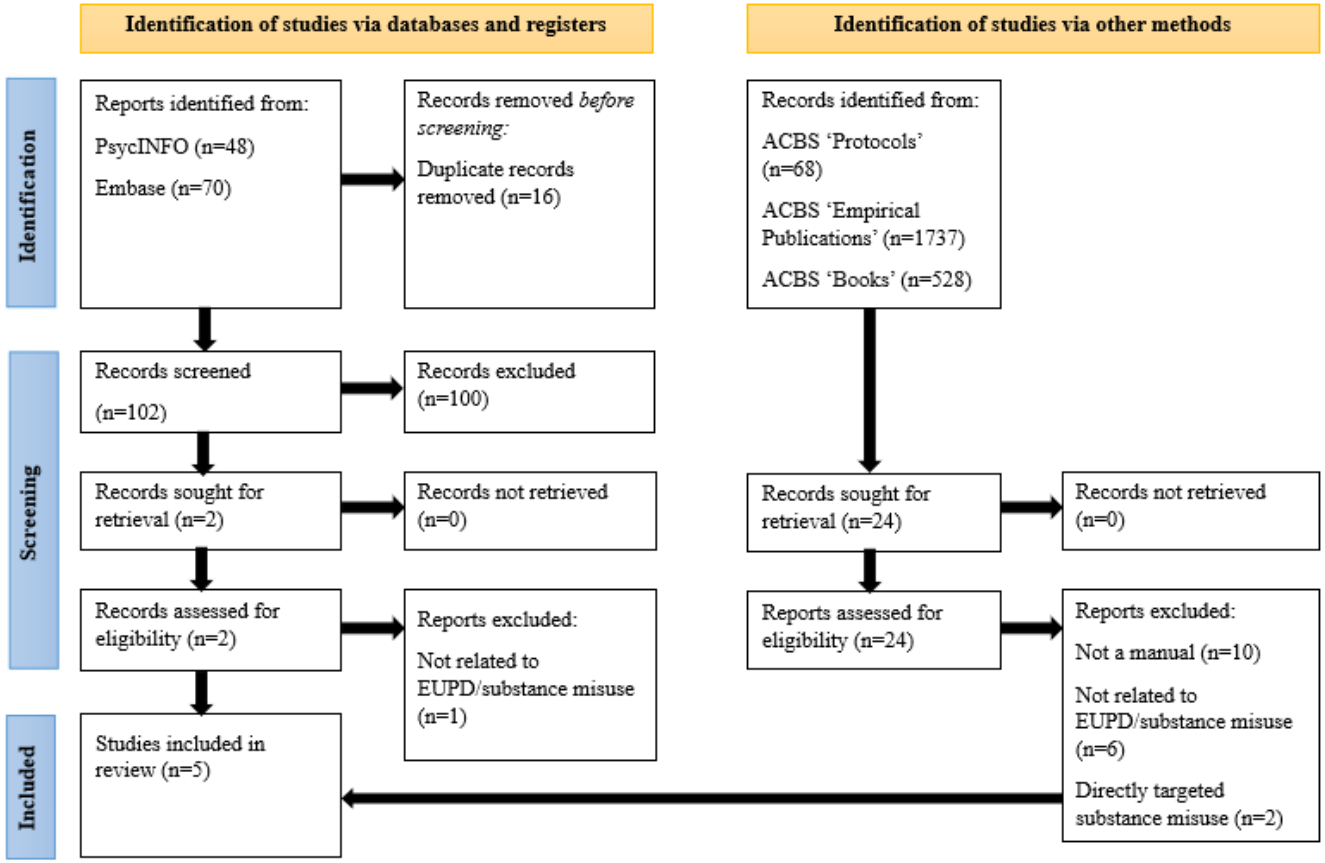
Systematic Literature Review

The systematic literature review identified 2,451 citations, and 2,435 after duplicates were removed. Five existing manuals were used in the review to identify appropriate and adaptable excerpts in manual development for the target population.

This process is demonstrated in Figure 2. Table I below illustrates the manual authors, years of publication, and target populations.

Figure 2

PRISMA Diagram Illustrating Existing Manual Identification



Note. A PRISMA diagram illustrating how existing manuals were identified. n = number of reports identified at each stage.

Table I

Manuals Identified

Author & Date	Name of manual	Target population
Luoma et al. (2005)	Acceptance and Commitment Therapy Group Therapy Manual for Self-Stigma and Shame in Substance Use Disorder	Adults who misuse substances
McKay et al. (2012)	Acceptance and Commitment Therapy for Interpersonal Problems	Adults with interpersonal difficulties
Meyer et al. (2019)	Acceptance and Commitment Therapy for Co-occurring Posttraumatic Stress Disorder and Alcohol Use Disorders in Veterans	Adults with post-traumatic stress disorder and alcohol misuse disorders, veterans
Zurita Ona (2020)	Acceptance & Commitment Therapy for Borderline Personality Disorder: A Flexible Treatment Plan for Clients With Emotion Dysregulation	Adults with a diagnosis of borderline personality disorder
Woodward (2017)	ACT on Your Recovery: A Fifteen Session Group Work Manual	Adults who misuse substances

Note. The authors, dates, names, and target populations of existing manuals identified in step one.

Rating Measure

Identifying Appropriate Excerpts. Across the five existing manuals, 96 excerpts were identified. Following screening, this was reduced to 41 excerpts, which were included in the booklet for Step Two. Twenty-eight excerpts scored ‘3’, 12 scored ‘2’ and one excerpt (‘Connect the DOTS’) scored ‘1’ and wase included due to a lack of alternative excerpts. Table II illustrates scores across the five manuals for each domain. Table III illustrates the highest scoring excerpts per domain according to author.

Identifying Empirical Support. Across all methods of gathering research related to existing manuals, 213 articles were screened, and 10 were identified as relevant, as illustrated in Figure 3. Following this, the domains included within the rating measure regarding empiricism were scored, as illustrated in Table II. All existing manuals had research conducted in relation to them. Two manuals had empirical support in relation to personality disorder diagnoses, but only one of these had efficacious support. One manual briefly measured tolerability for those diagnosed with a personality disorder through attendance, and none considered acceptability. Three existing manuals had empirical support in relation to substance misuse, and all three had some support for efficacy and tolerability. One manual had support for acceptability (through quantitative reports of treatment expectations and satisfaction).

Table II

Ratings within Each Domain Across All Manuals

Criterion	Luoma et al. (2005)	McKay et al. (2012)	Meyer et al. (2019)	Woodward (2017)	Zurita Ona (2020)
An emphasis on normalising difficult thoughts and feelings[a]	1	2	3	2	3
An emphasis on thoughts as separate experiences to the whole person[a]	3	2	3	2	1
An emphasis on "staying with" difficult thoughts and feelings[a]	2	2	3	3	3
A focus on the present moment[a]	2	3	3	3	2
A focus on noticing when a person is "hooked away" from the present moment[a]	0	2	1	1	3
A focus on a person as being bigger than / separate to their psychological experiences[a]	3	2	3	3	3
Does not attempt to distract from unwanted thoughts and feelings[a]	3	3	2	2	2
Does not use mindfulness or self-as-context methods to challenge the accuracy of thoughts or beliefs	3	3	3	3	3
A focus on workable / unworkable responses[a]	2	1	3	3	3
A focus on clarifying an individual's values[a]	3	3	3	3	3
A focus on setting goals[a]	1	0	3	2	3
Does the manual emphasise use for those diagnosed with a personality disorder? [a]	0	2	1	0	0
Does the manual refer to how it could be used for those who use substances? [a]	2	1	2	3	1
Is it suitable for all adult ages?	3	3	0	0	0
Does the manual have empirical support in general?	3	3	3	3	3
Does the manual have empirical support in for individuals with a diagnosis of personality disorder?	0	2	0	0	3
Empirical evidence for efficacy?	0	0	0	0	3
Empirical evidence for acceptability?	0	0	0	0	0
Empirical evidence for how tolerable it would be?	0	0	0	0	1

Criterion	Luoma et al. (2005)	McKay et al. (2012)	Meyer et al. (2019)	Woodward (2017)	Zurita Ona (2020)
Does the manual have empirical support in for individuals who misuse substances?	2	0	3	2	0
Empirical evidence for efficacy?	2	0	2	3	0
Empirical evidence for acceptability?	0	0	2	0	0
Empirical evidence for how tolerable it would be?	1	0	3	2	0
Total score for empirical evidence[b]	8	5	13	10	10
Is it suitable for individual administration?	0	1	3	0	3
Was the intervention co-produced?	1	0	0	0	0
Is the mode of delivery flexible? (e.g., appointment times, etc.)	N/A	2	2	1	1
Explanation of experiential avoidance[a]	2	1	2	2	1
Psychoeducation about how substance use is related to ACT	2	2	1	1	0
Psychoeducation about how personality disorder is related to ACT	0	2	0	0	1
Psychoeducation regarding psychological flexibility	0	1	0	1	2
Inclusion of in-session tasks	3	3	3	3	3
Inclusion of between-session tasks	3	3	3	3	3
It can be delivered by people without therapy / mental health training	3	0	3	0	0
Consideration of potential distress in relation to trauma (i.e., safety planning, staff approaches to managing distress)	0	0	1	1	2
Consideration of relevant adaptations (e.g., cognitive deficits, neurological difficulties)	0	0	2	1	1
Accessible language (e.g., ‘dissecting’, ‘anticipating’, ‘being void of unpleasant emotions’)	3	2	2	3	2
Flexibility regarding missed appointments	2	0	0	1	0
Flexibility regarding setting	0	0	1	0	2

Note. A table illustrating scores on the rating measure designed in step one across all identified existing manuals. Ratings were on a scale of 0-3 (3=highest).

[a]Domains which relate to specific exercises for clients. [b]Total scores for empirical support of each manual overall.

Table III

Excerpts Scores Across the Existing Manuals

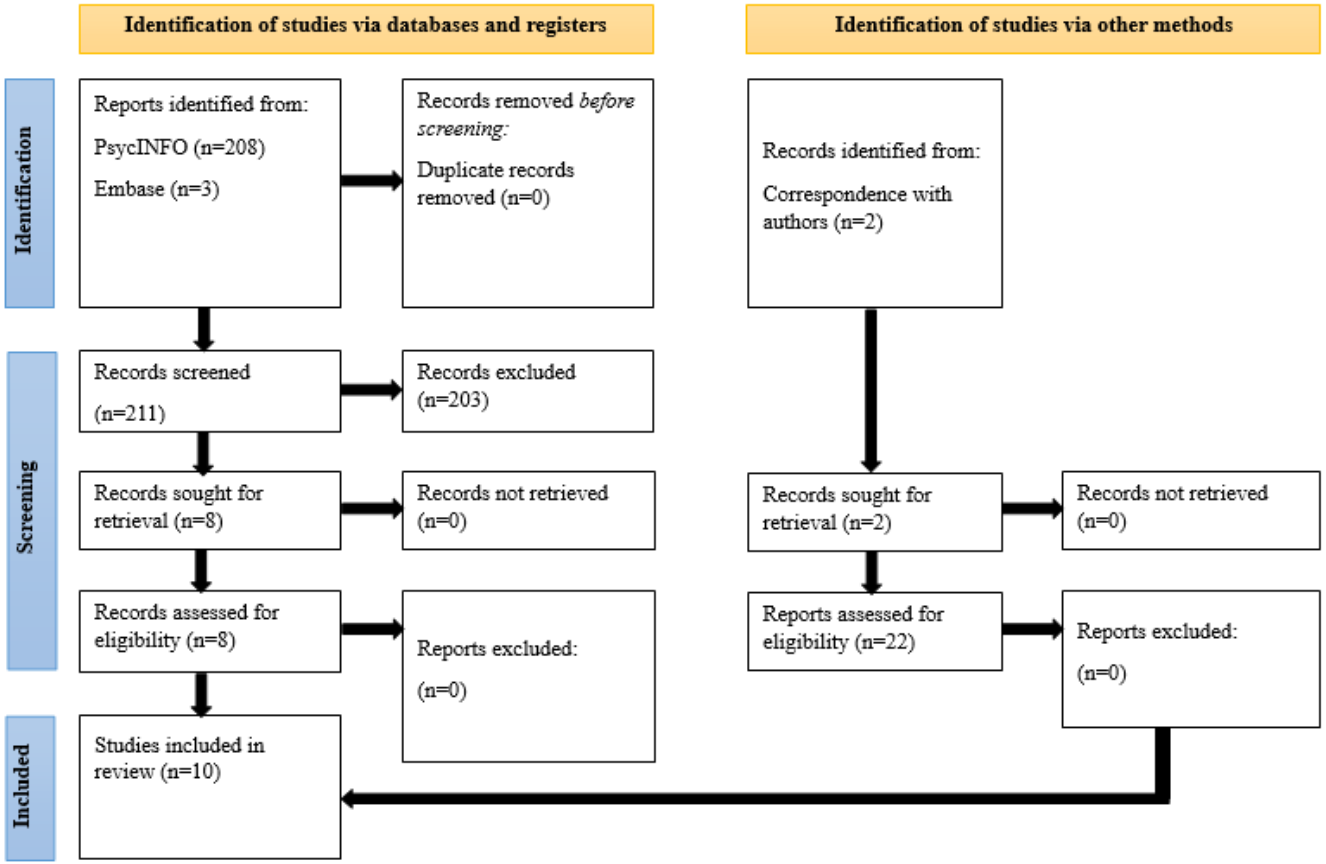
Domain	Exercise	Manual	Rating score
Traumatic experiences	Trauma – information for therapists	Zurita Ona	2
Experiential avoidance	Feeding a stray dog metaphor	Woodward	2
	Holding something heavy	Meyer	2
	Quicksand metaphor	Luoma	2
Workability	Checking the workability of thoughts	Meyer / Zurita Ona	3
	Workability	Meyer / Woodward	3
	Checking in on workability	Meyer	3
Personality disorder	Connect the DOTS worksheet	Meyer	1
	Interpersonal triggers worksheet	McKay	2
Substance use	How's it working? Substance use as a tool to do a job	Woodward	3
	High-risk situation card sort	Woodward	2
Difficult thoughts and feelings are normal	Thank you, mind	McKay	2
	Little kid exercise	Woodward	2
	No right or wrong	Meyer / Zurita Ona	3
	Validate the client	Meyer	3
Thoughts are not the whole person	Card carrying	McKay	2
	Leaves on a stream	Woodward	2
	I can't lift my arm	Meyer	3
	Milk, milk, milk	Luoma	3
You and your emotions and thoughts are separate	The inner voice	Zurita Ona	3
	Observer exercise	Woodward	3
	Eyes on exercise	Meyer / Luoma	3
Staying with difficult thoughts	Choosing to feel	Zurita Ona	3
	Tug of war with a monster	Woodward	3
	Acceptance of emotion	Meyer	3
	Unwanted neighbour Ned	Meyer	3

Domain	Exercise	Manual	Rating score
Not distracting ourselves from unwanted thoughts and feelings	When you're triggered, FACE	McKay / Luoma	3
	Mindful activities	McKay	3
	Mindful talking	McKay	3
Connecting with the here and now	Walking meditation	Meyer	3
	SOBER breathing	Woodward	3
Noticing being hooked away	Dropping anchor	Zurita Ona	3
	Defusion skills	McKay	2
Values	Identifying our values	Zurita Ona	3
	Bull's eye exercise	Zurita Ona	3
	Values card sort	Meyer / Woodward	3
Goals	Goals	Meyer / Zurita Ona	3
	Treatment roadmap	Meyer	3
	Assign first bold move	Meyer	3
Flexibility of treatment	Between-session tasks	All	3
	Session frequency	Zurita Ona	2

Note. A table illustrating the domains from the rating measure in step one, the highest scoring excerpts identified, and their authors. Ratings were on a scale of 0-3 (3=highest).

Figure 3

PRISMA Diagram Illustrating the Search for Empirical Literature



Note. A PRISMA diagram illustrating the stages of identifying empirical evidence in relation to each existing manual.

Ensuring Adaptability. Suitability for administration with adults was clearly specified in two base manuals, but all were suitable. Upon review, the researchers decided that all existing manuals were suitable for individual administration, unless an exercise relied on group administration. They could all also be delivered by professionals without specialist therapeutic or mental health training, despite this only being explicitly clear in one existing manual. All existing manuals included in-session and between-session tasks, and all included exercises with accessible language, with Luoma et al. (2005) and Woodward (2017) being the most simple and transferable in terms of language. There was a poor level of coproduction across all existing manuals, and none explicitly focused on trauma or adaptations for diverse populations; however, some did more than others.

Step Two: Incorporating Professional and Expert Feedback

Four professionals and three PWLE were recruited; however, one PWLE withdrew before the research commenced *[see 3.1 in extended for further information regarding the PWLE that withdrew]*. Professionals included four females aged 22 to 40, and PWLE included one male and one female aged 47 and 62. All participants were White English and chose to be interviewed online audio-visually.

Excerpt Ratings

Each excerpt received two ratings from each participant across two interviews. First interview scores reflected how "helpful" participants felt each excerpt was for the target population on first observation of excerpts. Second interview scores reflected their feelings after being presented with a summary of means and comments across the whole sample. Higher mean scores reflect perceptions of participants as more "helpful" for the target population.

Second interview mean scores across the whole sample were used to guide the order of excerpts within each domain. This was adhered to in all but one domain ("Personality Disorder") in which the two excerpts were presented as they were in the Step Two booklet. This was decided through research team discussions which concluded that the "Connect the DOTS" excerpt would be more useful for most clients, and the "Interpersonal Triggers" excerpt would be useful for clients wishing to focus on interpersonal relationship difficulties. This was in adherence with the guidance by Goldstein et al. (2012) which emphasises the researchers' expertise as a contributor to

manual development. Individual and mean scores across the whole sample, professionals, and PWLE, as well as excerpt orders are shown in Table IV.

No significant differences in scores were identified between first and second interviews across the sample, ruling out conformity effects *[see 3.2 in extended for further analysis of scores]*. First interview outcomes reflected lower scores (i.e., 5 or less) for 28 excerpts, and second interview outcomes reflected lower scores for 20 excerpts. Only one excerpt (“Milk, milk, milk”) received a low score from the majority of the sample across both interview, as shown in Table V.

Table IV

Mean Ratings for the Sample and Order of Excerpts

		Professionals										PWLE						Overall average		Order of excerpts within domain
		Chrissie		Nancy		Patti		Suzi		Average		David		Janis		Average				
		Interview Number																		
		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	
Domain	**Exercise**																			
Traumatic experiences	Trauma – information for therapists	9	9	8	8	9	9	9	9	8.75	8.75	6	6	9	8.8	7.5	7.4	8.3	8.3	n/a[a]
Experiential avoidance	Feeding a stray dog metaphor	9	9	8	8	4	6	7	7	7	7.5	8	8	8	8	8	8	7.3	7.6	1
	Holding something heavy	6	6	9	9	9	8	4	4	7	6.75	5	5	6	6	5.5	5.5	6.5	6.3	3
	Quicksand metaphor	6	6	8	8	8	8	8	8	7.5	7.5	8	8	8	8	8	8	7.6	7.6	2
Workability	Checking the workability of thoughts	9	9	9	9	10	9	7	8	8.75	8.75	7	7	10	8.8	8.5	7.9	8.6	8.46	1
	Workability	8	8	9	9	9	8	7	7	8.25	8	5	6	10	8.8	7.5	7.4	8.3	7.8	2
	Checking in on workability	7	7	X[c]	6	7	7	6	6	6.6	6.5	5	5	10	8	7.5	6.5	7	6.5	3
Personality disorder	Connect the DOTS worksheet	9	9	9	9	10	9	8	8	9	8.75	5	5	9	9	7	7	8.3	7.83	1

		Professionals										PWLE						Overall average		Order of excerpts within domain
		Chrissie		Nancy		Patti		Suzi		Average		David		Janis		Average				
		Interview Number																		
Domain	Exercise	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	
	as a tool to do a job																			
	High-risk situation card sort	10	10	10	10	9	10	9	9	9.5	9.75	10	10	10	10	10	10	9.6	9.83	1
Difficult thoughts and feelings are normal	Thank you, mind	5	5	10	10	8	9	8	8	7.75	8	6	6	8	8	7	7	7.5	7.6	1
	Little kid exercise	7	7	9	9	5	5	6	6	6.75	6.75	3	3	10	8	6.5	5.5	6.6	6.3	2
	No right or wrong	8	8	10	10	10	10	10	10	9.5	9.5	8	8	6	6	7	7	8.6	8.6	n/a[a]
	Validate the client	7	7	10	10	10	9.5	10	10	9.25	9.125	3	4	6	6	4.5	5	7.6	7.75	n/a[b]
Thoughts are not the whole person	Card carrying	8	8	9	8	7	5	5	5	7.25	6.5	6	6	5	5.5	5.5	5.75	6.6	6.25	3
	Leaves on a stream	8	8	9	8	7	7	6	6	7.5	7.5	5	5	9	8	7	6.5	7.3	7.16	2
	I can't lift my arm	8	8	10	8	8	8	4	6	7.5	8	10	10	4	7	7	8.5	7.3	8.16	1
	Milk, milk, milk	3	3	10	10	5	5	3	3	5.25	5.25	4	4	3	3	3.5	3.5	4.6	4.6	4
You and your emotions and thoughts are separate	The inner voice	6	6	10	10	7	7	7	7	7.5	7.5	7	7	5	6	6	6.5	7	7.16	1
	Observer exercise	5	5	9	9	5	5	7	7	6.5	6.5	5	5	6	6	5.5	5.5	6.16	6.16	3
	Eyes on exercise	7.5	7.5	10	10	5	7	6	6	7.125	7.625	6	6	5	5	5.5	5.5	6.538	6.916	2

		Professionals										PWLE						Overall average		Order of excerpts within domain
		Chrissie		Nancy		Patti		Suzi		Average		David		Janis		Average				
		Interview Number																		
		1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	
Domain	**Exercise**																			
Staying with difficult thoughts	Choosing to feel	7	7	9	9	10	10	8	8	8.5	8.5	5	5	10	10	7.5	7.5	8.16	8.16	1
	Tug of war with a monster	7	7	10	10	7	7	6	6	7.5	7.5	5	5	5	5	5	5	6.6	6.6	3
	Acceptance of emotion	8	8	8	8	10	9	5	6	7.75	7.75	7	7	7	7	7	7	7.5	7.5	2
	Unwanted neighbour Ned	7	7	10	9	4	4	8	8	7.25	7	5	5	6	6	5.5	5.5	6.6	6.5	4
Not distracting ourselves from unwanted thoughts and feelings	When you're triggered, FACE	8	8	9	9	10	10	8	8	8.75	8.75	5	6	7	7	6	6.5	7.83	8	n/a[a]
Connecting with the here and now	Mindful activities	10	10	10	10	10	10	9	9	9.75	9.75	2	2	8	8	5	5	8.16	8.16	2
	Mindful talking	9	9	9	9	10	10	8	7	9	8.75	2	2	9	9	5.5	5.5	7.83	7.6	4
	Walking meditation	10	10	9	9	7	8	9	9	8.75	9	5	5	6	6	5.5	5.5	7.6	7.83	3
	SOBER breathing	10	10	10	10	10	10	10	10	10	10	5	6	10	10	7.5	8	9.16	9.3	1
Noticing being hooked away	Dropping anchor	9	9	10	10	7	7	9	9	8.75	8.75	5	5	8	8	6.5	6.5	8	8	1
	Defusion skills	9	9	9	9	10	10	6	7	8.5	8.75	5	5	10	8	7.5	6.5	8.16	8	2
Values	Identifying our values	9	9	8	8	5	6.5	4	4	6.5	6.875	5	5	9	7	7	6	6.6	6.583	3

		Professionals										PWLE						Overall average		Order of excerpts within domain
		Chrissie		Nancy		Patti		Suzi		Average		David		Janis		Average				
		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		
Domain	Exercise	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	
	Bull's eye exercise	10	10	10	10	7	7	7	7	8.5	8.5	5	6	6	6	5.5	6	7.5	7.66	2
	Values card sort	9	9	10	10	6	7.5	6	7	7.75	8.375	9	10	9	9	9	9.5	8.16	8.75	1
Goals	Goals	9	9	10	10	8	8	8	8	8.75	8.75	7	6	7	7	7	6.5	8.16	8	2
	Treatment roadmap	10	10	10	10	7	8.5	7	8	8.5	9.125	7	7	10	8.5	8.5	7.75	8.5	8.6	1
	Assign first bold move	9	9	8	8	10	10	5	6	8	8.25	6	6	9	8	7.5	7	7.83	7.83	3
Flexibility of treatment	Between-session tasks	9	9	10	10	10	10	10	10	9.75	9.75	6	6	8	8	7	7	8.83	8.83	n/a[b]
	Session frequency	10	10	10	10	10	10	8	8	9.5	9.5	8	8	6	7	7	7.5	8.6	8.83	n/a[b]

Note. A table illustrating the ratings of each excerpts in each interview for each participant, the average ratings per sub-population and for the whole sample, and the order of excerpts within each domain. Ratings of 1-10 (10=most helpful).

[a] The only excerpt within the domain. [b] Incorporated into the introductory chapter of the manual (not an exercise). [c] No response provided by the participant.

Table V

Majority Views Across Professionals, PWLE, and Whole Sample for Each Excerpt

Exercise	Number of professionals (%)		Number of PWLE (%)		Whole sample (%)	
	Interview 1	Interview 2	Interview 1	Interview 2	Interview 1	Interview 2
Feeding a stray dog	1 (25.0)	0	0	0	1 (16.7)	0
Holding something heavy	1 (25.0)	1 (25.0)	1 (50.0)	1 (50.0)	2 (33.3)	2 (33.3)
Workability	0	0	1 (50.0)	0	1 (16.7)	0
Checking in on workability	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
Connect the DOTS	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
Thank you, mind	1 (25.0)	0	0	0	1 (16.7)	0
Little kid	1 (25.0)	1 (25.0)	1 (50.0)	1 (50.0)	2 (33.3)	2 (33.3)
Validate the client	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
Card carrying	1 (25.0)	2 (50.0)	1 (50.0)	0	2 (33.3)	2 (33.3)
Leaves on a stream	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
I can’t lift my arm	1 (25.0)	0	1 (50.0)	0	2 (33.3)	0
Milk, milk, milk	3 (75.0)	3 (75.0)	2 (100.0)	2 (100.0)	5 (83.3)[a]	5 (83.3)[a]
Inner voice	0	0	1 (50.0)	0	1 (16.7)	0
Observer	2 (50.0)	2 (50.0)	1 (50.0)	1 (50.0)	3 (50.0)	3 (50.0)
Eyes on	1 (25.0)	0	1 (50.0)	1 (50.0)	2 (33.3)	1 (16.7)
Choosing to feel	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
Tug of war with a monster	0	0	2 (100.0)	2 (100.0)	2 (33.3)	2 (33.3)
Unwanted neighbour, Ned	1 (25.0)	1 (25.0)	1 (50.0)	1 (50.0)	2 (33.3)	2 (33.3)
When you’re triggered, FACE	0	0	1 (50.0)	0	1 (16.7)	0
Mindful activities	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
Mindful talking	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
Walking meditation	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
SOBER breathing	0	0	1 (50.0)	0	1 (16.7)	0
Dropping anchor	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
Defusion skills	0	0	1 (50.0)	1 (50.0)	1 (16.7)	1 (16.7)
Identifying our values	2 (50.0)	1 (25.0)	1 (50.0)	1 (50.0)	3 (50.0)	2 (33.3)
Bull’s eye	0	0	1 (50.0)	0	1 (16.7)	0
Assign first bold move	1 (25.0)	1 (25.0)	0	1 (50.0)	1 (16.7)	2 (33.3)

Note. A table illustrating the number of participants overall, as well as in each sub-population, who scored excerpts as 5 or below across each individual interview.

[a] Majority of ratings was a score of 5 or less.

Qualitative Data

Qualitative data dictated the order of the domains (see Table VI). Using FA (Ritchie & Spencer, 1994), the lead research identified three themes of 'acceptability' of excerpts to the target population, and 'facilitators', and 'barriers' to implementation (see example: Figure S6). Key concepts were identified across the data, resulting in a thematic framework of 12 subthemes for 'acceptability', three for 'facilitators', and three for 'barriers' (see Figure S7). Data was indexed (see example: Figures S7 & S8) *[see 3.3 in extended for examples of feedback from participants pertaining to each of these categories],* and charted (see example: Figure S9) . All data was mapped and interpreted (see example: Figure S10) and the range and nature of responses were explores to identify polarities (see example: Figure S11). Key dimensions were developed (see example, Figure S12) and associations between responses were identified (see example: Figure S13). The researchers considered explanations of associations (see example Figure S14), and from those explanations developed strategies of how feedback could be incorporated into the adapted manual (see example: Figure S15).

FA allowed the researchers to derive the order of domains within the adapted draft manual from participant feedback. Examples of feedback and how this informed domain order is illustrated in Table VI.

Quantitative and qualitative data both demonstrated significant issues with one excerpt, "The Unwanted Neighbour, Ned". Quantitative data showed that one third of the whole sample, 25% of the professional sample, and 50% of the PWLE sample gave a score of below '5' (see Table V). Qualitative data suggested that the example was unhelpful in relation to the target population.

"You don't want to…talk the patient into thinking, oh my god, that's me. I am the person that everyone wants to get rid of. I haven't thought about the person visualising it as being themselves…that can be particularly difficult". (Nancy, Interview 2)

"Because so many of our clients are socially excluded and have real difficulties with their relationships and …are sensitive about the way that they're perceived. I think that specific example…would be…a little bit triggering. Because so many of our clients are the unwanted neighbour…it might hit wrong". (Patti, Interview 1)

"The example would have to be different for this to be impactful for them". (Patti, Interview 2)

As per Goldstein et al. (2012), the researchers identified two exercises which could replace this excerpt which had the same mechanism. These included "Demons on a Boat" and "Passengers on a Bus".

Table VI

Order of Domains as Per Qualitative Feedback

Domain number	Domain title	Qualitative feedback example	Source (Interview Number)
1	Goals	I like the idea looking at goals first then values.	Nancy (2)
		If the goals came before values it would make the conversation easier.	Patti (1)
2	Values	I would put this early on, motivational.	Chrissie (1)
3	Workability	None.	
4	Personality disorder	None.	
5	Substance use	Could do at the beginning of assessment.	David (1)
		Good early on.	Suzi (2)
6	Difficult thoughts and feelings are normal	Better later in therapy.	Chrissie (1)
7	Experiential avoidance	You'd only be able to use it if you had a good rapport.	Suzi (1)
		May be difficult earlier on, especially without a solid relationship.	Nancy (1)
		One for a later session, when you have the relationship.	Suzi (2)
8	Staying with difficult thoughts and feelings	Have that relationship to do this.	Nancy (1)
		This would be later in therapy as a reminder of their thoughts.	Suzi (1)
		If they are comfortable with you.	Patti (1)
9	You and your feelings are separate	Good at middle or end of treatment.	Chrissie (1)
		Well-placed, you have built a relationship.	Nancy (1)
10	Thoughts are not the whole person	If there's a rapport and comfort.	Suzi (1)
		Do this later in therapy.	Nancy (2)

Domain number	Domain title	Qualitative feedback example	Source (Interview Number)
11	Not distracting ourselves from unwanted thoughts and feelings	None.	
12	Connecting with the here and now	None.	
13	Noticing being hooked away	None.	

Note. A table illustrating how the order of domains was identified based on feedback from participant interviews.

Step Three: Make Initial Manual Revisions

All 41 excerpts from Step Two were included within the adapted manual (Appendix H). The ‘strategies’ from Step Two regarding ‘acceptability’ were used to amend excerpts for the target population and those related to ‘facilitators’ and ‘barriers’ were incorporated throughout the manual, as illustrated in Table VII. An introduction was also incorporated to encapsulate information pertaining to:

- Trauma
- No right or wrong responses
- Validating the client
- Between-session tasks
- Session frequency

Table VII

Strategies Derived from the Data and How They Were Actioned

Feedback	How it was actioned
Trauma: information for therapists	
Before beginning therapy, ask the client if they would like you to conduct a file review to understand their previous experiences.	A section on 'trauma' was written into the manual introduction chapter (p.5) to guide professionals through what they should consider in relation to trauma.
In trauma-related exercises, add a note in the manual for therapists to make it clear that clients will not be asked to divulge specific information related to any traumatic experiences.	"Attention!" boxes were added to relevant exercises to ensure clients are not asked to share such information.
Feeding a stray dog metaphor	
If the client provides a response which is not the one you were expecting, ensure this is validated and explore it further. If further exploration does not get to the point of the exercise, explain this to the client and then discuss.	A section about 'wrong' answers was written into the manual introduction (p.8) to ensure they are validated and explored.
Put it later on in therapy.	The 'Experiential Avoidance' chapter was moved from the first to the fourth session.
Condense it.	The exercise (p.50) was shortened.
Provide an explanation of the exercise first – something like "trying to gain control of our feelings / thoughts by doing x, we actually lose control. And the harder we try, the less possible the desired outcome becomes".	An explanation was written into the beginning of the exercise (Information for facilitators). .
Provide a summary that clients can take home.	A summary sheet (p.52) was developed which included written and pictorial communication.

Feedback	How it was actioned
Holding something heavy	
Being more specific, less abstract.	The phrasing was reviewed and amended to ensure it provided clarity. "…even if you put down the shovel you will probably find that old habits are so strong that the shovel is back in your hands only instants later. We will likely have to drop the shovel many, many time" was changed to "even if you stop using them, you will probably find that old habits are so strong that you are using them again only instants later. We will likely have to stop using unhelpful strategies many, many time. Changed "Instructions for therapists" to "facilitator to say" so that it is specific what the facilitator needs to say.
Keep the practical element in.	The practical element was maintained.
Be mindful of how your client best works and what would be most helpful to them in this exercise.	An "Adapt it!" box was added to prompt professionals to consider what works best for the client. This states, "If you feel that the language used in this exercise will be too complex/perceived as patronising, etc. please consider being flexible with the terminology and choose what works best for the client".
Review the wording.	The phrasing was reviewed to ensure clarity. "…even if you put down the shovel you will probably find that old habits are so strong that the shovel is back in your hands only instants later. We will likely have to drop the shovel many, many time" was changed to "even if you stop using them, you will probably find that old habits are so strong that you are using them again only instants later. We will likely have to stop using unhelpful strategies many, many time.
Quicksand metaphor	
Download the video.	Added a "You will need…" section at the beginning of the exercise instructions (p.53), including the downloaded video.
Therefore, a later session would be better so the relationship is there.	The 'Experiential Avoidance' chapter was moved from the first to the fourth session.

Feedback	How it was actioned
Prompts would be helpful.	"Adapt it!" box added to exercise (p.53) which states, "The client may find it difficult to think of things 'on the spot' – feel free to provide prompts".
Be more direct.	Phrasing amended to enhance clarity. The exercise format was broken down into clearer instructions, which a script for facilitators, then a prompt to show the client the video. Following this, instructions for facilitators were added to relate the exercise to the client's experiences of substance misuse.
<u>Checking the workability of thoughts</u>	
Phrasing could be changed.	Phrasing amended to enhance clarity. For example, the word "problematic" was changed to "difficult", and "over the last few weeks" was changed to "last week".
Change the example to reflect their lifestyle.	Changed the example. The example of "Would we take a holiday to Hawaii in the middle of a work commitment because our inner voice says that there's great weather? Would we spend thousands on the next music gadget because our inner voice tells us it's a great deal?" was changed to "Would we take a holiday to the coast when we are looking after a friends' pet because our inner voice tells us that there's great weather? Would we spend hundreds on the next music gadget because our inner voice tells us it's a great deal?" to relate it to a population who are less likely to have opportunities to go to Hawaii, have work commitments, or spend thousands of pounds.
Ensure the exercise is done collaboratively.	"Attention!" box which states, "To enhance engagement, this exercise should be done collaboratively with the client".
<u>Workability</u>	
Explaining the requirements of the exercise could increase the client's understanding that they don't need to divulge specific details related to trauma, and therefore engagement.	"Attention!" Box added, which stated, "Some clients may not wish to discuss their past experiences – be clear with the client that they will not be expected to divulge specific details of difficult experiences".
Reassurance that this is ok could be helpful.	"Validate" box added which states, "If the client struggles to understand what to do during the exercise, reassure them that this is okay ad ask what they are finding difficult – alternatively, a different exercise could be offered".

Feedback	How it was actioned
Ensure the client doesn't think the therapist is calling them "hopeless" due to the script phrasing.	Information for facilitators to be "non-judgemental" retained in the instructions section (p.30).
<u>Checking in on workability</u>	
Reword to make this clearer.	Rephrased to enhance clarity. "Has not being willing worked?" was changed to, "Has not being willing to experience difficult thoughts and feelings worked?"
Phrase in a way, delicately, the reasons they continue to use.	Rephrased to ensure sensitive delivery by professionals. "Reassure the client that they are still 'response-able" was changed to, "Reassure the client that they are still able".
Provide something visual for clients to have.	Developed a worksheet (p.33).
<u>Connect the DOTS worksheet</u>	
Shorter version.	Shortened the script.
Do with the therapist.	"Attention!" box added which states, "To enhance engagement, this exercise should be done collaboratively with the client".
Flexibility in when it is completed, i.e., do it in another session, provide it to look at between sessions before the next session.	"Adapt it!" box added which states, "Be flexible – if the client feels unable to complete this exercise during the session, provide the option for them to take the worksheet and information away and do it in the next session".
Provide a clear version for client to have and to take with them.	Summary sheet (p.37) developed for clients to take away.
<u>Interpersonal triggers worksheet</u>	
Take away and discuss in a later session.	"Adapt it!" box added which states, "If the client has difficulties with reading and writing, provide the option for them to take this worksheet away and to complete it in the next session, or to look at it together in more detail and completing later in the same session".

Feedback	How it was actioned
Make it less wordy.	Rephrased in a more condensed script. "…or sadness is likely triggering your schemas and should be listed…" was changed to "…or sadness should be listed in column 1…" "precipitate" was changed to "lead to". "Ali will need to hone observational skills in these triggering situations" was changed to "Ali will need to learn to notice these triggering situations".
Allow them to read it out rather than show their writing to the therapist.	"Adapt it!" box added which states, "In addition, provide the option for the client to write but read their responses rather than show their writing to you."
Have a break.	"Adapt it!" box added which states, ""Adapt it!" box added which states, "If the client finds this exercise emotive, provide the option for them to take a short break before returning to the exercise".
Do it in the next session.	"Adapt it!" box added which states, "If the client has difficulties with reading and writing, provide the option for them to take this worksheet away and to complete it in the next session, or to look at it together in more detail and completing later in the same session".
Validate their response and empathise.	"Validate" box added which states, "This exercise involves discussing important people in the client's life – be sure to validate their responses and empathise."
<u>How's it working? Substance use as a tool to do a job</u>	
Remove the concept of putting things in the bin.	"Adapt it!" box added which states, "Assess whether the client will find the physical bin helpful – if not, then this does not have to be used."
Assess, once you know the person more, whether they would find the physical bin helpful.	"Adapt it!" box which states, "Assess whether the client will find the physical bin helpful – if not, then this does not have to be used."
Shorten.	Rephrased to shorten.
Do it over two sessions.	"Adapt it!" box added which states, "This is an important exercise, but it may feel long for some clients – consider completing this over 2 sessions, or allow the client to take it away to think about before completing it in one session."

Feedback	How it was actioned
Allow the client to take this away to consider and then do it in the next session so it is done within one session.	"Adapt it!" box added which states, "This is an important exercise, but it may feel long for some clients – consider completing this over 2 sessions, or allow the client to take it away to think about before completing it in one session."
Add discussion points.	Instructions were divided into smaller chunks to make the conversational nature of the exercise clearer.
Other options?	Another exercise was included within this domain (the High-Risk Situation Card Sort).
Keep the tactile element in.	"Adapt it!" box added which states, "Assess whether the client will find the physical bin helpful – if not, then this does not have to be used."
Remain validating.	"Validate" box added which states, "Be sure to validate and discuss the client's substance use without judgement".
<u>High-risk situation card sort</u>	
Keep practical element.	Kept in the card sorting.
Keep visual element.	Kept in the physical cards.
Put earlier on in the manual.	Moved to third session from fifth.
Put a note in the manual for therapists not to invalidate low-risk ones.	"Validate" box added which states, "Please remember – the low-risk cards are still significant for the client, therefore it is important that these are also validated".
<u>Thank you, mind</u>	
Phrase in a way that resonates best with the person.	"Adapt it!" box added which states, "Phrase this exercise in a way that best resonates with the client – it does not need to be a script".
It doesn't need to be a script.	"Adapt it!" box added which states, "Phrase this exercise in a way that best resonates with the client – it does not need to be a script".

Feedback	How it was actioned
Be careful about patronising people.	"Adapt it!" box added which states, "Phrase this exercise in a way that best resonates with the client – it does not need to be a script".
Little kid exercise	
Establish a safe word.	"Attention!" box added which states, "Some clients may find this exercise uncomfortable for various reasons – provide the option of using a Safe Word where appropriate".
Ensure a rapport has been developed before doing this exercise.	"Attention!" box added which states, "Ensure a rapport has been developed before completing this exercise".
Do this later on in therapy.	Moved to later session.
The therapist to look for signs of distress.	"Attention!" box added which states, "Facilitators should be aware of signs of distress".
Explain the exercise to clients before you do it.	"Attention!" box added which states, "Explain the exercise to the client before completing it".
No right or wrong	
Break it down.	Section added to introductory chapter (p.6) and broken down into main points.
Validate the client.	Section added in introductory chapter (p.6) to remind professionals to do this.
Card carrying	
Say in the mirror.	Added as a suggestion in the exercise script: "If you don't want a card at all, you could use voice notes (if you have a phone that does them) or just say these things to yourself in a mirror."
Voice notes / notes if have a smartphone.	Added as a suggestion in the exercise script: "If you don't want a card at all, you could use voice notes (if you have a phone that does them) or just say these things to yourself in a mirror."

Feedback	How it was actioned
Could do it in session and throw it away.	Added as a suggestion in the exercise script: "Another option is that we could write on a card in the session and either throw it away when we're done, or I can keep hold of it and you can look at it in our sessions together".
Consider whether the client engages in negative self-talk, as this may be particularly useful.	Note for facilitators added on p.72 when the domain is introduced to consider this exercise for individuals who engage in negative self-talk. This states: "Note for facilitators: Exercise 3: May be particularly useful for clients who engage in negative self-talk".
Adaptations, pictures, etc.	Developed a pictorial version of a card (p.75).
Consider the client's current context.	Added as a suggestion in the exercise script: "If you don't want a card at all, you could use voice notes (if you have a phone that does them) or just say these things to yourself in a mirror."
Ask the client what would work best for them.	Added as a suggestion in the exercise script: "If you don't want a card at all, you could use voice notes (if you have a phone that does them) or just say these things to yourself in a mirror."
Explain the rationale.	Rationale incorporated into script by changing, "When a particularly troubling thought occurs to you, write it down on the card", to, "The idea of this exercise is that when a particularly troubling thought occurs to you, write it down on the card".
<u>Leaves on a stream</u>	
Ensure a rapport has been established before doing this exercise with the client.	"Attention!" box added which states, "Before doing this exercise, consider the rapport you have with the client – if you have less of a rapport, consider choosing another exercise".
Provide a solid rationale for the exercise.	Rationale incorporated into facilitator instructions: "The intention is not to get rid of the thoughts, but to allow them to come and go at their own pace."
Do this as a practical exercise (e.g., stream, paper boats, sounds).	Option to do as a practical exercise provided: "If you are using the version where the client wishes to use paper leaves, ask the client to write their thoughts down on each leaf or offer to write for them. The client can choose to move the leaves down the stream, or ask for the facilitator to do this as they watch them and complete the exercise".
Get buy-in from the start.	Rationale incorporated: "The intention is not to get rid of the thoughts, but to allow them to come and go at their own pace."

Feedback	How it was actioned
I can't lift my arm	
Deliver the exercise in a way that you feel the client would not find patronising.	"Adapt it!" box added which states, "Be aware of the delivery of this exercise – in particular, consider whether the client will find it patronising and adapting it to maximise the benefits for them".
For the therapist to be aware of their delivery.	"Adapt it!" box added which states, "Be aware of the delivery of this exercise – in particular, consider whether the client will find it patronising and adapting it to maximise the benefits for them".
Consider the best time to do this exercise.	Moved to session six.
Follow the exercise up with a conversation.	Discussion questions added following the exercise for professionals to ask the client: "How did that exercise feel? What this exercise tries to get across is that even though our mind sometimes puts out thoughts that we cannot do something, it does not mean that we can't do it. Our thoughts can lead us to consider behaving in different ways, but we don't have to pay attention. Are there any thoughts that your mind puts out?"
Milk, milk, milk	
Do it later on, with the right therapeutic relationship.	Moved to sixth session. "Attention!" box added which states, "Before doing this exercise, consider the therapeutic relationship – if this is damaged in some way, choose another exercise".
Be daft with it.	"Adapt it!" box added which states, "Be aware of the delivery of this exercise 0 it can be difficult for people – feel free to be daft/silly with it!".
The inner voice	
Skip it.	"Attention!" box added which states, "This exercise may be difficult for those who do not speak fluent English, as some of the idioms may not exist in other languages - consider other exercises if relevant".
Find another way of illustrating the point.	Two other exercises to choose from ("Eyes On" and "Observer").

Feedback	How it was actioned
Break it down so that discussion points are included at regular intervals, so the therapist is not talking at the client for long periods of time.	Discussion points added after each subsection: 1: Does that make sense? What do you think about that? Can you think of any experiences you have had that remind you of other experiences you have had? 2: Does that make sense? Do you ever find yourself comparing things? Or planning? Or analysing? 3: Does that make sense? Do you have any thoughts about it? 4: Does that make sense? Do you have any thoughts about it?
Specific script.	Script provided in italics.
Condense it.	Shortened by providing a script, rather than instructions for facilitators. E.g., "You can illustrate this associative characteristics of the inner voice by asking the client to complete this sentence" was replaced with, "If I ask you to complete a sentence". Shortened by replacing phrases such as "establishes symbolic" with "forms".
<u>Observer exercise</u>	
Go back to a 'safe' time.	"Attention!" box added which states, "Please be aware of the client's past trauma – you will be asking for memories from childhood, adolescence, and adulthood – these can be happier memories".
Be aware of their past.	"Attention!" box added which states, "Please be aware of the client's past trauma – you will be asking for memories from childhood, adolescence, and adulthood – these can be happier memories".
Look for signs of distress.	"Attention!" box added which states, "During this exercise, please assess for signs of distress."
Safe word.	"Attention!" box added which states, "The client may also find it helpful to have a "safe word"".
Debrief / harm reduction after to keep themselves safe after the session.	"Attention!" box added which states, "The client may wish to engage in this exercise, but it may still cause distress – consider harm reduction after completing the exercise".
Doesn't have to be a specific memory.	"Attention!" box added which states, "Please be aware of the client's past trauma – you will be asking for memories from childhood, adolescence, and adulthood – these can be happier memories".

Feedback	How it was actioned
Explain what the exercise entails first.	Rationale incorporated into script: "I am now going to invite you to take part in an exercise which is about noticing your thoughts, feelings, and urges it's like the you that sees you. I will ask you to think of a memory, but I want to make it clear that this can be any memory – it can be happy, neutral, or mildly difficult. However, it should not be a distressing or trauma-related memory".
Reword to make clearer.	Rephrased to enhance clarity in a way that provides a script for facilitators, rather than suggestions.
<u>Eyes on exercise</u>	
The language used – can have short breaks, it won't feel easy, no harm will come to you.	Incorporated into the script: "This exercise is all about getting some practice with being willing to experience difficult thoughts and feelings. As part of that, it involves us having eye contact because this usually brings up unwanted thoughts and feelings. The challenge is to keep eye contact even though those difficult thoughts and feelings show up. it won't be an easy exercise, but no harm will come to you".
Well-placed – have the therapeutic relationship, middle to end of treatment.	Moved to fifth session.
Think about what to say – a script? E.g., "Here is an example of what you might say…"	Script provided.
Risk assessment prior to therapy.	"Attention!" box added which states, "Consider risk as well as whether this exercise will do what it is aiming to do – If doing the exercise increases risk or the client would not benefit from it, choose another exercise".
<u>Choosing to feel</u>	
Good therapeutic relationship.	"Attention!" box added which states, "Before doing this exercise, consider the therapeutic relationship you have with the client – if you have less of a rapport, choose another exercise".
Well-placed.	Session five.
Tell them what the exercise will entail first.	Incorporated into script: "**Facilitator to provide a description of the exercise:** This exercise involves wither closing your eyes or focusing on a spot on the floor or wall and paying attention to your breathing. I will not ask you to think about anything very distressing or traumatic but I will ask you to

Feedback	How it was actioned
	think of a mildly upsetting memory. Then I will guide you through paying attention to your feelings, bodily sensations, and urges".
Assess their frame of mind.	"Attention!" box added which states, "Before doing this exercise, assess the client's current state of mind. How are they today? If this is a "bad day", consider another exercise".
There is an option to fix their gaze on a spot in the room rather than closing their eyes.	Incorporated into script: "This exercise involves either closing your eyes or focusing on a spot on the floor or wall".
Emphasise they should focus on a "mildly upsetting memory from last week" and not something related to significant trauma.	Incorporated into script: "I will not ask you to think about anything very distressing or traumatic, but I will ask you to think of a mildly upsetting memory".
<u>Tug of war with a monster</u>	
Reword.	Rephrased. Fr example, "sheer" changed to "lots of".
A physical element.	Incorporated as an option by offering this in the "You will need" section at the beginning.
<u>Acceptance of emotion</u>	
Do some work first to get buy-in.	Rationale incorporated into script by adding a section names, "Facilitator to provide a rationale for the exercise" which reads, "This exercise is done to help us to connect with difficult feelings and make room for them. This is important because if we can work to get comfortable with feeling uncomfortable, then we can accept those feelings are there while still doing the things which are valuable to us.".
Solid rationale.	Rationale incorporated into script (as above).
Rapport.	"Attention!" box added which states, "Before doing this exercise, consider the rapport you have with the client - if you have less of a rapport, choose another exercise".
Hook them in at the start.	Rationale incorporated into script (as above).

Feedback	How it was actioned
Shorten.	Shortened by removing, "Life is like a stage show, and on that stage are all your thoughts, all your feelings, everything you can see, hear, touch, taste, and smell. And for the last few minutes, we dimmed the lights on the stage and shined a spotlight on this feeling. And not it's time to bring up the rest of the lights. Not, bring up the lights on your body".
Factor in discussion points at regular intervals.	Discussion points added throughout: (1) "How does that feel?"; (2) "Is there anything that you have noticed? How does that feel?"; (3) "How are you doing?" .
Something more visual.	Visual summaries developed for sitting up straight, breathing, scanning the body, and noticing feelings within the body.
<u>Unwanted neighbour Ned</u>	
Change the example.	Changed to demons on a boat/passengers on a bus.
Something visual.	Video links provided at the beginning of the exercise.
Clearer description.	Broken down into information for facilitators, a script for facilitators to read for clients, and points to consider for each exercise.
Video.	Video links provided at the beginning of the exercise.
Shorter.	Both newly added exercises are shorter than the original exercise.
<u>When you're triggered, FACE</u>	
Stick it on a mirror – become ingrained.	Suggestion incorporated into "Notes for facilitators" section.
Time to process it / go over it a few times.	Suggestion incorporated into "Notes for facilitators" section.
Something visual to take away.	Card to take away with prompt developed.
<u>Mindful activities</u>	
Remove word "mindfulness".	Renamed the exercise "Focusing on Activities".

Feedback	How it was actioned
Ask them to try it out.	Incorporated.
Say why you are doing it – the blurb is already there.	Rationale provided in script: "This is an important skill as it helps us to focus on the here and now, and recognise the thoughts and feelings we have".
Opening sentences about what they would gain, why it is important, etc.	Rationale incorporated into script (as above).
Therapist to choose most appropriate ones from the list for the client.	"Adapt it!" box added which states, "You may feel that not all of the items on the list are relevant to the client (i.e., maybe they do not garden, etc.) – this is okay – just edit the list and choose the items you feel will be of most benefit".
<u>Mindful talking</u>	
Explain the rationale in a clear way.	Incorporated at the beginning: "I would like you to begin observing specific conversations. It is useful to do this, as we often get caught up in difficult interactions with other people. When we focus in on these conversations with other people, we can earn what is actually happening and consider doing things differently in the future".
Remove word "mindfulness".	Renamed the exercise "Focusing on our Conversations".
Rephrase.	"Choose one conversation you'd like to watch mindfully each day" changed to, "Choose one conversation you'd like to focus on each day". "Mindful talking" changed to, "focussing on our conversations".
<u>Walking meditation</u>	
Over the phone.	"Adapt it!" box added which states, "If it is not possible for your to do this physically with the client, consider doing this over the phone, or via a Recovery Connector".
In the corridors.	Adapt it!" box added which states, "This can be done outside or in the corridors of the service".
Recovery Connector.	Adapt it!" box added which states, "If it is not possible for your to do this physically with the client, consider doing this over the phone, or via a Recovery Connector".

Feedback	How it was actioned
Other exercise – arms, etc.	Adapt it!" box added which states, "If you or the client has mobility issues, you can adapt the exercise to include, for example, arm exercises" and an alternative script provided to enable this.
<u>SOBER breathing</u>	
Stick something visual somewhere so they can revisit.	Handout document "summary" developed.
Practice it a few times.	Incorporated into the session following, "Let's try this now".
A card to remember.	Developed and added at the end of the exercise.
Explain to the client that this is not the implication.	Incorporated into the script: "Just to note also, that the fact that this exercise is called 'SOBER breathing' is not an expectation for you to get sober – it is just the first letters of each of the steps put together to help us remember the name of the exercise".
<u>Dropping anchor</u>	
Explain that we are not expecting this to cure.	Incorporated into script: "This is something that takes some practice, so it's okay if we don't get it the first time, this isn't a quick fix".
Manage the client's expectations.	Incorporated into script (as above).
Not expected to get it first time.	Incorporated into script (as above).
State what the exercise is actually doing.	Incorporated into script: "It's about noticing when we get hooked on these difficult feelings, and once we notice it happening, we can try to stay in the here and now instead".
<u>Defusion skills</u>	
Present list and together pick which may be the most helpful for that person.	"Adapt it!" box added which states, "Go through the whole list with the client and ask them to choose the ones they would find most helpful – then provide them with their own bespoke list".

Feedback	How it was actioned
Identifying our values	
Someone else – celebrity / staff / musician / film character, etc.	Options provided: instead if "a sports figure", it now states, "a person they admire (for example, a sports figure, celebrity, staff member, film character, musician, etc.)".
Provide prompts.	"Adapt it!" box added which states, "Is the client experiencing difficulties in thinking of a 'person they admire'? Provide prompts to help with this exercise".
Someone outside the hostel setting.	"Attention!" box added at the beginning of the "Values" section which states, "Do you work in a hostel setting? If so, this work should be done with a professional outside of that hostel setting".
If working in a hostel setting, choose an alternative exercise.	"Attention!" box added (as above).
Bull's eye exercise	
In parts.	"Adapt it!" box added which states, "Is this worksheet too big or overwhelming for the client? If so, ensure that the worksheet is explained clearly, and consider whether to break it down into parts".
Explain it.	instructions have been broken down to make the explanation clearer.
Values card sort	
Customise the cards.	"Adapt it!" box added which states, "Are the cards not applicable to the client? You can customise them or ask the client if anything is missing and make new ones together".
Can add their own.	"Adapt it!" box added (as above).
Can throw some away.	Made clear by stating some cards will be "set aside".
Have examples.	Developed values cards which are included as copies at the end of the manual.
Collaborative.	The exercise is laid out in a way that ensures it is done within the session with the facilitator.
Laid out.	Steps emboldened to enhance clarity of the stages of the exercise.

Feedback	How it was actioned
Reword.	Values cards re-worded and expanded upon.
Do earlier in therapy.	Moved earlier to Session Two.
<u>Goals</u>	
Rearrange goals and values sections.	Actioned so that goals come before values.
Time limit for motivation.	This was already in the instructions and therefore not changed.
Reaction from therapist.	"Troubleshooting" box added which states, "Is the client resistant to making goals? This may be due to negative past experiences with services and professionals' reactions when they have not met their goals. If this is the case, explore this with the client and ensure your reactions are positive or neutral, rather than negative".
Shorten.	"Adapt it!" box added which states, "Does the client have a preference for shorter exercises? If so, it may be helpful to factor breaks into the discussion or to shorten it".
<u>Treatment roadmap</u>	
Over two sessions.	"Adapt it!" box added which states, "Does the client find the worksheet too big? Or overwhelming? This worksheet can be completed over two sessions if needed".
Provide prompts.	"Adapt it!" box added which states, "Will the client find it difficult to think up things to add to the worksheet on the spot? Provide prompts based on your knowledge of the client or generally".
Write and talk about it instead of showing writing.	"Adapt it!" box added which states, "Does the client find reading and writing difficult? Clearly inform the client that they could write and then explain what they have written to you, instead of showing their writing."
Go away and think about it and bring it back to the next session to discuss with therapist.	"Adapt it!" box added which states, "It may be helpful for the client to take the worksheet home to think about, and then to discuss it in the next session".

Feedback	How it was actioned
Assign first bold move	
Be mindful of harm reduction.	"Attention!" box added which states, "A 'next move' should not include stopping drinking alcohol suddenly, as this can be dangerous for the client. Be mindful of harm reduction".
Change the language / phrasing.	"Bold move" changed to "Next move".
Rapport – it is ok, moves can be changed.	"Validate" box added which states, "Is the client's 'next move' achievable? Or have they not achieved it between sessions? ensure they know this is play. 'Next moves' can be changed".
Between-session tasks	
Explore as experiential avoidance.	Added in introductory chapter for professionals under "Flexibility of treatment" subheading (p.6).
Session frequency	
Reflect on language.	Bullet points of take-home messages added to enhance clarity.
Deliver with compassion and empathy.	Incorporated by adding, "Ensure you clearly communicate with the client that you are aware that it may be difficult for them to attend every session because you understand that at times their lives may be chaotic. Ensure it is made clear that if they do miss a session they will not be discharged, but the session can be rearranged for as soon as possible".
Adapt metaphors to the client's life.	Already explained in the instructions.
Collaborative.	Already explained in the instructions.
Facilitators	
Therapeutic relationship	
After 2-3 sessions.	Incorporated in introductory chapter (p.10): "Please consider how the client may best work and what they may be more / less likely to discuss or participate in over the first 2-3 sessions".

Feedback	How it was actioned
Note in manual for therapists to expect this in first 1-2 sessions.	Incorporated in introductory chapter (p.10).
Tailor exercises to individual clients.	Incorporated in introductory chapter (p.10): "How you present information to the client based on how they work best. Asking the client what works best for them".
Provide a supportive setting.	Incorporated in introductory chapter (p.10): Please consider providing a supportive setting".
Give people the space to have a gentle debate with the therapist to show this will not be received badly.	Incorporated in introductory chapter (p.10): "Modelling that information will not be received in a negative wat if they do choose to share".
<u>Flexibility</u>	
Add a note for therapists to the manual.	Incorporated in introductory chapter (p.6-7).
Inform the clients that they won't be discharged if they do not attend.	Incorporated in introductory chapter (p.7): "Ensure it is made clear that if they do miss a session they will not be discharged, but the session can be rearranged for as soon as possible".
Allow clients to revisit parts.	Incorporated in introductory chapter (p.7): "Allow clients to revisit parts from previous sessions".
Explore it as experiential avoidance.	Incorporated in introductory chapter (p.7): "Be sure to explore any non-completion of between-session tasks as experiential avoidance with the client".
Allow flexibility of the language used / no rigid scripts.	Incorporated in introductory chapter (p.11): "If you feel that the language / terminology used in introducing an exercise is not going to be accessible for the client, please consider: Allowing flexibility in terms of the language you use".
<u>Individualising exercises to the person</u>	
In the first / second session, ask the client how they would like their treatment to look.	Incorporated in introductory chapter (p.10) under the "Therapeutic relationship" subheading: "Please consider: How you can tailor each session and exercise to your specific client to make them more accessible- think about the client's individual preferences, needs, how they express themselves, etc.".
Think about the individual client's preferences, needs, and how they best express themselves.	Incorporated in introductory chapter (as above).

Feedback	How it was actioned
Barriers	
<u>Lack of accessibility related to cognition</u>	
Have adapted versions.	Developed other versions, e.g., pictorial.
Be aware of reading and writing skills.	Incorporated in introductory chapter (p.8) under "Reading and writing" subheading.
Drawing.	Options provided (p.8) under "Reading and writing" subheading.
Making marks.	Options provided (p.8) under "Reading and writing" subheading.
Tweak it to make it accessible.	Incorporated in introductory chapter (p.8) under "Reading and writing" subheading.
Not expectation for the client to show their writing, but perhaps read what they have written to the therapist.	Incorporated in introductory chapter (p.8) under "Reading and writing" subheading.
Provide a visual alternative.	Developed where applicable through the exercises.
Layman's terms.	Phrasing reviewed and amended as appropriate throughout the manual.
Be aware of neurodivergence and how this may impact upon what you are delivering.	Incorporated in introductory chapter (p.9) under "Neurodiversity" subheading.
Discuss this in supervision.	Incorporated in introductory chapter (p.9) under "Neurodiversity" subheading.
<u>Practical issues</u>	
Download any relevant videos. Provide an alternative way of doing this.	Instructions incorporated where applicable. Actioned where appropriate.
Check soundproofing.	"Confidentiality" section added to introductory chapter (p.9).

Feedback	How it was actioned
Consider where to have sessions.	Introductory chapter (p.9).
<u>Therapist assumptions</u>	
Be mindful of making assumptions.	Section added in introductory chapter (p.10) under "Checking in on our own assumptions" subheading.
Discuss during clinical supervision.	In "Checking in on our own assumptions" section of introductory chapter (p.10).
Offer all and discuss the rationale for each exercise.	"Notes for facilitators" added to each domain where applicable.

Note. A table illustrating participant feedback in relation to all domains, and how the feedback was actioned to develop the manual.

Discussion

This study aimed to identify existing manualised ACT interventions that could be adapted for individuals diagnosed with EUPD who misuse substances and face homelessness. It aimed to consult with professionals and PWLE regarding these and adapt existing interventions to develop the first revisions of a new manual for this population. The first manual revisions developed through conducting this study marks the completion of the third step of nine in Goldstein et al.'s (2012) manual development guidance. Therefore, although excerpts were deemed feasible by the participants in this study, the first manual revisions are not necessarily feasible or acceptable to the target population. The product of this study is the first draft of a manual, and should be used by professionals working in settings which support individuals facing MD. Those professionals should have appropriate training in delivering the manual and deliver the manual under supervision. Outcomes of the implementation of the intervention should be measured in clinical practice as it remain subject to a pilot study, focus groups, expert review, an initial trial, and an RCT (Goldstein et al., 2012).

Following the complete manual development process (Goldstein et al., 2012), a standalone manual will be produced. This will be facilitated by professionals without specialist therapeutic or mental health training in the delivery of psychological therapies who support those with a diagnosis of EUPD, who misuse substances, and face homelessness (e.g., substance misuse practitioners). This study contributes to an offering of an adapted therapy which can be delivered by such professionals, which research has shown can be effective (Arnold et al., 2022). This is advantageous in the current climate where Clinical Psychologists are in short supply (ACP, 2020). As stated in Step Eight of the guidance by Goldstein et al. (2012), later manual developments would include an intervention plan (e.g., supervision with a professional with ACT expertise) and specialist training for future facilitators. The manual's effectiveness would be characterised by being perceived as acceptable to facilitators (i.e., based on their resources and the service within which they would deliver the intervention). For clients, effectiveness would be characterised by significant improvements in psychological flexibility and quality of life, and reductions in symptoms associated with EUPD and experiential avoidance (e.g., substance misuse).

This study followed recommendations regarding the involvement of PWLE in shaping service delivery and in research (e.g., NICE, 2022). To the researchers' knowledge, this is the first attempt at collaborating with relevant professionals and PWLE to develop a manualised ACT intervention for a population marginalised by both research and clinical fields. It provides an original contribution to the literature relating to psychological therapies for this population and provides future opportunities both clinically and in developing the evidence-base related to this population.

This study offers the beginnings of an alternative to recommended therapies such as DBT (NICE, 2009) which may be inaccessible for this population due to mode of delivery and individuals' lifestyles (Reid, 2009). ACT provides a level of flexibility not provided by other therapies, while being shown to be equally as effective (Reyes-Ortega et al., 2020). Additionally, it offers an avenue for research into the feasibility of a therapy developed in consultation with relevant professionals and PWLE.

To complete the development of the manual, future research should explore the feasibility, effectiveness, and acceptability of the adapted manual as per guidance (Goldstein et al., 2012). It should also evaluate whether the intervention improves psychological flexibility and quality of life, and reduces EUPD symptomatology and experiential avoidance (i.e., substance misuse) for the target population *[see 4.1 in extended for further information regarding the next steps in research and 4.2 for future research questions].* A pilot study which explores facilitators and barriers with would be appropriate prior to conducting a randomised controlled trial. Such research is necessary to broaden the evidence base regarding psychological therapies for this population. Encouragingly, there is every reason to be optimistic, as demonstrated by the literature which shows ACT to be equally as effective as DBT and CBT in improving mental health, psychological flexibility, and reducing experiential avoidance (González-Menéndez et al., 2014; Maia et al., 2021; Reyes-Ortega et al., 2020).

This research introduces the first revisions of an ACT intervention deemed feasible and supported by relevant stakeholders through a process of consultation as per guidance (NICE, 2022). This study shows innovation as it involved approaching a marginalised group and working alongside them rather than attempting to shape service delivery without opportunities for professionals and PWLE to contribute their knowledge and perspectives. This is in contrast to existing guidance (Mental Health Taskforce, 2016;

NICE, 2009, 2016) which does not provide voices for those accessing services which support individuals facing MD. As such, recommendations often impose impractical or unrealistic expectations upon services which may be inaccessible for clients (ACP, 2020; Homeless Link, 2017).

However, this study is limited by a small sample size, therefore, the views expressed here may only represent of a small number of professionals and PWLE *[see 4.3 in extended for further information regarding methodological limitations]*. Additionally, views may not represent all of those with the same demographics as participants recruited to this study (e.g., age, gender, ethnicity) or those diverse from those demographics. Malterud et al. (2016) suggest between six and ten participants for studies with a narrow aim, dense specificity, and established theory. As such, the researchers aimed to recruit between three and five professionals and between three and five PWLE to ensure a balance within the sample while also achieving information power. Due to a participant withdrawing, this threshold was not met, as only two PWLE participated. Therefore, it could be concluded that the study did not have sufficient information power, particularly in terms of the PWLE subsample. Arguably, the sample size could be considered sufficient due to those participants who did take part offering sufficient information power by holding characteristics that were highly specific to the study aims. All participants belonged to the specific target group in a position of occupation or lived experience. Additionally, the quality of dialogue can strengthen or weaken information power depending on interactions between the researcher and participants. In the current study, the lead researcher possessed more than average background knowledge regarding MD and EUPD because they had been a trainee studying the topic over the last two years, and the interviews were not their first encounter with the subject area. Furthermore, the lead researcher was confident in their ability to establish trust and rapport with others. This increases the likelihood of sufficient information power within the resultant sample.

Although the researchers attempted to recruit more participants to the study, it should be recognised that this was an anticipated challenge due to the nature of this population. For example, due to individuals' lifestyles (Reid, 2009) or a mistrust of or difficult past experiences with services (DoH, 2017), engagement can be challenging. For the same reason, some attrition was also expected and became a reality when one PWLE withdrew from the study. The process of engaging with this participant to provide the

support they required, as well as working with other services to ensure their wellbeing, was demonstrative of the difficulties that can be experienced during research with this population. In addition, it should be recognised that there was a gender balance among PWLE, which is useful given the dominant position of females in the literature regarding psychological therapies and EUPD (Cosham, 2013; González-Menéndez et al., 2014; Reyes-Ortega et al., 2020; Tadić et al., 2009).

Another consideration is whether participants with prior knowledge of ACT could have added valuable perspectives in addition to the participants recruited, who had no prior knowledge of ACT. Perhaps for those less knowledgeable, some exercises may appear unusual or paradoxical. For example, the "Eyes On" exercise may have been perceived by participants as an uncomfortable experience, which may be difficult to comprehend when they are informed that ACT is designed to improve wellbeing. Goldstein et al.'s (2012) guidance recommends that interviews are conducted with individuals from the target population (i.e., PWLE), and/or those related to the target population (i.e., professionals working with individuals facing MD). Even so, the validity of ratings provided by a sample with no prior knowledge of ACT should be considered, as ratings may reflect more general views rather than views within the context of ACT treatment. Goldstein et al.'s (2012) guidance also specifies that while participant feedback is fundamental in guiding manual revisions, the researchers' expertise in the therapy model, and clinical experience with the target population also contribute significantly. Fortunately for this study, all of the researchers were sufficiently knowledgeable about ACT to review participant feedback and consider whether it was consistent with theory, experience, and practical considerations. Consequently, all components of ACT remained within the manual. For example, "The Unwanted Neighbour Ned" was not removed based on participant feedback, but replaced with an option between "Demons on a Boat" and "Passengers on a Bus", which maintained the mechanisms of action necessary in ACT within the 'Staying with Difficult Thoughts' domain of the manual. To ensure participants understood the aim of excerpts, they were given opportunities to ask questions after receiving the Participant Information Sheet (Appendices B & C), and during the interview as stated in the Participant Information Sheet. Furthermore, an introduction to each domain was provided in the Step Two booklet to enhance participant's understanding of what the researchers were asking them to do. Such factors increase the likelihood that the participants recruited understood that the ratings being

requested from them were within the context of ACT, and not more general views, and also within the bounds of the guidance provided by Goldstein et al. (2012).

Conclusions

The current research demonstrates the process of systematically adapting an ACT manualised intervention for adults diagnosed with EUPD who misuse substances and are facing homelessness. This was conducted by utilising existing interventions and in consultation with relevant professionals and PWLE. Research such as this provides a foundation on which an evidence base can be built for ACT for this population. Future research should aim to explore the feasibility and effectiveness of this new intervention in practice, as well as explore further adaptations required.

Conflict of Interest: All authors declare they have no conflicts of interest.

Funding: This study was funded by Health Education England.

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Supplementary Materials

Figures

Figure S1

Rating Sheet

	Criterion	Rating				Comments
		0	1	2	3	
		Not mentioned	Implicitly mentioned	Explicitly mentioned but lacks detail	Explicitly addressed in detail	
ACT-FM	An emphasis on normalising difficult thoughts and feelings					
	An emphasis on thoughts as separate experiences to the whole person					
	An emphasis on "staying with" difficult thoughts and feelings					
	A focus on the present moment					
	A focus on noticing when a person is "hooked away" from the present moment					
	A focus on a person as being bigger than / separate to their psychological experiences					
	Does not attempt to distract from unwanted thoughts and feelings					

	Does not use mindfulness or self-as-context methods to challenge the accuracy of thoughts or beliefs					
	A focus on workable / unworkable responses					
	A focus on clarifying an individual's values					
	A focus on setting goals					
Aims, interventions & mechanisms (Kazdin, 2001)	Does the manual emphasise use for those diagnosed with a personality disorder?					
	Does the manual refer to how it could be used for those who use substances?					
	Is it suitable for all adult ages?					
	Is it suitable for individual administration?					
	Is the mode of delivery flexible? (e.g., appointment times, etc.)					
	Explanation of experiential avoidance					
	Psychoeducation about how substance use is related to ACT					
	Psychoeducation about how personality disorder is related to ACT					
	Psychoeducation regarding psychological flexibility					
	Inclusion of in-session tasks					
	Inclusion of between-session tasks					

	It can be delivered by people without therapy / mental health training					
	Consideration of potential distress in relation to trauma (i.e., safety planning, staff approaches to managing distress)					
	Consideration of relevant adaptations (e.g., cognitive deficits, neurological difficulties)					
	Accessible language (e.g., 'dissecting', 'anticipating', 'being void of unpleasant emotions')					
	Flexibility regarding missed appointments					
	Flexibility regarding setting					
Empirical support (Carroll & Nuro, 2002; Goldstein et al., 2012)	Does the manual have empirical support in general?					
	Does the manual have empirical support in for individuals with a diagnosis of personality disorder?					
	- Empirical evidence for efficacy?					
	- Empirical evidence for acceptability?					
	- Empirical evidence for how tolerable it would be?					
	Does the manual have empirical support in for individuals who misuse substances?					

	- Empirical evidence for efficacy?					

Figure S2

Search terms

"acceptance and commitment therapy manual" and "borderline personality disorder"

"acceptance and commitment therapy manual" and "emotionally unstable personality disorder"

"acceptance and commitment therapy manual" and "alcohol"

"acceptance and commitment therapy manual" and "substance use"

Figure S3

Booklet of Excerpts

Step 2 – Materials

Below, you will find suggested content for the final therapy manual. Each suggestion is in a coloured box. Each box contains either:

- Information for the therapist to teach the client,
- An exercise for the client and therapist to do, or
- An instruction for the therapist about how they should understand and work with the client.

Please read the following and rate on the scale how helpful you think they would be in therapy. You can write any comments you want below each rating.

Index

1. Traumatic Experiences

We wonder how important it is to be open about traumatic experiences.

Trauma (Information for therapists)

While ACT is not specifically a trauma treatment, clients with trauma will benefit from it because this treatment teaches clients that experiencing guilt, or fear, don't have to be driver of more unworkable behaviours; that while they don't have control of what their emotional machinery comes up with, they can learn how to be with those internal experiences; that they can learn to manage the physiological stress that comes along with trauma related cues; and that fundamentally, they can choose how to live their life to its full potential.

It is important to tell clients that they won't be asked to disclose the traumatic event they went through. Instead, they will learn ACT skills to manage all the struggles they are dealing with because of the event. Some clients with complex or chronic trauma histories may benefit from skills in emotion regulation before beginning trauma treatment.

Standard questions to assess for trauma are as follows:

- Have you ever experienced a traumatic or life-threatening event?
- Do you experience intrusive thoughts, memories, or nightmares about these events?
- Do you avoid people, places, or experiences because of this traumatic event?
- Have these experiences affected the way you see life, people, or relationships?

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

2. Experiential Avoidance

'Experiential Avoidance' is the term used when we talk about the things we do to avoid our painful thoughts and feelings. We would like to think about how best to explain this to clients.

Feeding a Stray Dog Metaphor (Information for clients)

Information for therapists: The feeding a stray dog metaphor offers a useful summary for clients. Highlighting that by trying to gain control of the dog, we progressively lose control. And the harder we try, the less possible the desired outcome becomes.

Therapist to say: *"So, I'd like to offer a thought about what might be happening here. What if it's something like this? Imagine that you have this stray puppy turn up at your house one day. It's quite sweet to begin with, but it does make this annoying yapping noise every once in a while. By chance we find that, when the dog makes this annoying noise, feeding the dog some food makes it goes quiet. We gain some control over the dog. But, by feeding the dog, we find the dog starts coming round a little more often, and having eaten, it's gotten a little bigger, louder, and stronger.*

So, when the dog comes round the next time, you feed it to keep the noise down. Once again you get control over the dog's annoying behaviour. But the dog turns up more often, and as the dog gets bigger and bigger, it expects to be fed; it learns that bearing its teeth and looking big and mean makes us more likely to feed it. Then, it seems to find its own corner in the house and sets up home. So, more and more you find yourself in the kitchen preparing its food, trying to control this dog from barking and showing its teeth. Our efforts to control the dog end up with the dog controlling us. Might our attempts to control our unwanted thoughts, feelings, and urges be like this?"

Debrief client's reflections on the metaphor and what that might suggest about how to deal with cravings, thoughts of using, and unpleasant emotions. Useful questions are:

- ✓ ***"If feeding the dog hasn't worked to keep it quiet, what else could we do?" (be careful around responses that suggest getting rid of the dog, getting rid of the dog is trying to control it, which is just more feeding)***
- ✓ ***"How might you go about teaching the dog that barking doesn't result in getting you to feed it?"***
- ✓ ***"If you weren't just feeding the dog, how else might you interact with it?"***

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

Holding something heavy (Exercise)

Therapist to say: *One thing you can practice between now and next session is to try to become aware of how BPD/EUPD/substance use actually looks when it shows up and how your struggle with it really looks. See if you are willing to notice what shows up and if you can notice all the things you normally do: all the strategies you use when thoughts, memories, feelings, or other internal experiences related to your trauma show up. Getting a sense of what unhelpful strategies are for you is important because even if you put down the shovel you will probably find that old habits are so strong that the shovel is back in your hands only instants later. We will likely have to drop the shovel many, many times.*

Note: This exercise requires a heavy object such as a bag full of heavy items. The object or what is inside of the bag represents the client's unwanted internal experiences. Using a bag allows us to play with the term "baggage". Moreover, it has a strap that can really facilitate carrying the pain while keeping it close.

Does it ever seem that although your mind tells you to push away from the pain, this increases the pain, makes it stronger? Let's try something if you're willing.

Instruction for therapists: Ask the client to hold the object close to them and then to slowly hold it with one hand further and further away. Remember, you don't like this stuff, and so your mind may tell you to keep it as far away as possible. Really notice the effort requires to push it away. You'd like to just drop or get rid of this stuff, but you've tried that for years and it doesn't seem to be possible. Holding it away from you kind of works, but for how long? What are the costs? Can you keep it up? Are you able to do anything else while you carry it in this way, or does this solution take all of your energy and focus?

Now, what about it you held it close, in a different position? What is that like? Does it free you up to do something ese with your hands? The object has not changed, but your ability to carry it while using your attention and energy on other things has likely changed. Notice that being willing to hold the object, which represents your unwanted "stuff" closer to yourself increases workability.

1	2	3	4	5	6	7	8	9	10
Not helpful at all	←								Very helpful

Please write down any comments you have on the exercise:

Quicksand metaphor: there is an alternative to struggle (Exercise)

Therapist to say: We have a problem here – your mind tells you to do what doesn't work, because it can't see anything else to do. It would be like if you were caught in quicksand. Naturally, you'd try to get out. But almost everything you've learned about how to get out will cause problems in quicksand. If you try to walk, jump, climb, or run, you just sink in deeper because you end up trying to push down on the sand. If you struggle, wiggle, push with your hands, or crawl, you sink in deeper. Often, as people sink, they get panicky and start flailing about, and down they go. In quicksand, the only thing to do it so create as much surface area as possible, to lay out on the quicksand, and get everything you have in full contact with it. It's like that. We need to get everything you have in full contact with what you've been struggling with, but without more struggle.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

3. Workability

It can be useful for us to think about whether what we do to cope with difficult feelings and thoughts works for us.

Checking the workability of thoughts (Exercise)

Information for therapists: The workability of thoughts is not about checking whether our thoughts are true or not, but whether taking action on them takes us closer or further away from our personal values.

You can emphasise the importance of this skill by telling clients to imagine for a second that we do exactly what our inner voice tells us to do without checking whether it's workable or not. Would we take a holiday to Hawaii in the middle of a work commitment because our inner voice says that there's great weather? Would we spend thousands on the next music gadget because our inner voice tells us it's a great deal? After discussing clients' responses for two or three minutes, go ahead with the next activity.

Activity: This activity has two parts aimed to discuss with clients the payoffs of getting fused with the mind noise that the inner voices come up with.

Part 1

On some paper or a whiteboard, draw a vertical line down the middle, then ask clients to give examples of the upsides and the downsides of getting fused with their inner voice: on the left, write down the upsides, and on the right, write the downsides. Then check with client what they noticed. As simple as this exercise may seem, it highlights that we can learn to observe, study, and examine our thoughts as private experiences we have and not as little dictators of our behaviour.

Part 2

Prompt clients to think about a problematic situation they encountered last week, the thoughts they struggled with, the behaviours associated with them, and whether their actions were a move toward or away from their values.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

Workability (Information & Exercise)

Information for therapists: Enquire about the client's experience of completing or not completing the between-session practice, and the workability of that decision, rather than focusing on completion.

Barriers to practice completion should be addressed in a non-judgmental fashion. Barriers are viewed as opportunities to examine the workability of whatever strategy the client used, including not completing the assignment. The therapist, embodying the ACT therapeutic stance, refrains from judging clients for their difficulty in completing the practice assignments. The therapist takes the position that if an agenda is unworkable, the client's life and its workability will let both therapist and client know. The client often already knows what the key problems are in their lives and how the barriers are interfering; they also often have others telling them what they ought to do or to know. Refraining from following suit is the ACT-consistent response. At the same time, the therapist never takes the reasons clients offer for doing or not completing an assignment literally – under no circumstance should the therapist pretend, along with the client, that the unworkable is somehow workable if the reasons offered are sufficiently compelling. The therapist enquires about how habitual patterns of behaviour work or do not work to help move the client in valued directions and invites the client to test out novel behaviours and report back on their workability.

Therapist to say: *In this exercise, we are going to make two lists, the first is a list of the things that you struggle with. We'll refer to this as the list of problems. We define problems as thoughts, feelings, and sensations, [any internal experience] that when they show up, you don't want them, and maybe you do something to get rid of them? The second list is a list of all the things you have ever tried to fix these problems, regardless of whether they have worked. We'll call that a list of solutions. We'll start by making the list of problems.*

It seems you spent quite a bit of time struggling. Let's take a closer look at exactly what it is you struggle with. Let's make a list on the left side of a piece of paper of the problems you have been experiencing. Ok, great, what a list (make sure typical suspects are on the list, if not, offer them up). So now, let's make another list of the solutions, which we define as all the ways you have tried, at any time in the past, or are still trying, to get rid of that stuff. Anything you've done. Is using alcohol/drugs on the list, is this something you do to in some way or another to not have these experiences (e.g., to try to not feel or to not think something)? (make sure substance use behaviours are on the list).

Therapist to say: *Wow, that is a lot of stuff, on both lists. Looking at all these problems and then all these solutions* [sit next to client, taking same perspective towards the board or paper], *the question for each solutions is: How well has this worked to get rid of the stuff you struggle with? And let's break it down, let's ask how well this has worked to get rid of the stuff you struggle with long-term/permanently.*

Workability (Exercise) continued…

How have your favoured strategies at avoiding your upsetting experiences worked to get rid of the stuff you struggle with? Have your strategies been effective in avoiding or eliminating distressful thoughts, feelings, or physical sensations associated with these experiences? How long have you been struggling with X? how about with Y? What does your experience tell you about how well these strategies work to get rid of difficult thoughts, feelings, etc.? For those that work in the short-term, are there any costs? Any not-so-great side effects? Has avoiding X had any costs on the quality of your life, choices available to you? Has using alcohol/drugs had any costs? [Elicit the impact the client's alcohol/SU has had in a number of life domains including family relations, employment, and physical health, among others. This work helps the client make contact with the damage substance involvement has produced and sets up work on the personal values their use has been violating.]

The therapist should remain non-judgmental. The therapist should resist starting from the position that these change efforts did not work. Unworkability will emerge on its own if the change efforts are followed out – after all, the client has come to treatment. It is fine for the therapist to acknowledge that things worked when they worked and in the ways that they worked. If we attack a client's change strategies, we will be more likely to promote a defence of those strategies. In part, we are helping the client make contact more fully with the extent of their own drug use, but we are also introducing a model of dispassionate and detailed examination of the workability of the client's various behavioural approaches to problem solving.

Does it fit to say that how you've been approaching trauma and substance use hasn't worked, that your choice of approach just isn't working, and it looks hopeless that it will ever completely work to get rid of the effects of trauma?

Perhaps struggling with trauma and substance use is a hopeless way to go, it simply can't ever work out. And you've been trying, putting in a lot of time and effort. Perhaps the so-called solutions are actually part of the problem. Perhaps substance use makes certain traumatic stress symptoms work in the long run, and perhaps certain ways of reacting to trauma actually fuels it?

Would you be interested in an alternative approach, something other than trying to solve your problems? Not going to get into what the alternative is, just asking if an alternative path is something you would honestly be interested in?

1	2	3	4	5	6	7	8	9	10
Not helpful at all	←							→	Very helpful

Please write down any comments you have on the exercise:

Checking in on Workability (Exercise)

Reason-giving is one of the major obstacles to willingness.

Therapist to say: *What stands between you and complete willingness to have unwanted thoughts and feelings of the trauma (Without buying into them or reacting automatically to them) AND take steps to complete valued goals?*

Information for therapists: Whatever reasons are given (other than "nothing stands in the way") can be discussed in the context of reasons not being causes. Remind client that willingness is not an emotion, but a choice to have what you already have. The only thing that stands between the client and 100% willingness, is choosing the have it be so.

Therapist to say: *In your experience, has not being willing worked? Has fighting against thoughts, feelings, memories, urges worked to get you a more meaningful life?*

Information for therapists: [If client says they do not *know* what goals, actions, or choices would "work", point out that "working" is something experience teaches us: "How does an animal, a dog or cat, know what works?" Reassure the client that they are still "response-able", able to begin again (and again and again) to take a direction with their life that will work.]

What reasons are you buying into that lead you to keep using alcohol/drugs?

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

4. Personality Disorder

The materials presented below are exercises which could be useful to think about for people with a diagnosis of borderline / emotionally unstable personality disorder.

Connect the DOTS Worksheet

Therapist to say: *Let's discuss the connect the DOTS exercise (below). What have you tried doing so mar to avoid and get rid of unwanted thoughts and feelings?*

Information for therapists: Usually the client will have noted some things that are normal and typical strategies. These should be explored, without interpretation or an attempt to understand them but with a real interest in the exact nature of these manoeuvres. The therapist will ask questions to elucidate the nature of the client's struggle, as a set up to the next step.

At this point, no big deal is made of any of this – it is touched on, clarified, formulated in common-sense terms, and then just left on the shelf. But this is important, because the immediate goal of the next phase is to gather this set of events into a single class: conscious, deliberate, purposeful control. The monster's name is Control. Its manifestation is Escape and Avoidance.

You can be certain that the list of strategies identified will mostly be interpretable as methods for the control and avoidance of private events: especially emotions, thoughts, memories, and bodily sensations.

Connect the DOTS (Exercise)

For three situations, take note of (1) the thoughts, feelings, sensations, and urges showed up related to mental and physical health challenges, including alcohol and substance use; (2) what DOTS you use in response to these experiences; and (3) the immediate and longer term outcomes.

D – Distraction: How have you tried to distract yourself from these thoughts and feelings? (e.g., TV, sports, overeating, etc.)

O – Opting out: We often opt out (quit, avoid, withdraw from) people, places, activities, and situations when we don't like the thoughts and feelings they bring up for us. What are some of the things/activities you opt out of?

T – Thinking: How have you tried to think your way out of it? (e.g., blaming others, worrying, rehashing, the past, fantasising, positive thinking, problem-solving, planning, self-criticism, 'What if?', 'If only…', 'Why me?', 'Not fair!', analysing, trying to make sense of it, debating with yourself, denial, beating yourself up, etc.)

S – Substances, self-harm, and other strategies: What substances have you tried putting into your body (including food and prescription medication)? Have you ever tried self-harming activities, such as suicide attempts or reckless risk-taking? Any other strategies you can think of, e.g., excessive sleeping?

Connect the DOTS Worksheet continued…

"How did that work?

Did these strategies work to get rid of these unwanted or painful experiences? Think in terms of both the immediate moment and in the longer term – so that they never came back?

Did using these strategies cost you anything in terms of health, vitality, energy, relationships, work, leisure, money, missed opportunities, wasted time?"

Unwanted thoughts, feelings, physical sensations, urges	What did I do to try and get rid of them (DOTS)?	How did that work? (short & long term? Any costs to you?)
	1 2	
	1 2	

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

Interpersonal triggers worksheet (Exercise)

"To use this worksheet, begin by listing all the people who trigger strong emotional reactions. Think of the different domains of your life – work, family, children, partner, friends, and so on. Anyone who can set off feelings of shame, anger, guilt, fear, or sadness is likely triggering your schemas and should be listed in column 1 "triggering people". Don't skimp on this – make as big as list as you can.

Now, in the right-hand column, list the things these people do to push your buttons. What actually is the behaviour that offends or upsets you? List every triggering behaviour you can think of, and be aware that some people can do more than one thing to precipitate emotional pain."

Interpersonal Triggers Worksheet

Triggering People	Triggering Behaviours
1.	
2.	
3.	
4.	
5.	
6.	

Interpersonal triggers worksheet (Exercise) continued…

Example

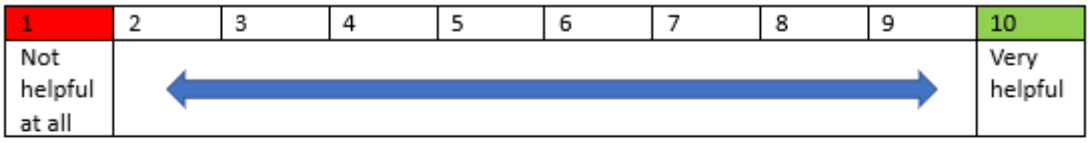
I'm Ali. I struggle with always thinking people will abandon or reject me and that there is something wrong with me. I feel overwhelming shame. Here's how I filled out the interpersonal triggers worksheet:

Interpersonal Triggers Worksheet

Triggering People	Triggering Behaviours
1. Boyfriend.	When he seems aloof; when he gets busy and can't schedule time together; when he gets angry about something; when he criticises my parenting or how I manage my life.
2. Mother.	When she criticises my lifestyle; when she seems distracted or uninterested during our conversation.
3. Ex-husband.	When he's cold or detached on the phone; when he criticises my parenting decisions.
4. Son (age thirteen).	When he ignores me and shuts himself in his room; when I invite him to do things and he refuses; when he gets angry about my rules and how I run the house.
5. The head teacher (my boss)	When she criticises my lesson plans; monthly meetings where she points out problems.
6. Parents (of this children I teach).	When they complain about homework assignments, grades, problems in the classroom, and so on.
7. Friend.	When she doesn't return my calls, when she criticises my parenting (says my son is out of control); when she's late; when she talks about moving out of state.

Therapist to explain to client: Ali will need to hone observational skills in these triggering situations. And Ali will need to be alert – with each of these people – for that moment when old thoughts and feelings get activated. Partly this involves planning ahead with the problematic individuals in Ali's life.

- Remembering to observe what happens during a weekly call to their mother.
- Being alert when picking son up from weekends with ex-husband.
- Planning to watch internal reactions during parent-teacher meetings.
- Watching internal responses during monthly meetings with her boss.



Please write down any comments you have on the exercise:

5. Substance Use

The materials presented below are exercises which could be useful to think about for people who use substances.

How's it Working? Substance Use as a Tool to do a Job (Information for Clients)

Therapist to say: *"Most things we do in life have a purpose. We do things because they are aimed at achieving something. Using drugs and alcohol is no different; it serves a purpose. So, I'd like you to consider substance use as if it were a tool to do a job. Like, the job of a hammer is to knock nails into wood; the job of a saw if to cut wood into pieces; the job of drugs and alcohol is to…"*

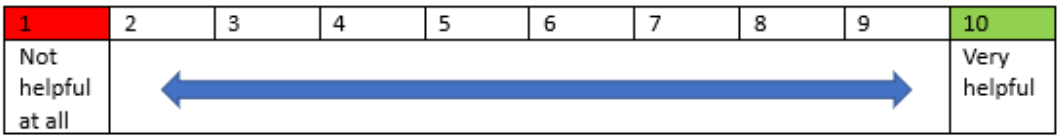
Clients typically identify themes of control, escape, self-medication, feeling better, and so on. These statements reflect the experiential avoidant function of substance use. Sometimes clients may focus on the positive, euphoric feelings associated with substance use. This, too, may reflect experiential avoidance. This can be explored by asking, *"When are you most likely to seek out euphoric feelings?"* or *"How are you usually feeling just before you use drugs?"* Another line of questioning might be to ask, *"If you weren't to use on these occasions, how would you feel then?"* Clients can be helped to notice whether they are avoiding discomfort as much as they are seeking out pleasurable experiences.

Once the purpose of substance use has been clarified (feeling free to use whichever term seems to capture ideas – escape, self-medicate, control etc.), the therapist should write it on paper or a flipchart. They should then proceed to elicit examples of the psychological content that have noticed they have been avoiding with substance use. Each psychological experience should be written on individual pieces of paper and placed in a bin. This physical metaphor conveys that client is the container of their experiences (the bin), and they hold these experiences (the paper). Therapists should refrain from screwing up these pieces of paper to distinguish them from later additions. This helps help draw out the distinction between clean and muddied discomfort.

During this part of the exercise, the therapist will need to work with the client to clarify the distinction between external events and internal reactions. Instances of fusion can be evident, where clients are responding to a world structured by thought rather than the world as directly experienced. For example, if a client states they drink when their partner is being unreasonable, the therapist might ask, *"Could you give me an example of what your partner is doing when you're having the thought 'they're being unreasonable'?"* This response highlights the distinction between the partner's actions, and the client's thoughts about those actions. For this client, fusion leads to the perception that their partner's behaviour and 'unreasonableness' are one and the same thing. Where a client suggests they drink to 'deal with arguments', inquire about how that person feels when they have arguments, and to note it as such (e.g., *"so when you have an argument, you feel angry and frustrated, lets write anger and frustration down and place that in the bin. What happens to anger and frustration when you drink? What happens in that relationship over time?"*).

How's it Working? Substance Use as a Tool to do a Job (Exercise) continued…

Therapists should take a genuinely curious and compassionate approach to this discussion. Aiming to model acceptance of whatever content shows up, and validating how clients have been responding to it (e.g., *"It makes sense why you drink in this moments. Who wouldn't want to not feel this stuff – to empty the bin? I'm curious, though, what your experience says about the way things work out when you try to not feel this stuff. What have you noticed?"*).



Please write down any comments you have on the exercise:

High-Risk Situations Card Sort (Exercise)

Information for therapists: Reviewing the between-session work works allows therapists to introduce into the discussion that the likelihood of substance use is made more likely in some circumstances and less likely in others. Increasing awareness of relevant high-risk situations affords group members the opportunity to consider the effectiveness of their coping responses in context.

Provide the client with a pack of 'high-risk situation' cards. These consist of 39 high risk situations are adapted from the 'Situational Confidence Questionnaire'. Ask group members to sort through the cards and place them in three piles:

- **Highly Likely to Drink/Use**
- **Moderately Likely to Drink/Use**
- **Unlikely to Drink/Use**

Once the client has completed this task, therapists should invite the client to take the cards in the 'highly likely' pile and order them according to how frequently they encounter each situation. The top five situations on this list, then, reflect those that are both high-risk and frequently encountered. Before collecting up the packs of high-risk situation cards, the therapist should have the client record their top five high risk situations on the 'My High Risk Situations' worksheet (in their between-session work packs).

The therapist should first ask for the client's reflections on the exercise. Following this debrief, the client should be provided an opportunity to share their top five high risk situations. For their top one or two situations (depending on time and group size), invite the client to consider the last time they encountered that situation and to describe what emotions, sensations, urges, and thoughts show up in this situation.

Examples of cards:

If I felt I had let myself down	If other people didn't seem to like me	If I had an argument with a friend

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

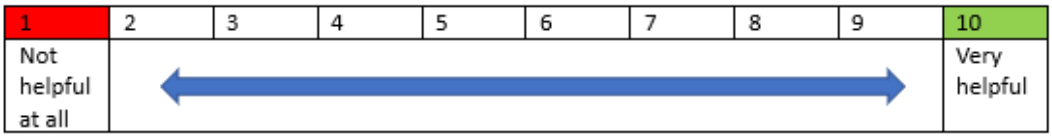
Please write down any comments you have on the exercise:

6. Difficult thoughts and feelings are normal

It is important for clients to know that their therapist understands that the difficult thoughts and feelings they have are completely normal.

"Thank you, mind" (Education for clients)

Your mind is always busy, working every moment to do its main job, which is to help you survive. Your mind is always on the lookout for danger and more than willing to point it out to you. Your mind is constantly making judgements about what's good or bad for you. Your mind keeps a running commentary on events to try to explain why everything that happens to you happens.



Please write down any comments you have on the exercise:

"Little Kid" (Exercise)

Instructions for therapist: This exercise can be emotive and powerful. As such, therapists should consider the timing of this exercise for clients and ensure they are fully willing to engage in the exercise.

Therapists should settle the client into an eyes closed mindfulness exercise where, initially, they focus on present moment experiences.

Have your client imagine that there is filing cabinet in front of them containing all the memories of their life. Invite them to open the draw and flick back through memories to a time when they were about 7 or 8. Have them pull out a photograph of themselves at this age at a home they were in around that time and look at the little kid, their younger self, in this memory; inviting them to notice any felt sensations, emotions, or thoughts that show up.

Then, have your client imagine they can pour their consciousness into this little kid and experience the world as it is through their eyes. Invite them to look at the place in or outside a home they were in around that time and notice any thoughts, emotions, or felt sensations in the moment.

Ask your client to take themselves to the room they would have felt most comfortable, and to go there as the adult 'you.' Then, so see the little kid walk in.

Ask group members to look at that little kid and notice details, such as what they are wearing, the expression on their face etc.

Then, provide an opportunity to take a self-compassionate stance toward their own history, thoughts, emotions, and sensations. For example, by saying:

"Taking a look at this little kid, and acknowledging all the pain, suffering, difficulties, wrong choices, and struggles this kid will have to go through to be where you are today, here and now. Knowing that you can't save that little kid from those experiences. And, taking a moment to offer some words of wisdom to this little kid, about how to walk through this history of yours. Not saying this out loud, but kind of speaking to this little kid knowing they can hear you."

Leave some time for the client to engage in this self-compassionate act before moving toward eliciting values and commitment:

"And if you could see inside this little kid and acknowledge what this kid really wants from life: be it safety, love, friendship, acceptance, whatever, see if you can just acknowledge that. And, seeing if this is important to you too, here and now. Exploring whether you could give this to yourself as a gift in your actions over the coming days and weeks. And seeing if you can work through to a place where the answer to this is a 'yes,' a commitment to take a stand for something that was important then, that is important now, and guides you into shaping a future that is meaningful to you."

"Little Kid" (Exercise) continued...

Therapists should gently lead the client into a few minutes of present moment awareness before ending the exercise.

Following the exercise, inquire into the client's experience of the exercise:

- ***"What stood out to you in this exercise?"***
- ***"What was your experience of looking at your history from this perspective? Was there harshness in how you treated your younger self, or a kinder stance?***
- ***"What about the gift to yourself, and this little kid, what stood out there? What might that look like if you were to take a stand for that?***

Following this exercise, therapists should proceed to provide paper, a pen, and an envelope to the client. The client should be invited to write a letter to themselves in the third person - from the perspective of being a kind, compassionate friend. They can be encouraged to include what they have learned, or felt was useful, from participating in the ACT treatment. These letters should be completed *without* sharing their content with the therapist. This point should be made explicit from the start of the exercise. Once completed, letters should be placed in the envelope, sealed, and the client should write their address on the front. The therapist should keep the letters and post it 15 weeks later.
Whilst the content of the letters should remain private, therapists should inquire about the experience of writing the letter itself.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

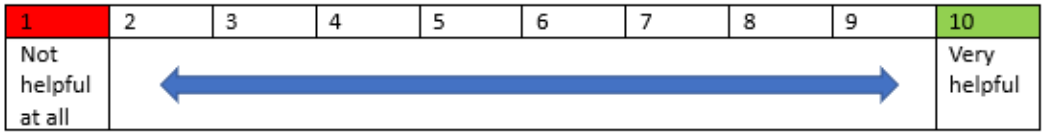
No right or wrong (Information for Therapists)

There is no "right" or "wrong" criteria for a client's choices and actions; rather, the value of any action is its workability measured against the client's most authentic and deeply held values.

Clients are not internally broken (i.e., thoughts, feelings, sensations are not in and of themselves problematic), and thus do not need to be "fixed."

Behaviour and living a more meaning-filled life is the target of the intervention, not fixing thoughts and feelings.

For instance, ACT therapists believe that clients have the psychological resources needed to gain skills that increase behavioural flexibility and effectiveness. The therapist must always be compassionate, interested, and non-judgemental towards the client.



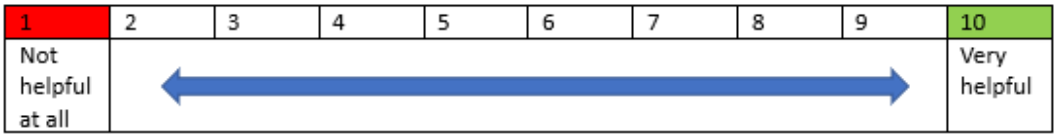
Please write down any comments you have on the exercise:

Validate the client (Information for Therapists)

It is important to keep in mind that the pain and internal difficulties of the individuals who have come to see us in therapy are not fundamentally different from the pain and internal difficulties of any other human being – including the therapist.

Thus, one of the key processes inside the therapeutic relationship involves maintaining a stance of *compassion* toward your client – sitting with him or her in their pain in an open and accepting way, while continuing to encourage participation in the treatment.

Validate the client. Clarify that most people experiencing these problems would try these solutions. The solutions seem logical. Acknowledge that the client has clearly been working hard to solve these problems. So, the fact that they're continuing to struggle is not due to lack of effort or competence.



Please write down any comments you have on the exercise:

7. Thoughts are not the whole person

It is important for clients to learn that they are separate from their thoughts. This is so that they can begin to learn skills to make room for their difficult thoughts but still do the things they value in life.

Card carrying (Exercise)

Therapist to say: This exercise gets the thoughts out of your head and onto a card that you carry with you. Get some card and put it in your pocket so that you'll have it with you as you go about your daily routine. When a particularly troubling thought occurs to you, write it down on the card. When the thought returns, tell yourself, *I don't have to think about this, it's on the card.*

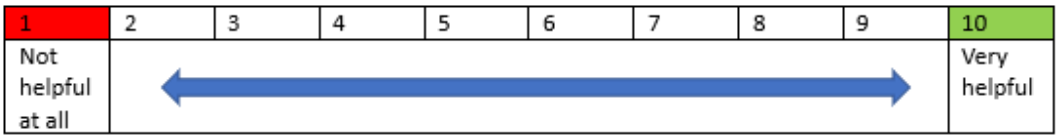
Example:

I'm Brian. I'm twenty-two years old. I used the card-carrying technique after a weekend trip with my new girlfriend, Sally. I had been nervous about everything going smoothly and our having the perfect time. Whenever Sally seemed distracted or quiet, I had thoughts that she was bored or angry with me. I worried about spending too much or too little money, wanting to give just the right impression of being neither a cheapskate not a spendthrift. I tried to keep a conversation going every moment, which led me to blurt out some things about my old girlfriend that perhaps would have been better left unsaid.

On Monday, my mind was rehashing the weekend so constantly that I couldn't concentrate. Monday night and Tuesday I carried a card around. Here is what my card looked like by Tuesday night:

I'm boring
Talked too much
Stupid about money
Offended her somehow
She thinks I'm weird
She'll dump me
Blabbermouth

Having this card in my pocket helped me disconnect from my difficult thoughts about my unworthiness and ineptness around women in general, and Sally in particular.



Please write down any comments you have on the exercise:

"Leaves on a Stream" mindfulness (Exercise)

Information for therapists: This exercise provides clients with an opportunity to practice stepping back and looking at thoughts, rather than from them. It is also practice at noticing when they have been 'hooked' by a thought (experientially *in* the thought, rather than looking *at* the thoughts floating on a leaf in front of them).

Therapists should help clients centre into the present moment and bring their awareness to the ongoing flow of experience. Inviting group members to imagine sitting on the bank of a river, with a slow-moving stream in front of them, and leaves floating past. With this image in mind, instruct clients to simply watch for thoughts. When they notice a thought, instruct them to *catch* that thought and place it on a leaf out in front of them so that can look *at* it.

Clients should be advised to let the thought float by in its own time. And, meanwhile, look for the next thought to show up, catch, put on a leaf, and watch float past. They should continue this exercise for at least five minutes.

Therapists should also invite clients to notice when they find themselves immersed *in* a thought rather than looking *at* it. If this happens, they should take a moment to see if they have been 'hooked' by that thought, and 'buying into' the literal truth of its content. If this should happen (highly likely) they should notice it, place that thought on a leaf, and continue with the exercise.

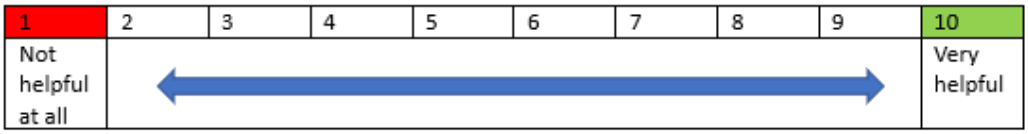
Following the exercise, therapists should debrief clients' experience of the exercise.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

"I can't lift my arm" (Exercise)

Therapist to say: If you're willing, let's try something right now. I'd like you to repeat a phrase silently to yourself, just say to yourself "I can't lift my arm." Say it over and over again in your head a couple of times… keep saying it in your head and while saying it, lift your arm up… So, you can lift your arm even though your mind says you can't. You could do this with all sorts of words, like "I can't go in there," "I need to get out of here," "I can't handle this."



Please write down any comments you have on the exercise:

"Milk, milk, milk" (Exercise)

Instructions for therapists: Say "milk." Ask clients what came to mind when you said that. Explore various functions (e.g., something you drink, something cows produce, something nice, something you put on cereal, etc.).

Therapist to say: "OK, so let's see if this fits. What shot through your mind was things about actual milk and you experience with it. All that happened is that we made a strange sound – milk – and lots of these things showed up. Notice that there isn't any milk in this room. None at all. But milk was in the room psychologically. You and I were seeing it, tasting it, feeling it – yet only the word was actually here. Now, here is the little exercise if you're willing to try it. The exercise is a little silly, and so you might feel a little embarrassed doing it, but I am going to do the exercise with you, so we can be silly together. what I am going to ask you to do it to say the word "milk" out loud, rapidly, over and over again and then notice what happens. Are you willing to try it?

Say "milk" over and over again for 1-2 minutes, with the therapist periodically encouraging the client to keep it going, keeping saying it, or to go faster.

Debrief what happened as the functions disappeared and only a sound remained.

1	2	3	4	5	6	7	8	9	10
Not helpful at all	←								Very helpful

Please write down any comments you have on the exercise:

8. You and your emotions and thoughts are separate

These exercises are designed to help us to understand that we are separate and bigger than the difficult thoughts and emotions we sometimes have.

The Inner Voice (Information/Education)

Information for therapists:

The inner voice's natural tendency to create associations: Explain to clients the idea that, from the time we are born, our inner voice learns and builds on our experience, and because of language, it constantly establishes symbolic relationships based on the millions of experiences we've had in our life. It doesn't matter what age we are – our inner voice is always creating new associations.

You can illustrate this associative characteristic of the inner voice by asking the client to complete this sentence: *"Keep your friends close, and your…"* Next ask, *"What does your inner voice say?"* Quite likely, the client will complete the phrase with the words "enemies closer." Here is another example: *"There is no place like…"* Wait for the client's response, quite likely the participant will say *"home."* These are examples of how our inner voice will hold onto these learned associations until our last breath, even when we don't want them or when these associations don't correspond to our situation.

The natural ongoing activity of the inner voice: Explain that if we pay close attention to our inner voice, we will find that it is constantly chattering in the back of our mind about all types of things. Our inner voice doesn't take holidays. It's on all the time – comparing, analysing, evaluating, planning – and we just don't have control over what shows up in our mind, in the same way we don't have control over what shows up on the screen of our TV.

The natural evolution of the inner voice as a "danger detector": Explain to clients that our ancestors were exposed to all types of threats and dangerous situations like bad weather, challenging territory, wild animals, or enemies within and outside their group. In order to survive, they had to be able to keep track of what could possibly go wrong and what went wrong. So, in order to stay alive, our ancestors constantly relied on their inner voice telling them, *"Watch out, that could be dangerous; watch out, that looks similar to what you went through before."* Over time, the inner voice evolved as a "danger detector" and continues to perform as such these days, even though we're not living under prehistoric conditions any longer.

For instance, people scared of having a panic attack may pay constant attention to any variation in their body, whether it's the heart beating fast, butterflies in the stomach, or having less saliva in the mouth: naturally, the emotional machinery focuses on fear, and the inner voice does its job coming up with the thoughts, *"Is this a panic attack? Watch out, it could be one of those moments!"*

The natural protective function of the inner voice: Continue explaining to clients that because our ancestors were constantly in danger, their inner voice, as a danger detector, was in charge of protecting them from all potential threats. These days, our inner voice is doing exactly the same thing: protecting us from being hurt. Continuing with the example of the person struggling with panic attacks, their mind is naturally protecting them.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

Observer Exercise

Information for therapists: The observer exercise is designed to help clients make experiential contact with a 'self' separate from the content of experience. It is an eyes closed exercise which invites a variety of different psychological content so that the consistent place where that content has always been experienced (i.e., self-as-context).

Therapists should engage the client in an eyes closed mindfulness exercise aimed at noticing present moment experiences for a few minutes.

Then, invite the client to pick a memory from last summer (have them raise a finger when they have a memory, so you know when to proceed). Once they have a memory in mind, the facilitator should invite them to 'step into that memory' and 'get behind the eyes of the *you* that was there'. Clients can be guided to see what they were seeing then, hear what they were hearing then, and feel what they were feeling then.

Then, therapists can ask: *"Notice who is noticing this?"* or *"Notice the part of yourself that is noticing this?"* After a pause, facilitators might invite group to consider that, *"in some deep sense, the you that was there then, is here now. See if you can notice the continuity in that that part of you doesn't change."*

Therapists should then repeat the above procedure for two more memories: one from client's teenage years, and one from childhood; each time, have the client notice who is noticing, and to notice that part of themselves has always been there.

Therapists should proceed to label this part of themselves 'the observer self.' The distinction between the observer self and psychological content can then be explored within this eyes closed exercise in several domains. For example:

- ✓ **Physical self** – notice how your body has changed and grown and that sometimes you are ill and sometimes you are healthy....but notice who notices that physical self...and although you have a body, you are also not that body
- ✓ **Emotions** – notice how over the years emotions come and go, sometimes happy, sometimes, anxious, sometimes not feeling anything much....but notice who notices these emotions...and that although you have emotions, you are not your emotions.
- ✓ **Roles** – notice roles in your life...even being in the role of client or group member right now...but who notices this role...although you have roles, you are not those roles.
- ✓ **Thoughts** – notice how at one time you had few thoughts, thoughts and beliefs have changed and grown. But notice who notices this...

Observer Exercise continued...

Clients should end the exercise with a return to mindful awareness of the present moment for a few minutes.

Following the exercise, invite the client to reflect on their experiences of the exercise, reinforcing where appropriate the distinction between the '*noticer*' and the '*noticed*'.

As a summary from this exercise, therapists can note that:

"There is a part of you that is bigger than the cravings, thoughts, emotions, and urges you struggle with. Furthermore, it is not damaged by those experiences. This means, that when we experience a difficult thought, emotion, or urge, there is a part of you that is notice who's noticing that experience, to step back into board level – the observer self – and make room for that experience. Then ask, what is the most workable action I can take, right here and right now? And then, take those experiences along for the ride."

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

"Eyes On" (Exercise)

Information for therapists: The function of the exercises contained here is to gain practice with willingness and defusion, including making contact with unwanted internal experiences and continuing to engage in actions even though these unwanted internal experiences show up.

This exercise below can be particularly powerful for clients in part because there is a kind of emotional exposure that supports the acceptability of whatever shows up. The therapeutic relationship itself is also an exercise in this sense: whatever shows up for clients in terms of thoughts, feelings, beliefs, etc. is never to be invalidated or challenged by the therapist. This unconditionality on this level is essential because it models the proper relationship for the client to have toward their experience. the issue is not the content of their thoughts or feelings or memories or urges, rather, it is what they choose to do with it.

Therapist to say: *Let's keep practicing this way of observing with another exercise, if you're willing. Now, this exercise can be challenging in certain ways, so we'll take it slow and we will practice several times. All I ask is that you do your best to notice what feelings, thoughts, and urges come up and see if you can just have these, without reacting automatically, even if only for a moment or two. When a thought or feeling or urge show up, just say to yourself, "I just had a thought about…and fill in the blank," "I am feeling…and fill in the blank," and when you have the urge to do something just notice the urge, but choose not to follow it, even if just for a moment.*

If you are willing, let's begin by sitting across from each other, and look at each others' eyes and make eye contact.

Now watch what arises and see if your Observer self can just make note of what thoughts, feelings, and urges come up but be Willing to have them without automatically averting your gaze.

If your mind tells you to do something other than keep eye contact, just make a mental note of it.

The point is not to grit and bear it, but to take a breath, notice the feeling or thought, and breathe out, continuing to make eye contact with me.

"Eyes On" (Exercise) continued…

If this exercise becomes too challenging, you can turn away for the moment, but then see if you can come back and return to looking at me. Just tell yourself what you notice while continuing to choose to keep eye contact with me.

[If the client turns away or moves back, normalise their difficulty and then invite them to come back to the exercise.]

Discuss what internal experiences came up. If the client struggled with the exercise, repeat it, sitting further apart and making intermittent eye contact (Therapist breaks away and then comes back). Tell the client you will be doing that and provide the rationale that this takes practice, small steps, as the client is learning a new skill that is difficult. It is hard to keep eye contact with someone. The therapist should also share their thoughts, feelings, and urges during the exercise.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

9. Staying with difficult thoughts

It is important for clients to learn to stay with their difficult thoughts when they come up, and understand that avoiding them can lead to more problems.

Choosing to feel (Exercise)

Information for therapists: This exercise helps clients notice how control strategies for their emotional experience are ineffective and actually create more restrictive behaviour. This teaching point focuses on a core process in ACT: acceptance.

Briefly share with clients that as much as we wish it were the case, we don't have control of feelings in a given moment. You may want to ask participants the following: "Can you tell yourself to be happy? Can you be sad in this moment? Or can you tell yourself to be angry?" Finally, ask participants: "How did it work?" Some clients may show a facial expression of happiness or sadness, but explain to them that those are overt behaviours, not necessarily emotional states they can control.

Here is a reality to share with your clients: we feel what we feel, and learning to have fleeting, overwhelming, and unpleasant feelings that come up with requires a particular skill – choosing to feel. This is a core inner skill in response to emotional states when putting values into action.

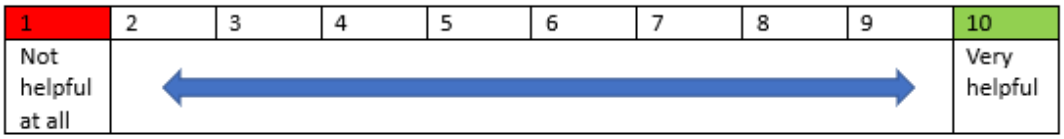
Choosing to feel when it matters (Exercise)

Information for therapists: This exercise demonstrates experientially how participants can choose to sit, open up, and get in contact with a feeling – any feeling. Invite participants to sit in a comfortable position and make themselves as comfortable as possible. If they prefer to stand, that's an option, too. Then read the suggested script:

Therapists to say: *For the next couple of moments, I'm going to invite you to either focus your gaze on a single point in the room or to close your eyes, and gently focus your attention on your breathing. Pause for two or three minutes.*

Next, bring into your mind a mildly upsetting memory you had last week, and for a couple of moments, notice what happens in your body. Pay attention to the sensations that come up while holding this memory in your mind. See if you can name the feelings that come along. Notice their intensity, the thoughts that show up in your mind, and even the go-to actions. What do you feel like doing? Do you have any urge to suppress or run away from this feeling? If so, see whether you can make some space for it and allow it to be there. See if you can notice the life of this emotion – how it changes naturally, and how maybe a new sensation comes its way.

Information for therapists: Gather clients' observations, appreciate them, and do your best to convey that the options of engaging in quick fixes, avoidant responses, and quick gut reactions are always available for clients as much as the choice to feel an emotion, as uncomfortable as it is, when it matters. ACT is not about forcing clients to be in discomfort (that's called torture); it's about learning to be in contact with those distressing feelings when it matters as a choice!



Please write down any comments you have on the exercise:

"Tug of war with a Monster" (Exercise)

Information for therapists: Acting out this exercise requires a rope. By now, clients will hopefully have gained awareness that their thoughts and emotions can invite them into actions that move them away from their values. The tug of war with a monster metaphor is a useful way of illustrating this. It also provides group members with repetition of key aspects of this treatment: Acceptance of thoughts and emotions paradoxically allows greater behavioural control.

Therapists might introduce the metaphor as follows:

"Let's imagine our struggle with these thoughts and emotions like being in a tug of war with a monster. In between you and the monster is this bottomless pit. So, when this monster makes itself known, it throws out the rope and we catch it. We get into a struggle with this monster. It seems like, though sheer efforts, if we could pull this monster into the bottomless pit, we will have won. We won't get to see that thought again, and we can get on and move in directions that are important to us. But this monster is pretty strong and the harder we pull the harder it pulls. And what's worse, we can feel like we're getting pulled closer to this bottomless pit, so we pull harder and the struggle goes on. If our experience says we can't win the war here, what can do in this scenario?"

information for therapists: If the client doesn't offer the idea of dropping the rope, facilitators can gently guide them to consider this option. Reflection on the metaphor should highlight the idea that 'dropping the rope' with thoughts doesn't get rid of the unwanted thought (the monster is still there), but reduces the discomfort associated with the struggle itself.

Invite the client to engage in an experiential version of this metaphor. The Therapist can take the role of the monster who throws the tug of war rope out to the client. Therapists should inquire about the direct experience of trying to win the tug of war vs letting go of the rope, and then relate these experiences to 'dropping the rope' with thoughts and emotions.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

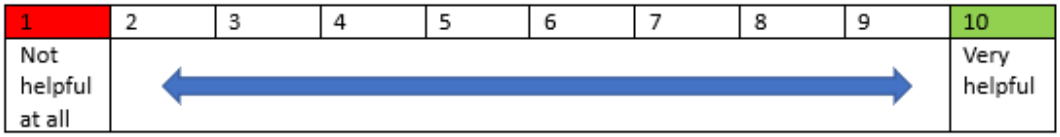
"Acceptance of Emotion" (Exercise)

Therapist reads: *I invite you to sit upright in your chair with your back straight and your feet flat on the floor. Most people find they feel more alert and awake sitting this way, so check it out and see if this is the case for you. And either close your eyes or fix them on a spot in front of you, whichever you prefer. And take a few slow deep breaths, and really notice the breath flowing in and out of your lungs. Now quickly scan your body from head to toe starting with your scalp and moving downward. And notice sensations you feel in your head, throat, neck, your shoulders, chest, abdomen, arms, hands, legs, and feet.*

Now zoom in on the part of the body where you're feeling whatever this emotion is most intensely. Observe the feeling closely as if you're a curious scientist who has never encountered anything like this before. Observe this sensation carefully. Let your thoughts come and go like passing cars and keep your attention on the feeling. Notice where it starts and where it stops. Learn as much about it as you can. If you drew an outline around it, what shape would it have? Is it on the surface of the body or inside you, or both? Where is it most intense? Where is it the weakest? If you drift off into your thoughts as soon as you realise it, come back and focus on the sensation. Observe it curiously. How is it different in the centre than around the edges? Is it a light or heavy feeling? Moving or still? What's its temperature? Are there hot spots or cold spots? Notice the different elements within it. Notice that it's not one sensation. There are sensations within sensations. Notice the different layers. As you're observing this feeling, breathe into it. Imagine your breath flowing into and around this feeling, breathing into and around it. As you're breathing into this feeling, it's as if in some magical way all the space opens up inside you. You open up around this feeling. Make space for it. Expand around it, however you make sense of that. Breathing into it and opening up around it. And see if you can just allow this feeling to be there. You don't have to like it or want it; just allow it, just let it be.

Observe it, breathe into it, open up around it, and allow it to be as it is. You may feel a strong urge to fight with it or push it away. If so, just acknowledge the urge without acting on it, and continue observing the sensation. Don't try to get rid of it or alter it. If it changes by itself, that's okay. If it doesn't change, that's okay too. Changing or getting rid of it is not the goal; your aim is to simply allow it to let it be. This feeling tells you some valuable information. It tells you that you're a normal human being with a heart. It tells you that you care that there are things in life that matter to you. And this is what we humans feel when there's a gap between what we want and what we've got. The bigger the gap, the bigger the feeling.

Life is like a stage show, and on that stage are all your thoughts, all your feelings, everything you can see, hear, touch, taste, and smell. And for the last few minutes, we dimmed the lights on the stage and shined a spotlight on this feeling. And now it's time to bring up the rest of the lights. Now, bring up the lights on your body. Notice your arms and legs, your head and neck, and notice that you're in control of your arms and legs regardless of your feeling. And just move them around a little to check that out for yourself. And then stretch a little bit, notice yourself stretching. And bring up the lights on the room around you. Open your eyes, look around, notice what you can see. Notice what you can hear. Notice that there's not just a feeling here. There's a feeling here inside a person, inside a room, inside of a world that has opportunity.



Please write down any comments you have on the exercise:

"Unwanted neighbour Ned" (Exercise)

Information for therapists: This exercise is aimed at bringing all ACT core processes together into a single exercise. Complete this exercise experientially. Encouraging the client to connect with it by asking questions throughout so that they can project themselves into the metaphor.

Therapist to read: *Keeping valued commitments, as you've been experiencing, is often not easy. It's often a choice to do something in spite of your mind offering reasons not to do it or despite what you may be feeling at the time. We also need to notice that there is effort involved and consequences to not being willing; there are costs to not following through with valued commitment. It's sort of like this…*

Imagine that you got a new place, and you invited your family and friends over to a housewarming party. You even put up a flyer on your street sign to tell people where the party is. So, your invited guests show up, the party's going great, and all of a sudden, a knock on the door…and it's your neighbour Ned, who lives around the corner from you. He's harmless but a little odd, a little different. He's wearing weird clothes, and he's loud and you think, "Oh no, why did he show up?" But you did say on the sign, "welcome to the party!"

The question facing you is this: can you see that it's possible for you to welcome him, and really, fully, do that without liking that he's here? You can welcome him even if you don't think well of him or he embarrasses you. You don't have to like him, the way he looks or what he says. Your opinion of him, your evaluation of him, is distinct from your willingness to have him as a guest in your home.

Now, you could decide instead that Ned is not welcome, that you need to put up a struggle against having him in your house. But as soon as you do that, the party changes, particularly for you. If he wants to stay and you throw him out, you now have to be at the front of the house, guarding the door so he can't come back in. Or if you say "OK, you're welcome," but you don't really mean it, you only mean that he's welcome as long as he stays in the kitchen and doesn't mingle with the other guests, then you're going to have to be constantly monitoring him and making him do that and your whole party for you will be about that.

If that's the decision you make, the party will go on and people will enjoy themselves. You, however, will be busy guarding Ned. It's not life enhancing. Your experience at the party won't be much fun. It's a lot of work, without any real reward to you.

What this metaphor is about, of course, is all the feelings and thoughts and memories that show up in life that you don't like; they're just more unwanted neighbours at the door. The issue is the perspective you take towards your own internal stuff. Can you choose to welcome those neighbours, even though you don't like the fact that they showed up? If not, what's the party going to be like for you?

What has been your experience with not being willing to have difficult thoughts and feelings?

"Unwanted neighbour Ned" (Exercise) continued…

Has your struggle with your mental health improved your quality of life? What have been the costs to your values of buying into unwanted thoughts and urges? Has your struggle and use of alcohol/drugs allowed you to pursue the things you value?

From our discussions about this past week, it looks like _____ was a barrier, an unwanted neighbour Ned. In terms of the skills we've been practising, how could you approach that so it would not derail you from following through with the valued action?

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

10. Not distracting ourselves from unwanted thoughts and feelings

This exercise is all about staying with difficult thoughts and emotions, because if we fight them or avoid them, it can make our difficulties worse.

When you're triggered, FACE (Information & Exercise)

Therapist to say: We're going to shift from practising acceptance and defusion in remembered scenes to doing it in real life. When you're hit suddenly by difficult emotions, we encourage you to use a response called "FACE" which is an acronym for:

1. Feel
2. Accept
3. Call thoughts a name
4. Express intention

These are all things you've practiced before, but now it's time to do them *as you are triggered*. The first step is to open yourself to the emotion. Running away has bruised your relationships. The best thing to do is observe the feeling and find words to describe it.

Next, accept this experience. A difficult emotion has shown up in your life, and it will run its course. It is weather that will exist for a while in your sky. Let this feeling be what it is. Make room for it.

As thoughts show up, give them a name: *I'm having a judgment thought… I'm having a scary thought… I'm having a failure thought… I'm having a "why" thought* (trying to explain why things happen). Make up your own labels. And abbreviate the label if that feels better (*worry thought, bad thought).*

The last step of FACE is to express your intention. Based on your values, what actions have you committed to in this relationship? if you could be the person you want to be, what would you do *right now?* Then do it.

Notice how FACE gives you an opportunity to expose yourself to feelings and defuse from thoughts as they show up. We know this isn't easy, and there will be triggering situations where you fall back into old patterns of thinking and feeling. One way to increase the likelihood of using FACE is to create reminders. Put a FACE sign up on your bathroom mirror, in your pocket, by your bed, or anywhere else you will see it regularly. Let these reminders help you stay aware of your commitment to FACE.

When you're triggered, FACE (Information & Exercise) continued…

Example from a client:

I decided to use FACE, initially, with situations that came up in this group I belong to. I find that people there frequently hurt me. The next time I was triggered, I actually used it. I watched the feelings (hurt, worthlessness) and thoughts (judgments, "why" thoughts). Then, instead of withdrawing, I acted on my intention to clarify the other person's motivation in saying what he or she said. I was pleased with myself and then I promptly forgot to use FACE. I got triggered a number of times, once to the point where I flew out of a meeting and considered quitting.

Three weeks went by. I was about to visit my dad, and I thought about FACE again. The man drives me nuts – opinionated, full of advice, critical. This time I decided to use the FACE card.

1	2	3	4	5	6	7	8	9	10
Not helpful at all	←								Very helpful

Please write down any comments you have on the exercise:

11. Connecting with the here and now

It is important for clients to learn to connect with the here and now, rather than the past or the future, to help them to make decisions, accept difficult feelings, savour pleasurable experiences, gently observe thoughts, and ground themselves when they experience overwhelming feelings.

Mindful activities (Exercises)

Information for therapists and clients: Mindfulness – the ability to observe each moment – isn't just about watching your inner experience. It's something you can learn through ordinary activities that you do every day. Instead of doing them in the usual distracted fashion, you can perform these tasks with full awareness.

Here are some examples:

Mindful dishwashing: noticing the warm water, the slippery soap, the hard edges of dishes and utensils, the sound of the running tap.

Mindful walking: noticing the pressure of your steps (perhaps counting them), the sway of your hands, the shifting balance, the sights, sounds, and smells.

Mindful gardening: noticing the cool feel of the soil, the tug while you are pulling weeds, the thrust of pushing in a trowel, the smell of flowers.

Mindful bathing or showering: noticing the sound and feel of the water, the slippery soap, the shifting sensations as water sprays on various parts of your body.

Mindful eating: start with a snack or a light meal. Noticing the texture or temperature of the food, the smell and taste, the sensation of lifting a fork or spoon.

Mindful drinking: noticing the liquid in your mouth, the temperature, the viscosity, the smell and taste, the feelings in your throat and stomach, the texture and weight of the glass or cup.

The goal, of course, for mindful activities is to stay with your sensory experience. If thoughts or other private events come up, you can note them while returning your attention to your five senses.

During one or more mindful activities each day strengthens the skill of self-observation. It helps you learn to notice your experience – moment to moment – and to accept the experience for what it is, without judgment. We suggest starting with one or two mindful activities this next week, and committing to a specific time to do them. And then add one new activity each week thereafter until you are doing four to five mindfulness activities each day. Note that you don't need to take a lot of time with these activities. Rather, they are brief opportunities to be here, now.

Mindful activities (Exercises) continued…

Example

I'm Sam. I was sceptical about whether mindfulness would be of any value to me. I chose mindful drinking as my first activity, using my morning coffee for the exercise. I began by simply holding the mug, feeling its warmth in my hands. Then I felt the steam on my face and noticed the aroma. As I began to drink, I felt the sensation of each sip, the sudden hear and bitter taste in my mouth.

Sometimes I'd lose concentration and start thinking of things I had to do that day. And I'd realise I had drifted off and then would go back to the smell and taste. I actually enjoyed the coffee more when I paid attention.

During the second week, I added a mindful shower and tried to mindfully walk the 20 minutes to the shop. So, I was doing these three mindful activities in the morning – and that's when I started to see a change. I was calmer and more aware at the same time. I was settled inside myself, yet super aware of what I was feeling and doing, I felt awake.

1	2	3	4	5	6	7	8	9	10
Not helpful at all	←								Very helpful

Please write down any comments you have on the exercise:

"Mindful Talking" (Exercise)

Therapist to say:

I would like you to begin observing specific conversations. Choose one conversation you'd like to watch mindfully each day. The simplest way to do this is my making the choice in the morning – after thinking about who you're likely to see in the next twelve hours. At this point, don't choose problem people or interactions where you might get upset.

Here are the guidelines for mindful talking. While the conversation is underway try to notice:

- Your thoughts (including judgments and assumptions about the other person)
- Your emotions (enjoyment, sadness, boredom, irritation, and so on)
- The other person's tone, posture, and facial expression.

The goal of mindful talking is to observe the boundary or intersection between you and the other person. Your thoughts and feelings belong to you. They are reactions, not facts. They are just your experience. The facts are what you observe about tone, posture, and facial expressions – and the literal words chosen by your conversational partner. The ways you interpret, be it words, tone, expression, and posture, are your thoughts. They are not real or necessary as they live inside of you.

Each day, as you experience a few moments of mindful talking, separate what you observe using your senses from your private experience of thoughts and emotions. Knowing the difference between what you see and hear and what you think, and feel can make a big shift in how you respond to people.

Example

I'm Robin. I've struggled with anger towards my family. Here's what I noticed after experimenting with mindful talking for a week. I stayed away from doing this with problem people, but even so, I was getting irritated and was noticing a lot of thoughts about how people don't act right. There were lots of judgments. And while this was going on, I noticed, one the other side, people smiling, having a friendly tone, just blathering away about something or other.

And I was feeling this gap between what was going on inside of me and what seemed to actually be going on with these other people. It's as if there were two different conversations – the one they were having and the one in my head. And now, after a week of paying attention this way, I realise how often this happens.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

"Walking Meditation" (Exercise)

Information for therapists: There are several ways to practice walking meditation. As with each of the practices, this meditation is best led from experience. The therapist might narrate the process they are engaging in while doing the walking meditation themself. Again, we provide an example at the end of the chapter, but it is our hope that facilitators will not use this as a "script" or as the "correct" way to lead this exercise.

Walking meditation can be led as a formal, structured practice ("lifting, placing, shifting") or as a more open awareness of the whole process allowing a curious, even childlike quality (What is it like to walk? What do the feet feel like as they move? Notice all the muscles it takes to move the leg). The therapist might suggest imaging walking for the first time, as though having just dropped into this human body; and our job is just to observe it as it walks.

Clients might experiment with different speeds. To begin with, one might walk at a pace that is slower than usual, to give oneself a better chance to become fully aware of the sensations of walking. Once clients feel comfortable, walking slowly with awareness, they might experiment with walking at faster speeds. If agitation or restlessness arise, it might be helpful to begin walking faster, with awareness, and to slow down naturally as the mind settles.

Walking meditation can be done "formally," in one's home or an appropriate outdoor area, or "informally," outside or in public, in day-to-day life. The practice can be a way to check in as one moves through the day. While walking to get somewhere, one might practice the "4 Modes" by noticing how the body feels, then shifting to awareness of sounds, then to the experience of seeing, then to the breath. Or one might simply stay with physical sensations of walking.

Often people feel awkward, silly or self-conscious while doing this exercise. Awareness of these reactions, too, is part of the practice. It can be helpful to include all of this when leading the exercise, encouraging clients to notice whatever arises including any thoughts they are having about the exercise, or feelings of embarrassment or silliness, and then focusing again on the experience of walking.

When possible, lead the client through the initial instructions, and then have them move into a larger area to practice on their own for a while. We encourage clients to pick a short length of ground, and walk the length of that course, turn, and walk back in the opposite direction. The idea is to experience just walking versus trying to get somewhere. In certain settings it is not possible to walk back and forth or leave the room to practice, in which case we might stay in the room and walk in a circle.

Facilitators to say: *For this exercise we will have our eyes open. Begin by simple standing with your knees soft and arms just resting comfortably at your sides. Letting your focus be soft, maybe just resting on the ground a few feet in front of you. Now bringing your awareness to the bottoms of your feet, sensing the physical sensations of your feet contacting the floor and the weight of your body supported by your legs and feet.*

"Walking Meditation" (Exercise) continued…

Allow your weight to shift very gently over to the left side, so that the left leg is bearing the weight and the right leg is light. Feeling how the left leg becomes "full" and the right sort of empties out. Now shifting the weight back to centre, noticing how the body knows where that is. Maybe noticing if there are any urges to shift to the other side. Now, allowing the weight to shift to the right, transferring the weight onto the right leg.

Now very slowly taking a step with the left leg, staying with all the sensations as you do this. Feeling the left heel come off the floor, the muscles contracting, the joints moving. Placing that foot down on the floor in front of you and allowing the weight to shift a little onto that foot. Pausing here for a moment. Noticing if there are any urges present – maybe to move the right leg.

And then moving the right leg – lifting the heel, moving the leg forward, placing the heel then the whole foot on the ground, then shifting the weight forward onto the right leg.

Continuing in this way, lifting the leg, moving it forward, placing it on the ground. Walking in this way, being aware, as best you can, of physical sensations in the feet and legs, and of the contact of the feet with the floor. Keeping your gaze directed softly ahead. You might label the movements of each step as a way to focus your attention: "lifting, moving, placing."

Now, try shifting the attention to different modes of experience. you might start with physical sensations in the body, or even just the bottoms of the feet. Then, when you reach the end of your path and need to turn around, paise and shift attention to sight. As you walk, bring your attention to the experience of seeing. When you reach the end of your path or a place where you need to turn around, take that opportunity to shift again, this time to sound. As you walk, bring your attention to the sounds, to the experience of hearing. Then when you are ready, shift to the sensations of breathing (or smell, if you are outside).

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

SOBER Breathing (Exercise)

Therapist to say: We want to begin to bring a specific practice into our lives in a way that can help us cope with daily challenges, stressful situations, triggers, etc., while not reacting in a way that isn't in our best interest. This is an exercise that you can do almost anywhere, anytime, because it is very brief and quite simple. Often when we are triggered by things in ourselves, such as pain, or in our environment, we tend to go into "automatic pilot," which can result in our behaving in ways that are not in our best interest. This is a technique that can be used to help us step out of that automatic mode and become more aware and mindful or our actions.

The steps are:

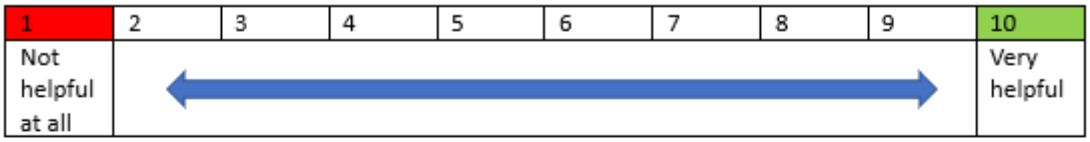
1. Stop – stop or slow down right where you are and make the choice to step out of automatic pilot by bringing awareness to this moment.
2. Observe – now shift your attention from the "story" of what's happening to you, to your internal experience. Observe what is happening in your body, your emotions and your thoughts.
3. Breathe – gather your attention and focus simply on the sensations of breathing.
4. Expand – expand awareness again to include a sense of the whole body and the situation you are in.
5. Respond – now notice that you can respond with mindful awareness. Notice how this is different from reacting automatically.

Let's try this now. You may either close your eyes or keep them open.

1. The first step is to stop, stepping out of automatic mode.
2. The next step to observe what is happening in your mind and body right now. What is your experience in this moment? What sensations do you notice? Is there any discomfort or tension in your body? What thoughts are present? What emotion might you notice and where is that in your body? Just acknowledging that this is your experience right now.
3. So, now you have a sense of what is going on right now in this moment. Now gathering your attention, focusing attention on the breath, the rise and fall of the abdomen, moment by moment, breath by breath, as best you can.
4. And the next step is to allow your awareness to expand and include a sense of your entire body. Holding your entire body in this softer, more spacious awareness.
5. Sensing that this is a place from which you might be able to respond to any situation with more awareness.

And then, when you are ready, very gently just allowing your eyes to open.

What did you notice about this experience if anything?



Please write down any comments you have on the exercise:

12. Noticing being hooked away

It is important for us to notice when we are "hooked away" by difficult thoughts and feelings. Once we notice this happening, we can try to stay in the here and now.

Dropping Anchor (Exercise)

Therapist to say: *When distressing and overwhelming emotions show up, sometimes they come so quickly and strongly that it's like we're being kicked, stomped on, or knocked down to the floor. Naturally, we get hooked on them and forget that we can have those feelings instead of them having us. So, the skill of dropping anchor is about grounding ourselves in the moment in which we experience overwhelming or distressing emotions. Let's practice. For the next moments, press your feet against the floor as hard as you can, as a way to anchor yourself, and intentionally slow down your breathing. Pause for a couple of seconds. You can even place your hand on your stomach or chest to notice the quality of your breathing.*

Information for therapists: After gathering the client's reactions, tell them that now we'll practice dropping the anchor as a skill when dealing with a troublesome situation they're encountering. Here are the basic directions for this activity that you can modify to fit your style: As the client continues to stand up, invite them to think for a moment about a challenging encounter they had last week where they experienced overwhelming or distressing emotions. After selecting a situation, invite the client to imagine that encounter for a couple of moments, and notice and name the feelings, sensations, and go-to actions that come along with it. For example, the may say, "I'm noticing the feeling of…" (Pause for a couple of moments). Gently, encourage them to drop their anchor. They can press their feet against the floor as hard as they can, slow down their breathing, kindly place a hand on their body, or slowly balance their body from front to back to bring themselves into this moment. Next, invite them to focus intentionally on three different objects in front of them and silently notice their qualities while they continue to press their feet and slow down their breath.

After this exercise, ask clients to sit down and then ask for feedback. Highlight the process of contacting their experience as it is, as an overwhelming feeling that shows up, and while they intentionally struggle, they also bring themselves back to the present: right here, right now (instead of starting an emotional reaction chain). Lastly, clarify to the client that when they practice dropping anchor, after slowing down their breathing and acknowledging their struggle, their task is to focus on the external world, whether that's focusing on the person talking to them, their surroundings, or things they see, hear, or smell.

Dropping Anchor (Exercise) continued…

Explain to the client that the purpose of this skill us to help them bring themselves back into the present moment when they're getting hooked on intense feelings and the emotion is taking over. Grounding themselves in the moment won't make the emotion go away, but it will give them a moment to pause, centre, and check what really matters in that moment. Lastly, this skill is not about running away and quickly escaping from overwhelming emotions, it's about learning to notice when they're getting hooked on those feelings, letting go of the struggle with their internal experience, and giving themselves an opportunity to learn to live their values in challenging moments.

Contextualising why, how, and when to use the dropping the anchor skill is important, so you're not just teaching a technique.

You may wonder, why is contact with the present moment important? Here is a brief response: if we pay attention, more often than not, we'll notice that we're hooked on the stuff produced by our minds, trapped by intense uncomfortable experiences, fighting distressing sensations, or struggling with strong urges to take action; we just don't notice how absent we are from the present.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

Defusion skills (Exercises)

1. Naming the mind. Give your mind a name (other than your own name, of course)
2. Scheduling a time to worry, obsess, ruminate, get angry, blame, and so on. An example would be "I'll put this aside for now and worry about what a failure I am at eight o'clock tonight.
3. Assigning descriptive labels to whatever passes through your mind. As you observe you experience, you can simply acknowledge and label your internal experience with broad terms like "thought," "memory," "desire," "feeling," "urge," "regret, "yearning," "image," "impulse," "wish," "plan," and "idea."
4. Having (not being) your experiences. You can use the phrase "I'm having the thought that…" "I'm having the evaluation that…" "I'm having the sensation that…" "I'm having the feeling that…" "I'm having a thought that it is predicting…"
5. Labelling thoughts. when you notice specific thoughts, labelling them can help you let them go; for example, "that was a 'harsh' thought," "that was a 'judgmental' thought," "that was a 'prediction' thought," "that was a 'fear' thought" or "that was a 'self-hating' thought."
6. Thanking your mind. Sometimes the mind will quiet down a bit if it feels it's been heard. Try thanking your mind for its sometimes no-so-helpful efforts to help you: "Thank you, Mind, for that thought [judgment, prediction, memory, or whatever]." You can even use the name you've come up with for your mind or say you aren't interested at this time: "Thank you, Amanda, for that thought, but I don't want to buy it right now."
7. Repeating the thought out loud in a silly voice. You can also sing thoughts.
8. Putting thoughts on clouds. You can visualise putting your thoughts on clouds and then watching them drift away. Or you may prefer a different image, such as boxcars on a train passing by, balloons floating away in the sky, or leaves being carried away on a stream.
9. Objectifying, or thinking of thoughts as physical objects. Imagine what physical characteristics your thought might have – size, colour, texture, shape, density, consistency, weight, flexibility, temperature, and so on. This technique is also very useful for disentangling yourself from emotions and other internal experiences.
10. Physically letting go. As thoughts arrive, rotate your hand so your palm is facing down and imagine the thought dropping out of sight.
11. Card carrying. In this defusion technique, you carry a card with you and write down thought monsters as they come up. Then, whenever these painful cognitions recur, you can remind yourself, "It's on the card," and let it go.

	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

13. Values

It is important for us to identify our true life values, so that we can think about how to work towards them.

Identifying our Values (Exercise)

Information for therapists: Tell the client to think for a moment of a sports figure they admire or a friend they respect. After clients choose a person (they don't need to say the person's name), ask them to imagine for a second that there is a family gathering and that the person they chose is giving a speech about them (the client) and what matters to them with regard to their physical wellbeing.

Next, ask the following questions: ***"What would you want this person to say about your physical self-care values? Which qualities would you want this person to mention that matter to you when taking care of your body?"*** Give clients the option to write down their responses.

Briefly, remind clients that values are things that deeply matter to us; they're not rules, goals, or feelings. Our values are qualities we choose as important to us, and they're verbs because we're constantly living them.

Weekly Practice Worksheet: Values in Action

Personal value: _____

Is my value a personal value or am I trying to change a person or a person's behaviours?

_____

_____

After checking my value, what is the specific action I choose to take? (When, where, for how long?)

_____

_____

When taking that specific action, my emotional machinery may come up with uncomfortable feelings such as: _____

How willing am I to have that feeling? (Mark the number from 0 – lowest to 10 = highest)

0 1 2 3 4 5 6 7 8 9 10

What are the sensation(s) that I may struggle with when taking my values-based action?

_____

What are the thought(s) that may show up when taking my values-based action?

_____

What was the outcome after taking a value-based action?

_____

_____

Values Meter: Place a mark where is corresponds:

Far away Closer

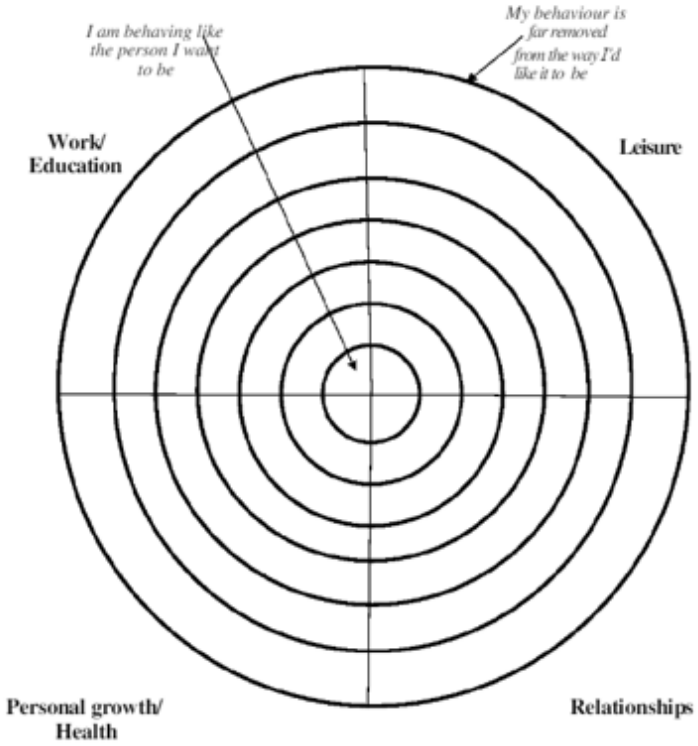
0 1 2 3 4 5 6 7 8 9 10

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

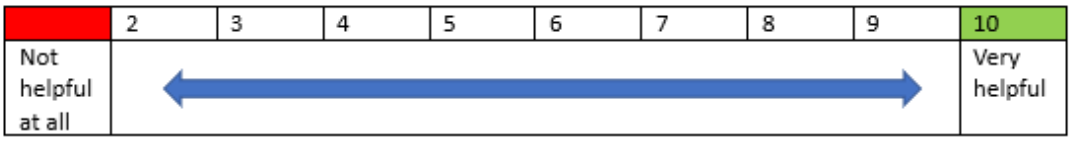
Bull's Eye Exercise

Information for therapists: Pass the handout to the client, distinguish the four areas that are identified I the handout, and then invite them to place a mark where it corresponds based on how consistently or inconsistently they're living their values in each one of those four domains up to this point. The closer the mark, the more congruent behaviours a person has in that valued domain. Give the client a couple of moments to complete this activity.



Invite the client to share their responses and reflections after completing the exercise. What do they notice? Are they living the life they want to live in all domains?

Explain to the client that throughout this treatment, they will be invited to choose values-based behaviours.



Please write down any comments you have on the exercise:

Values Card Sort (Exercise)

Therapists to say: Clarifying your values can be helpful in making choices about how you want to move forward in your work and personal life. Sometimes when we are stressed we lose sight of what is important to us. Reconnecting with what brings meaning and purpose to your life can help you to get re-oriented and provide a "compass direction" for how you want to engage and behave toward yourself and others. Take the values card sort below to help clarify your values.

Step 1: Sort through the full set of cards, separating them into two piles: "important to me" and "not important to me." Try to select rapidly at first – going with your "first instinct". When you are done, set aside the not important to me pile.

Step 2: Take the "important to me" group and sort the cards again into three categories "very important to me", "important to me", and "of little importance to me". Set those cards in the *of little importance to me* aside.

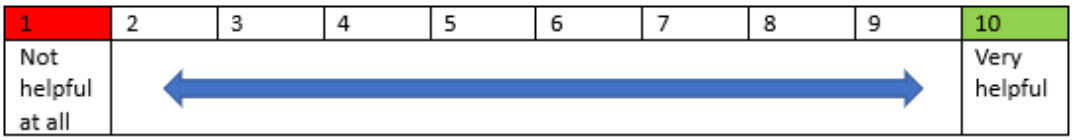
Step 3 and beyond: repeat this process until you have identified your top five values.

Look closely at the top five cards – these are your top values. If these are out of balance in terms of priorities, then you will be out of balance as well. Notice if you've left them behind, or if you've set them aside in the service of something else; notice if you've been neglecting some of your values.

Ask: what can I do today to bring these values to life?

Do: what is possible as you engage in the process of ongoing values-based living.

Intellect	Spontaneity	Integrity
Honesty	Gratitude	Service
Learning	Sacredness	Recognition
Engagement	Surrender	Contribution
Success	Love	Reliability
Creativity	Patience	Compassion



Please write down any comments you have on the exercise:

14. Goals

It is important for us to set goals so that we can work towards positive change.

Goals (Exercise)

Goals are:

1. Time-limited
2. Specific
3. Measurable
4. Achievable

Information for therapists: Poor examples of goals include those reflecting the absence of something (e.g., not feeling anxiety, fear). Striving for the absence of something typically perpetuates avoidance. However, the flip side of this is that there is typically a significant value underneath these types of statements. That is, a desire to be free from pain, anxiety, etc. is often expressed so that someone can move toward core values. Examples may include "having a life with meaning", "being a loving partner", "contributing to society" and so forth. Another way of exploring this is to ask questions along the lines of *"What if I could guarantee you would be pain free, but in order to do so, you could never have contact with your children again and they would forget that you ever existed?* The latter example can be reversed (i.e., "What if I could give you a fulfilling relationship with your children, but you would always have pain?"). When clients express narrow values/goas focused around remission of emotional or physical pain, it is useful to introduce the concept of broad focus versus "tunnel vision". This can be an opportunity for the therapist to align with the client around ensuring that the work in therapy takes a broad focus and is not hijacked by the client's mind's attempt to focus solely on the control/avoidance agenda.

In generating Values and Goals, the therapist may have to assist the client either in generating the directions/Values inherent in specific life goals, or conversely in generating specific goals from more global directions/values. Clients may also list goals that are not possible. In these instances, try to find the underlying value, and goals that might be achievable if one were moving in that direction.

Based on the above information, open with a general discussion about values and goals. Note that the focus of today's session will be on identifying values and goals that are important to the client. Discuss how clarifying values and goals will serve as a guide throughout the course of treatment.

Therapist to say: *Let's talk a little bit about goals, just so we're clear how they are different from values. If values are directions, then goals are the steps, the actions you take, in the service of your values. Learning to set goals that work for us is a skill. Goals are things we can check-off on a to-do list, things I could see you do or not do.*

Goals (Exercise) continued…

For example, did you plan on coming to session today? And did you come to session today? So, you did something that we both observed accomplish. That's a goal. You planed it and then you did it. Now, what value was coming to session in support of? What value led you to choose to set the goal of coming to session and following through with it?

[Discussion to elicit what value may have guided client's behaviour. Therapist drills down with *"but why?"* through reasons until patient responds *"because _____ is important to me"*, or some phrase that illuminates a value with intrinsic importance. This may include growth, vitality, self-respect, being a certain type of parent or spouse or other role, being respectful by keeping the appointment, etc.

[with gentleness] *Let's talk about how we can discuss reducing or stopping drinking in these terms. Is changing your drinking behaviour a goal? If so, what value(s) does it support? Which important areas of your life does it affect?*

If client insists that "not drinking" is their goal and has trouble linking this to values or to important life domains, ask, *"If you were not drinking, what could you do instead? What would I see you do that's important to you if you reduced or stopped your drinking?"* and behave when you're "not drinking"?]

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

Treatment roadmap (Exercise)

Instructions for therapists: Below is a list of life areas where most people hold important values. There is usually something important in these areas that people are working on or would like to be working on. Values are subjective, what may be important to you is not necessarily important to someone else. Please complete the form in terms of what is important to you. In each life area, write down a value and then list two concrete goals that would help you to know you are living that value.

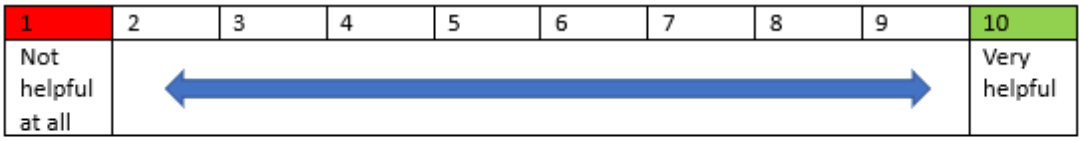
Example: 'Relationship Value' = being a loving partner.

Goals: tell my partner "I love you" or do a kind thing for your partner like give him or her a gift. Remember values can never be attained, only lived, whereas goals can be regularly attained. List two internal barriers, such as feelings, thoughts, or physical sensations or urges that are currently getting in the way of living the value. Rate your current success in living the value using the scale below. Rank the 3 most important life areas.

Life Area*	List one or more of your value(s) for the life area	List 2 concrete goals related to the value(s)	Which problem(s) get in the way (trauma, drinking, others such as pain or depression) of living those values? How?	Which lingering effects of BPD or substance use get in the way of living those values? How?	List 2 internal barriers (e.g., thoughts, emotions, sensations) to completing the goals	List your current success**
Relationships (intimate, marriage, couples, families)		1. 2.				
Friendships /social relations		1. 2.				
Employment/ education/ training		1. 2.				
Recreation /citizenship		1. 2.				
Spirituality		1. 2.				
Health, physical & mental		1. 2.				

**Complete the full worksheet, then rank the top 3 most important areas you'd like to work on by writing a number to the left.*

***0=not at all successful; 1=somewhat successful; ; 2=moderately successful; 3=successful; 4=very successful*



Please write down any comments you have on the exercise:

Assign first bold move (Exercise)

Information for therapists: Starting with this session, the therapist works with the client to develop a "bold move" assignment each week. This is a committed action in which the client commits to completing a values-consistent behaviour. Using the bold move worksheet, work with the client to develop a values-consistent behavioural goal that is achievable, but that is not something they would already do on their own, or something that is so easy that it isn't at least somewhat challenging (hence, a "bold" move). They work around collaboratively developing bold move assignments and assisting the client in completing them by engaging ACT processes is viewed as the most important work in therapy from this point forward.

The primary goal with the initial bold move assignments is to get the client moving in valued directions, to engage in the process of noticing what internal experiences show up when they make these efforts, and to notice the process through which they were able to complete the bold move as internal barriers show up. Therefore, encourage the client to err on the side of a relatively smaller bold move that is likely to lead to success. Building success bolsters motivation and momentum. For the initial assignments, the question *"What is the smallest action you could take that would be consistent with your values?"* may be useful in guiding a client who is reluctant to commit to a bold move. In our experience, most clients complete most of the bold move assignments, beginning with the first assignment. Conversely, the client may not complete the first couple of bold moves; however, that process is useful if the client is open to learning from their experience of noticing the unworkability that emerges from lack of willingness. Noticing the mind stuff that shows up when clients are considering whether to increase their willingness is also quite helpful when clients do not complete a bold move.

Collaboratively develop the first bold move assignment focusing on any of the life domains that the client has ranked as being among the most important to then. If this bold move does not already involve modifying their drinking/substance use behaviour, ask them if they would be willing to make a second bold move assignment related to reducing their drinking/substance use. The question of whether the client is willing is not rhetorical. The decision on whether the client is willing to begin reducing their drinking at this time must remain their decision. If lack of willingness shows up around making drinking-related bold move assignments, this will be addressed explicitly during sessions. clients should be encouraged to select initial goals that are realistic and achievable. Examples might include selecting a particular day that they would normally drink then they will not drink, reducing the number of drinks they have on a particular day, not exceeding a certain number of drinks on any day that week, et. In our experience, once clients begin to gain practice with reducing drinking and connecting this to living in accord with their values, momentum typically accelerates. The key is to start moving.

Assign first bold move (Exercise) continued…

Information for therapists: Therapists are encouraged to draw from this list and make suggestions to the client if they are having trouble identifying their own bold move. Many clients feel encouraged by hearing stories like "Other people have found it helpful to start with X. That helped them take some initial steps toward eventually X, which is consistent with their value of X". In fact, when we conducted qualitative interviews at the end of our pilot trial using this manual, several clients told us that it was useful to hear about past successes by other clients. Referring to past successes by other clients likely bolsters the credibility of the treatment and enhances clients' positive expectancies, both of which have been shown to be associated with better treatment outcomes.

Over the course of several weeks, these bold moves should become more challenging as the client learns additional ACT processes and gains practice in applying them in overcoming internal barriers to committed action. The therapists' goal is to guide the client in developing successively larger patterns of values-consistent behaviour over time.

Bold Move Worksheet:

If just for today you could do exactly what you wanted to do, according to what you value, what would that be? Choose something to work on between sessions that you would feel "bold" about doing. This action should be something that would show you your value was being lived. The action should be very specific; for example, instead of "I will be nice to my partner," the action would be "I will take my partner out to dinner to her favourite restaurant on Thursday night this week." The action should not be too easy or something you would already do. It should not be so difficult as to set you up for not being able to complete the task. It should challenge you, but be thoughtful in choosing an achievable task. Make sure the action is linked to a value.

I will do (action):

Consistent with this value:

Potential barriers to completing this action:

Did you complete the bold move above? If you did, what was that experience like for you? If you didn't, what was that experience like for you?

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

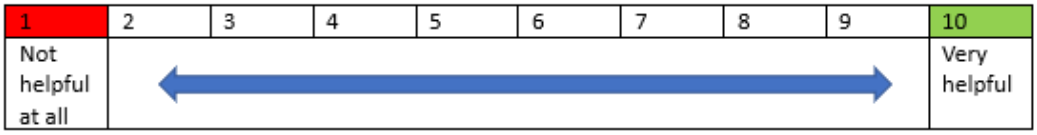
Please write down any comments you have on the exercise:

15. Flexibility of Treatment

We wonder how flexible treatment needs to be for people facing multiple disadvantage.

Between-session tasks (Information for Therapists)

There are usually clients that won't complete the weekly practice, and without making a big deal, simply acknowledge that it's hard to start making new behaviours and checking with others about them. Those who didn't complete their practice will still learn from the experiences of those who have.



Please write down any comments you have on the exercise:

Session Frequency (Information for therapists)

While the most common session frequency is one individual session per week, it is not necessary to follow this structure. Therapists should use their judgment regarding whether the client may benefit from additional work on a given topic before moving forward. Similarly, it may be useful in a subsequent session to revisit a topic that has already been covered. This can be done at any point in the treatment, and resources are provided that will aid clinicians in selecting additional content and exercises for additional work on a concept.

Most importantly, across each part of the session, the therapist relates the metaphors and exercises to the client's specific challenges: finding ways wherein the material is made relevant to the client's life. The client may feel less motivated, and exercises may feel "dead" or "heartless" if not linked directly to what the client is experiencing. Metaphors and exercises are NOT designed to be delivered in a mechanical fashion. They are to be lively and linked to what is happening in the session. At times, an exercise may not be needed because it just does not fit. It is okay to leave a metaphor or exercise out – so long as the therapist is cautious in doing so and the targeted process is still being developed in other ways. Finally, to ensure exercises are conducted effectively and with greater ease (without being mechanical), it is important to place the exercises in context. First introduce the exercise focusing on how the core process being illustrated is relevant to the case conceptualisation. Then, conduct the exercise. Finally, discuss the client's reactions to the exercise, keeping the discussion focused on the exercise's function and its connection to the client's life. Additionally, transitioning into new exercises is designed to be fluid, rather than delivering one exercise after the next, as if following a recipe. Again, providing rationales that are appropriate to the exercises and processing the experience is considered an important part of implementing the therapy successfully. The goal is to flexibly implement the model while exploring and adapting to the client's needs.

1	2	3	4	5	6	7	8	9	10
Not helpful at all									Very helpful

Please write down any comments you have on the exercise:

Figure S4

Score Sheet Template

		Professionals										PWLE						Overall average	
		Chrissie		Nancy		Patti		Suzi		Average		David		Janis		Average			
		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number	
Domain	Exercise	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Traumatic experiences	Trauma – information for therapists																		
Experiential avoidance	Feeding a stray dog metaphor																		
	Holding something heavy																		
	Quicksand metaphor																		
Workability	Checking the workability of thoughts																		
	Workability																		
	Checking in on workability																		
Personality disorder	Connect the DOTS worksheet																		
	Interpersonal triggers worksheet																		
Substance use	How's it working?																		

		Professionals										PWLE						Overall average	
		Chrissie		Nancy		Patti		Suzi		Average		David		Janis		Average			
		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number	
Domain	**Exercise**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**
	Substance use as a tool to do a job																		
	High-risk situation card sort																		
Difficult thoughts and feelings are normal	Thank you, mind																		
	Little kid exercise																		
	No right or wrong																		
	Validate the client																		
Thoughts are not the whole person	Card carrying																		
	Leaves on a stream																		
	I can't lift my arm																		
	Milk, milk, milk																		
You and your emotions and thoughts are separate	The inner voice																		
	Observer exercise																		
	Eyes on exercise																		
Staying with difficult thoughts	Choosing to feel																		
	Tug of war with a monster																		
	Acceptance of emotion																		
	Unwanted neighbour Ned																		
Not distracting ourselves from unwanted	When you're triggered, FACE																		

		Professionals										PWLE						Overall average	
		Chrissie		Nancy		Patti		Suzi		Average		David		Janis		Average			
		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number		Interview Number	
Domain	Exercise	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
thoughts and feelings																			
Connecting with the here and now	Mindful activities																		
	Mindful talking																		
	Walking meditation																		
	SOBER breathing																		
Noticing being hooked away	Dropping anchor																		
	Defusion skills																		
Values	Identifying our values																		
	Bull's eye exercise																		
	Values card sort																		
Goals	Goals																		
	Treatment roadmap																		
	Assign first bold move																		
Flexibility of treatment	Between-session tasks																		
	Session frequency																		

Figure S5

Example of Information Presented in the Second Interview

3. Holding something heavy					
		Comments			
Your rating	5	• I don't like things like this, I feel uncomfortable. Can work for some people.			
Average rating	6.5				
Staff average	7	• I didn't like this one – people will struggle to understand the point. People are anxious coming here, and to ask them to do this could be embarrassing. You'd need to have a good rapport, a good relationship, and they would need to understand. It would be better later down the line in therapy. It can be hard to develop a rapport because of people missing appointments. • Like this because you're acting it out with the person, and it would resonate better with literal-thinking people. Physically moving with people can help maintain a person's attention. • Powerful visual exercise, but may struggle to get clients to buy into it. They need to open to treatment to do the practical stuff. • I like that it is physical and practical, which can help when people feel overwhelmed by information when they are struggling with their mental health. "Baggage" could be a bit vague – make it more specific and direct, tailor it to the individual.			
PWLE average	5.5	• For some people this would be good, but I would find this irritating because I think about this anyway already. Think about whether your client will find this patronising.			
Adjust score?					

Figure S6

Example of a Spreadsheet During Familiarisation

	A	B	C	D	E
1	No.	Exercise	CHRISSIE		
2			acceptability & tolerability	facilitators	barriers
3	1	trauma	they need to be ready for it	do it at the right time, not primary focus of treatment	
4	2	feeding a stray dog	.	the relationship is key	.
5	3	holding something heavy	.	.	.
6	4	quicksand	.	video would be good	didn't like language at the end, internet is unreliable i
7	5	workability of thoughts	.	we need to mindful of the terminology/language we use, the therapeutic relationship	.
8	6	workability information	if they are ready for it	the therapeutic relationship	.
9	7	checking in on workability	.	visual aids help people learn and remember	difficult wording
10	8	connect the DOTS	useful to discuss non-completion of between-session tasks	could be a part 1 and 2 because it is long	.
11	9	interpersonal triggers worksh	.	we need to consider literacy issues	.
12	10	how's it working? Substance	.	.	.
13	11	high risk card sort	.	.	.
14	12	thank you mind	.	the worker needs to understand it in order to deliver it	.
15	13	little kid	.	therapeutic relationship, we need to understand the client	.
16	14	no right or wrong	.	.	.
17	15	validate the client	.	.	.
18	16	card carrying	it's about knowing your client	make it applicable to your individual client	.
19	17	leaves on a stream	.	.	.
20	18	I can't lift my arm	it's about knowing how your client will feel about it	.	some won't want to do role play/movement exercises
21	19	milk, milk, milk	not keen on this	.	.
22	20	inner voice	.	.	too wordy
23	21	observer	not sure how well this will work	.	.
24	22	eyes on	.	.	.
25	23	choosing to feel	.	.	.

Figure S7

Indices within the Thematic Framework

Index 1 – Acceptability

1.1 Simplicity and clarity of the language
1.2 Leads to further helpful discussion
1.3 Length of exercise (too long, short, etc.)
1.4 Target audience (e.g., post-recovery process, chaotic, etc.)
1.5 Practitioner implementation (i.e. comfort in implementing, how to implement, etc.)
1.6 Client implementation
1.7 How clients might feel / willingness
1.8 Resources
1.9 Point in therapy (earlier, later, etc.
1.10 Mode of delivery / adaptations (practical, visual, movement, between-session, collaboration, etc.)
1.11 Helpful tools (prompts, scripts, therapist preparation, video, formats, written, etc.)
1.12 Getting buy in

Index 2 – Facilitators

2.1 Therapeutic relationship / knowing your client
2.2 Flexibility (of language, sessions, order of exercises)
2.3 Importance of individualising the exercise / tailor to client needs

Index 3 - Barriers

3.1 Lack of accessibility related to cognitive ability (e.g., literacy, attention, etc.) / neurodivergence
3.2 Practical issues (rooms, etc.)
3.3 Therapist assumptions

Figure S8

Example of a Transcript with Indices Applied

1 2	R	OK, so we'll start with the first section, which is around traumatic experiences. So, the first box was around trauma, and this was information for therapists. So, what rating did you give this exercise?	
3	P	I gave it a 9.	
4	R	Yeah.	
5 6 7 8 9 10 11 12 13 14	P	Yeah, quite straight forward really. I think thing what I like about that is actually a lot of our clients because they've got such complex support needs have had to recount their trauma a lot to a lot of different people and a lot of those people got transitory in their kind of journey to actually it's quite nice for them to kind of not feel the burden of having to explain over and over again. The all of the nitty gritty details of all of the things that traumatised them across the course of their lives. But the only the only reason I didn't give it is a 10 is because I think sometimes, people want you to have that full information because they feel like without it, you as a worker won't be able to understand where they're coming from, you know, I think that that crops up quite often. They say, well, you know, how can you understand what I'm what I'm going through if you don't understand why? So there's there's sometimes, but I think that's really person dependent, isn't it? And I think not putting the onus on them to kind of have to share that is really, is really nice in terms of building a nice kind of, yeah, positive relationship with people. So, I like that actually.	**1.1** **1.7** **1.7** **2.3** / **2.1**
15 16	R	Yeah, so when you say that they think that you should already know that. Do you mean before they've come into sessions, they want you to know about what's happened?	

Figure S9

Example of Charting

		and you will be mindful of those (p45, 689-91)			
Patti	1	Not putting the onus on them to share is really nice in terms of building a positive relationship (p1, 12-4) Sometime it depends on the point in your relationship with the person (p3, 47-8) Some people struggle more with relationships with professionals (p11, 162-3) Or at the wrong time (p18, 276-7)		Useful to be flexible (p44, 697)	It's person dependent (p1, 12) Some people like metaphors and some hate them (p3, 40-1) It's person dependent (p18, 273-4) Ask for their input in terms of values (p41, 649)
	2	Concerns about feeling uncomfortable will have lessened due to the supportive (p6, 82-3) Giving people the space to have a gentle debate with you in a supportive setting can be really nice in building the relationship (p21, 315-6) It gives people the space to see they can disagree and it will not be received badly,		Flexible (p2, 27) Having a grab bag of stuff (p5, 74) Flexibility of wording (p19, 285) I like it and the wording is flexible (p53, 810)	It is an individual thing (p5, 69) People are different so you need to be able to tailor things and kind of incorporate people's preferences, needs, and how they express themselves (p6, 76-7) I've never worked with anybody who hasn't liked to see their positive progress (p50, 762-3)

Figure S10

Mapping and Interpretation

1. Trauma – information for therapists	Summary of responses
1.1 Simplicity & clarity of language	• Straightforward • Took away the wrong emphasis
1.2 Leads to further helpful discussion	• They are not open questions, open questions would be better. It's yes or no.
1.4 Target audience	• Some don't want to talk about trauma
1.5 Practitioner implementation	• Therapist needs to be very skills or could trigger people • Important to get across they're not expected to divulge • Get point across without causing distress • Be compassionate • Gauge whether someone is ready to discuss trauma and in what level of detail
1.7 How clients might feel / willingness	• Many don't want to talk about trauma • Can be triggering • Nice for people not to have to explain repeatedly • Some people want you to know everything so you understand them • In hostel some people feel you can't understand them without knowing their history • Check how comfortable they are
1.9 Point in therapy	• Easier later down the line • They need to be ready for it • Too quick if no explanation has been given • Do it later on • A difficult first stage for many people • It's about where it falls • Once you have built a rapport • The first or second follow-up you can talk more openly

Figure S11

Range and Nature

1. Trauma – information for therapists	**Summary of responses**	**Range and nature**
1.1 Simplicity & clarity of language	• Straightforward • Took away the wrong emphasis	Wasn't clear enough (**clarity**)
1.2 Leads to further helpful discussion	• They are not open questions, open questions would be better. It's yes or no.	Need more open questions (**type of question**)
1.4 Target audience	•	
1.5 Practitioner implementation	• Therapist needs to be very skills or could trigger people • Important to get across they're not expected to divulge • Get point across without causing distress • Be compassionate	**Therapist skills** – compassion, deliver without distress, check comfort **Clarity** – not expected to divulge
1.7 How clients might feel / willingness	• Can be triggering • Nice for people not to have to explain repeatedly • Some people want you to know everything so you understand them • In hostel some people feel you can't understand them without knowing their history • Check how comfortable they are	**Clarity** – to avoid triggering people **Information sharing** – some want you to know already
1.9 Point in therapy	• Easier later down the line • They need to be ready for it • Too quick if no explanation has been given • Do it later on • A difficult first stage for many people • It's about where it falls • Once you have built a rapport	**Point in therapy** – better later on, once rapport built, after 1 or 2 sessions

Figure S12

Key Dimensions

1 Trauma – information for therapists

Clarity	Not clear enough
	Be clear they are not expected to divulge
	To avoid triggering people
Type of questions	Need more open questions
Therapist skills	Compassion
	Deliver without distress
	Check comfort of client
Information sharing	Some want you to know their histories already
Point in therapy	Better later on, after 1 or 2 sessions
	When a rapport is built

Figure S13

Associations

3. Holding something heavy

Previous negative experience and current engagement?
Practical exercises help embed ideas?
Specific / direct helps aid understanding?
Clients feeling patronised associated with the wording?
Association between abstract nature and lack of engagement?
Association between practical nature of the exercise and literal thinkers?
Association between practical exercises and increased engagement in restless individuals?
Association between physical aspect and increased engagement in those who struggle with verbal metaphors?
Association between this exercise being after a rapport is developed and increased engagement?

*disagreement: client feelings negative vs OK

Who?	Nature of comment	Notes
PWLE	Uncomfortable	X
	but can work	
	Would irritate me	X
	but for some people would be good	
Staff	Frustrated	X
	People would like acting it out	
Staff	Embarrassing	X
	Uncomfortable	X

Conclusion: more feel it could be uncomfortable than comfortable

Figure S14

Explanations

1 – Trauma: information for therapists

- Residents in hostels can become frustrated if professionals don't already know about their histories (trauma), therefore knowing this can increase the accessibility of the discussion by the client knowing that they will not be asked, which could lead to frustration.
- The therapist being clear (that the client is not expected to share specific trauma-related details) can increase accessibility through ensuring the client understands that they will not be asked to share such information.

Figure S15

Strategies

1 – Trauma: information for therapists

- Residents in hostels can become frustrated if professionals don't already know about their histories (trauma), therefore knowing this can increase the accessibility of the discussion by the client knowing that they will not be asked, which could lead to frustration.
  - Before beginning therapy, ask the client if they would like you to conduct a file review to understand their previous experiences
- The therapist being clear (that the client is not expected to share specific trauma-related details) can increase accessibility through ensuring the client understands that they will not be asked to share such information.
  - In trauma-related exercises, add a note in the manual for therapists to make it clear that clients will not be asked to divulge specific information related to any traumatic experiences

Extended Paper

1.0 Extended Background

1.1 Diagnostic Criteria for Emotionally Unstable Personality Disorder

Emotionally Unstable Personality Disorder (EUPD) is defined by several characteristics including difficulties in interpersonal relationships, self-perception, emotions, and impulsivity emerging by early adulthood and experienced across diverse situations (American Psychiatric Association [APA], 2013). To receive a diagnosis of EUPD according to the Diagnostic and Statistical Manual of Mental Disorders (APA, 2013), an individual must fulfil five or more criteria. Criteria include recurrent feelings of emptiness, unstable emotional experiences to everyday situations, unstable self-image, stress-related paranoia or severe dissociative symptoms. Individuals may also make considerable efforts to avoid abandonment (either real or imagined), and/or engage in impulsive behaviours which could be damaging to them (e.g., spending money, substance abuse, reckless driving). Criteria also include difficulties controlling feelings of anger, unstable and intense interpersonal relationships, and recurrent suicidal behaviour (including threats, gestures, or self-harming behaviours).

1.2 Aetiology of EUPD

Genetics

A range of reviews, including twin and longitudinal studies, have examined the heritability of EUPD, with varying findings. Heritability has been found to vary between 30-69% in individuals diagnosed with EUPD (Amad et al., 2014; Belsky et al., 2012; Bornovalova et al., 2009; Distel et al., 2008; Kendler et al., 2011; Skoglund et al., 2021; Torgersen et al., 2000). Furthermore, genetic associations seemingly reduce as relations between people are less associated (Skoglund et al., 2021). However, heterogeneity in clinical assessments across studies, and use of self-report measures increase the risk of bias (Amad et al., 2014; Bornovalova et al., 2009; Distel et al., 2008). In addition, studies that found higher heritability had less power, therefore potentially reducing the estimates of environmental factors (Torgersen et al., 2000).

Psychosocial

The remaining variance in the aetiology of EUPD has been shown to include various environmental factors including childhood abuse (Belsky et al., 2012), poor maternal

attachments, parental substance misuse, and parental psychopathology (Amad et al., 2014). Other studies focused on environmental factors more broadly and concluded that EUPD development is modestly influenced by 'unique' environmental factors (Bornovalova et al., 2009; Skoglund et al., 2021). One review found that long-term separations from a parent during childhood were common for individuals later diagnosed with EUPD, and clients often perceived their mothers as distant and/or overprotective (Zanarini & Wedig, 2014). A review by Yuan et al. (2023) focused on the association between childhood trauma and development of EUPD in 59 studies conducted between 2000 and 2020 to understand this association, which would have clinical and future research implications. They categorised trauma into five types of abuse: sexual, physical, emotional, physical neglect, and emotional neglect. They found that 52 of the studies found that at least one type of childhood abuse was significantly correlated with the development of EUPD. Emotional abuse and sexual abuse were the most reported significant predictors, followed by physical abuse, emotional neglect, and physical neglect. However, due to heterogeneity across studies in design, method, and samples, firm conclusions of aetiology are not possible. The response of caregivers may also influence the development of EUPD, especially when caregivers do not acknowledge or deny the emotional experience of a child. Indeed, Zanarini et al. (2000) conducted semi-structured interviews to assess childhood experiences of abuse and neglect by both parents in individuals diagnosed with EUPD compared to those without the diagnosis. They found that parental denial of the validity of the child's thoughts and feelings, failure to provide protection, inconsistent treatment, and emotional withdrawal was significantly more prevalent in those diagnosed with EUPD compared to controls. However, this study was limited by retrospective self-report and all participants were inpatients, increasing the risk of bias and reducing generalisability. Combined with trauma, this is unlikely to provide a model from which a child can learn to cope with traumatic experiences.

The Mentalising Model

The psychodynamic mentalising model is rooted in attachment (Sharp & Fonagy, 2015) and focuses on an individual's ability to 'mentalise', (i.e., understand the thoughts and feelings, and reasons for those, of themselves and others). This ability is important to be able to regulate emotions and therefore cope with distress. A child learns how to mentalise by this being modelled and communicated by caregivers in the context of a secure attachment (Fonagy & Bateman, 2008). Without the secure attachment, the caregiver cannot effectively

model this process and the child will not develop the ability to mentalise. Individuals with a diagnosis of EUPD have been found to largely have insecure attachments, with 6-8% having secure attachments (Levy, 2005), largely due to poor childhood environments and caregiver responses. As such, it is suggested that those with a diagnosis of EUPD have a limited ability to mentalise, which leads to difficulties in interpersonal relationships (Fonagy & Bateman, 2008). Mentalisation-based therapy (MBT) was developed by Bateman and Fonagy (2010) to provide the opportunity to learn how to mentalise. This therapy typically takes place over 18-months and involves both individual and group therapy sessions. Individual sessions focus on the development of the ability to mentalise within a secure attachment relationship. Group sessions provide opportunities to practice new skills in a more complex relational setting (Daubney & Bateman, 2015). The aim of therapy is for the individual to mentalise when they need to, so they do not move into a state wherein behaviours associated with EUPD are likely to occur. Interventions include the therapist taking a supportive role while clarifying and challenging the client (Daubney & Bateman, 2015). A review of 14 studies by Vogt and Norman (2019) examined the effectiveness of MBT in treating EUPD symptoms. They found MBT to be more or as effective in reducing symptom severity and parasuicidal behaviour in comparison to other treatments (including supportive group therapy, standard psychiatric care, and structured clinical management [SCM]). They also found it to significantly improve wellbeing and interpersonal functioning. Although promising, future research should examine MBT's effectiveness compared to treatments routinely offered for EUPD, such as Dialectical Behaviour Therapy (DBT). Additionally, due to mostly female samples, future research should focus on males as well to improve generalisability.

The Biosocial Model

The biosocial model of EUPD (Linehan, 1993) states that interactions between biological vulnerability and invalidating environments lead to broad emotion dysregulation. This leads to a heightened emotional sensitivity, an inability to regulate intense emotions, and a slow return to emotional baseline. Subsequently, individuals demonstrate dysfunctional behavioural responses during situations which they find emotionally challenging. Invalidating environments are characterised by caregivers' lack of tolerance for a child's emotional expression which communicates that the child should not express emotion and should cope with them internally and independently. Consequently, the child does not learn to understand, label, regulate, or tolerate emotional responses. DBT was developed to aid clients diagnosed

with EUPD in developing skills in emotion regulation, interpersonal interactions, and distress tolerance (Linehan, 1993). DBT aims to reduce behaviours related to suicide and those which stop the individual living a rich and meaningful life. It involves a combination of group skills training and individual therapy as well as telephone coaching over 24-weeks (Panos et al., 2014).

Compared with SCM, DBT has demonstrated significant effects in improving suicidal ideation, impulsivity, and self-harm. Koons et al. (2001) explored how effective DBT could be and randomly assigned 20 females diagnosed with EUPD to either DBT or Treatment-As-Usual (TAU) (60-minutes of weekly individual therapy) for six months. DBT participants experienced significantly greater reductions in suicidal ideation than those in TAU, and only participants in the DBT group experienced significant reductions in the number of parasuicidal acts. Verheul et al. (2003) identified that there was little research regarding the effectiveness of DBT and so randomly assigned 58 females with a diagnosis of EUPD to either DBT or TAU (clinical management) for 12-months. They found that DBT participants experienced a significant reduction in self-injurious behaviours and impulsivity in comparison to the TAU group. Kröger et al. (2006) conducted DBT with 50 inpatient clients diagnosed with EUPD and measured psychopathology at three time points over three months of treatment, which included weekly individual sessions and group sessions every three weeks. They found that psychopathology significantly reduced. In a review of the effectiveness of psychotherapies on EUPD symptomatology, Storebø et al. (2020) conducted a review of 75 Randomised Controlled Trials (RCTs) involving 4,507 participants over 16 types of psychotherapy, most of which involved DBT. Compared to TAU, DBT was significantly more effective at reducing EUPD severity and self-harm and improving psychosocial functioning. This suggests that DBT is useful in alleviating the difficulties associated with EUPD. However, due to heterogeneity in methodologies, small samples, female-dominated samples, and lack of control groups, findings must be interpreted with caution due to an increased risk of bias.

The Biosocial Developmental Model

Crowell et al. (2009) further developed the biosocial model and suggested that the risk of developing EUPD, particularly impulsive self-harm and suicidal behaviours, is increased by an interaction between level of trait impulsivity and invalidating environmental factors.

They suggested that impulsivity and difficulties with emotion regulation could develop independently of one another, with trait impulsivity being an inherited biological factor and emotion dysregulation being developed socially. There is empirical support for this model across both child and adult populations. Due to limited literature relating childhood experiences and EUPD, Stepp et al. (2012) examined the extent to which children with trait impulsivity developed characteristics of EUPD in a sample of 1,233 girls ages 8 to 14. They found that higher levels of impulsivity at age 8 predicted EUPD symptomatology at age 14. Soloff et al. (2017) examined the effects of trait impulsivity on regional brain response in 31 individuals diagnosed with EUPD and 25 control subjects without this diagnosis using functional magnetic resonance imaging (fMRI) as it was unclear to what extent impulsivity modulated brain responses. They found that for participants diagnosed with EUPD, trait impulsivity was positively correlated with activation in various brain regions associated with emotional appraisal and arousal, which differed from the response of healthy controls. This suggested a disorder-specific response as the effects of trait impulsivity differed between groups. Terzi et al. (2017) investigated the role of impulsivity and emotion dysregulation in determining vulnerability to self-harming behaviours in a sample of 79 outpatients diagnosed with EUPD. They found that trait impulsivity significantly predicted self-harm, and that emotion dysregulation was found to significantly account for self-harm in addition to the variance explained by impulsivity. This literature therefore suggests that trait impulsivity is a characteristic of EUPD that requires consideration in psychological treatment. In another study, Selby et al. (2013) found trait impulsivity to predict self-harming behaviours. However, this research is vulnerable to bias due to predominantly female samples, small samples, the use of self-report measures, and lack of controls.

Emotional Cascade Model

The Emotional Cascade Model (Selby & Joiner, 2009) also builds on concepts from the biosocial model (Linehan, 1993) and aims to understand how affect and dysregulated behaviours are associated in individuals diagnosed with EUPD (Selby et al., 2013). ‘Dysregulated behaviours’ are defined as behaviours that result in harm to the individual exhibiting them, and commonly include self-harm, substance misuse, and suicide (Selby et al., 2008). The model states that when an emotionally challenging event occurs, the individual ruminates upon it to a significant extent, which increases the intensity of the distress they experience. As this occurs, rumination increases, and again so does distress,

resulting in an increasing level of difficulty in paying attention to anything other than their thoughts and feelings in relation to the event. Particular to EUPD, Selby and Joiner (2009) propose that this disorder emerges due to various emotional cascades over time, which are related to invalidating environments. An individual ruminates on their environment, and their distress and rumination increase in a cascade, which they may attempt to inhibit by self-harming. If this response is invalidated, the cascade intensifies and the likelihood of unhelpful behaviours occurring increases.

Indeed, rumination has been shown to be more prevalent in individuals diagnosed with EUPD compared to those without a diagnosis (e.g., Selby et al., 2016). Low-level distractions (e.g., drawing) are less likely to break the rumination-distress cycle, and so increasingly significant distraction attempts are used, which may be considered as behavioural dysregulation (e.g., physical sensations gained from substance misuse). In support of this concept, in a study which asked why individuals engage in higher-risk behaviours rather than lower level behaviours when distressed, Selby et al. (2008) found a relationship between rumination and behavioural dysregulation in 200 students related to drinking to cope, reassurance seeking and binge-eating. However, the study is limited by sample characteristics, sample size, and behaviours non-specific to EUPD. In a study seeking to predict dysregulated behaviours, Martino et al. (2018) found that anger and depressive ruminations were significantly associated with self-harming and aggressive behaviours in individuals diagnosed with EUPD. Therefore, it appears crucial that individuals with EUPD receive support in managing their distress and thoughts related to challenging situations. However, the lack of control group in this study limits specificity of the findings, and the use of self-report measures increases the risk of bias.

Neuroanatomical Factors

The anterior cingulate cortex (ACC) is vital for individuals to regulate their emotions (Braem et al., 2017). Evidence shows that people diagnosed with EUPD may experience less activation in the ACC when faced with challenges such as pain (Schmahl et al., 2006), compared to neutral stimuli (Schnell et al., 2007) and healthy control subjects (Minzenberg et al., 2007). However, studies are limited by small sample sizes, limiting generalisability. The amygdala helps an individual process fearful and threatening stimuli and neuroimaging studies have identified differences in the amygdala in individuals diagnosed with EUPD in

comparison to those without a diagnosis of EUPD (Amaral, 2002). Indeed, Silvers et al. (2016) explored the reactivity of the amygdala in response to emotionally challenging stimuli in 60 females diagnosed with EUPD. They found that greater amygdala activity was associated with heightened levels of intense emotion which reduces wellbeing and is associated with suicidality in individuals diagnosed with EUPD (e.g., Wedig et al., 2012). This study supports previous research demonstrating increased activity in the amygdala when individuals diagnosed with EUPD are presented with thoughts about unresolved life events (Schmahl et al., 2006). However, the use of a control group would have allowed firmer conclusions to be drawn. The hippocampus has implications in learning and memory (Driessen et al., 2000) and it has been posited that early dysfunction of the amygdala and hippocampus results in unstable affect and poor implicit affective memory. As such, infants with deficient hippocampi may be more likely to develop a memory system which cannot cope efficiently with trauma (Baird et al., 2005). Therefore, it is important for individuals diagnosed with EUPD to access the appropriate support to help to compensate for such differences to improve their wellbeing.

Neurotransmitters

HPA Axis. The hypothalamic-pituitary-adrenal axis (HPA) is a neuroendocrine system that controls the body's response to stress and involves the hypothalamus, pituitary and adrenal glands (Pompili et al., 2005). When an individual experiences a stressful event, the hypothalamus secretes corticotropin releasing hormone, which then leads to the secretion of adrenal corticotropic hormone in the pituitary gland. This can then lead to the secretion of several hormones in the adrenal glands, including cortisol, which is key in regulating the body's response to stress. If cortisol levels become too high, a negative feedback loop feeds back into the hypothalamus and pituitary gland for the body to manage and reduce cortisol levels (Pompili et al., 2005). Evidence has shown HPA abnormalities in individuals diagnosed with EUPD (Cattane et al., 2017); however, the literature in this area remains limited. Evidence suggests that individuals diagnosed with EUPD do not produce enough cortisol for their body to respond to manage stress. For example, Thomas et al. (2019) systematically reviewed cortisol levels in individuals diagnosed with EUPD and found significantly lower mean cortisol levels in comparison to non-psychiatric controls. This suggests that individuals diagnosed with EUPD secrete less cortisol in response to challenging events, limiting the likelihood of feeding back into the hypothalamus and pituitary gland to manage the stress

associated with the event. A review by Wilson et al. (2021) found that the genes involved in HPA axis regulation may be altered by exposure to childhood trauma. This suggests that the secretion of cortisol in individuals with EUPD may be associated with poor development due to childhood trauma. However, both meta-analyses are limited by methodological differences and small samples across the studies reviewed.

Serotonin. Serotonin is a neurotransmitter that relays signals between nerve cells and regulates their intensity, thus contributing to mood and overall wellbeing (Jonnakuty & Gragnoli, 2008). The lack of availability of ways for serotonin to relay between cells has been shown to negatively influence levels of impulsivity and emotional lability in individuals diagnosed with EUPD (e.g., Ni et al., 2006; Schaaff et al., 2007), in particular, suicidality (Coccaro et al., 2015). However, more research with larger samples is required to develop a knowledge of why this may be the case. The existing literature, however, suggests that individuals diagnosed with EUPD may benefit from support in which they can learn how to effectively manage distress and increase their awareness of thoughts and feelings that could precede impulsivity.

1.3 EUPD and Substance Misuse Comorbidity

Two systematic literature reviews conducted 18 years apart monitored the literature regarding comorbid EUPD and substance misuse in terms of aetiology. An initial 43 reviewed studies demonstrated that substance misuse can lead to difficulties with emotion regulation, impulsivity, and interpersonal relationships; all of which are characteristic of EUPD. It was also identified that childhood traumatic experiences predicted both EUPD development and substance misuse; increasing the likelihood of both in combination (Trull et al., 2000). The review found that individuals diagnosed with EUPD were more likely to misuse substances to cope with distress, leaving them vulnerable to this comorbidity. Additionally, excessive and prolonged alcohol misuse can lead to low levels of serotonin, which can increase impulsivity. The most common predictor of alcohol misuse was a desire to alleviate stress, reinforcing alcohol misuse and increasing the likelihood of future misuse. Later studies provided further support with 0-53.19% of individuals diagnosed with EUPD having substance misuse difficulties, the most common substance being alcohol (Trull et al., 2018). In addition to childhood trauma, a family history of impulsivity was also found to predict this comorbidity, and evidence demonstrated that EUPD and substance misuse may share genetic mechanisms

associated with unstable affect. However, both reviews included retrospective studies and heterogeneous samples, limiting reliability and generalisability. The literature therefore points to a need for the development of an effective treatment which considers both EUPD and substance misuse.

1.4 Further Information Regarding Coproduction

UK services are commissioned without contributions from people experiencing Multiple Disadvantage (MD) (Fulfilling Lives, 2020). The Five Year Forward View (Mental Health Taskforce, 2016) encourages 'coproduction' with People With Lived Experience (PWLE) to ensure client voices contribute to service development (NHS England, 2018). 'Coproduction' is the highest level of client participation and involves input at every stage of research. When this is not feasible, researchers should aim for the most participation possible (Roper et al., 2018). 'Consultation' is one alternative and involves gathering PWLE's views to inform services (Hollins, 2019). Consultation has shown utility in services supporting individuals experiencing EUPD (Springham & Xenophontes, 2021), homelessness (Hines et al., 2015), and substance misuse (Allman et al., 2006). Including PWLE and relevant professionals is vital as they are key stakeholders in services and possess valuable knowledge and expertise which can be used to develop and support services to create meaningful change (NHS England, 2022). Coproduced research can help to combat inequalities, reducing the risk of exclusion from services (NHS England, 2022).

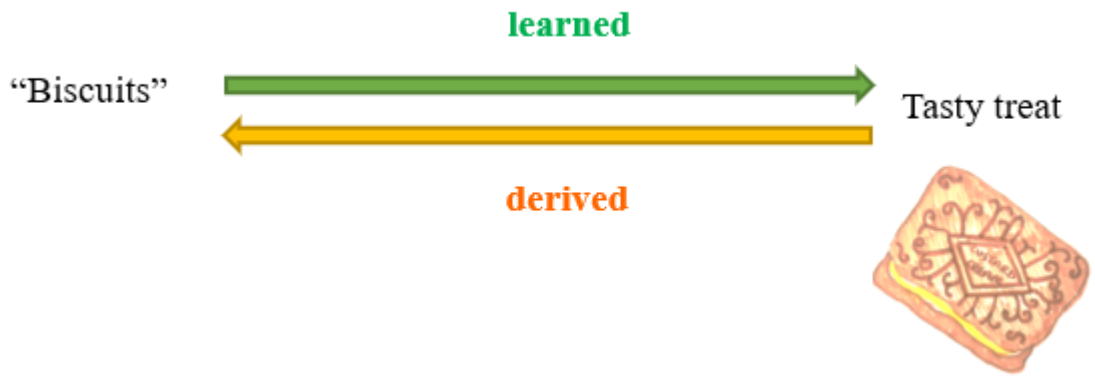
UK guidance encourages researchers to ensure research is conducted 'with' such stakeholders, rather than 'for' them to increase relevance and impact (INVOLVE, 2021). Despite this guidance, there are a lack of opportunities for PWLE to engage in consultation used to shape service delivery. Frequently reported barriers include a lack of time and resources (Park, 2020), and lack of support for PWLE (Boswell et al., 2021), perceived risk and ethical issues (Wadman et al., 2019), and cost (Nicholls et al., 2003). Furthermore, it is common for researchers to misunderstand the true concept of coproduction, resulting in tokenistic opportunities marked by power imbalances (Lukes, 2005). This can deter PWLE from participating in research again (Bee et al., 2015).

1.5 ACT's Theoretical Underpinnings

Relational frame theory (RFT) states that individuals learn language relationships (e.g., "that pink tree is a blossom") and also infer further relationships based on those they have learned (i.e. therefore, "blossoms are pink trees") (Hayes & Brownstein, 1986). This is an ability unique to humans as although a cat may interpret the word "biscuits" to mean they will receive a tasty treat because they are reminded of the satisfaction they felt when they last ate a biscuit, they do not equate a tasty treat with the word "biscuits". In contrast, humans would infer that a tasty treat involves "biscuits" (see Figure 4).

Figure 4

Inferring Relationships

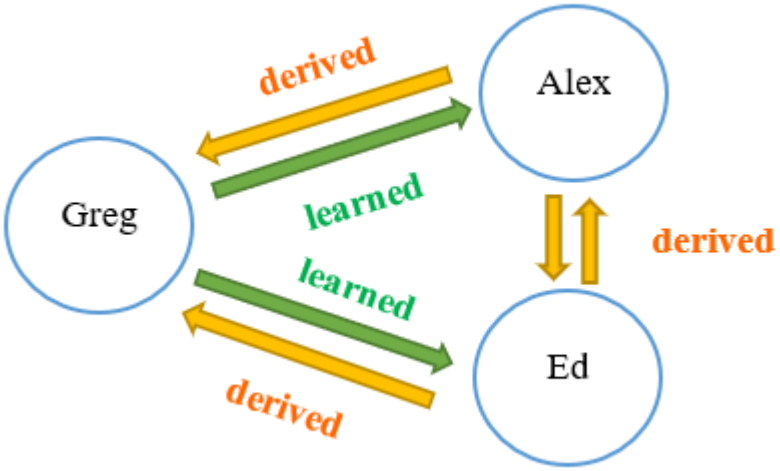


Note. An illustration of how language relationships can be inferred.

Humans learn to infer language relationships through observation (Hayes et al., 2001). When a child learns that a biscuit is a "treat" and they can derive that a "treat" is a way of describing a biscuit, they have developed a "relational frame". As individuals gather examples from experiences, numerous relational frames are developed based on learned information. For example, if a person's new partner Greg introduces them to their brother Alex and their father Ed they have told that person that Alex is Greg's brother and Ed is their father. However, from those facts, the person will derive various other relationships: Greg is Alex's brother, Greg is Ed's son, Alex is Ed's son, and Ed is Alex's father. Therefore, the person learns about six relationships when only being taught about two (see Figure 5).

Figure 5

Greg's Relationships



Note. An illustration of how a person may infer Greg's relationships.

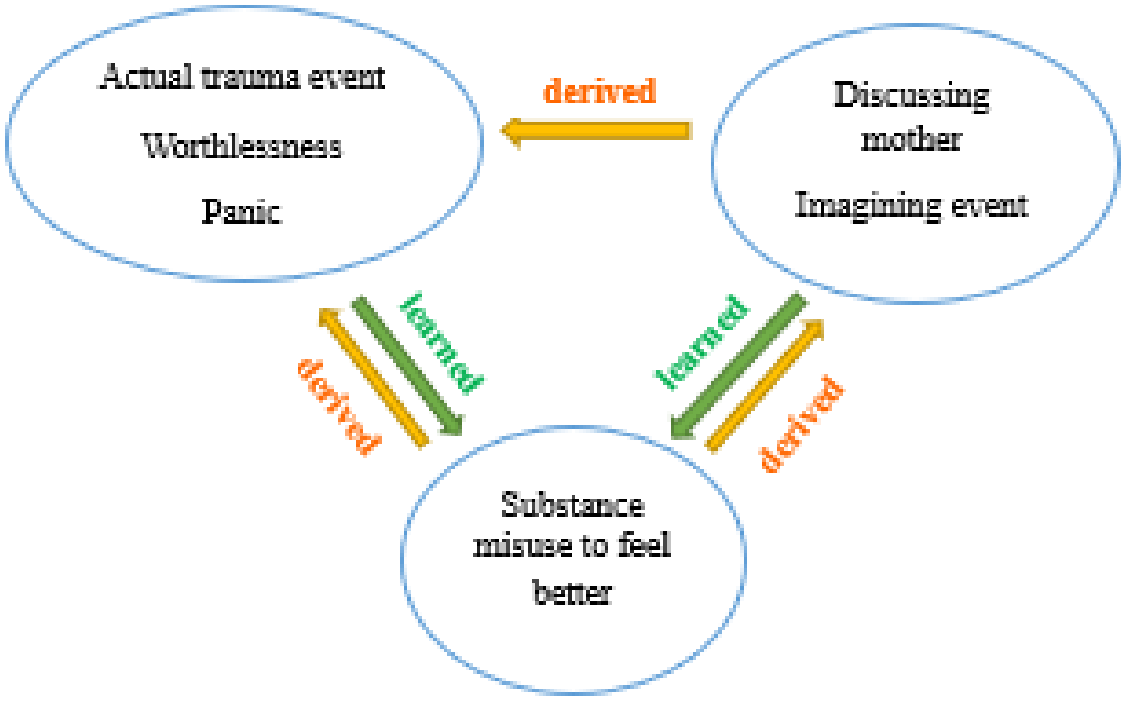
When Greg later introduces the person to his mother Jo and her niece Rosie, the mind would combine this information with pre-existing information and the person would derive various other relationships.

Humans also create relational frames using thoughts and memories based on the same principle, explaining why distress can occur when talking about a previous difficult experience (Hayes, 2004). For example, if Jessie was physically abused by her mother which made her feel "worthless" and caused panic, talking about her mother would evoke the distress felt by Jessie at the time of the traumatic event. The language used, the actual event, the physiological sensations, and the memory are all within a relational frame together, and this is why Jessie can experience distress even when she imagines it. This can be made worse by attaching other language to the distressing event. For example, one way in which Jessie would avoid the distress caused by the thought of this trauma may be to replace it with the thought of something positive, which may be facilitated by the misuse of substances. If Jessie distracts herself by misusing substances and she does not become distressed, then this would be successful. However, because Jessie knows she is misusing substances to avoid thinking about her childhood trauma, that substance misuse may come to remind her of that trauma,

which in turns causes distress. This would mean that Jessie has introduced her misuse of substances into the same relational frame as the trauma (see Figure 6). The more Jessie tries to prevent distress, the more things become reminders of the distress that she is trying avoid, which is reflective of many pain-avoidance strategies used by humans and can have a significant impact on people's lives.

Figure 6

Jessie's Relational Frame



Note. An illustration of how Jessie may infer language relationships involving feelings and trauma.

1.6 Epistemological Position

ACT is rooted in a position of 'functional contextualism' which seeks to predict and influence events using empirically based concepts and rules which adhere to a truth criterion (Gifford & Hayes, 1999). Functional contextualism is concerned with the context in which phenomena occur, as well as function. For example, if we imagine a tap and then think about turning on the tap and seeing glitter come from the faucet rather than clean water, we may conclude that the tap is "broken" within the context of wanting to use the tap to clean the dishes. However, if we consider the function of the tap within the context of a practical joke,

or to make everything glittery, then the tap functions effectively. Similarly, the context of thoughts and feelings can be problematic, rather than the thoughts and feelings themselves. Within the context of substance misuse as experiential avoidance, thoughts and feelings may function in a harmful way (e.g., if substance misuse precipitates homelessness). However, in a context in which an individual can defuse from difficult thoughts, the thoughts may have less of a harmful impact on the individual (Harris, 2019).

1.7 ACT Theory of Psychopathology

ACT states that psychological difficulties stem from the way that language and cognition interact with other factors which results in an individual being unable to change their behaviour to be more in line with their values (Hayes, 2023). Due to unhelpful relational frames, psychological inflexibility, and therefore psychological difficulties, can emerge due to unhelpful verbal contexts. One example of an unhelpful verbal context is ‘cognitive fusion’ wherein an individual does not identify a difference between their relational response and what would actually be helpful. When an individual becomes fused with their thoughts, they may behave in values-inconsistent ways due to experiential avoidance (e.g., self-harming behaviour) (Haywood et al., 2023). The content of the thoughts is not problematic here; the difficulties arise when the thoughts are seen as reflections of reality and lead to unhelpful behaviours. Such unhelpful relational frames are typically developed and maintained by verbal communities (Hayes, 2023). For example, a context of experiential control is based on manipulating an emotional state and considering this to be a principal measure of success in life.

When individuals are fused with their thoughts experiential avoidance is more likely. For example, when a person feels distressed, they may, in the first instance, try to change the content or frequency of the thoughts and feelings by misusing substances, even if this leads to further distress or harm (e.g., difficult thoughts, no money for food). Due to the relational frames related to verbal language, “distress” is then predicted, and attempts are made to avoid it. This pattern then develops and becomes strengthened by the verbal community which focuses on avoiding pain and suffering and increasing good feelings. However, when the person tries to avoid the distress, attempts to avoid distress become more important because the misuse of substances is itself linked to relational frames associated with negative consequences. This then limits the person to the number of ways they can avoid distress, and

so many behaviours come to evoke distress. The social demand to provide reasons for avoidant behaviours leads to individuals explaining their reasons (often associated with the past or future) and not living in the present moment, reducing psychological flexibility. For example, an individual may explain that their substance misuse stems from trauma experiences to justify their self-concept (e.g., being a victim) rather than develop alternative workable behaviours in contrast to that concept.

1.8 The ACT Process

The six processes of ACT, which are described in further detail below, do not have to be discussed with a client in any set order, but the focus must remain on facilitating the client's understanding that their current behaviours are unworkable (Harris, 2019). For example, if a client misuses substances to avoid anxiety, the therapist would facilitate their understanding that although this may be effective in the short-term, it is not a long-term solution, and may not be in line with the client's values (e.g., to be healthy). In addition, the therapist should attend to where the client has the most need. For example, the client may be able to state what they value in life (e.g., to be physically healthy, to have a job), but find it difficult to acknowledge their thoughts as thoughts and not facts, which could then lead to unworkable behaviours (e.g., "I'm a failure" could lead to substance misuse). In this example, the client may find it advantageous to initially spend time on developing self-as-context to identify their thoughts and developing defusion skills so that substance misuse (experiential avoidance) becomes less likely.

Cognitive Defusion

'Cognitive fusion' refers to the "excessive or improper regulation of behaviour by verbal processes, such as rules and derived relational networks" (Hayes et al., 2006, p. 6). This is addressed through 'cognitive defusion' techniques, which "attempt to alter the undesirable function of thoughts and other private events, rather than trying to alter their form, frequency, or situational sensitivity" (Hayes et al., 2006, p. 8). That is, cognitive defusion works to change the function and context of unhelpful thoughts rather than the content, thus providing the person with distance from the thoughts and lessening the belief in them (e.g., *"I'm having the thought that I'm bad"* rather than *"I'm bad"*) (Hayes et al., 1999). Individuals diagnosed with EUPD experience emotion regulation difficulties and are therefore at an increased risk of becoming 'fused' with particular thoughts about emotions

(Zurita Ona, 2020). For example, fusion with thoughts such as, *"I cannot have this emotion, I need to get rid of it"* can lead to engagement in impulsive behaviours without considering the consequences (e.g., substance misuse). There is a lack of research exploring the effects of ACT on cognitive fusion; however, Firouzjaei et al. (2020) found that cognitive fusion and both EUPD and impulsivity were positively and significantly correlated ($p < .01$). However, the study's use of self-report measures increase the risk of social desirability bias. No studies have focused on the effect of cognitive defusion on emotion regulation or behaviours associated with avoiding difficult thoughts. Existing studies have found ACT to reduce dysregulation, self-harming behaviours, and EUPD symptom severity (Gratz & Gunderson, 2006; Morton et al., 2012; Reyes-Ortega et al., 2019). However, small, homogeneous samples reduce generalisability to the target population. This suggests that ACT could help individuals diagnosed with EUPD to gain distance from thoughts, allowing them to see them only as thoughts.

Acceptance

'Acceptance' encourages individuals to acknowledge difficult thoughts without avoiding them, as avoidance causes further distress (Hayes et al., 1999). Chapman et al. (2006) posit that experiential avoidance for those diagnosed with EUPD most commonly involves self-harming behaviours, impulsive behaviours, and substance misuse. In a study of 105 participants, Chapman et al. (2005) found that EUPD severity was associated with higher levels of experiential avoidance; although generalisability is limited due to an all-female incarcerated sample. Morton et al. (2012) compared ACT+TAU and TAU (supportive contact, medication management, admission and crisis contact) among individuals diagnosed with EUPD. The ACT+TAU group experienced a significant increase in acceptance and reduction in engaging in experiential avoidance, with a large effect size (d=.98). TAU resulted in no significant differences pre- and post-intervention. However, the study used self-report measures, increasing the risk of social desirability bias. Due to the association between experiential avoidance and EUPD symptom severity, acceptance should be an integral part of psychological intervention for this population (Morgan & Aljabari, 2019).

Present moment awareness

'Present moment awareness' promotes "ongoing non-judgmental contact with psychological events and events in the environment as they occur" (Hayes et al., 2006, p. 8).

The goal is to help individuals attend to their changing experience in a flexible, values-led way (Hayes et al., 1999). For individuals diagnosed with EUPD, tolerating uncomfortable thoughts and emotions can be extremely difficult. Many typically avoid those processes by engaging in experiential avoidance such as substance misuse and impulsive behaviours in an effort to reduce distress (Wupperman et al., 2009). Present moment awareness can help enhance individuals' awareness of being fused with particular thoughts and of urges to avoid uncomfortable experiences, providing opportunities to choose to behave in alternative, more helpful, ways (Zurita Ona, 2020). In a review of the literature, Chiesa and Serretti (2014) found that present moment awareness interventions were effective in reducing the misuse of various substances. However, small samples and methodological limitations across studies limited the reliability and generalisability of results. Elices et al. (2016) compared the effects of a 10-week mindfulness group and a control group (interpersonal effectiveness skills) on EUPD symptoms and mindfulness capacity. Participants in the mindfulness group experienced a significant reduction in EUPD symptoms, and a significant increase in mindfulness capacity; whereas no changes were observed in the control group. Furthermore, impulsivity significantly reduced in the mindfulness group compared to the control group ($p < 0.001$) (Farrés et al., 2019). However, the small sample size jeopardises the extent to which results can be generalised to the wider target population. In their systematic review, Kounidas and Kastora (2022) found that across studies, mindfulness led to improvements in impulsivity, emotion regulation, and a non-judgemental stance among individuals diagnosed with EUPD. Therefore, mindfulness may be effective in reducing difficulties characteristic of EUPD. However, it is difficult to conclude long-term effects due to a lack of follow-up across studies.

Values

Identifying 'values' helps individuals to consider their actions according to their life goals, and alternative approaches if their actions are not consistent with their values (Hayes et al., 1999). ACT posits that all individuals, regardless of their previous experiences, possess values and the ability to live a meaningful life (Hayes et al., 2004). A recent study (Buckley et al., 2024) provides preliminary evidence that values identification can impact positive changes in behaviour. No previous research has specifically studied the effect of values identification on experiential avoidance such as substance misuse; however, some explores the use of ACT more generally and in fields other than substance misuse. Osaji et al. (2020)

systematically reviewed the literature regarding ACT as a treatment for substance misuse. Across studies, ACT was used to encourage participants to accept urges to misuse substances and to use psychological flexibility and values-based interventions to reduce those urges. The majority of studies found ACT to be effective in the management of substance misuse, as many participants experienced a significant reduction in substance misuse or abstinence following treatment. However, limitations across studies included small sample sizes, self-report measures, and a lack of blinding, increasing the risk of bias. These studies suggest that values interventions may have utility within ACT and for this population.

No previous literature has studied the effectiveness of values interventions on individuals' ability to tolerate discomfort in this population; however, evidence to support this notion has been found in other fields. For example, Branstetter-Rost et al. (2009) compared the effects of an acceptance intervention with and without a values component among people who completed the cold-pressor task (placing hands in cold water to induce pain). They found that the inclusion of values interventions led to significantly greater pain tolerance than acceptance alone, and both were associated with greater tolerance than a control group. However, it should be noted that generalisability may be limited due to a small sample size. Chase et al. (2013) examined the impact of goal-setting with and without values identification on a measure of undergraduate academic performance in psychology students. Participants were randomised into a goal-setting group, goal-setting and values, or a waitlist. The results showed that the combination of goal-setting and values significantly improved academic performance. However, small samples, and sample characteristics should be considered as potentially introducing bias. For example, Chase et al. (2013) studied a larger sample, but the majority of participants were students under the age of 22 years, potentially limiting to generalisability of the findings to the target population.

Committed Action

'Committed action' describes the process of developing increasingly effective actions that adhere to a person's values through short, medium, and long-term goals (Hayes et al., 2006), despite difficult thoughts that surface while doing so (Hayes et al., 1999). This applies to overt behaviour, but also internal experiences and managing them by being open to experiencing uncomfortable emotions, sensations, thoughts and urges, while living in line with personal values (Zurita Ona, 2020). As discussed, this is particularly poignant for

individuals diagnosed with EUPD, as they are likely to become fused with unhelpful and uncomfortable thoughts (Zurita Ona, 2020). Cameron et al. (2014) suggest that although treatments such as DBT are effective for reducing EUPD symptoms, individuals diagnosed with EUPD typically continue to experience a poor quality of life. For example, McMain et al. (2009) found that a one-year DBT treatment led to improvements in symptoms, interpersonal functioning and distress; however, not in quality of life. However, it is impossible to ascertain whether concurrent interventions had a significant impact on the results. Morton et al. (2012) compared ACT+TAU with TAU, and found larger and significant changes in psychological flexibility, emotion regulation, mindfulness, and fear of emotions in the ACT+TAU condition. The effect size was large for the values-focused treatment (*d*=.81) demonstrating that completing work about values and committed action could enhance treatment. However, these findings were based on a small sample. There is therefore a deficit in terms of psychological intervention which targets quality of life in this group of individuals. As individuals diagnosed with EUPD often have difficulties with emotion dysregulation, distress tolerance, and emotional reactivity, enhancing their motivation and quality of life in the context of those difficulties is paramount. Therefore, psychological intervention is required which focuses on symptom reduction and improving quality of life simultaneously.

Self-As-Context

Rooted in relational frame theory, 'self-as-context' is the notion that a person can be "aware of ones own flow of experiences without attachment to them or an investment in what experiences occur: thus defusion and acceptance is fostered" (Hayes et al., 2006, p. 8). This skill encourages individuals to notice their thoughts, feelings, sensations, and actions, without being influenced by them (Hayes et al., 1999) and is fundamental in the development of perspective-taking, empathy, self-compassion, and compassion (Hayes et al., 2012). A core feature of EUPD is an unstable sense of identity (APA, 2013). Developing self-as-context skills enhances a person's ability to make contact with a perspective in which they can observe their internal processes non-judgementally. This is achieved through the use of mindfulness exercises which allow them to notice a "them" that is outside of the thoughts and feelings they experience. Therefore, it could provide an alternative approach to counter an unstable sense of identity, allowing individuals to notice their fluctuating sense of self without judgement, distress, or need for immediate action in response to it. There is little

existing literature regarding the effect of self-as-context, mostly due to a lack of means to measure this until recently (Jeffcoat et al., 2015; Zettle et al., 2018).

Developing skills across all six domains could therefore increase psychological flexibility in individuals diagnosed with EUPD. Increasing awareness and acceptance, and improving a person's motivation to live a values-led life, together with noticing internal experiences, would provide opportunities to resist urges to avoid (e.g., substance misuse) and to choose to respond in healthy ways. This, in turn, would reduce the likelihood of unwanted consequences such as homelessness (Single Homelessness Project, 2017).

1.9 In-depth Review of the Literature

General Mental Health

ACT has been shown to be efficacious across various difficulties, including pain, mood difficulties, psychotic symptoms, anxiety, and stress (Öst, 2008, 2014). A systematic review of RCTs showed ACT to be significantly more effective in reducing a variety of mental health difficulties compared to control groups, with studies mostly yielding moderate effect sizes (Stenhoff et al., 2020). However, heterogeneity of control groups across studies reduces the confidence in which conclusions can be drawn. In addition, participants were not diagnosed with EUPD, and therefore findings may not be generalisable to the target population.

Substance Misuse

ACT has also shown effectiveness in individuals who misuse substances. One RCT by González-Menéndez et al. (2014) compared the effectiveness of ACT and Cognitive Behavioural Therapy (CBT) in 37 prisoners who misused substances. They found significant reductions in avoidance and improvements in acceptance for both treatments, with no significant difference between groups, suggesting that ACT is as effective as CBT in improving acceptance and reducing experiential avoidance in individuals misusing substances. However, the small sample size reduces generalisability. Additionally, a review of 17 studies by Maia et al. (2021) found that ACT significantly increased psychological flexibility in participants who misused substances. However, many studies were not randomised, increasing the likelihood of baseline differences between groups.

Personality Disorder

For individuals diagnosed with a personality disorder, research has shown promise for ACT. ACT has been shown to be equally as effective as CBT in significantly improving distress, quality of life, and personality disorder symptomatology (Chakhssi et al., 2015; Clarke et al., 2012) as well as mindfulness and psychological flexibility (Clarke et al., 2014). However, small sample sizes, lack of comparison groups, and confounding variables limit the generalisability of findings across studies.

EUPD

ACT has also shown promise in individuals diagnosed with EUPD. In comparison to TAU involving general support and medication management, ACT as well as TAU led to significant improvements in EUPD symptoms, psychological flexibility, emotion regulation and mindfulness (Morton et al., 2012). Reyes-Ortega et al. (2020) found similar results, including significant improvements in perceived control over experiences and experiential avoidance, and demonstrated that ACT was equally as effective as DBT and functional analytic psychotherapy. In addition, ACT has also been found to significantly reduce EUPD symptomatology in participants who misused substances (Piri et al., 2020). In a qualitative study, Cosham (2013) found that participants felt more able to consider their responses flexibly, and perceived difficult emotions as less problematic following ACT. However, it is important to note that some studies used group ACT and studies were limited by their small samples, self-report measures, limiting generalisability and increasing the risk of bias. Therefore, ACT may have a place in the treatment of individuals diagnosed with EUPD who also misuse substances.

Impulsivity

Other studies have focused on specific difficulties associated with EUPD. For example, Baghani and Akbari (2020) found ACT to significantly reduce impulsivity in individuals who misused substances compared to a control group. However, as participants did not have a diagnosis of EUPD and the format of ACT included group sessions, the generalisability is limited.

Suicidal Ideation

ACT has also been studied in relation to suicidal ideation. ACT has been shown to significantly reduce suicidality severity (Ducasse et al., 2014), self-harming behaviour (Tighe et al., 2018), attempts, aborted attempts, preparatory behaviour, and cognitive fusion with suicidal ideation (Barnes et al., 2021). In addition, participants have often perceived ACT to be helpful, including within samples of which 40% of participants were facing homelessness (Barnes et al., 2021; Ducasse et al., 2014). However, samples across studies were limited in the number of participants diagnosed with EUPD, and participants who misused substances. Further issues were identified in small sample sizes and the use of self-report measures, reducing generalisability and increasing the risk of bias. However, the literature suggests that ACT may be acceptable intervention for individuals facing homelessness.

Emotion Regulation

Studies have shown that ACT significantly improves emotion regulation compared to control groups (Artusio, 2018; Mahmoudpour et al., 2021) with no significant difference in effectiveness found compared to mindfulness based cognitive therapy (Googhari et al., 2022). However, it is unclear whether participants across studies misused substances, and participants were not diagnosed with EUPD, limiting the generalisability of findings.

Distress Tolerance

ACT has been shown to significantly improve distress tolerance compared to a no treatment control group (Ghanbari et al., 2020) and motivational interviewing (Kashefizadeh et al., 2023). It has also been shown to be as effective as ‘Quality of Life Improvement Training’ (Ghanbari et al., 2020) and mindfulness groups (Kashefizadeh et al., 2023). However, studies are limited by all-male samples who did not have a diagnosis of EUPD, thus reducing generalisability, as well as self-report measures which increase the risk of bias.

Psychological Flexibility

ACT has been shown to significantly increase psychological flexibility compared to standard treatments (Gul & Aqeel, 2021), including in samples who misuse substances (Hoseininezhad et al., 2022). However, participants did not have an EUPD diagnosis, and generalisability was limited by all-female samples.

2.0 Extended Method

2.1 Further Information Regarding the Identification of Existing Interventions

In Step One, Goldstein et al. (2012) highlight the need for a comprehensive literature review to identify any existing empirically supported interventions which could be adapted for the target population. For the current study, this would include existing manualised interventions for individuals diagnosed with EUPD, who misuse substances, and face homelessness. Such interventions should be identified in any setting (e.g., inpatient, outpatient, charitable organisations, etc.) and population (e.g., incarcerated, male, female, etc.). Once identified, the advantages and disadvantages of each existing manualised intervention should then be recorded in terms of how appropriate they are for adaptation to the target population. Goldstein et al. (2012) recognised that despite thorough searching, there may remain a lack of manualised interventions that already exist for some target populations and their relative requirements in an intervention. However, the search of the literature may still facilitate the identification of interventions which have been shown to be effective, even though they would require significant adaptations to meet the requirements of the target population. Once existing manuals have been identified, Goldstein et al. (2012) recommend evaluating each intervention for their empirical support, as the intervention with the most encouraging results would be the most appropriate for use with the target population, provided it can be adapted for them. Once existing empirically supported manuals have been identified, their theoretical foundation and mechanisms of action should be reviewed.

All identified existing manuals should then be evaluated to ensure that the research goals can be addressed, and that the interventions and mechanisms of action are appropriate for the target population (Goldstein et al., 2012). For the current study, this would involve evaluating existing manuals for their consistent use of ACT, and the aim to increase psychological flexibility. Once clarified, appropriate existing manuals would then be reviewed in terms of whether they could be adapted to meet the needs of the target population (Goldstein et al., 2012). This decision should be made by researchers based on three key considerations. Firstly, compatibility of the theoretical structure of the intervention and the target population should be considered. For example, abstinence strategies in a manual designed for adults who are seeking to stop misusing substances may not be compatible for adaptation for adults

whose priority is not to abstain for substance misuse. Secondly, the existing manual should, if possible, have been shown to be effective with a similar population to the target population. For example, a manualised treatment with a population who attend a trauma group and misuse substances is likely to be adaptable for the target population. Finally, the researchers must examine whether it would be feasible the implement the existing manual with the target population. For example, if an existing manual involved intensive family-based approaches for the individual, this may not be feasible for the target population, as they often have difficulties in interpersonal relationships, organisations supporting them may not have the resources, and the time-frame may be too demanding for the individual.

2.2 Further Information Regarding Gathering Information from Professionals and Experts

Goldstein et al. (2012) suggested focus groups with the target population; however, stipulated that the data collection methodology for this stage should take into consideration the strengths and needs of the target population. In addition, and if possible, they also stated that multiple formats for data collection should be utilised, and if appropriate, those related to the target population should also contribute their perspectives.

Once data has been collected, the researchers should consider the representativeness of the data in the context of the wider target population and whether the feedback should be incorporated into the adapted manual. Feedback from participants should guide the adapted manual; however, previous research, theoretical considerations, researchers' clinical experience with the target population, and practical factors (e.g., setting, resources, etc.) should also be considered. In addition, prior to data collection, researchers should consider what would happen in the event of contradictory feedback across participants (e.g., expert panel, majority views, etc.). The researchers decided prior to the interviews that, in the event of contradictory feedback, the majority views would informed decisions about which excerpts to adapt, which would be clear from the analysis findings.

2.3 Further Information Regarding Content and Structural Changes According to Goldstein et al. (2012)

Modifications of existing interventions for the adapted manual can be made to both clinical and procedural content (Goldstein et al., 2012). Clinical content relates to the

materials included in the manual and may require modification due to advances in the clinical area of interest since the original interventions were published. Adaptations to procedural content involve adapting the way in which the intervention is facilitated in terms of the activities used in each session and the discussions that take place (Goldstein et al., 2012). Procedural content modifications may be appropriate when there are significant differences between the population the existing manual was originally designed for and the target population. This may include differences in cognitive functioning, development, interests, and experiences. For example, if the target population is likely to capture a range of intellectual abilities, then a mixture of simple written explanations as well as pictures and symbols may be appropriate. Procedural content may also relate to differences between the originally intended and the target population in terms of requirements. For example, if a base manual was originally intended for individuals in an inpatient setting, then the requirements in terms of treatment location and missed appointments may need to be changed for individuals diagnosed with EUPD who misuse substances who access the intervention as an outpatient. Regardless of content modifications, the researchers should ensure that the mechanisms of action (i.e., increase in psychological flexibility due to defusion, mindfulness, self-as-context, acceptance, committed action, and values) are maintained (Goldstein et al., 2012).

2.4 Further Information Regarding the Acceptance and Commitment Therapy Fidelity Measure

The Acceptance and Commitment Therapy Fidelity Measure (ACT-FM) (O'Neill et al., 2019) is a 25-item measure that rates clinician fidelity to ACT in a range of contexts in clinical practice or as a research tool. It assesses therapist stance, and open, aware, and engaged response styles. Research demonstrates moderate to excellent inter-rater reliability (O'Neill et al., 2019). The ACT-FM was used as a framework of ACT-consistent domains, against which potential base manuals were scored.

2.5 Further Information Regarding Participants

Professional and PWLE participants recruited for Step Two of the research were recruited from Framework, which is a charitable organisation established in 2001 and based across the East Midlands. It includes numerous services which support individuals facing MD and was therefore suitable for the recruitment of participants relevant to the current research.

Professionals were recruited from the Nottingham Recovery Network and the Crescent Recovery Service. The Nottingham Recovery Network supports people looking to change their relationship with substances (Nottingham Recovery Network, 2023). The Crescent Recovery Service provides supported housing to individuals with mental health difficulties who misuse substances with the aim of supporting them to live more independently (Framework Housing Association, 2023). PWLE were recruited through the Participation Coordinator of Framework who facilitated the organisation's Expert Citizens group which consists of past and current recipients of their services. This group contribute to policy and practice changes, as well as service development, and share their experiences with others, mentor and volunteer within the organisation, and help to recruit future employees (Changing Futures, 2023).

2.6 Further Information Regarding Recruitment and Participation

Including all professionals and PWLE who volunteered to take part helped to avoid skewing the sample (e.g., selecting participants predicted to provide particular responses). Gatekeepers were managers of services which support people facing MD. Gatekeepers provided potential participants with Participant Information Sheets (see Appendices B and C). Confidentiality regarding who opted in was emphasised to gatekeepers, whose roles are bound by data protection legislation. Eligible and willing participants completed a Consent Form (see Appendix D) and a demographics questionnaire (see Appendix E). If more than five professionals or five PWLE volunteered to participate, computer-generated sampling would have been used to select participants. Following participation, all participants received a debriefing letter which reinstated the purpose of the study, contact details for queries, and signposting to additional support (see Appendices F and G).

2.7 Further Information Regarding Interview Format

Participants were given the choice of either face-to-face or online interviews. This option was provided to offer flexibility and arranged at a convenient time for the participant. It was also anticipated that the Covid-19 pandemic may influence participant's willingness to attend face-to-face interviews due to safety concerns (e.g., Santhosh et al., 2021). In addition, PWLE were given longer appointment slots in accordance with previous literature (e.g., Fulfilling Lives, 2020). This is in line with guidance by Goldstein et al. (2012) which states that multiple methodology formats, as well as the target population, should inform manual

adaptation. Individual interviews provide privacy and comfort, particularly those conducted online, which may increase their willingness to talk openly (Nehls et al., 2015).

2.8 Information Regarding the Semi-structured Interviews and Alternative Methods of Data Collection Considered

Semi-structured Interviews

Semi-structured interviews aim to explore, in-depth, participant's experiences and the meanings they associate with them (Adams, 2010). The interviewer conversationally asks pre-determined closed- and open-ended questions; however, is not required to follow the set questions rigidly. For example, if the participant begins talking about something aside from the research topic, the interviewer can follow the participant's lead rather than immediately return to the question being asked. Follow-up questions of "How?" and "Why?" are often used to encourage participants to elaborate on their responses (Adams, 2015; Langdridge & Hagger-Johnson, 2009).

One advantage of semi-structured interviews is that participants may be more likely to discuss topics which they may not wish to discuss within a group setting, for example, a focus group (Adams, 2015). This was of particular importance within the current research, as participants, particularly PWLE, would potentially discuss sensitive information related to their own personal backgrounds or needs. For professional participants, this was important where hierarchical structures existed (e.g., staff positions) (e.g., Mansell et al., 2004), as not all professionals had the same role. Kruger et al. (2019) compared individual interviews to focus groups with respect to young women's verbalisations about body image. Participants in semi-structured interviews disclosed more personal thoughts and feelings than those in focus groups. They also had more positive perceptions of the interview setting than participants in the focus groups. In addition, Schuster et al. (2023) found that individual interviews elicited a greater range of sensitive information and a greater number of themes than focus groups. This suggests that semi-structured interviews may provide a more supportive environment in which to discuss sensitive topics.

In addition, semi-structured interviews provide opportunities for reciprocal discussions between the researcher and participant (Galletta, 2013), allowing the interviewer to ask further focused questions based on individual participant responses (Polit & Beck, 2010).

This type of interaction allows researchers to gather more in-depth data and ensure no topics are missed and ensures that participants feel they can elaborate (Langdridge & Hagger-Johnson, 2009). This was advantageous for the current research as participants were being asked for their personal perceptions, which may have been restricted by others voicing their opinions within a group setting. As participants were required to share their opinions, it was important in the current research for participants to feel comfortable in voicing their thoughts openly and honestly. Individual semi-structured interviews provided an opportunity to do this, which may have been limited in other formats, such as focus groups. For example, if one participant did not agree with the majority about a rating, then the risk of conforming, rather than challenging this, may increase as a result of the dynamics of the group (Sim, 1998). This is a disadvantage of group interviews (Kitzinger, 1995) which can have a negative impact on the extent to which quieter group members voice their thoughts, thus reducing the accuracy of the data (e.g., Baiardi et al., 2015). McElroy et al. (1995) demonstrated that the participants who make up a group can influence the degree to which individual participants may conform, and as such, heterogeneous groups are usually not desirable, such as in the current research.

One of the principal shortcomings of semi-structured interviews is the time-consuming nature of preparation, execution, and analysis (Adams, 2015). In addition, the interviewer is required to be suitably knowledgeable regarding the research topic. However, in the current research, the interviewer was suitably knowledgeable and could complete the required number of interviews within the time period permitted to them. Another limitation is that semi-structured interviews typically yield smaller sample sizes in comparison to other methods (e.g., focus groups each containing 12 participants) and are subsequently less likely to provide generalisable data relative to the wider population. However, within qualitative research it is important to consider “information power”, based on the concept that the more information relevant to the research the participants possess, the lower the number of participants required (Malterud et al., 2016). Due to the narrow aim of the current research, its specificity, and the theory it is based on being established, between six and ten participants was considered reasonable.

Focus Groups

Focus groups are often used in healthcare research (Kevern & Webb, 2001) to assess needs within services and can therefore inform more effective delivery and the design of interventions (Krueger & Casey, 2015). They involve groups of eight to 12 participants and a researcher who facilitates a group discussion about a topic they are researching (Kitzinger, 1995). The aim is to explore participants' knowledge and experiences, how they think about the topic, and why (Kitzinger, 1995). Participants in a focus group are typically homogenous and invited because they share something in common; for example, they work for the same organisation. When different groups require exploration, separate sets of focus groups are required (Krueger & Casey, 2015). A potential advantage of focus groups is that participants are able to support one another in expressing feelings that are specific to their subgroup but may not be the norm, which can be important when discussing uncomfortable topics (Kitzinger, 1995). In general, more than one focus group would be conducted with different homogeneous groups of participants for researchers to identify patterns across groups. For the current research, this would not have been possible, as focus groups would need to be divided into 'professionals' and 'PWLE' and there would have been three in one group and two in the other; numbers too small for focus groups. In addition, there would have been hierarchical differences within the groups, particularly the group containing 'professionals'. This has been found to precipitate discomfort among participants in previous research due to limits in trust and degree of information participants disclosed (Mansell et al., 2004).

Delphi Method

The Delphi method (Dalkey & Helmer, 1963) aims to gather an accurate consensus of opinion of a group of participants who possess knowledge related to the research topic through a series of questionnaires and feedback. A group of experts are selected and asked to provide their opinions and experience on topics using a questionnaire designed to understand participants' reasons for their responses. The researcher then groups the comments and sends the compiled comments to each participant, along with an opportunity to comment further. The experts can adjust their answers based on how they interpret the "group response" provided to them (Dalkey & Helmer, 1963). Once participants have commented for the second time, the researcher compiles the comments and decides whether consensus has been reached or another round is required. The questionnaire rounds can be repeated as many times

as necessary to achieve a sense of consensus. One disadvantage of the Delphi method, therefore, is that it can take a significant amount of time, increasing the risk of participant attrition before study completion; particularly where there are opposing views (Belton et al., 2019). This may be particularly likely in the current research due to the instability individuals facing homelessness, who are diagnosed with EUPD and who misuse substances experience (Reid, 2009).

One defining feature of the Delphi method is that participants do not have direct contact with one another in an attempt to avoid disadvantages related to direct discussions that would occur within the group (Dalkey & Helmer, 1963). Like in serial individual interviewing (Read, 2018), it has the advantage of sharing information between participants anonymously so that they can consider information they may not have considered before. The difference between the Delphi method and the current research is that the Delphi method aims to reach a consensus, which was not required for the current research. The sample was homogeneous in that all participants had expertise in the research topic. However, it was hoped that the sample was heterogeneous in ways that meant broad issues could be explored based on each participant's unique experiences, to ensure that the new manual could be adapted for a broad range of clients (Dowding, 2020). For example, individual participants may have experiences of offending, domestic abuse, etc., and therefore be able to provide unique information generalisable to the wider population. It is therefore important to have multiple voices to create a balance of information that feeds into the research.

2.9 Gaining Ethical Approval and Ethical Considerations

Ethical considerations in research are of principal importance to protect the welfare of participants and to ensure that psychologists practicing research ensure accuracy and honesty in their practice, as well as respect the dignity of those they work with (APA, 2017). The proposal for this research was reviewed by the University of Nottingham (UoN). It also adhered to the ethical principles of British Psychological Society's Code of Human Research Ethics (Oates et al., 2021), and the UoN's Code of Research Conduct and Research Ethics (UoN, 2021). This ensures an ethical approach with regards to confidentiality, informed consent, participant withdrawal, the protection of participants, and debriefing, all of which are explained further below. The study was not initiated before the protocol was accepted. Consent forms and participant information sheets received ethical approval, and amendments

were reviewed and approved by the Research Ethics Committee at the University of Nottingham (see Appendix I). This committee requested amendments regarding clarification of:

- How the research team would know that participants are having an acute mental health crisis or are a danger to themselves or others for Step To,
- Details of the manual, and whether the focus was on one or various manuals for Step One,
- The stages of the research,
- Details related to the interview questions for Step Two,
- How many groups would be tested and whether these would be equal in terms of gender,
- Signposting to supportive services in the Participant Information Sheets,
- An explanation of what the participants would be asked to comment on specifically in the Step Two Participant Information Sheets,
- The format of the second interviews in Step Two,
- Estimated timings for delivery of the sessions and collection of questionnaire data for Step Four *[see 2.15 for details regarding step four, which was not conducted]*
- Details of demographic questions,
- Whether audio recordings would be retained or deleted following transcription,
- The debriefing process,
- A safety plan due to the nature of the questions being asked,
- Contingency plans, such as breaks related to fatigue related to questionnaire completion in Step Four.

Confidentiality

In accordance with the Data Protection Act (2018), all information was stored confidentially. Data was accessible to the researcher, their supervisors, and a limited number of university course staff where applicable. A Data Management Plan was conducted for the UoN to ensure that "all research data be managed in a manner that supports its authenticity, reliability, security, discoverability and, where appropriate, accessibility for re-use" (UoN, n.d.). Recordings were transferred onto the lead researcher's UoN OneDrive. Participants were assigned a pseudonym by the lead researcher so participants could not be identified in

transcripts. A list linking participants to their pseudonyms was stored electronically as a password-protected file. Once transcribed, interview recordings were deleted. Transcripts will be stored on the secure network within the UoN system for seven years from completion and then destroyed securely. Consent forms, demographic information, questionnaires, and contact details were scanned and stored electronically in password-protected files and originals were stored in a locked cabinet at the lead researcher's home. Before the closure of the study these were transferred to the UoN archived storage. Personal data was destroyed three months after the completion of the study. Confidentiality and its limits were explained to participants at the beginning of each interview. In instances wherein a participant disclosed information regarding the potential of harm to themselves or others, the lead research planned to discuss this with them and contact the appropriate contact at the service from which they were recruited.

Informed Consent

All participants were provided with an explanation of the research and a detailed Participant Information Sheet. Participants were given at least 24 hours to consider taking part to ensure they had sufficient time to fully consider their participation and had the opportunity to ask questions. Participants provided written consent before participating and were provided with a copy of their Consent Form for their records which confirmed their understanding of the purpose of the study, as well as potential risks involved. The Participant Information Sheet clearly stated that the decision to participate was voluntary and a decision not to participate would not affect their roles, or the quality or quantity of their care in the future.

Participant Withdrawal

The Participant Information Sheets and Consent Forms highlighted participants' right to withdraw. Up to one week after participating participants could withdraw and their data would have been removed. After one week, participants were unable to withdraw their data as it would have been transcribed and anonymised.

Protection of Participants

The Participant Information Sheets made it clear that participants could potentially discuss distressing personal experiences during the two interviews and the researcher aimed

to manage such distress. Where participants asked for advice beyond the lead researcher's competency, the lead researcher referred them to the appropriate service. Contact details for useful helplines and organisations were provided.

Debriefing

All participants were sent a Debrief Letter (Appendices F and G) on completion of Step Two of the research. The lead researcher's contact details were provided, as well as the contact details of their supervisor and the appropriate ethical sub-committee. The letter also included signposting to additional local support should any participant feel this was required.

Thank You Gift

To thank participants for taking part in Step Two they received a token gesture of a £20 voucher. It is commonplace for researchers to provide a token gesture for the time participants provide with their participation (Zand, 2019) and research has shown that appropriate tokens of appreciation do not influence the responses of participants (e.g., Van Dyke et al., 2020). This gift was not considered sufficient to incentivise participation and the research was not advertised in way that focused on the voucher as an incentive to participate (Zand, 2019). If a participant were to withdraw from the study, they would still receive their voucher.

2.10 Epistemology of the Current Research

'Epistemology' refers to the theory of knowledge that defines the type of knowledge that is possible and justifiable (Crotty, 1998), and typically guides a researcher's chosen methodologies (Feast & Melles, 2010). Researchers who choose to adopt quantitative approaches commonly subscribe to a positivist epistemological position, which states that observations can be applied to the social sciences to derive truths about the world (Tuli, 2010). This position suggests that there is a single truth which can be measured through valid and reliable measurement. In contrast, qualitative researchers more commonly subscribe to constructivist or interpretivist positions which state that reality is subjective and numerous truths can exist across individuals and social constructs (Krauss, 2005). This position suggests that 'truth' is derived by groups of individuals and requires interpretation to explore the underlying meaning of phenomena. An epistemological position of pragmatism posits that

the most effective method to use is the one that solves the problem being explored (Maarouf, 2019) and is a logical position to adopt when mixing methodological approaches (Creswell, 2013). As pragmatism focuses on solving real-world problems, pragmatism is suitable for research which aims to act in ways that makes a practical difference (Goldkuhl, 2012). This epistemological position was felt suitable for the current research as it involved a practical aim of exploring how ACT could be adapted for a new population. From this position, research methods were chosen based on how best to explore the aims of the research, and as a consequence, quantitative and qualitative methods were used. The position of pragmatism is also well-suited to ACT as a theoretical perspective and in terms of functional contextualism. Where pragmatic goals are a part of research, various methodologies, including both quantitative and qualitative methods, can be used (Biglan & Hayes, 1996).

2.11 Further Discussion Regarding Framework Analysis and Other Methods of Analysis Considered

The data collection method of semi-structured interviewing is compatible with a number of data analysis methods, including discourse analysis, grounded theory, interpretative phenomenological analysis (IPA), and thematic analysis (Willig, 2013). However, different qualitative data analysis methods are based on differing epistemological positions which influences the way in which data is handled and interpreted (Lyons, 2011).

Discourse analysis (Potter & Wetherell, 1987) is a social constructionist approach which focuses on how language is used to construct social realities where there is no objective reality, but accounts of reality are constructed for a purpose (Coyle, 2011). Discourse analysis is useful for research focusing on how particular actions are discussed and describing the linguistic resources participants use during conversations, conversational patterns, and the types of social interactions being performed (Potter, 2003). Therefore, discourse analysis was not employed within the current research, as the aim was not to examine the construction of reality through language, but to develop an intervention adapted for the target population. Grounded theory (Glaser et al., 1968) aims to expand, develop, or challenge the existing theoretical understanding of a phenomenon. It takes an epistemological position of symbolic interactionism and generates new theory through the constant movement between data collection and analysis (Payne, 2011). Grounded theory was therefore not used in the current research, as the aim was not to generate theory. IPA aims to explore, in detail, individual

personal and lived experience, and to examine how participants are making sense of their personal and social world (Eatough & Smith, 2017). It is useful for exploring topics where there is a need to discern how people perceive and understand significant events in their lives (Eatough & Smith, 2017). This is reflective of its epistemological position of hermeneutics (Palmer, 1969), which relates to an individual's personal perception or account of an object or event as opposed to attempting to produce an objective statement of the object or event itself. IPA was therefore not used within the current research, because the focus was not upon participants' sense making of their experiences.

Thematic analysis (Braun & Clarke, 2006) is a flexible method of analysis which can be guided by a variety of theoretical and epistemological frameworks. That is, it can be applied to a broad range of research aims, including the exploration of lived experience, perspective, processes, practices, representations of particular individuals within particular contexts, and social construction of phenomena. Thematic analysis can be used to identify, analyse, and report upon themes within data, and allows the interpretation of various aspects of a research topic (Braun & Clarke, 2006). As this method focuses on the description and interpretation of participants' views in relation to the adaptation of a novel manual, this was thought to fit with the current research aims. However, due to the flexibility of epistemological positions researchers can take with thematic analysis, this can lead researchers into analysing data without a firm epistemological position. The consequence of this is that it can affect the consistency and coherence of the reporting of data, thus affecting the conclusions drawn from a study (Pitt, 2002). One approach which exists within the family of thematic analytical approaches and operates from a pragmatic epistemological position (Goldsmith, 2021) is Framework Analysis (FA) (Ritchie & Spencer, 1994).

FA was developed to help researchers to define concepts, map the range, nature, and dynamics of phenomena, create typologies, find associations, seek explanations, and develop new ideas (Ritchie & Spencer, 1994). In particular, a 'contextual' framework maintains participants' original accounts (Sighvatsson et al., 2020) (example questions in Appendix J). For example, perceptions held by people within a particular population, the nature of peoples' experiences, the needs of a population, and factors which influence a system (Ritchie & Spencer, 1994). FA is not a linear process, and although researchers are required to analyse data in a systematic way, they are also required to be creative (Ritchie & Spencer, 1994). As such, the analytic process often relies on the researcher moving forward and back to return to

previous concepts (Ritchie & Spencer, 1994). As the aim of the current research was to explore perceptions of professionals and PWLE with regards to adapting a manual for the target population, FA was deemed an appropriate method of data analysis.

The key features of FA are that it is:

- Grounded or generative: it is based in and driven by original accounts and observations provided by the participants,
- Dynamic: open to changes and amendments throughout the process of analysis,
- Systematic: to provide a methodical process of analysis,
- Comprehensive: it is not selective, but allows a whole review of the data collected,
- Retrievable: it provides original textual data,
- Analytic: it enables between- and within-case analysis to allow for comparisons between and within cases,
- Accessible: analysis and interpretations developed are clear to others (Ritchie & Spencer, 1994).

FA was conducted for both sets of interviews to generate perceptions of the base manual(s) in relation to participant's experiences. The analysis was guided by the following steps:

- Familiarisation: the researcher immerses themselves in the data to gain an overview and note key ideas.
- Identifying a thematic framework: using the notes, the key concepts form the basis of a thematic framework which is used to classify the data.
- Indexing: sections of data are be linked to themes.
- Charting: indexed data is arranged into charts of themes.
- Mapping and interpretation: the charts are analysed for key characteristics to guide data interpretation (Ritchie & Spencer, 1994).

Familiarisation

Although the lead researcher had some ideas about key concepts through interviewing participants, they gained an overview of the depth and diversity of the data gathered during the 'familiarisation' stage. At times, a selection of data is used in this stage due to time constraints or the volume of materials (Ritchie & Spencer, 1994); however, in this study, the researcher was able to review all data from all interviews. This involved listening to audio-

recordings of interviews, reading transcripts, and studying notes made during the interview phase and noting key ideas and recurrent themes.

Identifying a Thematic Framework

The lead researcher drew upon the original research aims and new themes which emerged through the familiarisation stage to formulate tentative themes that represented the overall data set. These themes consisted of acceptability, facilitators, and barriers.

Indexing

Developing indices within the thematic framework enables the researcher to label the data in a way that is manageable in later retrieval and analysis and maintain an overview of the data. It involves the systematic application of the thematic framework to the interview transcript data, where themes become more refined (Ritchie & Spencer, 1994). When refining themes, the researcher sought conceptualisations to represent the diversity of responses from the interviews. While refining this thematic framework, the researcher used both analytical and intuitive thinking styles, making judgements about the meaning of data, and the significance of particular issues, as well as associations between concepts. This led to the emergence of 18 indices: 12 for ‘acceptability’, three for ‘facilitators’, and three for ‘barriers’ (Figure S7). As can be seen in Figure S7, the overall ‘themes’ were reflective of original aims for the research; however, the specific indices within each theme were led by the content of the interview data. The lead researcher read and annotated all interviews according to the thematic framework, with indexing references being recorded in the right-side margins of transcripts using the numerical system associated with each index (Figure S8). This process involved making judgements about the meaning and importance of the data, and considering the data in isolation and in the context of the interview (Ritchie & Spencer, 1994). It is common for whole passages to contain more than one theme which requires referencing using numerous indices; this often highlights patterns of association within the data (Ritchie & Spencer, 1994). It is important to note that this process is subjective, and so open to differing interpretations. However, by utilising an index refencing system and systematically applying this to the data, others can view how the data was sorted, and research teams can discuss their views of the annotations. Once labelled with indices, the lead researcher was more easily able to access references and analyse patterns and the contexts in which they arose.

Charting

To develop a sense of the data as a whole while also considering the range of attitudes and experiences for each theme, 'charting' was used to reorganise the data according to thematic references (Ritchie & Spencer, 1994). As the analysis was thematic, the charts were arranged in order to view each theme across all participants and participants were repeatedly listed in the same order for simpler retrieval (Ritchie & Spencer, 1994). This enabled the lead researcher to make comparisons between or within participants. For the thematic framework, a chart of indices was created for all of the 41 exercises so that the researchers could clearly view each index for each exercise (example in Figure S9). The original text was referenced to enable replication.

Mapping and Interpretation

Once the data were charted, the lead researcher synthesised key characteristics of the data, to map and interpret the data as a whole in order to identify categories, associations, and patterns. During this stage researchers can focus on defining concepts, mapping the range and nature of phenomena, creating typologies, finding associations, providing explanations, and developing strategies (Ritchie & Spencer, 1994). The original research questions and emergent themes guide which concepts are focused upon. For the current research, the lead researcher focused on mapping the range and nature of phenomena, finding associations, providing explanations, and developing strategies. These domains were in line with the original research aims of collating data from a range of participants, explaining reasons for adaptations of existing base manuals, and in developing a new adapted manual for the target population. The lead researcher reviewed the charts and research notes and compared and contrasted participant perceptions, accounts, or experiences. They searched for patterns and connections and looked for explanations for these within the data by weighing up the salience and dynamics of issues and searching for a structure rather than a multiplicity of evidence (Ritchie & Spencer, 1994).

Mapping the Range and Nature of Phenomena

A common function of qualitative research is to map differences in perspectives within the data to gather from various points of view (Ritchie & Spencer, 1994). Due to the study aiming to consider how to adapt existing interventions to enhance effectiveness for the

target population, the lead researcher was required to detect key dimensions of what could be done to develop a new manualised intervention. To do this, charts were reviewed for references to the various indices within this thematic framework, and a table based on the indices of each thematic framework (accessibility, facilitators, and barriers) was developed. For 'accessibility', there was a separate table for each of the 41 exercises presented to participants prior to being interviewed (Figure S10), and tables for 'facilitators' and 'barriers'. Participant responses were mapped onto these indices, and the range and nature were hypothesised in the right hand column for all three frameworks (Figure S11). From these notes, 'key dimensions' were identified by considering the data as a whole (Figure S12).

Finding Associations

The charts were reviewed systematically to search for associations either in explicit participant responses or implicit suggestions among the data. This was conducted across the 41 exercises included in the 'Accessibility' charts, and for the 'Facilitators' and 'Barriers' charts. Where disagreements were identified between participant responses (Figure S13), information was weighed up and an overall conclusion made by the researchers.

Providing Explanations

Explanations as to why particular adaptations were required for the adapted manual were sought from the associations to address the original research aims. These were derived by noting explicit suggestions made by participants or formulated based on implicit suggestions. Once explanations were established, the researchers were able to consider useful strategies for change for the development of an adapted manualised intervention. This was taken either explicitly from participant's responses and suggestions, or implicitly, based on the data and subsequent analyses (Ritchie & Spencer, 1994).

2.12 Considerations Regarding Conformity Bias

Due to first interview ratings and comments being presented to individual participants during their second interviews, there was a risk of conformity bias within the sample (Padalia, 2014). Therefore, a decision was made to check for differences in scores between interviews. Normal distributions across scores for all 41 excerpts across the sample were

checked. All statistical analysis was conducted using IBM SPSS for Windows 26. For normally distributed data, parametric dependent *t*-tests were conducted, and for non-normally distributed data, nonparametric Wilcoxon signed ranked tests were conducted (Langdridge & Hagger-Johnson, 2009).

2.13 Further Discussion of the Decision Not to Define Concepts or Create Typologies

Defining Concepts

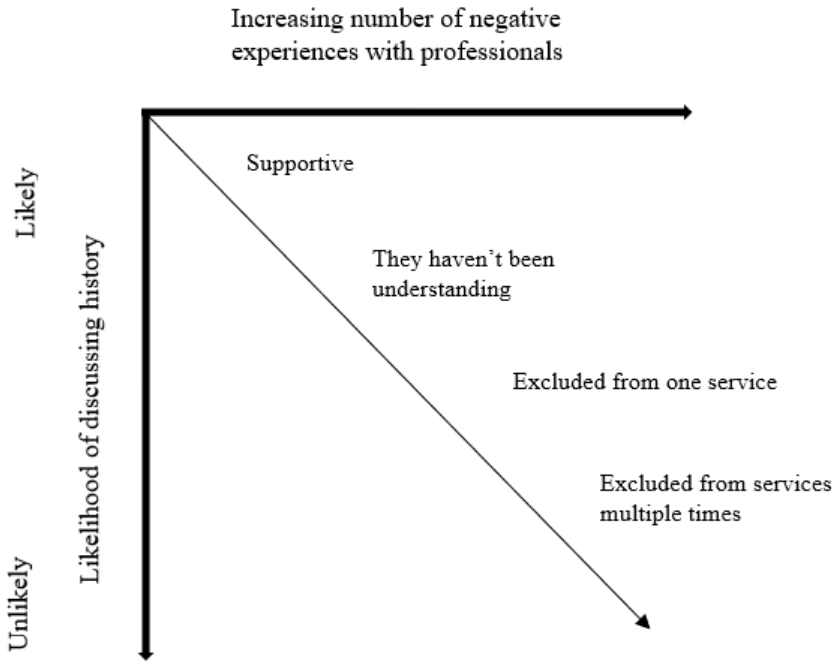
Ritchie and Spencer (1994) outline that while charting, the researcher may note the way in which particular phenomena are defined across participants. For example, if the research explored participant definitions of 'substance misuse', an analysis would be conducted regarding how different participants defined this. However, as the current research aims did not focus on defining any particular concepts, this was not carried out.

Creating Typologies

According to Ritchie and Spencer (1994), after a researcher has identified key dimensions within the data (in the current research this would refer to the indices), they may wish to create 'typologies'. This is where two or more factors are associated with one another at different points, which would give a variety of 'types' of cases. For example, if clients' feelings about participating in discussions about traumatic experiences was linked to the number of negative experiences they have had in the past with professionals. By plotting participants' histories and current feelings about discussing trauma along these two dimensions, a typology could be constructed about how likely clients are to engage in such discussions. Figure 7 shows what this would look like.

Figure 7

Typology of Negative Experiences of Professionals and Current Willingness to Discuss Trauma



Note. An illustration of how typologies can be explored within qualitative data.

Having reviewed the interview data, no dimensions appeared to be associated in this way. There was a discussion among the research team regarding a potential link between literacy and experiential learning in that the data suggested that the lower the level of literacy, the more useful experiential exercises would be. However, as experiential learning is a fundamental tool within ACT (Hayes et al., 2006), the decision was made not to create a typology from this.

2.14 Safeguarding Rigour and Quality

For Step One, the Critical Appraisal Skills Programme (CASP, 2018a) checklist for systematic reviews was referred to in order to assess quality. While Step One did not involve a typical systematic review process, referring to the checklist enabled the researchers to consider key areas related to quality. This included ensuring appropriate literature was searched to identify existing ACT manualised interventions. In addition, during the scoring of

each manualised intervention (Figure 2), all manuals were scored independently by two members of the research team, and differences were discussed and concluded.

During Step Two, the CASP (2018b) checklist for qualitative studies was referred to. This helped the researchers to ensure that the recruitment strategy and data collection methods were appropriate. It also ensured that the lead researcher reflected on their thoughts, feelings, and relationship with the research throughout the research process. To adhere to this guidance, the lead researcher maintained a reflexive diary which facilitated reflections regarding their relationship to the research during research supervision. This ensured that any decisions or conclusions were made in relation to the data, rather than personal motivations.

During Step Three, the CASP (2018b) checklist for qualitative studies was referred to. Qualitative analysis processes conducted by the lead researcher were crosschecked with the first research supervisor who had extensive experience in qualitative research. The processes included familiarisation, identifying the thematic framework, indexing, charting, mapping, interpretation, identifying the range and nature of data, key dimensions, and associations, and formulating explanations and strategies. The lead researcher's maintenance of a reflexive diary also enabled them to reflect on any assumptions or biases during qualitative analysis. A clear audit trail was also maintained to accurately record the steps involved in data analysis. This allowed all interpretations to be clearly traced back to the original data, increasing the clarity and transparency of how findings were concluded and interpreted.

2.15 Step Four

Originally, this programme of research included a Step Four to which one participant pair (a client and a professional) were recruited, two professionals were trained in delivering the manualised intervention, and one session took place. However, due to issues relating to domestic violence, the client participant left the county and did not attend any further sessions. A description of the plan for Step Four is detailed below.

Aims

Test the uncertainties of implementation by answering the following questions:

a. Is the intervention acceptable to the target population?
b. Is the intervention tolerable to people experiencing MD?
c. What are the facilitators and barriers for the intervention?

Test the uncertainties of the efficacy of the adapted manual though addressing the following questions:

a. Does the intervention improve psychological flexibility?
b. Does the intervention reduce self-reported symptoms of EUPD?
c. Does the intervention increase self-reported quality of life?
d. Does the intervention lead to changes in substance misuse?
e. Did the professional adhere to the intervention?

Design

A convergent parallel design would have been used where quantitative and qualitative data would be gathered independently and an overall interpretation would be made in relation to the research aims (Schoonenboom & Johnson, 2017). A pilot study involving a small sample of the target population would explore feasibility and signals of efficacy of the adapted manual. Semi-structured interviews and frequency data would be used, as well as pre- and post-intervention quantitative measures in a multiple baseline single-case experimental design (SCED).

Sample

Purposeful random sampling was used to identify and select information-rich participants (Patton, 2014). In terms of inclusion criteria, client participants were required to be aged 18 or over, be willing to participate and be able to provide consent, be experiencing homelessness, misuse substances, and have a diagnosis of EUPD. In addition, they were required to be able to speak, read, and write in English to ensure they had the appropriate levels of verbal fluency and comprehension to fully participate in the discussions, and to allow the researcher to transcribe and analyse the data. Exclusion criteria included individuals experiencing acute mental health crises or being a high risk to themselves or others. Professional participants were required to be staff members without clinical expertise employed within MD services and would be excluded if they were trained in delivering psychological therapies.

Sample Size

The research team aimed to recruit three client participants as single cases in a multiple baseline design in which ‘baseline data are gathered across two or more individuals’

(Kazdin, 1980, p.363). Although three participants would not have represented the target population, a pilot study of a new manual should be conducted to examine the feasibility of the target population, as a group or SCED to allow further manual modifications (Kazdin, 2001). As the power of a SCED comes from the number of repeated measures, three participants would have been sufficient to draw reliable conclusions (Krasny-Pacini & Evans, 2018). Three implementers would deliver the intervention, each to one client participant.

Recruitment

Implementers. All staff without clinical expertise in the targeted services were provided with the opportunity to deliver the intervention. Managers provided staff with a Participant Information Sheet (Appendix K). Interested staff were asked to contact the lead researcher and if eligible, sign a consent form (Appendix L).

Clients. Service managers approached prospective client participants from the same services as in Step Two. They provided them with a Participant Information Sheet (Appendix M) and where required, facilitated contact with the lead researcher for those interested. Eligible and willing participants were required to sign a consent form (Appendix N) which included the lead researcher's contact details for if participants had any questions. In the event that more than three professionals or clients volunteered, it was planned that computer-generated random sampling would appoint participants.

Procedure

The research team developed and delivered training to the implementers to enable them to deliver the intervention. It was planned for client participants to receive the manualised intervention in eight face-to-face weekly audio-recorded therapeutic sessions delivered by an implementer within the service from which they were recruited from. Each participant would begin treatment at a predetermined time, provided baseline differences were limited in variability (Watson & Workman, 1981).

Questionnaires would be completed with client participants every week from four-weeks before client participants' first session until four-week after their last session, and at 12-week follow-up. Approximately four weeks after their final session, client participants and implementers would attend a 30-60 minute audio-recorded semi-structured face-to-face interview with the lead researcher.

Quantitative Analysis

The plan was for demographic information (age, gender, ethnicity) to be gathered when participants provided consent. This would aid comparisons with existing literature regarding the target population. To measure tolerability, data would have been gathered regarding session attendance, participation in in-session exercises, and completion of between-session tasks.

To explore the secondary aims, multiple outcomes would have been administered with client participants to signal efficacy as follows:

1. **Comprehensive Assessment of Acceptance and Commitment Therapy-8 (CompACT-8).** The CompACT-8 (Morris et al., 2019) is an 8-item self-report measure that minimises participant burden by minimising the number of questions asked. It assesses psychological flexibility across openness to experience, behavioural awareness, and valued action. Participants respond to items such as, "I work hard to keep out upsetting feelings" on a 7-point Likert scale (0 = strongly disagree, 6 = strongly agree). Research demonstrates acceptable internal reliability ($\alpha > .70$) and good convergent and divergent validity with measures of experiential avoidance and distress (Morris et al., 2019).

As multiple methods are required to understand both stable and dynamic aspects of EUPD (Hasler et al., 2022), two measures would have been used:

2. **Borderline Symptom List-23 (BSL-23).** The BSL-23 (Bohus et al., 2009) evaluates symptoms of EUPD. Participants evaluate their symptoms over the past week. Participants rate their agreement with statements such as, "I felt helpless" on a 5-point Likert scale (0 = not at all, 4 = very strong). Research demonstrates high internal consistency ($\alpha = .935$ - .969), high test-retest reliability (.82) and positive moderate to high convergent validity (Bohus et al., 2009).
3. **Recovering Quality of Life-10 (ReQol-10).** The ReQol-10 (Keetharuth et al., 2018) assesses quality of life. Using 10 items participants rate their thoughts, feelings, and activities over the past week. Participants rate their agreement with statements such as, "I felt happy" on a 5-point Likert scale (0 = none of the time, 4 = most/all of the

time). Research demonstrates high internal consistency (α = .87 - .92), and very good test-retest reliability at .85 (Keetharuth et al., 2018).

4. **Leeds Dependence Questionnaire (LDQ).** The LDQ (Raistrick et al., 1994) measures the severity of dependence on drugs and alcohol. This 10-item self-report measure is sensitive to degree of dependence for individuals with severe mental health problems (Ford, 2002). Participants state their main substance groups and answer questions such as, “Do you feel your need for drink or drugs is too strong to control?” on a 4-point Likert scale (0 = never, 3 = nearly always). A score of 20 out of 30 or more approximates to a score of severe dependence. Research demonstrates high internal consistency (α = .94) and test-retest reliability (.95; (Raistrick et al., 1994).
5. **The Acceptance and Commitment Therapy Fidelity Measure (ACT-FM).** The ACT-FM (O'Neill et al., 2019) is a 25-item measure that rates clinician fidelity to ACT in a range of contexts. It assesses therapist stance, and open, aware, and engaged response styles. Research demonstrates moderate to excellent inter-rater reliability (O'Neill et al., 2019).

Although there are more dependent variables than client participants, a pilot study of this nature would have provided an opportunity to gather indicatory data regarding efficacy which would then require further exploration. In this study, signals of efficacy would provide information about an under-researched topic in preparation for a larger RCT (Eldridge et al., 2016).

Qualitative Analysis

Tolerability would have been analysed using frequency data regarding client participant attendance and participation in both in-session and homework tasks. Further qualitative data would have been gathered during the interviews. A multiple baseline design (Hersen & Barlow, 1976) would have been used to evaluate the efficacy of the adapted manual. Questionnaire data would have been analysed using visual analysis which clearly demonstrates clinically meaningful information, allows for ongoing evaluation, and is open for others to judge (Parsonson & Baer, 2015). Statistical analysis would be used to address any issues related to both clinical significance and contextual factors (Brossart et al., 2008). If visual and statistical analyses do not corroborate one another, the researcher would know there is a problem with one of the analysis methods (Parker & Brossart, 2003). A Tau-U

analysis would evaluate whether scores change between phases and identify a rank order association between phase and score (Brossart et al., 2018).

The primary research tutor would complete the ACT-FM and conclude whether the implementers delivered the intervention in an ‘ACT-consistent’ or ‘ACT-inconsistent’ way.

Qualitative Data Collection and Analysis

An interview schedule would be developed for the purpose of the study. Participants would be asked about the acceptability and tolerability of the intervention and perceived facilitators and barriers. Participants would be encouraged to be specific and would be prompted where responses were vague. Implementers would also participate in a similar interview four weeks after the final session to discuss the acceptability, facilitators, and barriers of delivering the intervention. Interviews would be transcribed using the UoN Automated Transcription Service. An FA (Ritchie & Spencer, 1994) would be performed using an ‘evaluative’ analysis which would appraise whether the intervention could be implemented (Ritchie & Spencer, 1994). Examples questions can be found in Appendix O.

3.0 Extended Results

3.1 Further Information Regarding the PWLE that Withdrew

A further participant was initially enrolled in Step Two of the study but later withdrew. Initially, the lead researcher contacted the participant via telephone and provided information about the study and answered their queries. The lead researcher also liaised with the Expert Citizens team (Changing Futures, 2023) to ensure that the participant had access to Microsoft Teams in order to participate in online interviews. During this initial discussion, the lead researcher concluded that the participant was eligible to take part in the study as a PWLE participant. It was agreed after this initial discussion that the lead researcher would contact the participant again after two weeks to complete the Consent Form (Appendix D) if they still wished to participate, which the participant was happy with. Due to delays in recruitment, the lead researcher and the participant agreed that the lead researcher would contact them on a fortnightly basis to provide updates on the progress of the study. The lead researcher arranged to deliver the booklet for Step Two in person to the participant and to discuss this. During this discussion, the participant explained that they were concerned about the depth the interview would go into in terms of their previous history. The lead researcher clearly explained that no personal questions would be asked during the interviews; however, if they chose to share personal information and then decided they did not wish to elaborate, then this would be accepted. Following this discussion, the participant signed the Consent Form. Some days later the participant contacted the lead researcher and explained they were confused about one of the excerpts. The lead researcher discussed the excerpt with them, and the participant stated that this explanation clarified their query and thanked them. Fifteen days after delivering the booklet, the lead researcher contacted the participant to book the first interview; however, was unable to make contact. Six days following this the participant sent text messages to the lead researcher which implied that they were experiencing suicidal ideation. The lead researcher discussed this with the research team as well as the Expert Citizens Manager who confirmed that they had been in contact with the participant who would receive appropriate support. As a consequence, the participant withdrew from the study.

3.2 Further Analysis for Quantitative Data

Normality was checked to make decisions about the most appropriate method of statistical analysis of data. As can be seen in Table VIII, 31 pairs of data were normally distributed. As eight pairs of data did not change at all, no tests were conducted. For the remaining 23 pairs of data, dependent *t*-tests were conducted. As can be seen in Table IX, no significant differences were identified between group means (i.e., no significance scores fell below .05) (Langdridge & Hagger-Johnson, 2009). Therefore, no conformity effects were identified. Effect sizes ranged from small to large. Ten pairs of data were not normally distributed, and so Wilcoxon signed rank tests were conducted (see Table X). As can be seen, there were no significant differences in ratings between the first and second interviews and therefore, no conformity effects. Effect sizes ranged from small to medium.

Table VIII

Normality Testing

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
trauma1	.376	6	.008**	.666	6	.003
trauma2	.329	6	.041**	.699	6	.006
stray1	.315	6	.064	.797	6	.055
stray2	.293	6	.117	.915	6	.473
heavy1	.262	6	.200*	.875	6	.248
heavy2	.238	6	.200*	.950	6	.737
quick1	.492	6	.000**	.496	6	.000
quick2	.492	6	.000**	.496	6	.000
checkwork1	.263	6	.200*	.823	6	.093
checkwork2	.325	6	.047**	.753	6	.021
work1	.212	6	.200*	.933	6	.607
work2	.237	6	.200*	.926	6	.548
checkin1	.300	5	.161	.908	5	.453
checkin2	.183	6	.200*	.960	6	.820
DOTS1	.315	6	.064	.797	6	.055
DOTS2	.365	6	.012**	.634	6	.001
inter1	.297	6	.106	.847	6	.149
inter2	.333	6	.036**	.873	6	.238
subs1	.315	6	.064	.781	6	.039
subs2	.251	6	.200*	.869	6	.223
high1	.407	6	.002**	.640	6	.001
high2	.492	6	.000**	.496	6	.000
thank1	.278	6	.161	.920	6	.505
thank2	.238	6	.200*	.950	6	.737
little1	.150	6	.200*	.979	6	.945
little2	.121	6	.200*	.983	6	.964
noright1	.293	6	.117	.822	6	.091
noright2	.293	6	.117	.822	6	.091
validate1	.291	6	.121	.839	6	.128
validate2	.259	6	.200*	.876	6	.252
card1	.180	6	.200*	.920	6	.505
card2	.237	6	.200*	.803	6	.062
leaves1	.180	6	.200*	.920	6	.505
leaves2	.214	6	.200*	.958	6	.804

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
arm1	.263	6	.200*	.823	6	.093
arm2	.208	6	.200*	.908	6	.425
milk1	.285	6	.140	.711	6	.008
milk2	.285	6	.140	.711	6	.008
inner1	.333	6	.036**	.873	6	.238
inner2	.378	6	.007**	.751	6	.020
obs1	.267	6	.200*	.809	6	.070
obs2	.267	6	.200*	.809	6	.070
eyes1	.287	6	.134	.842	6	.137
eyes2	.202	6	.200*	.912	6	.449
choose1	.172	6	.200*	.912	6	.452
choose2	.172	6	.200*	.912	6	.452
tug1	.262	6	.200*	.862	6	.195
tug2	.262	6	.200*	.862	6	.195
acc1	.214	6	.200*	.951	6	.752
acc2	.183	6	.200*	.960	6	.820
ned1	.121	6	.200*	.983	6	.964
ned2	.122	6	.200*	.982	6	.961
FACE1	.205	6	.200*	.961	6	.830
FACE2	.167	6	.200*	.982	6	.960
activity1	.312	6	.069	.687	6	.005
activity2	.312	6	.069	.687	6	.005
talk1	.356	6	.017**	.687	6	.004
talk2	.341	6	.028**	.751	6	.020
walk1	.251	6	.200*	.927	6	.557
walk2	.226	6	.200*	.912	6	.452
SOBER1	.492	6	.000**	.496	6	.000
SOBER2	.492	6	.000**	.496	6	.000
anchor1	.212	6	.200*	.933	6	.607
anchor2	.212	6	.200*	.933	6	.607
defuse1	.318	6	.057	.824	6	.096
defuse2	.212	6	.200*	.933	6	.607
values1	.270	6	.194	.836	6	.121
values2	.149	6	.200*	.977	6	.938
bull1	.262	6	.200*	.875	6	.248
bull2	.307	6	.081	.788	6	.045
cardsort1	.352	6	.019**	.786	6	.044

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
cardsort2	.246	6	.200*	.879	6	.264
goals1	.223	6	.200*	.908	6	.421
goals2	.167	6	.200*	.982	6	.960
roadmap1	.319	6	.056	.683	6	.004
roadmap2	.223	6	.200*	.908	6	.421
bold1	.226	6	.200*	.912	6	.452
bold2	.208	6	.200*	.908	6	.425
between1	.267	6	.200*	.809	6	.070
between2	.267	6	.200*	.809	6	.070
freq1	.310	6	.074	.805	6	.065
freq2	.293	6	.117	.822	6	.091

Note. A table illustrating normality testing. Sig. > .05 indicates normality.

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Table IX

Dependent t-test Data

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)	Effect size[a]
					95% Confidence Interval of the Difference					
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper				
Pair 1	stray1 - stray2	-.33333	.81650	.33333	-1.19019	.52353	-1.000	5	.363	.16
Pair 2	heavy1 - heavy2	.16667	.40825	.16667	-.26176	.59510	1.000	5	.363	.16
Pair 3	work1 - work2	.20000	.80000	.32660	-.63955	1.03955	.612	5	.567	.06
Pair 4	checkin1 - checkin2	.40000	.89443	.40000	-.71058	1.51058	1.000	4	.374	.16
Pair 5	subs1 - subs2	.16667	.40825	.16667	-.26176	.59510	1.000	5	.363	.16
Pair 6	thank1 - thank2	-.16667	.40825	.16667	-.59510	.26176	-1.000	5	.363	.16
Pair 7	little1 - little2	.33333	.81650	.33333	-.52353	1.19019	1.000	5	.363	.16
Pair 9	validate1 - validate2	-.08333	.49160	.20069	-.59923	.43257	-.415	5	.695	.03
Pair 10	card1 - card2	.41667	.91742	.37454	-.54611	1.37944	1.112	5	.317	.19
Pair 11	leaves1 - leaves2	.16667	.40825	.16667	-.26176	.59510	1.000	5	.363	.16
Pair 12	arm1 - arm2	-.83333	1.32916	.54263	-2.22820	.56153	-1.536	5	.185	.32
Pair 15	eyes1 - eyes2	-.33333	.81650	.33333	-1.19019	.52353	-1.000	5	.363	.16
Pair 18	acc1 - acc2	.00000	.63246	.25820	-.66372	.66372	.000	5	1.000	.00
Pair 19	ned1 - ned2	.16667	.40825	.16667	-.26176	.59510	1.000	5	.363	.16
Pair 20	FACE1 - FACE2	-.16667	.40825	.16667	-.59510	.26176	-1.000	5	.363	.16
Pair 22	walk1 - walk2	-.16667	.40825	.16667	-.59510	.26176	-1.000	5	.363	.16
Pair 24	defuse1 - defuse2	.16667	.98319	.40139	-.86513	1.19846	.415	5	.695	.03
Pair 25	values1 - vakues2	.08333	1.11430	.45491	-1.08605	1.25272	.183	5	.862	.00

Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)	Effect size[a]
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower	Upper				
Pair 26	bull1 - bull2	-.16667	.40825	.16667	-.59510	.26176	-1.000	5	.363	.16
Pair 27	goals1 - goals2	.16667	.40825	.16667	-.26176	.59510	1.000	5	.363	.16
Pair 28	roadmap1 - roadmap2	-.16667	1.03280	.42164	-1.25052	.91719	-.395	5	.709	.03
Pair 29	bold1 - bold2	.00000	.63246	.25820	-.66372	.66372	.000	5	1.000	.00
Pair 31	freq1 - freq2	.16667	.40825	.16667	-.26176	.59510	1.000	5	.363	.16

Note. A table illustrating dependent *t*-test data. if Sig. (2-tailed) is below .05, there is a significant difference between the two sets of scores.

a. Where .01 = small effect, .06 = moderate effect, .14 = large effect (Cohen, 1988).

Table X

Wilcoxon Signed Rank Tests

Wilcoxon Signed Rank Tests

Test Statistics[a]

	trauma2 - trauma1	quick2 - quick1	checkwork2 - checkwork1	DOTS2 - DOTS1	inter2 - inter1	high2 - high1	inner2 - inner1	talk2 - talk1	SOBER2 - SOBER1	cardsort2 - cardsort1
Z	-1.000[b]	.000[c]	-.816[b]	-1.000[b]	-1.000[b]	-1.000[d]	-1.000[d]	-1.000[b]	-1.000[d]	-1.633[d]
Asymp. Sig. (2-tailed)	.317	1.000	.414	.317	.317	.317	.317	.317	.317	.102
Effect size[e]	.28	.00	.23	.28	.28	2.8	.28	.28	.28	.47

Note. A table illustrating non-parametric data analysis. If Asymp. Sig. (2-tailed) is below .05, the difference between two scores is statistically significant.

a. Wilcoxon Signed Ranks Test

b. Based on positive ranks.

c. The sum of negative ranks equals the sum of positive ranks.

d. Based on negative ranks.

e. Where .1 = small effect, .3 = medium effect, .5 = large effect (Cohen, 1988)

3.3 Examples of Feedback Pertaining to Accessibility, Facilitators, and Barriers (Table XI)

Table XI

Examples of Feedback

Category of Feedback	Index	Participant comment
Acceptability: Trauma – information for therapists	1.1: Simplicity and clarity of the language	Patti: "Quite straightforward" Patti: "I'd taken the wrong emphasis away…I'd kind of read that as acknowledging the role of the traumas played in people's experience without having to make them kind of specify what that trauma had been"
	1.4: Target audience	Suzi: "It won't be applicable…for like a certain group of clients… We get some people who come in and have experienced trauma, but they don't want any support for that from us"
	1.5: Practitioner implementation	Chrissie: "Knowing our service user group…especially initially, they're not wanting to go there" Nancy: "I think it's just really important for therapists to definitely get that across that they won't necessarily be expected to divulge and stuff, and it can be really triggering for some people" Patti: "You kind of gauge whether someone's ready to talk about what and what they're ready to talk about and at what level and in what detail"
	1.7: How clients might feel/willingness	Nancy: "It can be really triggering for some people that first thing they're asked to do all that"

Category of Feedback	Index	Participant comment
		Patti: "It's quite nice for them to kind of not feel the burden of having to explain over and over again"
		Patti: "I think sometimes, people want you to have that full information because they feel like without it, you as a worker won't be able to understand where they're coming from"
		Patti: "In hostels…we've got, you know, their kind of risk assessment and history of, you know and and quite an extensive kind of history of their kind of, of their life…if you don't have that information kind of readily…they pick up on the fact that maybe you haven't read that extensive history…sometimes they can be a little bit kind of ooh well you know, you haven't taken the time to read my history, you don't understand where I'm coming from"
		Patti: "That would surely be a conversation that you would have you know to say ooh, how, how comfortable are you?"
	1.9: Point in therapy	Chrissie: "For later down the line, that would be easier"
		David: "If this is the first question before explanation, I think it's too quick"
		Nancy: "That's going to be a difficult first stage for a lot of patients"
Facilitators	2.1: Therapeutic relationship	Chrissie: "Again it comes back to the therapeutic relationship and understanding your patients"
		David: "More like the company. Once you get to know someone, I can speak to them directly, but someone else comes up and asks me the time I'll put my head down"

Category of Feedback	Index	Participant comment
		Janis: "With this BPD thing, sometimes I'm quite distanced from my feelings and and can step aside from my feelings and be quite hard sometimes, and sometimes it's so much easier to talk about traumatic things for me to a complete stranger…I'll tell them all sorts of stuff and then I think after why? Why did I do that?" Nancy: "I know what a good analogy is going to be for this client because I've worked with them and I kind of know what they're getting at" Patti: "Some people who may be here more kind of struggle a bit more with their kind of relationship with professionals" Patti: "Letting people kind of actually, if they…want to challenge it a little bit or if they want to ask questions about it…that's quite a safe thing to have a discussion about….That can be really nice I think in terms of building a relationship with people in a supportive setting, actually giving people the space to have a gentle, gentle debate with you…It can give them space to think, ooh okay…if I'm able to say that I disagree with things and it's not received badly" Suzi: "I think it's using that professional judgement"
	2.2: Flexibility (of language, sessions, order of exercises)	Chrissie: "I kind of go, this is your treatment. It's up to you. You can have as much or as little input into it as you want" Nancy: "A little caveat in there, that people won't attend every session" Nancy: "Allowing clients to revisit parts so if you know they do an exercise and it's really…helpful but they're in the next session

Category of Feedback	Index	Participant comment
		they've perhaps forgotten it or they've struggled"
		Nancy: "The ability to skip is, I think is important as well"
		Patti: "It's a kind of having a grab bag of stuff"
	2.3: Importance of individualising the exercise	Chrissie: "Some of our patients worked really well with this booklet template where some of them have to kind of be more led for it"
		Chrissie: "Made more applicable to the individual patient that you're working with, rather than as a generic tool"
		David: "Assess each individual and help if needed because I'm very quiet…what works for one client may not work for another"
		Nancy: "Being able to say you don't have to do it, it's not that we're going to kick you off the course if you refuse to do this…it's just an option"
		Patti: "Some people who really like things to be kind of role in that kind of metaphor, and some people who absolutely hate it"
		Patti: "People are so different that actually you need to be able to tailor things and kind of incorporate people's preferences and people's kind of needs and how they kind of express themselves as well"
Barriers	3.1: Lack of accessibility related to cognitive ability	Chrissie: "It could be useful to have adapted versions of exercises for people so that literacy is less of an issue"
		Chrissie: "Not everyone has the…auditory attention span to be listening, but sometimes

Category of Feedback	Index	Participant comment
		having something visual can help trigger, and help people learn and remember it better"
		Janis: "That does put me off. Writing it sometimes if they oh God, I can't remember how to spell this word…do I let this person see that I'm dyslexic?"
		Janis: "Maybe a not to say that there's not an expectation to show the written version, but maybe the person could read it within the session…You can draw it, make little marks"
		Nancy: "They can really struggle to retain absolutely loads of information like that because there's already so much going on with their mental health"
		Patti: "People who are neurodivergent don't have those same kind of perceptions around eye contact. And sometimes actually will make a lot of eye contact"
		Patti: "Maybe it needs a bit of tweaking to make it work best for everyone"
		Suzi: "Attention span, just cognitive ability in general…it's more like layman's terms"
	3.2: Practical issues	Chrissie: "Maybe one in five times the internet works in the office"
		Janis: "I can never find these cards"
		Nancy: "Phones, that is a significant issue we come across. A lot of people don't have phones"
		Patti: "People who are using substances and injecting substances really struggle to walk because a lot of the time they've got sore injection sites and things like that"
		Patti: "To be thinking about from another from a planning perspective in terms of what

Category of Feedback	Index	Participant comment
		alternative spaces there are to use, but also...the building is really poorly soundproofed" Suzi: "People would hear walking past"
	3.3: Therapist assumptions	Patti: "We do make assumptions that people aren't going to engage with certain things because of, you know, the point that they're at in their lives. When actually you're perpetually surprised actually, when you give people opportunities to engage with different things that actually, they will pick them up and…they will engage with them"

Note. A table illustrating examples of qualitative participant feedback in relation to each index.

4.0 Extended Discussion

4.1 Further Information Regarding Next Steps in Research

According to Goldstein et al. (2012) the next step of the research process when a manual has been adapted is to conduct a pilot study to examine the feasibility of the intervention with the target population to identify whether further adaptation is required. The pilot study should meet the needs of the research team and can include single-case experimental designs (Kazdin, 2001). The pilot study should involve gathering feedback from both client and facilitator participants. Client participants should be asked about the acceptability and feasibility of the intervention, and facilitator participants should be asked about the content, process, and feasibility of each session and exercise. This feedback is then incorporated where relevant, into the second manual draft (Carroll & Nuro, 2002).

Following the development of the second draft, a focus group with a sample of potential facilitators should be conducted (Goldstein et al., 2012). For this research, this would include professionals without expertise in the delivery of psychological interventions, who work with adults with a diagnosis of EUPD, who misuse substances and face homelessness. This stage is important, as potential facilitators will likely possess knowledge about specific delivery-related factors, such as whether their service is equipped to deliver the intervention (Carroll & Nuro, 2002). The focus groups aim to gather feedback regarding the overall structure and content of the manual, as well as readability and ease of use. It also provides an opportunity to compare the intervention with existing interventions used by facilitators with individuals from the target population. Quantitative and qualitative data should be gathered and incorporated into a third draft manual.

The second draft should also be reviewed by a panel of experts who have experience in the topic and the target population, either individually or as a group (Goldstein et al., 2012). All reviewers are required to review the entire manual and provide feedback regarding the overall structure, the therapeutic content, anticipated feasibility for both clients and facilitators, the structure of each session, the content of each session, and predicted outcomes. Quantitative and qualitative data should be gathered regarding the strengths and weaknesses of exercises and sessions, their recommendations for amendments, and the structure of the manual. The expert panel and facilitator focus groups can occur simultaneously, and feedback from both is incorporated into the third draft.

The research team then decides how to best evaluate and potentially incorporate feedback from both facilitator focus groups and the expert panel. The research team develops guidelines for determining how to address feedback. For example, a concern raised by two or more experts should be considered for incorporation. The research team should also recognise unique feedback as this may be important to incorporate if the person feeding back is particularly knowledgeable in the topic. The research team should remember to maintain the theoretical mechanisms of action from the original manual and should consider the relevant literature on the target population for which the intervention is being adapted.

The third draft of the manual should then be trialled. As in the initial pilot study, client and facilitator feedback should be gathered, and facilitator adherence to the manual should be measured. The purpose of this stage is to identify whether any further amendments are required prior to conducting an RCT. Client participants should be asked about helpful and unhelpful elements of the manual. Facilitator participants should be asked about elements that require improvements, session content and structure, feasibility of individual exercises, and ease of use. This feedback should be incorporated into the RCT manual draft. In addition, a facilitator training manual should be developed including eligibility criteria for facilitators, theoretical underpinnings of the manual, and information specific to the target population. Once the RCT manual draft and the facilitator training manual are finalised, the effectiveness and efficacy of the manualised intervention should be evaluated in an RCT.

4.2 Future Research Questions

Primary Aims:

1) Test the uncertainties of implementation by answering the following questions:
    a) Is the intervention acceptable to the target population?
    b) Is the intervention tolerable to the target population?
    c) What are the facilitators and barriers for the intervention?

Secondary Aims:

2) Test the uncertainties of the efficacy of the adapted manual through addressing the following questions:

a) Does the intervention improve psychological flexibility?

b) Does the intervention reduce self-reported symptoms of EUPD?

c) Does the intervention increase self-reported quality of life?

d) Does the intervention lead to changes in substance misuse?

e) Did the researcher adhere to the intervention?

4.3 Further Information Regarding Methodological Limitations

As first interview ratings and comments were pooled and presented during participants' second interviews, one may question the effect of conformity of participants to adapt their ratings to be closer to those of other participants (Goodman, 1987). In the current study, however, quantitative analysis demonstrated no significant individual or group differences between first and second interviews, ruling this out as a significant methodological issue. In addition, the ratings were intended to be indicative, and not a tool to use to omit particular excerpts from the developed manual. Despite differences between participant scores across excerpts, all exercises remained in the developed manual to support choice and flexibility of delivery. Serial interviewing appeared to benefit the methodology overall, and the participants had time between interviews to consider the materials in further detail, increasingly the likelihood of enriched data during participants' second interviews (Read, 2018).

5.0 Reflections

For the purpose of this reflective section, I will write in the first person. As I subscribed to pragmatism in terms of epistemological position, it was important to ensure that the research aims were addressed using the most effective methods. Therefore, it was important to be considerate of my own thoughts and feelings regarding the research process, as they could potentially influence actions which may not have been the most effective in addressing the research. To ensure I considered the influence of my own internal processes on the research process I kept a regular reflexive diary over the course of the research. I ensured that I noted my reflections on a monthly basis, and in times of increased activity; for example, following research panels or assignments. Consequently, I wrote in the diary more regularly during busier or more challenging times. I also reflected on any challenges I experienced during regular research supervision. Below I have reflected on various challenges that I experienced over the course of the research and have offered relevant quotes both from my reflexive diary and research supervision records.

Developing the Research

Prior to beginning training, I was interested in conducting research that could have positive clinical implications for marginalised groups. I was therefore excited to read about opportunities to conduct research regarding individuals facing MD in the research project booklet. I made contact with Anna to discuss ideas for specific areas of research further, as I knew she had extensive knowledge and expertise in this area. Between discussions about specific research ideas, I took the time to conduct extensive reading about different areas of research for this population. I also spoke with previous trainees about their experiences of conducting research in this area, which was useful as I had not worked in this field before. Anna and I then discussed the idea and process of adapting a manualised intervention for this population and made the decision to focus on ACT due to the flexibility it provided for this population, the existing literature, and because it could be conducted by non-psychologists.

During the initial Research Panel I explained my research plans to university research tutors in order to gather feedback related to the different stages of the study, which helped to identify a need for clarity and specificity throughout. Following this I spent a significant amount of time working to improve the clarity of the research plans; however, my research protocol did not reach pass standard. This was largely due to the mixed-methods element of

the protocol not being sufficiently clear, as well as it requiring more details about how existing manualised interventions would be deemed appropriate in Step One of the research. I felt upset because it was the first time I had failed a piece of academic work, and anxious because many of my peers had passed the assignment and I felt inferior in some way in comparison:

Diary: I can't believe I failed a piece of work. I don't know anyone else on the course who has failed this. I don't know whether to be open about it because if no one else has failed then that would be embarrassing, but if they have then this would be comforting to know that it isn't just me. I need to speak to my supervisors about how to make it all much clearer or whether this is worth doing.

As can be seen in my diary entry, these difficult feelings influenced thoughts about whether I was capable of conducting the research. However, in the spirit of pragmatism, it was important to use the most effective method to address the research aims. For me, this meant learning more about the most effective methods, and communicating this in an articulate way, rather than allowing my feelings related to 'failing' influence the research. Despite these uncomfortable feelings and thoughts, one benefit of the situation was that I received extremely detailed feedback from the research team which helped me to learn, and the course staff were very supportive in facilitating that learning. In addition, my peers were also supportive, and those which had not succeeded in the first submission of the protocol thought together about what we could learn from the experience:

Diary: I let everyone in the cohort know that I had not passed today and quite a few people messaged to say they hadn't either. It felt quite comforting in a way, to know that it isn't just me, and that there are various reasons why we might not pass this assignment.

Looking back, I notice that I was overwhelmed by my feelings about 'failing', when, in fact, this is a common experience in the process of planning and refining research plans. I concluded that it would have been more efficient to have utilised research supervision more regularly before the panel and protocol submission, as this would have led to further discussions, learning, and clarity. Therefore, following this experience, I ensured that I used supervision more regularly to safeguard against any unexpected difficulties. I have consequently felt much more confident in discussing my research and submitting work which involves the research, which has been reflected by positive outcomes:

Research supervision log: Presenting tomorrow. Reviewed slides and any necessary amendments to ensure the most was made of the panel.

Step Four

Although the research team aimed to recruit three client participants for Step Four, only one was recruited and the participant later withdrew from the study (they fled the county after being a victim of domestic abuse). Aside from the disappointment I felt in terms of not having any client participants to test the feasibility of the manual, I felt sad because the participant appeared to be an ideal candidate for therapy, and I felt they could have benefitted from it. However, above all, I felt admiration for the participant because of the courage required to leave such a difficult situation.

Diary: It's so sad that Cyndi has had to leave the entire county and a treatment she was really enthusiastic about because she couldn't feel safe otherwise. However, I know that she would have made the decision for herself and her children and that's amazing. I need to talk to Anna about it next because I don't think we're going to have time to recruit anyone else.

In terms of the research, this was challenging because I had hoped to test the feasibility of the manual and was unable to. However, this situation helped me to further understand the challenges that may arise when conducting research with individuals facing MD. From the perspective of pragmatism, I felt that it may have been more efficient to have aimed to recruit more than three client participants, especially when only one was recruited.

Diary: Definitely don't have time now to recruit any more client participants to stage four. Maybe we should have considered more services to recruit from the start.

I could have looked to recruit from a broader range of services to increase the number of participants recruited in the first instance. I also learned how difficult it can be for people facing MD to engage with research for a variety of reasons. Therefore, it may be helpful in future research to consider working across services and counties, to ensure continuity of the therapy even when individuals have to move. If I were to conduct similar research in the future, I would look to recruit from a broader range of services and organisations. I would also consider how to conduct the research across counties and services.

Participant Withdrawal

During the recruitment process for Step Two, a PWLE had to withdraw due to a deterioration in their mental health. This occurred after 11 weeks of contact which involved arranging how the individual would participate, where interviews would take place, and who would support them in their participation. During this time, I liaised with other services to make them aware of the PWLE's mental health at the time.

I felt incredibly frustrated during this time because I knew how much the participant valued contributing to research because they wished to help others in similar situations. Unfortunately, their mental health difficulties at the time hindered their ability to contribute. I also felt quite anxious at times because the participant began texting my research phone with details pertaining to their suicidal ideation. I was concerned that they would text me at a time when I did not have my research phone, such as when I was on placement.

Diary: It's such a shame that Joan can't take part anymore because I know she really wants to help other people facing multiple disadvantage. It doesn't seem fair that the thing she wants to help other people with is the thing that is stopping her.

Diary: I received a text today from Joan saying, "I'm getting ready 2 end it goin 2 meet my maker take care an keep up with da gud work ur doin". I passed the information on to the team that work with her, but I feel guilty that I can't do anything to help.

This experience was challenging as I had to distance myself from a role as a clinician to one of a researcher. However, this helped me personally to develop clear boundaries between my roles as a researcher and a clinician, which I had not had to consider before. This was a useful experience as I hope to be able to coproduce research in the future. In addition, I felt proud that I had provided the opportunity to contribute to the research to this PWLE and felt as though I had modelled that services can facilitate coproduction in research as much as possible. On further analysis, I realise that engaging PWLE from this population was always going to be a challenge due to their understandable difficulties. However, this should not stop researchers and services in supporting PWLEs' involvement as much as is possible in shaping research and service delivery, as their contributions are so valuable. In light of this, I do not think I would have done anything differently in hindsight. Instead, it has further contributed to my understanding of the various challenges that can arise when coproducing research. In

the future, I will be more aware of the differences between my clinical and research roles, to ensure that participants understand what to expect of me as a researcher.

Final Reflections

Although the research process has been challenging at times in terms of emotions and the amount of time spent on various elements of the research, reflecting on the whole experience has helped me to understand how valuable the process has been. Not reaching pass standard and receiving feedback on my work was a particularly useful process, as I learned so much more from these experiences, and believe that the research was better for it. Although two participants withdrew, I learned a lot about research requirements when using coproduction within this population and developed as a psychologist by learning to maintain boundaries between clinical and research roles. I hope that future trainees will be interested in continuing the manual adaptation process. I would be enthusiastic to become a field supervisor, as I have remained interested in working with this population throughout the research process, and this interest grew during a placement where I worked with individuals facing MD. I feel that the finished product of this intervention could be a valuable addition to the treatment options for this population, who deserve to receive the same standard of care as anyone else.

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Appendices

Appendix A: Journal Submission Guidelines

Formatted for the journal: International Journal of Mental Health and Addiction

Guidelines obtained from: International Journal of Mental Health and Addiction | Submission guidelines (oclc.org)

Please note that the 6,000 work wordcount includes the title page, abstract, footnotes, and references.

Appendix B: Participant Information Sheet for Professional Participants

University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Acceptance and commitment therapy for people facing multiple disadvantage and borderline personality disorder: Adapting a talking therapy manual.

Researcher/Student: Hannah Holland, Hannah.holland@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle, lwaat@exmail.nottingham.ac.uk

Ethics Reference Number: 2855

We would like to invite you to take part in a research study about developing a new manualised intervention for people facing multiple disadvantage who have a diagnosis of borderline personality disorder (BPD). Before you begin, we would like you to understand why the research is being done and what it involves for you. One of our team will go through the information sheet with you and answer any questions you have. You can talk to other people about the study if you feel this would be helpful. Please feel free to ask us if there is anything that is not clear.

What is the purpose of this study?

The study aims to develop an adapted manual based on Acceptance and Commitment Therapy (ACT) for individuals who are experiencing multiple disadvantage and have a diagnosis of borderline personality disorder (also known as emotionally unstable personality disorder). We would like to gather feedback from professionals who work with people facing multiple disadvantage, to inform the adaptations made to the manual. We will also be gathering feedback from people with lived experience of multiple disadvantage. This is in the hope that the adapted manual can be used by services with this group of individuals to support them. In addition, this study will be written up as a thesis for a Doctorate in Clinical Psychology for the University of Nottingham.

Although the study may not help you directly, the information we get may help us to develop a therapy manual for people facing multiple disadvantage. This will then be tested with a small sample of people who are experiencing these difficulties. Should this prove to be effective, it may lead to future research on a larger scale, which could have positive implications for the ways in which services work with people experiencing multiple disadvantage.

Why have I been invited?

You have been invited because you are a staff member who has not had formal training in the delivery of psychological therapies and are working within a service which supports individuals experiencing multiple disadvantage who have a diagnosis of borderline personality disorder. We are inviting between three and five participants like you to take part.

14 April 2021

Do I have to take part?

It is up to you to decide whether or not to take part. You do not have to take part in the study, even if it has been suggested by someone you know. If you do decide to take part, you will be given this information sheet to keep and be asked to sign either a written or electronic consent form. And you may change your mind about being involved at any time or decline to discuss a particular question. You are free to withdraw at any point before or during the study without giving a reason. If you withdraw, we will no longer collect any information about you or from you, but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally identifiable information possible.

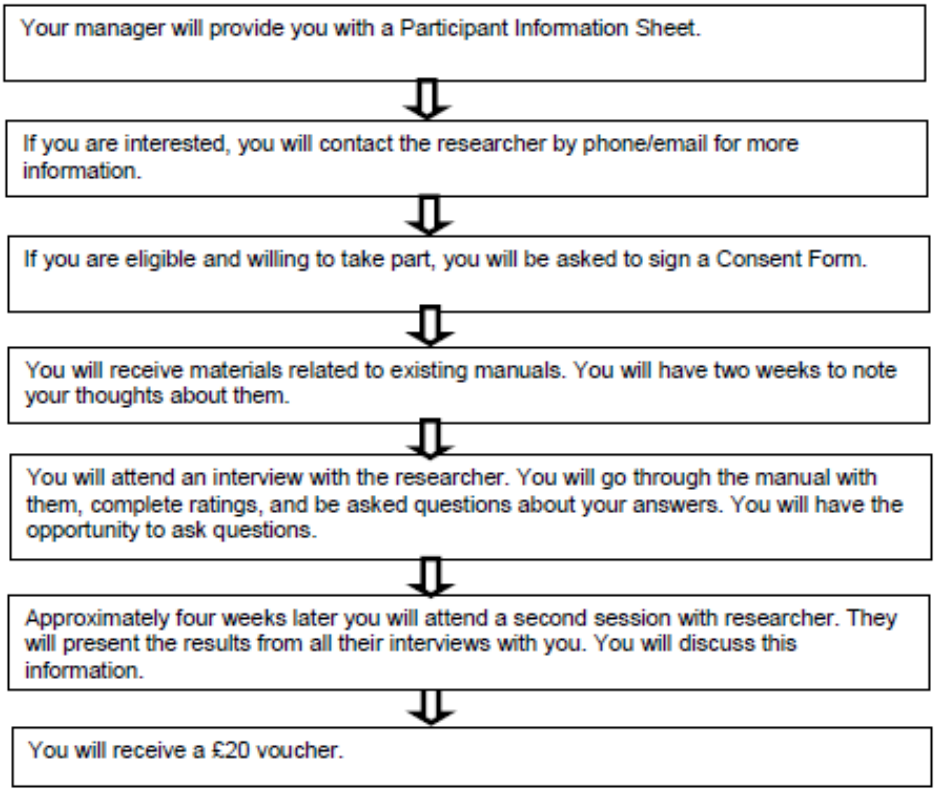
What will I be asked to do?

If you choose to participate in the study the researcher will contact you by either telephone or email, depending on your preference, to ensure that you are a suitable candidate to take part. If you are eligible to participate then the researcher will arrange a convenient time to conduct an interview. This will be done either face-to-face or via Microsoft Teams. Approximately two weeks before your interview you will be sent some materials from either one existing manual or parts of more than one existing manual so that these can be discussed during your interview. You will receive these by post or electronically, depending on your preference. You will be asked to note your thoughts about the materials in relation to people facing multiple disadvantage who have a diagnosis of borderline personality disorder.

The interview is estimated to last for up to one hour. During the interview you will discuss how useful the materials are to people facing multiple disadvantage, how acceptable and accessible they are, and the content. At the beginning of the interview the researcher will introduce herself and explain the purpose and procedure of the study. It will be explained that the interview will be audio-recorded. This is so that a transcript can be produced for the analysis of data gathered during the interview. You will be provided with the opportunity to ask any questions. The researcher will then ask for some general details (name, age, ethnicity, occupation, gender). The interview will then begin. The researcher will ask you to complete some ratings in relation to the materials previously sent to you and will ask a set of questions to obtain your feedback.

Following the interview, you will be provided with the opportunity to ask questions or address any concerns. Approximately four weeks later you will be asked to attend a further audio-recorded meeting of up to one hour with the researcher (again, either face-to-face or via telephone or Microsoft Teams). The researcher will present the results of all interviews to you, and you will have the opportunity to provide further feedback. Within the four weeks following your second meeting you will receive a £20 voucher via post.

The flow chart below shows what will happen should you choose to take part.



What will happen to the information I provide?

The information you provide will only be accessible to the researcher, their supervisors, and a limited number of the University of Nottingham course staff where applicable. Recordings will be transferred onto the researcher's university OneDrive and the originals will be destroyed. Once transcribed, recordings will be deleted. To ensure that you cannot be identified by name you will be assigned a pseudonym on transcripts. A list linking participants' names and pseudonyms will be stored electronically as a password-protected file by the researcher. Your consent form, personal details, and contact details will be scanned and stored electronically in password-protected files and the originals will be stored in a locked cabinet. Your personal data will be destroyed 3 months after the completion of the study unless you consent to the researcher retaining your contact details should you wish to receive the study's findings.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security), and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data will be kept securely for 7 years. After this time, your data will be disposed of securely. During this time, all precautions will be taken by all those involved to maintain your confidentiality. Only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's, and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Should you disclose information which pertains to the potential risk of harm to yourself or another person, we may report this to the appropriate persons.

The results from this study will be used by the research team to develop an adapted therapy manual for individuals experiencing multiple disadvantage and a diagnosis of borderline personality disorder. Decisions will be made based on participant feedback. This will be in relation to both content and procedural adaptations. This will ensure that the manual is acceptable to people experiencing multiple disadvantage with a diagnosis of borderline personality disorder. If you would like to be informed of the results, please provide consent on the consent form for the researcher to retain your contact details so that they can inform you on completion of the study.

The results of this study will be submitted as a thesis for the Doctorate in Clinical Psychology at the University of Nottingham. It will also be submitted for publication in a peer-reviewed journal after February 2023. You will not be identifiable in any report or publication. Should you consent

to your contact details being retained, we would be happy to send the results of the research and any publications.

Are there any possible disadvantages or risks in taking part?

We don't expect there to be any disadvantages or risks to taking part. In the unlikely event that it does give rise to any concerns for you, we advise you to consider that, due to the nature of the study there is a chance that you will discuss difficult past experiences. In such instances, the researcher will address any concerns directly with you following the interview and will signpost you to relevant services where appropriate.

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We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

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Additional support
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Appendix C: Participant Information Sheet for PWLE Participants

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School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Acceptance and commitment therapy for people facing multiple disadvantage and borderline personality disorder: Adapting a talking therapy manual.

Researcher/Student: Hannah Holland, Hannah.holland@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle, lwaat@exmail.nottingham.ac.uk

Ethics Reference Number: 2855

We would like to invite you to take part in a research study about developing a new talking therapy intervention for people facing multiple disadvantage who have a diagnosis of borderline personality disorder (BPD, also known as emotionally unstable personality disorder or EUPD). We would like you to understand why the research is being done and what it involves. One of our team will go through the information sheet with you and answer any questions you have. You can talk to other people about the study if this would be helpful.

What is the purpose of this study?

This study aims to adapt a therapy manual for people facing multiple disadvantage (homelessness, substance misuse, mental health difficulties, contact with the criminal justice system) who have a diagnosis of BPD. We are gathering feedback from people with these experiences, to inform the changes made to the manual. We will also be gathering feedback from professionals. Hopefully the adapted manual can be used by services to support people facing multiple disadvantage who also have a diagnosis of BPD. This study will also be written up as part of the researcher's Doctorate in Clinical Psychology.

Although the study may not help you directly, the information we get may help us to develop a therapy manual for people facing multiple disadvantage. The manual will then be tested with a small group of people. If it is effective, more research may be done which could impact the ways services work with people facing these problems.

Why have I been invited?

You have been invited because you are a person with lived experience of multiple disadvantage and a diagnosis of BPD / EUPD. We are inviting between three and five participants who have lived experience like you.

Do I have to take part?

- It is up to you to decide whether or not to take part.
- You do not have to take part in the study, even if it has been suggested by someone you know.

14 April 2021

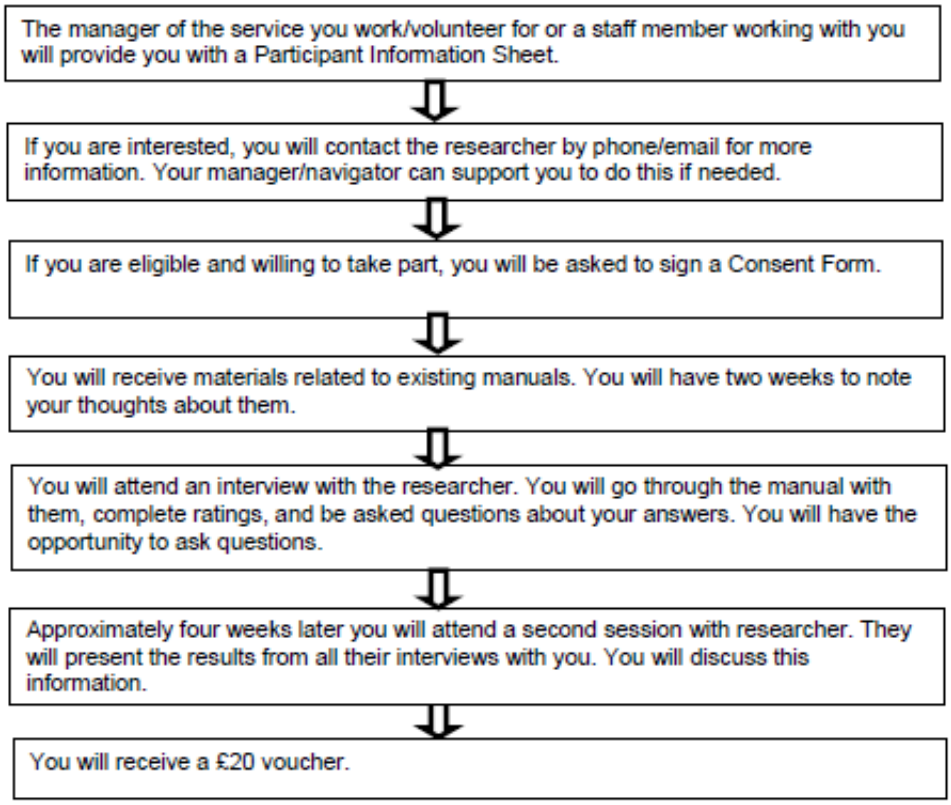
- You can keep this information sheet.
- We will ask you to sign either a written or electronic consent form.
- You can change your mind about being involved at any time or choose not to discuss a particular question.
- You are free to withdraw at any point before or during the study without giving a reason.
- If you withdraw, we will no longer collect any information about you or from you. However, we will keep the information that we have already gathered as we are not allowed to tamper with study records. Also, this information may have already been used in some analyses and may still be used in the final study analyses.
- To safeguard your rights, we will use the minimum personally identifiable information possible.
- If you do choose to withdraw, this would not affect your legal rights or any services which you receive support from.

What will I be asked to do?

- If you choose to take part, the researcher will contact you by either telephone or email, depending on your preference, to ensure that you meet the criteria to take part.
- If you can participate then the researcher will arrange a convenient time to conduct an interview. This will be done either face-to-face or online via Microsoft Teams.
- Approximately two weeks before your interview you will be sent some materials from either one existing manual or parts of more than one existing manual so that these can be discussed during your interview. You will receive these by post or electronically, depending on your preference.
- You will be asked to note your thoughts about the materials in relation to people facing multiple disadvantage and a diagnosis of BPD before your interview. The interview will last for up to an hour.
- During the interview you will be asked about your views regarding the materials sent to you. This will include questions about how acceptable they are, whether they apply to people facing multiple disadvantage, how useful they are, and the content.
- At the beginning of the interview the researcher will introduce herself and explain the purpose and procedure of the study.
- It will be explained that the interview will be audio-recorded. This is so that the interview can be typed up and analysed.
- You will be able to ask any questions.
- The researcher will then ask for some general details (name, age, ethnicity, gender). The interview will then begin.
- The researcher will ask you to complete some ratings in relation to the materials previously sent to you and will ask questions to get your feedback.

Following the interview, you will have the opportunity to ask questions or address any concerns. Approximately four weeks later you will be asked to attend a further audio-recorded meeting of up to an hour with the researcher (again, either face-to-face or via telephone, Microsoft Teams). The researcher will present the results of all interviews to you, and you will have the opportunity to provide further feedback. Within the four weeks following your second meeting you will receive a £20 voucher via post to thank you for your participation.

The flow chart below shows what will happen should you choose to take part.



What will happen to the information I provide?

The information you provide can be accessed by the researcher, their supervisors, and a limited number of the University of Nottingham course staff where applicable. Recordings will be transferred onto the researcher's university computer OneDrive account and originals will be destroyed. Once typed up, recordings will be deleted. To ensure that you cannot be identified by name you will be assigned a pseudonym (pretend name) on transcripts. A list linking participants' names and pseudonyms will be stored electronically as a password-protected file by the researcher. Your consent form, personal details, and contact details will be scanned and stored electronically in password-protected files and the originals will be stored in a locked cabinet. Your personal data will be destroyed 3 months after the completion of the study unless you consent to the researcher retaining your contact details should you wish to receive the study's findings.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security), and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

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If you would like to be informed of the results, please provide consent on the consent form for the researcher to retain your contact details so that they can inform you on completion of the study.

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What if there is a problem?

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Additional support

Talk to the member of staff who works with you most closely, e.g., your support worker or support planner. If you are already open to a mental health team or substance use team (Nottingham Recovery Network or Clean Slate) you might want to talk to your worker there. If you want additional support with your mental health, you can contact Wellness in Mind for support and signposting: https://www.wellnessinmind.org/; Telephone: 0800 561 0073 '

If you are having thoughts about self-harm or suicide, you can access support from Harmless (https://harmless.org.uk/) or the Tomorrow Project (http://www.tomorrowproject.org.uk/.

Appendix D: Consent Form

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School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

Participant Consent

Paper form for face-to-face consent

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Acceptance and commitment therapy for people facing multiple disadvantage and borderline personality disorder: Adapting a talking therapy manual.

Researcher/Student: Hannah Holland, Hannah.holland@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle, lwaat@exmail.nottingham.ac.uk

Ethics Reference Number: 2855

- Have you read and understood the Participant Information? YES/NO
- Do you agree to take part in two audio-recorded interviews with the Researcher, the first of which will require you to review relevant materials and complete rating scales in relation to adapting a manual intervention for people facing multiple disadvantage who have a diagnosis of borderline personality disorder? YES/NO
- Do you know how to contact the researcher if you have questions about this study? YES/NO
- Do you understand that you are free to withdraw from the study without giving a reason? YES/NO
- Do you understand that once you have taken part it may not be technically possible for us to withdraw your data? YES/NO
- Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected? YES/NO
- Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications? YES/NO
- I confirm that I am 18 years old or over YES/NO
- If you would like a summary of the research findings, please contact the researcher at Hannah.holland@nottingham.ac.uk and this will be arranged for you.

Signature of Participant ..... Date .....

Name (in capitals) .....

Signature of Researcher ..... Date .....
14 April 2021

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This consent form will be stored separately from your contributions to the study. So, your responses in the study will not be identifiable.

Appendix E: Demographics Questionnaire

Participant Demographic Form

Identifier:

1. Age (years) ☐

2. Gender *(please tick)* M ☐ F ☐ Other ☐ Prefer not to say ☐

3. Which one nest describes your ethnicity? *(please tick)*

White

- ☐ English / Welsh / Scottish / Northern Irish / British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Roma

Any other White background, please describe ☐

Mixed / Multiple ethnic groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian

Any other Mixed / Multiple ethnic background, please describe ☐

Asian / Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese

Any other Asian background, please describe ☐

Black / African / Caribbean / Black British

- ☐ African
- ☐ Caribbean

Any other Black / African / Caribbean background, please describe ☐

Other ethnic group

- ☐ Arab

Any other ethnic group, please describe ☐

Appendix F: Debrief Letter for Professionals

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School of Medicine
University of Nottingham
Medical School
Nottingham
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Debrief Form

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What is the purpose of this study?

The purpose of this study was to gather feedback regarding existing manual interventions for people facing multiple disadvantage who also have a diagnosis of borderline personality disorder. Currently, little is known about the effects of Acceptance and Commitment Therapy (ACT) for this group of individuals, although research suggests that it could be beneficial. It is therefore important to gather the view of staff working with this group as well as people with lived experience, to inform the development of a talking therapy for this group of people.

For more information

If you have any queries or complaints, please contact the student's supervisor in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry and Applied Psychology's Research Ethics Sub-Committee mczrjg@exmail.nottingham.ac.uk who will pass your query to the Chair of the Committee.

If you feel concerned about anything you have talked about, please visit your GP as your first port of call.

Additional support

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Appendix G: Debrief Letter for PWLE

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School of Medicine
University of Nottingham
Medical School
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Debrief Form

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Division of Psychiatry & Applied Psychology

Project Title: Acceptance and commitment therapy for people facing multiple disadvantage and borderline personality disorder: Adapting a talking therapy manual.

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Appendix H: The Adapted Manual

ACCEPTANCE AND COMMITMENT THERAPY (ACT) MANUAL

For adults with a diagnosis of Borderline / Emotionally Unstable Personality Disorder and experience substance misuse difficulties

Hannah Holland &
Dr Anna Tickle

0

CONTENTS

Introduction to the Manual

Information and a guide for facilitators

What will this introduction tell me?

Who is this manual for?

Clients are eligible to receive this manualised intervention if:

- They are aged 18 or over **AND**
- They have a diagnosis of borderline personality disorder (BPD) or emotionally unstable personality disorder (EUPD) **AND**
- They are facing challenges related to homelessness **AND**
- They misuse substances (this can include alcohol and / or prescription medications)

How does the manual work?

This manual contains guidelines for 8 sessions of ACT therapy.

It is advised that you read about the session you will deliver next in good time to prepare.

All of the facilitators scripts are *written in italics*.

The session outline is as follows:

Session number	Topics
Session 1	• Introductions • Goals • Values
Session 2	• Workability • Personality disorder
Session 3	• Substance use • Difficult thoughts and feelings are normal
Session 4	• Experiential avoidance
Session 5	• Staying with difficult thoughts • You and your emotions and thoughts are separate
Session 6	• Thoughts are not the whole person
Session 7	• Not distracting ourselves from unwanted thoughts • Connecting with the here and now
Session 8	• Noticing being hooked away • Review • Ending

Throughout the manual, you will find helpful information boxes. These will help you to consider clients on an individual basis and allow you to tailor each session in a way that best suits them. These boxes will look like this:

What else do we need to consider?

Trauma

- Before beginning therapy with the client, if you are aware of any key details of their trauma history, make them aware of this and that you will not be asking them, but also let them know that there might be details that you are not aware of.

Question: Do you already know this type of information about the client? Make a note to cover this in your first session.

- For the exercises within sessions as well as general discussions with the client, make it clear that the client will not be asked to divulge specific information related to any traumatic experiences.

While ACT is not specifically a trauma treatment, clients with trauma will benefit from it because this treatment teaches clients that experiencing guilt or fear does not have to lead to more unworkable behaviours; that while they don't have control of what thoughts and emotions come up, they can learn how to be with those internal experiences; that they can learn to manage the physiological stress that comes along with trauma related cues; and that fundamentally, they can choose how to live their life to its full potential.

It is important to tell clients that they won't be asked to disclose the traumatic event they went through. Instead, they will learn ACT skills to manage all the struggles they are dealing

with because of the event. Some clients with complex or chronic trauma histories may benefit from skills in emotion regulation before beginning trauma treatment.

Standard questions to assess for trauma are as follows:

- Have you ever experienced a traumatic or life-threatening event?
- Do you experience intrusive thoughts, memories, or nightmares about these events?
- Do you avoid people, places, or experiences because of this traumatic event?
- Have these experiences affected the way you see life, people, or relationships?

No right or wrong

There is no "right" or "wrong" criteria for a client's choices and actions; rather, the value of any action is its workability measured against the client's most authentic and deeply held values.

Clients are not internally broken (i.e., thoughts, feelings, sensations are not in and of themselves problematic), and thus do not need to be "fixed."

Behaviour and living a more meaning-filled life is the target of the intervention, not fixing thoughts and feelings.

For instance, ACT facilitators believe that clients have the psychological resources needed to gain skills that increase behavioural flexibility and effectiveness. The facilitator must always be compassionate, interested, and non-judgemental towards the client.

Validate the client

It is important to keep in mind that the pain and internal difficulties of the individuals who have come to see us in therapy are not fundamentally different from the pain and internal difficulties of any other human being – including the facilitator.

Thus, one of the key processes inside the therapeutic relationship involves maintaining a stance of *compassion* toward the client – sitting with them in their pain in an open and accepting way, while continuing to encourage participation in the treatment.

Validate the client. Clarify that most people experiencing these problems would try these solutions. The solutions seem logical. Acknowledge that the client has clearly been working hard to solve these problems. So, the fact that they're continuing to struggle is not due to lack of effort or competence.

Flexibility of treatment

Between-session tasks

There are usually clients that won't complete the between-session practice, and without making a big deal, simply acknowledge that it's hard to start making new behaviours and

checking with others about them. Those who don't complete their practice will still learn from the experience.

Inform the client that you are aware that they may not always be able to complete between-session tasks. This will help to reduce any feelings of guilt or disappointment in the client.

In addition, be sure to explore any non-completion of between-session tasks as experiential avoidance with the client.

Session frequency

Ensure you clearly communicate with the client that you are aware that it may be difficult for them to attend every session because you understand that at times their lives may be chaotic. Ensure it is made clear that if they do miss a session they will not be discharged, but the session can be rearranged for as soon as possible.

While the most common session frequency is one individual session per week, it is not necessary to follow this structure. Facilitators should use their judgment regarding whether the client may benefit from additional work on a given topic before moving forward. Similarly, it may be useful in a subsequent session to revisit a topic that has already been covered. This can be done at any point in the treatment, and resources are provided that will aid facilitators in selecting additional content and exercises for additional work on a concept.

- Allow clients to revisit parts from previous sessions
- Ask the client if there are any exercises or discussions that they would like to revisit

Most importantly, across each part of the session, the facilitator relates the metaphors and exercises to the client's specific challenges: finding ways wherein the material is made relevant to the client's life. The client may feel less motivated, and exercises may feel "dead" or "heartless" if not linked directly to what the client is experiencing. Metaphors and exercises are NOT designed to be delivered in a mechanical fashion. They are to be lively and linked to what is happening in the session. At times, an exercise may not be needed because it just does not fit. It is okay to leave a metaphor or exercise out – so long as the facilitator is cautious in doing so and the targeted process is still being developed in other ways.

To ensure exercises are conducted effectively and with greater ease (without being mechanical), it is important to place the exercises in context. First introduce the exercise focusing on how the core process being illustrated is relevant to the case conceptualisation. Then, conduct the exercise. Finally, discuss the client's reactions to the exercise, keeping the discussion focused on the exercise's function and its connection to the client's life. Additionally, transitioning into new exercises is designed to be fluid, rather than delivering one exercise after the next, as if following a recipe. Again, providing rationales that are appropriate to the exercises and processing the experience is considered an important part of implementing the therapy successfully. The goal is to flexibly implement the model while exploring and adapting to the client's needs.

'Wrong' answers

There will be lots of exercises for you and the client to participate in over the course of therapy, and some of them can be difficult to get the hang of. If the client provides a response which is not the one you were expecting or hoping for, ensure that this is validated and explore it further. If further explanation does not get to the point of the exercise, you might try an alternative explanation. If the client still does not understand, acknowledge that you notice your explanation is not helping and move on to the next exercise.

Technology

If you are using videos or sound during any of the exercises you do with a client, ensure that you download these before the session. This will help avoid any difficulties with streaming or accessing the files.

Reading and writing

Difficulties with reading and writing can limit participation for some clients and they may feel uncomfortable. Be aware of their reading and writing skills and where applicable tweak the exercises to make it accessible for the client. This may include:

- Providing the client with an adapted / simplified version of the exercise
- Having an option to draw rather than write, if possible
- Be clear with the client that there is no expectation for them to show their writing to you, and perhaps they could instead read what they have written to you

Attention span

Some people may struggle to pay attention to written or spoken information or both. This can make it hard to retain information. Reasons for this may include their mental health at the time because they struggle to sit still, or because of current substance misuse.

To help people to retain information, please consider:

- Providing a visual version of the exercise you are discussing
- Simplifying the language of the exercise
- Ensuring you are aware of the client's attention span – for example, twenty minutes may be good for one person, but one hour may be good for another
- Asking the client what helps them to concentrate
- Shorter sessions
- Breaks in sessions

Neurodiversity

Clients may have neurodevelopmental differences, such as learning difficulties / disabilities, autism, or Attention Deficit Hyperactivity Disorder (ADHD). This may impact upon their ability to engage in some of the exercises in this manual.

For example, a neurodivergent person may not feel uncomfortable in the 'Eyes On' exercise, which may take away from the point of the exercise.

Neurodivergent people may also find it difficult to pick up on cues and to understand metaphors.

If the client is neurodivergent please consider:

- How this may impact on the information you are delivering
- Discussing this with your supervisor

Phones

Many clients will not have Smartphones. This means that they will be unable to use phone notes or voice notes, which may be helpful for some people.

In instances where you client does not have a Smartphone, consider alternatives such as written notes.

Physical disability

Some exercises within this manual rely on clients to be physically able. However, if the client is less physically able (for example, due to mobility issues, injection site sores, infections, etc.), provide an alternative exercise. It is important that clients who are less physically able are provided with experiential exercises that they can manage.

Confidentiality

You may find that the rooms you ordinarily use for therapy / client sessions are not soundproofed. This may put clients off discussing certain topics or participating in particular exercises.

Please consider:

- Letting the client know that they can stop if they are concerned about others hearing what they are saying
- Booking rooms further away from those most commonly used
- Where to have your sessions

Checking in on our own assumptions

For many of the sessions within this manual there are exercises to choose from. When making decisions about which exercises to do with the client, please consider:

- Have you chosen the exercise or topic of discussion based on the client's preferences? Or have you made an assumption about what their preference would be?
- Your own preferences and whether they have influenced your decision
- Discussing this during supervision
- Offering all of the available exercises to the client and giving a brief overview of each exercise. This will help them to make an informed decision about which to participate in

Therapeutic relationship

A good therapeutic relationship will enhance the client's ability to speak to you directly, as well as their willingness to participate in exercises.

Please consider:

- How the client may best work and what they may be more / less likely to discuss or participate in over the first 2-3 sessions
- That some clients may not find it difficult to speak openly to a new facilitator at all

The more you build a therapeutic relationship with the client, the more you will get to know the client. As you get to know the client, please consider:

- How you can tailor each session and exercise to your specific client to make them more accessible – think about the client's individual preferences, needs, how they express themselves, etc.
- How you present information to the client based on how they work best
- Asking the client what works best for them

Example 1: You may know that they are a quiet person, and so you may choose not to ask them to provide a lot of verbal information at once.

Example 2: You may know that the client has had previous traumatic experiences, and so may choose to adapt a particular exercise so they are not put in touch with that experience and lose focus on the aim of the exercise.

Asking people to share personal information can be difficult. The client may have had difficult relationships in the past with professionals or may not feel ready to share personal information. Please consider:

- Providing a supportive setting
- Modelling that information will not be received in a negative way if they do choose to share
- Being clear that the client is not expected to share information they do not want to

Language

If you feel that the language / terminology used in introducing an exercise is not going to be accessible for the client, please consider:

- Allowing flexibility in terms of the language you use
- Adapting any scripts suggested for particular exercises

Session 1: Goals & Values

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Session 1: Goals & Values

Introduction

- Introduce yourself as a facilitator and explain your role
- Explain that there will be 8 sessions and explore how frequent sessions can be (one per week is ideal)
- Discuss the length of sessions (this can be flexible – please refer to the manual introduction)
- Ask the client if they have any expectations of ACT therapy, and any concerns
- Ensure you are clear with the client that they will not be asked to divulge any information in relation to traumatic experiences

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Goals

Troubleshooting

Is the client resistant to making goals?
This may be due to negative past experiences with services and professionals' reactions when they have not met their goals.
If this is the case, explore this with the client and ensure your reactions are positive or neutral, rather than negative.

Note for facilitators:

- There are 3 available exercises for the client to choose from to explore and make goals. Give a brief overview of each exercise and ask them which they would prefer.

Exercise 1: Goals[1]

Information for facilitators:

Goals must be:

1. Time-limited
2. Specific
3. Measurable
4. Achievable

- Poor examples of goals include those reflecting the absence of something (e.g., not feeling anxiety, fear). Striving for the absence of something typically leads to more avoidance.
- However, the flip side of this is that there is typically a significant value underneath these types of statements. This could be a desire to be free from pain, anxiety, etc. and this is often expressed so that someone can move towards core values.
- Examples of values may include "having a life with meaning", "being a loving partner", "contributing to society" and so forth.
- Another way of exploring this is to ask questions along the lines of ***"What if I could guarantee you would be pain free, but in order to do so, you could never have contact with your children again and they would forget that you ever existed?"*** This can be reversed (***"What if I could give you a fulfilling relationship with your children, but you would always have pain?"***).
- When clients express narrow values / goals focused around reducing emotional or physical pain, it is useful to introduce the concept of broad focus versus "tunnel vision".
- This can be an opportunity for the facilitator to align with the client around ensuring that the work in therapy takes a broad focus and is not hijacked by the client's mind's attempt to focus solely on the control / avoidance agenda.

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In generating Values and Goals, the facilitator may have to assist the client either in generating the values related to specific life goals, or conversely in generating specific goals from values.

Clients may list goals that are not possible. In these instances, try to find the underlying value, and goals that might be achievable if one were moving in that direction.

Based on the above information, open with a general discussion about values and goals. Note that the focus of today's session will be on identifying values and goals that are important to the client. Discuss how clarifying values and goals will serve as a guide throughout the course of treatment.

Facilitator to say: *Let's talk a little bit about goals, just so we're clear how they are different from values. If values are directions, then goals are the steps, the actions you take, in the service of your values. Learning to set goals that work for us is a skill. Goals are things we can check-off on a to-do list, things I could see you do or not do.*

For example, did you plan on coming to session today? And did you come to session today? So, you did something that we both observed. That's a goal. You planned it and then you did it. Now, what value was coming to session in support of? What value led you to choose to set the goal of coming to session and following through with it?

[Discussion to elicit what value may have guided client's behaviour. Facilitator drills down with *"but why?"* through reasons until client responds *"because _____ is important to me"*, or some phrase that shows a value that is important to them. This may include growth, vitality, self-respect, being a certain type of parent or spouse or other role, being respectful by keeping the appointment, etc.

If substance use is discussed:

[with gentleness] *Let's talk about how we can discuss reducing or stopping drinking / using substances in these terms. Is changing your drinking behaviour a goal? If so, what value(s) does it support? Which important areas of your life does it affect?*

If the client insists that "not drinking" is their goal and has trouble linking this to values or to important life domains, ask, *"If you were not drinking, what could you do instead? What would I see you do that's important to you if you reduced or stopped your drinking?"* and behave when you're "not drinking"?

Adapt it!

Does the client have a preference for shorter exercises?

If so, it may be helpful to factor breaks into this discussion or to shorten it.

Exercise 2: Treatment Roadmap[1]

You will need:

- **2 copies of the Treatment Roadmap worksheet.**

Adapt it!
Does the client find the worksheet too big? Or overwhelming?
This worksheet can be completed over two sessions if needed.

Adapt it!
Will the client find it difficult to think up things to add to the worksheet on the spot?
Provide prompts based on your knowledge of the client or generally.

Adapt it!
Does the client find reading and writing difficult?
Clearly inform the client that they could write and then explain what they have written to you, instead of showing their writing.
It may be helpful for the client to take the worksheet home to think about, and then to discuss it in the next session.

Facilitator instructions for the client:

On this page is a list of life areas where most people hold important values. There is usually something important in these areas that people are working on or would like to be working on. Values are different for everyone, so what may be important to you may not be important to someone else. Please complete the form in terms of what is important to you. In each life area, write down a value and then list 2 concrete goals that would help you to know you are living that value.

An example:

'Relationship value' – being a loving partner.

Goals: Tell my partner "I love you" or do a kind thing for your partner like give them a gift.

Remember:

- Values can never be achieved, only lived
- Goals can be achieved
- List 2 internal barriers (such as feelings, thoughts, physical sensations, or urges), that are currently getting in the way of living the value. Rate your success in living the value using the scale below
- Rank the 3 most important life areas

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Life Area*	List one or more of your value(s) for the life area	List 2 concrete goals related to the value(S)	Which problem(s) get in the way (trauma, drinking, others such as pain or depression) of living those values? How?	Which lingering effects of BPD or substance use get in the way of living those values? How?	List 2 internal barriers (e.g., thoughts, emotions, sensations) to completing the goals	List your current success**
Relationships (intimate, marriage, couples, families)		1. 2.				
Friendships /social relations		1. 2.				
Employment/ education/ training		1. 2.				
Recreation /citizenship		1. 2.				
Spirituality		1. 2.				
Health, physical & mental		1. 2.				

**Complete the full worksheet, then rank the top 3 most important areas you'd like to work on by writing a number to the left.*

***0=not at all successful; 1=somewhat successful; ; 2=moderately successful; 3=successful; 4=very successful*

Exercise 3: Assign your 'next move'[1]

You will need:

- **3 copies of the worksheet available for the client and ensure they take this home.**
- **An envelope so they can carry the worksheet privately.**
- **You may wish to consider making a copy of their worksheet before they leave the session.**

Information for facilitators:

- Starting with this session, you will work with the client to develop a "next move" assignment each week.
- This is a committed action in which the client commits to completing a values-consistent behaviour.
- Using the Next Move worksheet, work with the client to develop a values-consistent behavioural goal that is achievable, but that is not something they would already do on their own, or something that is so easy that it isn't at least somewhat challenging (hence, a "next" move).
- Then work around collaboratively developing next move assignments and assisting the client in completing them by engaging ACT processes - this is viewed as the most important work in therapy from this point forward.

- The primary goal with the initial next move assignments is to get the client moving in valued directions, to engage in the process of noticing what internal experiences show up when they make these efforts, and to notice the process through which they were able to complete the next move as internal barriers show up.
- Therefore, encourage the client to err on the side of a relatively smaller next move that is likely to lead to success.
- Building success bolsters motivation and momentum. For the initial assignments, the question ***"What is the smallest action you could take that would be consistent with your values?"*** may be useful in guiding a client who is reluctant to commit to a next move.
- In our experience, most clients complete most of the next move assignments, beginning with the first assignment.
- Conversely, the client may not complete the first couple of next moves; however, that process is useful if the client is open to learning from their experience of noticing the unworkability that emerges from lack of willingness.
- Noticing the mind stuff that shows up when clients are considering whether to increase their willingness is also quite helpful when clients do not complete a next move.

- Collaboratively develop the first next move assignment focusing on any of the life domains that the client has ranked as being among the most important to then.
- If this next move does not already involve modifying their drinking / substance use behaviour, ask them if they would be willing to make a second next move assignment related to reducing their drinking / substance use.

- The question of whether the client is willing is not rhetorical. The decision on whether the client is willing to begin reducing their drinking / substance use at this time must remain their decision.
- If lack of willingness shows up around making drinking-related next move assignments, this will be addressed explicitly during sessions.
- Clients should be encouraged to select initial goals that are realistic and achievable. Examples might include selecting a particular day that they would normally drink then they will not drink, reducing the number of drinks they have on a particular day, not exceeding a certain number of drinks on any day that week, etc.
- Once clients begin to gain practice with reducing drinking and connecting this to living in accordance with their values, momentum typically accelerates.
- The key is to start moving.

- Facilitators are encouraged to draw from this list and make suggestions to the client if they are having trouble identifying their own next move.
- Many clients feel encouraged by hearing stories like "Other people have found it helpful to start with X. That helped them take some initial steps toward eventually X, which is consistent with their value of X".
- In fact, in one study's interviews, several clients said that it was useful to hear about past successes by other clients.
- Referring to past successes by other clients likely bolsters the credibility of the treatment and enhances clients' positive expectancies, both of which have been shown to be associated with better treatment outcomes.

Over the course of several weeks, these next moves should become more challenging as the client learns additional ACT processes and gains practice in applying them in overcoming internal barriers to committed action. The facilitator's goal is to guide the client in developing successively larger patterns of values-consistent behaviour over time.

Facilitator to say to client:

If just for today you could do exactly what you wanted to do, according to what you value, what would that be? Choose something to work on between sessions that you would feel could be something you do "next". This action should be something that would show you your value was being lived. The action should be very specific; for example, instead of "I will be nice to my partner," the action would be "I will take my partner out to dinner to her favourite restaurant on Thursday night this week." The action should not be too easy or something you would already do. It should not be so difficult as to set you up for not being able to complete the task. It should challenge you, but be thoughtful in choosing an achievable task. Make sure the action is linked to a value.

Next Move Worksheet

I will do (action):

Consistent with this value:

Potential barriers to completing this action:

(in the next sessions) - Did you complete the next move above? If you did, what was that experience like for you? If you didn't, what was that experience like for you?

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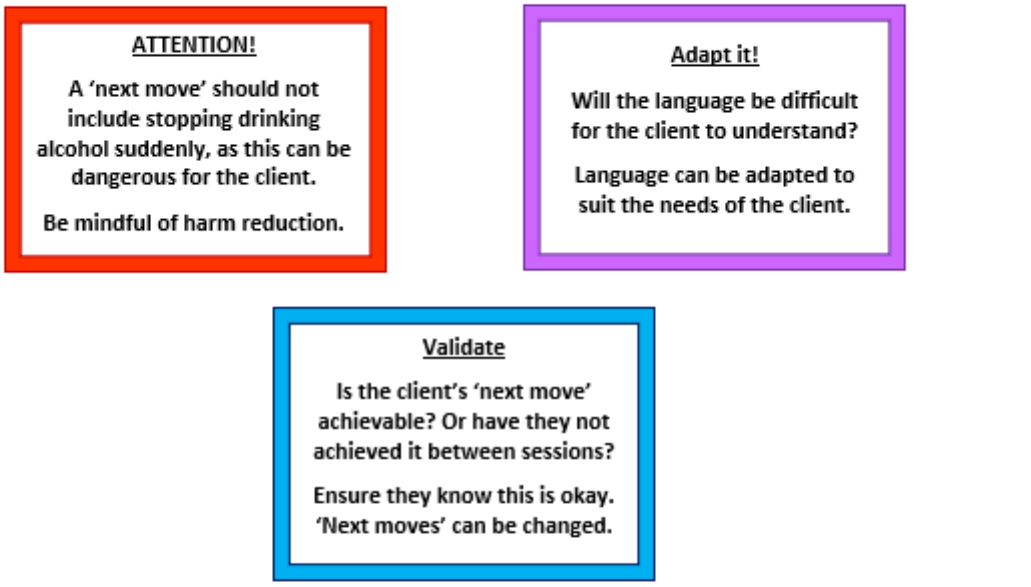
ATTENTION!
A 'next move' should not include stopping drinking alcohol suddenly, as this can be dangerous for the client.
Be mindful of harm reduction.
Adapt it!
Will the language be difficult for the client to understand?
Language can be adapted to suit the needs of the client.
Validate
Is the client's 'next move' achievable? Or have they not achieved it between sessions?
Ensure they know this is okay. 'Next moves' can be changed.
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Values

Note for facilitators: There are 3 available exercises for the client to choose from to explore their values. Give a brief overview of each exercise and ask them which they would prefer.

ATTENTION!

Do you work in a hostel setting?

If so, this work should be done with a professional outside of that hostel setting.

Exercise 1: Values Card Sort[1]

You will need:

- **A set of Values Cards for this exercise.**

Facilitator to say to client:

Clarifying your values can be helpful in making choices about how you want to move forward in your work and personal life. Sometimes when we are stressed, we lose sight of what is important to us. Reconnecting with what brings meaning and purpose to your life can help you to get re-oriented and provide a "compass direction" for how you want to engage and behave toward yourself and others. Take the values card sort below to help clarify your values.

Step 1: Sort through the full set of cards, separating them into two piles: "important to me" and "not important to me." Try to select rapidly at first – going with your "first instinct". When you are done, set aside the "not important to me" pile.

Step 2: Take the "important to me" group and sort the cards again into three categories "very important to me", "important to me", and "of little importance to me". Set those cards in the *of little importance to me* aside.

Step 3 and beyond: Repeat this process until you have identified your top five values.

Look closely at the top five cards – these are your top values. If these are out of balance in terms of priorities, then you will be out of balance as well. Notice if you've left them behind, or if you've set them aside in the service of something else; notice if you've been neglecting some of your values.

Ask: What can I do today to bring these values to life?

Do: What is possible as you engage in the process of ongoing values-based living.

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Adapt it!

Are the cards not applicable to the client?

You can customise them or ask the client if anything is missing and make new ones together.

Exercise 2: Bull's eye[2]

You will need:

- **The Bull's Eye worksheet for this exercise.**

Instructions for facilitators:

- Pass the handout to the client, point out the four areas that are identified in the handout, and then invite them to place a mark where it corresponds based on how consistently or inconsistently they're living their values in each one of those four domains up to this point.
- The closer the mark, the more congruent behaviours a person has in that valued domain.
- Give the client time to complete this activity.

- Once complete, invite the client to share their responses and reflections after completing the exercise.
- What do they notice?
- Are they living the life they want to live in all domains?
- Explain to the client that throughout this treatment, they will be invited to choose values-based behaviours.

Adapt it!

Consider whether life is all leisure for the client. If this is the case, consider whether this exercise if appropriate, depending on what is known about the client.

Adapt it!

Is this worksheet to big or overwhelming for the client?

If so, ensure that the worksheet is explained clearly, and consider whether to break it down into parts.

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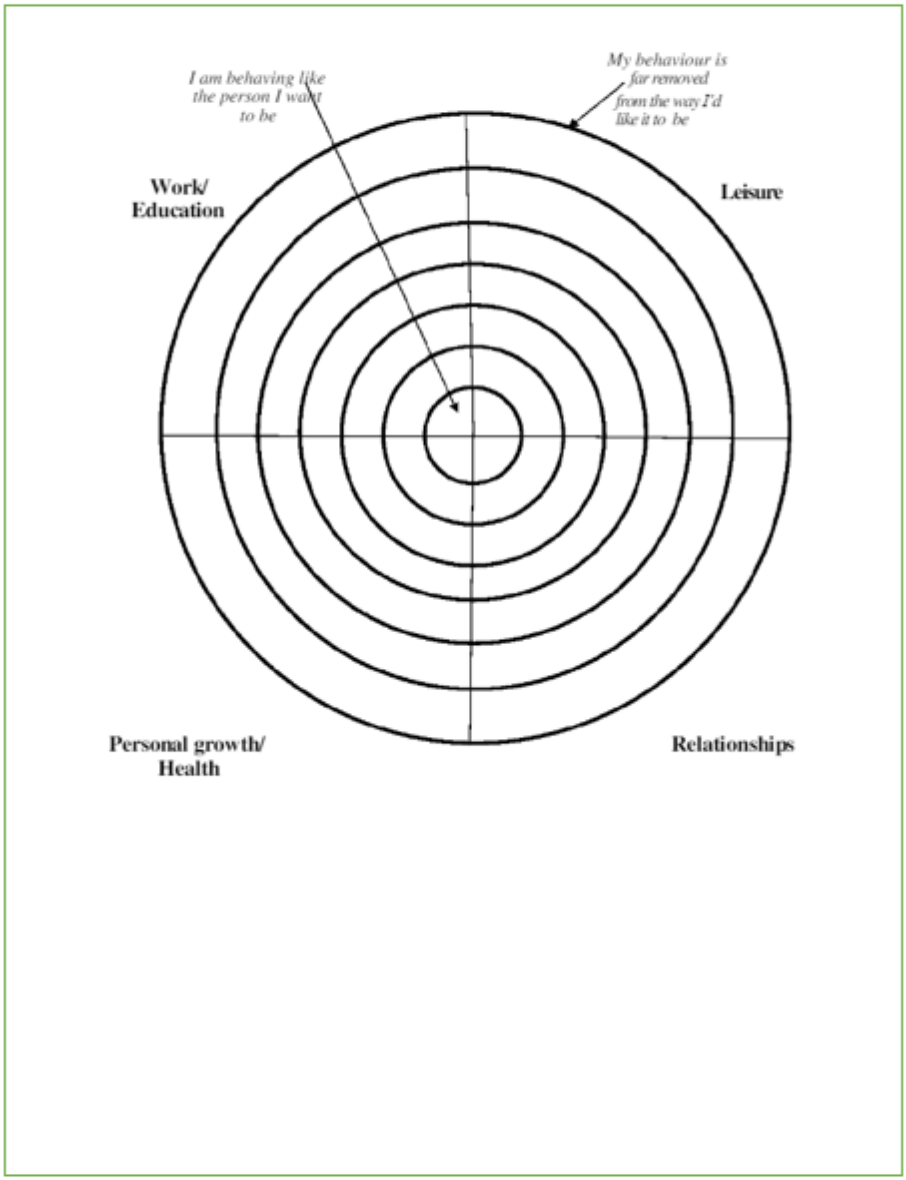
Bull's Eye Worksheet



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Exercise 3: Exploring Values[1]

You will need:

- **2 copies of the worksheet on the next page and an envelope for the client to take it away in.**
- **If the client takes their worksheet home, you may want to consider making a copy of it first.**

Information for facilitators:

- Tell the client to think for a moment of a person they admire (for example, a sports figure, celebrity, staff member, film character, musician, etc.) or a friend they respect.
- After clients choose a person (they don't need to say the person's name), ask them to imagine for a second that there is a gathering and that the person they chose is giving a speech about them (the client) and what matters to them with regard to their physical wellbeing.

Adapt it!

Is the client experiencing difficult in thinking of a 'person they admire'?

Provide prompts to help with this exercise.

Exercise:

Next, ask the following questions: ***"What would you want this person to say about your physical self-care values? Which qualities would you want this person to mention that matter to you when taking care of your body?"*** Give clients the option to write down their responses.

Briefly, remind clients that values are things that deeply matter to us; they're not rules, goals, or feelings. Our values are qualities we choose as important to us, and they're verbs because we're constantly living them.

Worksheet:

Invite the client to complete the worksheet with you.

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Worksheet: Exploring Values

Weekly Practice Worksheet: Values in Action

Personal value: _____

Is my value a personal value or am I trying to change a person or a person's behaviours?

_____

_____

After checking my value, what is the specific action I choose to take? (When, where, for how long?)

_____

_____

When taking that specific action, my emotional machinery may come up with uncomfortable feelings such as: _____

How willing am I to have that feeling? (Mark the number from 0 – lowest to 10 = highest)

0 1 2 3 4 5 6 7 8 9 10

What are the sensation(s) that I may struggle with when taking my values-based action?

_____

What are the thought(s) that may show up when taking my values-based action?

_____

What was the outcome after taking a value-based action?

_____

_____

Values Meter: Place a mark where is corresponds:

Far away Closer

0 1 2 3 4 5 6 7 8 9 10

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Session 2: Workability & 'Personality Disorder'

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Session 2: Workability & 'Personality Disorder'

Workability

Note for facilitators: There are 3 available exercises for the client to choose from to explore and make goals. Give a brief overview of each exercise and ask them which they would prefer.

Exercise 1: Checking the Workability of Thoughts[2]

You will need:

- **A white board / large piece of paper**
- **Pens**

Information for facilitators: The workability of thoughts is not about checking whether our thoughts are true or not, but whether taking action on them takes us closer or further away from our personal values.

You can emphasise the importance of this skill by telling clients to imagine for a second that we do exactly what our inner voice tells us to do without checking whether it's workable or not. Would we take a holiday to the coast when we are looking after a friend's pet because our inner voice says that there's great weather? Would we spend hundreds on the next music gadget because our inner voice tells us it's a great deal? After discussing clients' responses for two or three minutes, go ahead with the next activity.

Activity: This activity has two parts aimed to discuss with clients the payoffs of getting fused with the mind noise that the inner voices come up with.

ATTENTION!

To enhance engagement, this exercise should be done collaboratively with the client

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Part 1

On some paper or a whiteboard, draw a vertical line down the middle, then ask clients to give examples of the upsides and the downsides of getting fused with their inner voice: on the left, write down the upsides, and on the right, write the downsides.

Then check with the client what they noticed. As simple as this exercise may seem, it highlights that we can learn to observe, study, and examine our thoughts as private experiences we have and not as little dictators of our behaviour.

Part 2

Prompt clients to think about a difficult situation they encountered over the last few weeks, the thoughts they struggled with, the behaviours associated with them, and whether their actions were a move toward or away from their values.

Exercise 2: Workability[1]

You will need:

- **A white board / large piece of paper**
- **Pens**

Information for Facilitators: Enquire about the client's experience of completing or not completing the between-session practice, and the workability of that decision, rather than focusing on completion.

Barriers to practice completion should be addressed in a non-judgmental fashion. Barriers are viewed as opportunities to examine the workability of whatever strategy the client used, including not completing the between-session tasks. The facilitator, embodying the ACT therapeutic stance, refrains from judging clients for their difficulty in completing the between-session tasks. The facilitator takes the position that if an agenda is unworkable, the client's life and its workability will let both facilitator and client know. The client often already knows what the key problems are in their lives and how the barriers are interfering; they also often have others telling them what they ought to do or to know. Refraining from following suit is the ACT-consistent response. At the same time, the facilitator never takes the reasons clients offer for doing or not completing an assignment literally – under no circumstance should the facilitator pretend, along with the client, that the unworkable is somehow workable if the reasons offered are sufficiently compelling. The facilitator enquires about how habitual patterns of behaviour work or do not work to help move the client in valued directions and invites the client to test out novel behaviours and report back on their workability.

ATTENTION!

Some clients may not wish to discuss their past experiences – be clear with the client that they will not be expected to divulge specific details of difficult experiences

Validate

If the client struggles to understand what to do during the exercise, reassure them that this is okay and ask what they are finding difficult – alternatively, a different exercise could be offered

Facilitator to say: *In this exercise, we are going to make two lists, the first is a list of the things that you struggle with. We'll refer to this as the list of problems. We define problems as thoughts, feelings, and sensations, [any internal experience] that when they show up, you don't want them, and maybe you do something to get rid of them? The second list is a list of all the things you have ever tried to fix these problems, regardless of whether they have worked. We'll call that a list of solutions. We'll start by making the list of problems.*

It seems you spent quite a bit of time struggling. Let's take a closer look at exactly what it is you struggle with. Let's make a list on the left side of a piece of paper of the problems you have been experiencing. Ok, great, what a list (make sure typical suspects are on the list, if not, offer them up). So now, let's make another list of the solutions, which we define as all

the ways you have tried, at any time in the past, or are still trying, to get rid of that stuff. Anything you've done. Is using alcohol/drugs on the list, is this something you do to in some way or another not have these experiences (e.g., to try to not feel or to not think something)? (make sure substance use behaviours are on the list).

Facilitator to say: *Wow, that is a lot of stuff, on both lists. Looking at all these problems and then all these solutions* [sit next to client, taking same perspective towards the board or paper], *the question for each solution is: How well has this worked to get rid of the stuff you struggle with? And let's break it down, let's ask how well this has worked to get rid of the stuff you struggle with long-term/permanently.*

How have your favoured strategies at avoiding your upsetting experiences worked to get rid of the stuff you struggle with? Have your strategies been effective in avoiding or eliminating distressing thoughts, feelings, or physical sensations associated with these experiences? How long have you been struggling with X? How about with Y? What does your experience tell you about how well these strategies work to get rid of difficult thoughts, feelings, etc.? For those that work in the short-term, are there any costs? Any not-so-great side effects? Has avoiding X had any costs on the quality of your life, choices available to you? Has using alcohol/drugs had any costs? [Elicit the impact the client's alcohol/substance use has had in a number of life domains including family relations, employment, and physical health, among others. This work helps the client make contact with the damage substance involvement has produced and sets up work on the personal values their use has been violating.]

The facilitator should remain non-judgmental. The facilitator should resist starting from the position that these change efforts did not work. Unworkability will emerge on its own if the change efforts are followed out – after all, the client has come to treatment. It is fine for the facilitator to acknowledge that things worked when they worked and in the ways that they worked. If we attack a client's change strategies, we will be more likely to promote a defence of those strategies. In part, we are helping the client make contact more fully with the extent of their own drug use, but we are also introducing a model of dispassionate and detailed examination of the workability of the client's various behavioural approaches to problem solving.

Does it fit to say that how you've been approaching trauma and substance use hasn't worked, that your choice of approach just isn't working, and it looks hopeless that it will ever completely work to get rid of the effects of trauma?

Perhaps struggling with trauma and substance use is a hopeless way to go, it simply can't ever work out. And you've been trying, putting in a lot of time and effort. Perhaps the so-called solutions are actually part of the problem. Perhaps substance use makes certain traumatic stress symptoms work in the long run, and perhaps certain ways of reacting to trauma actually fuels it?

Would you be interested in an alternative approach, something other than trying to solve your problems? Not going to get into what the alternative is, just asking if an alternative path is something you would honestly be interested in?

Exercise 3: Checking in on Workability[1]

You will need

- **A copy of the Workability Worksheet.**

Reason-giving is one of the major obstacles to willingness.

Facilitator to say: *What stands between you and complete willingness to have unwanted thoughts and feelings of the trauma (without buying into them or reacting automatically to them) AND take steps to complete valued goals?*

Information for facilitators: Whatever reasons are given (other than "nothing stands in the way") can be discussed in the context of reasons not being causes. Remind the client that willingness is not an emotion, but a choice to have what you already have. The only thing that stands between the client and 100% willingness, is choosing for it to be so.

Facilitator to say: *In your experience, has not being willing to experience difficult thoughts and feelings worked? Has fighting against thoughts, feelings, memories, or urges, worked to get you a more meaningful life?*

Information for facilitators: [If client says they do not *know* what goals, actions, or choices would "work", point out that "working" is something experience teaches us: "How does an animal, a dog or cat, know what works?" Reassure the client that they are still able, able to begin again (and again and again) to take a direction with their life that will work.]

What reasons are you buying into that lead you to keep using alcohol/drugs?

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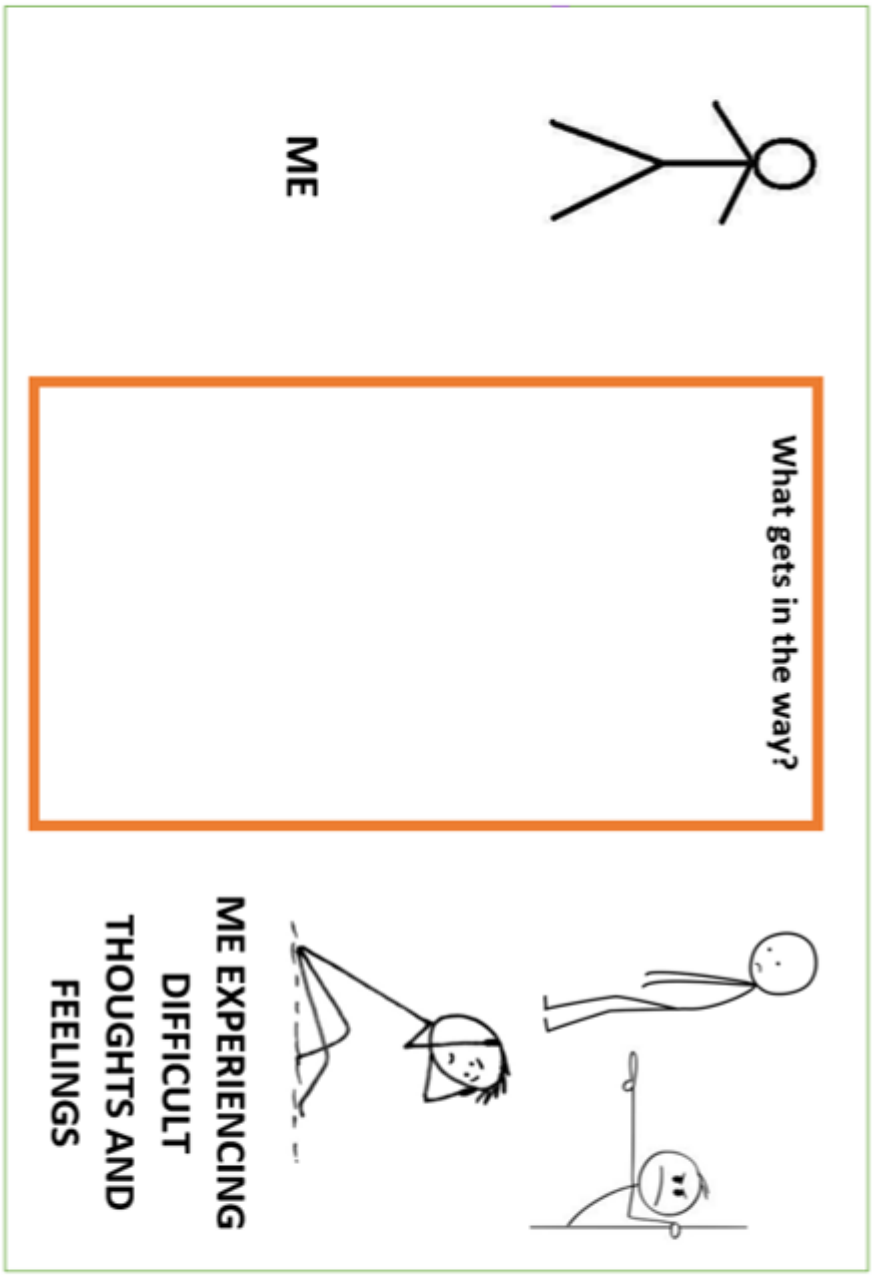
Workability Worksheet



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Personality Disorder

Note for facilitators: There are 2 available exercises for the client. Please complete Exercise 1, and if the client experiences difficulties in relationships with others, please also complete Exercise 2.

Exercise 1: Connect the DOTS[1]

You will need:

- **A copy of the Connect the DOTS Worksheet**
- **A copy of the DOTS for the client to have as a reminder**

Facilitator to say: *Let's discuss the connect the DOTS exercise (below). What have you tried doing so far to avoid and get rid of unwanted thoughts and feelings?*

Information for facilitators: Usually the client will have noted some things that are normal and typical strategies. These should be explored, without interpretation or an attempt to understand them but with a real interest in the exact nature of these strategies. You should ask questions to elucidate the nature of the client's struggle, as a set up to the next step.

At this point, no big deal is made of any of this – it is touched on, clarified, formulated in common-sense terms, and then just left on the shelf. But this is important, because the immediate goal of the next phase is to gather this set of events into a single class: conscious, deliberate, purposeful control. Control is the problem, and it is shown through Escape and Avoidance.

You can be certain that the list of strategies identified will mostly be interpretable as methods for the control and avoidance of private events: especially emotions, thoughts, memories, and bodily sensations.

ATTENTION!

To enhance engagement, this exercise should be done collaboratively with the client

Adapt it!

Be flexible – if the client feels unable to complete this exercise during the session, provide the option for them to take the worksheet and information away and do it in the next session

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Connect the DOTS (Exercise) – Facilitator to guide the client through the exercise

Try to think of 3 situations and take note of:

1. The thoughts, feelings, sensations, and urges showed up related to mental and physical health challenges, including alcohol and substance use
2. What DOTS you use in response to these experiences
3. The immediate and longer term outcomes

D – Distraction: *How have you tried to distract yourself from these thoughts and feelings? (e.g., TV, sports, overeating, etc.)*

O – Opting out: *We often opt out (quit, avoid, withdraw from) people, places, activities, and situations when we don't like the thoughts and feelings they bring up for us. What are some of the things/activities you opt out of?*

T – Thinking: *How have you tried to think your way out of it? (e.g., blaming others, worrying, rehashing, the past, fantasising, positive thinking, problem-solving, planning, self-criticism, 'What if?', 'If only…', 'Why me?', 'Not fair!', analysing, trying to make sense of it, debating with yourself, denial, beating yourself up, etc.)*

S – Substances, self-harm, and other strategies: *What substances have you tried putting into your body (including food and prescription medication)? Have you ever tried self-harming activities, such as suicide attempts or reckless risk-taking? Any other strategies you can think of, e.g., excessive sleeping?*

How did that work?

Did these strategies work to get rid of these unwanted or painful experiences? Think in terms of both the immediate moment and in the longer term – so that they never came back?

Did using these strategies cost you anything in terms of health, vitality, energy, relationships, work, leisure, money, missed opportunities, wasted time?

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Connect the DOTS Worksheet

Unwanted thoughts, feelings, physical sensations, urges	What did I do to try and get rid of them (DOTS)?	How did that work? (short & long term? Any costs to you?)
	1 2	
	1 2	

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The DOTS – A reminder

D – Distraction: How have you tried to distract yourself from these thoughts and feelings? (e.g., TV, sports, overeating, etc.)

O – Opting out: We often opt out (quit, avoid, withdraw from) people, places, activities, and situations when we don't like the thoughts and feelings they bring up for us. What are some of the things/activities you opt out of?

T – Thinking: How have you tried to think your way out of it? (e.g., blaming others, worrying, rehashing, the past, fantasising, positive thinking, problem-solving, planning, self-criticism, 'What if?', 'If only…', 'Why me?', 'Not fair!', analysing, trying to make sense of it, debating with yourself, denial, beating yourself up, etc.)

S – Substances, self-harm, and other strategies: What substances have you tried putting into your body (including food and prescription medication)? Have you ever tried self-harming activities, such as suicide attempts or reckless risk-taking? Any other strategies you can think of, e.g., excessive sleeping?

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Exercise 2: Interpersonal Triggers[3]

You will need:

- **A copy of the example**
- **2 copies of the Interpersonal Triggers Worksheet**

Facilitator to say: *To use this worksheet, begin by listing all the people who trigger strong emotional reactions. Think of the different areas of your life – work, family, children, partner, friends, and so on. Anyone who can set off feelings of shame, anger, guilt, fear, or sadness should be listed in column 1 "triggering people". Don't skimp on this – make as big a list as you can.*

Now, in the right-hand column, list the things these people do to push your buttons. What actually is the behaviour that offends or upsets you? List every triggering behaviour you can think of, and be aware that some people can do more than one thing to lead to emotional pain.

Adapt it!
If the client has difficult with reading and writing, provide the option for them to take this worksheet away and to complete in the next session, or to look at it together in more detail and completing later in the same session

In addition, provide the option for the client to write but read their responses rather than show their writing to you

Adapt it!
If the client finds this exercise emotive, provide the option for them to take a short break before returning to the exercise

ATTENTION!
Use this exercise as an opportunity to connect the discussion to other ACT processes – for example, acceptance, and willingness to have difficult feelings

Validate
This exercise involves discussing important people in the client's life – be sure to validate their responses and empathise

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Example

I'm Ali. I struggle with always thinking people will abandon or reject me and that there is something wrong with me. I feel overwhelming shame. Here's how I filled out the interpersonal triggers worksheet:

Interpersonal Triggers Worksheet

Triggering People	Triggering Behaviours
1. Boyfriend.	When he seems aloof; when he gets busy and can't schedule time together; when he gets angry about something; when he criticises my parenting or how I manage my life.
2. Mother.	When she criticises my lifestyle; when she seems distracted or uninterested during our conversation.
3. Ex-husband.	When he's cold or detached on the phone; when he criticises my parenting decisions.
4. Son (age thirteen).	When he ignores me and shuts himself in his room; when I invite him to do things and he refuses; when he gets angry about my rules and how I run the house.
5. The head teacher (my boss)	When she criticises my lesson plans; monthly meetings where she points out problems.
6. Parents (of this children I teach).	When they complain about homework assignments, grades, problems in the classroom, and so on.
7. Friend.	When she doesn't return my calls, when she criticises my parenting (says my son is out of control); when she's late; when she talks about moving out of state.

What now?: Ali will need to learn to notice these triggering situations. And Ali will need to be alert – with each of these people – for that moment when old thoughts and feelings get activated. Partly this involves planning ahead with the problematic people in Ali's life.

- Remembering to observe what happens during a weekly call to their mother.
- Being alert when picking son up from weekends with ex-husband.
- Planning to watch internal reactions during parent-teacher meetings.
- Watching internal responses during monthly meetings with her boss.

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Interpersonal Triggers Worksheet

Interpersonal triggers worksheet (Exercise)

List all the people who trigger strong emotional reactions.

Now, in the right-hand column, list the things these people do to push your buttons.

Triggering People	**Triggering Behaviours**

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Session 3: Substance Use & Difficult Thoughts and Feelings

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Session 3: Substance Use & Difficult Thoughts and Feelings

Substance Use

Note for facilitators: **There are 2 exercises in this section. Please complete both.**

Exercise 1: High-risk Situation Card-sort[4]

You will need:

- **The high-risk situation cards**
- **A copy of the Top 5 Situations Worksheet**

Validate

Please remember – the low-risk cards are still significant for the client, therefore it is important that these are also validated

Information for facilitators: Reviewing the between-session work works allows facilitators to introduce into the discussion that the likelihood of substance use is made more likely in some circumstances and less likely in others. Increasing awareness of relevant high-risk situations affords group members the opportunity to consider the effectiveness of their coping responses in context.

Instructions for facilitators: Provide the client with a pack of 'high-risk situation' cards. Ask the client to sort through the cards and place them in three piles:

- **Highly Likely to Drink/Use**
- **Moderately Likely to Drink/Use**
- **Unlikely to Drink/Use**

Once the client has completed this task, invite the client to take the cards in the 'highly likely' pile and order them according to how frequently they encounter each situation. The top five situations on this list, then, reflect those that are both high-risk and frequently encountered.
Ask for the client's reflections on the exercise. Following this debrief, the client should be provided an opportunity to share their top five high risk situations. Invite the client to consider the last time they encountered that situation and to describe what emotions, sensations, urges, and thoughts show up in this situation.

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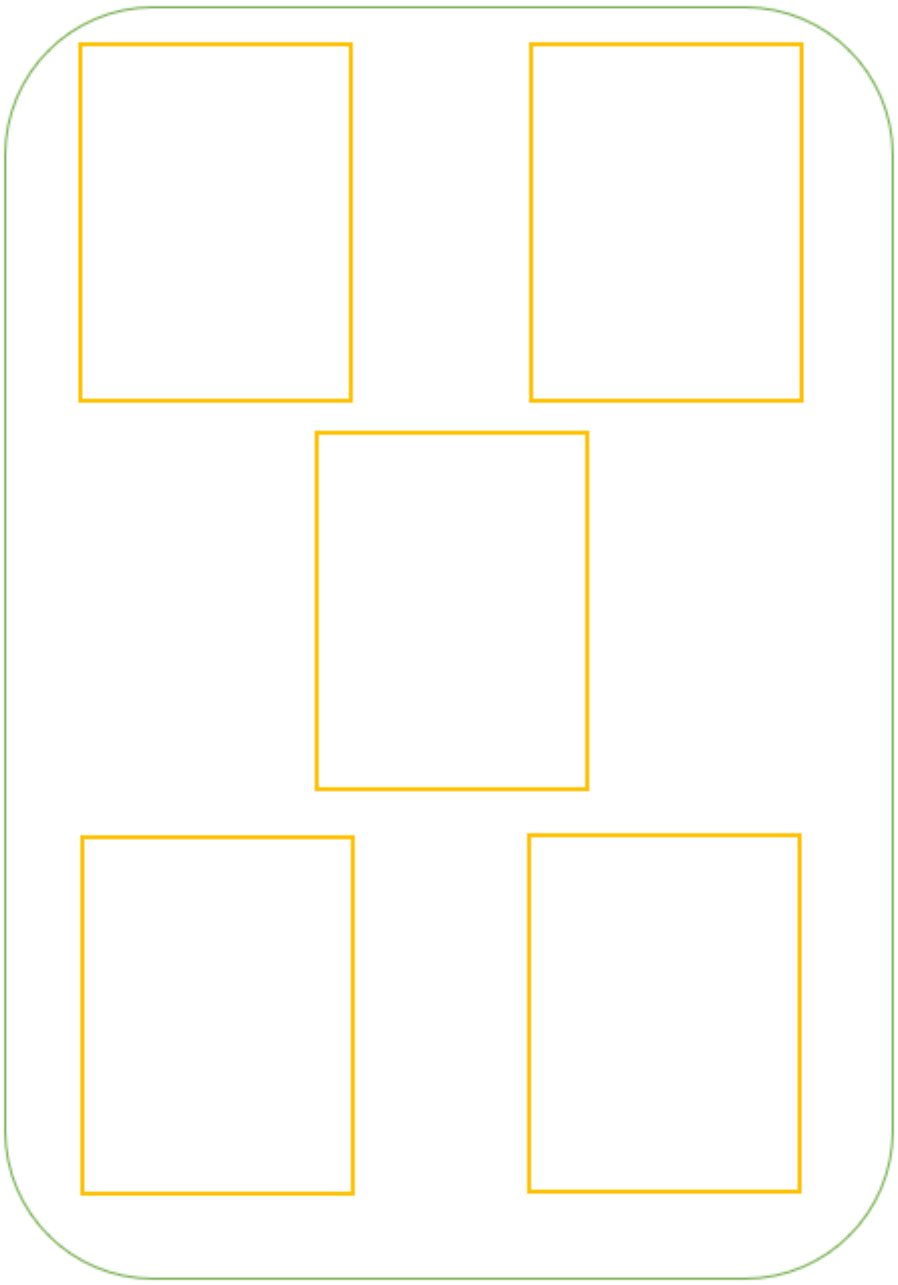
Top 5 Situations Worksheet



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Exercise 2: How's it Working? Substance Use as a Tool to do a Job[4]

You will need:

- **Paper or a flipchart**
- **A bin**

Facilitator to say: *Most things we do in life have a purpose. We do things because they are aimed at achieving something. Using drugs and alcohol is no different; it serves a purpose. So, I'd like you to consider substance use as if it were a tool to do a job. Like, the job of a hammer is to knock nails into wood; the job of a saw if to cut wood into pieces; the job of drugs and alcohol is to…*

Information for Facilitators: Clients typically identify themes of control, escape, self-medication, feeling better, and so on. These statements reflect the experiential avoidant function of substance use.

Sometimes clients may focus on the positive, euphoric feelings associated with substance use. This, too, may reflect experiential avoidance. This can be explored by asking, *"When are you most likely to seek out euphoric feelings?"* or *"How are you usually feeling just before you use drugs?"*

Another line of questioning might be to ask, *"If you weren't to use on these occasions, how would you feel then?"*

Clients can be helped to notice whether they are avoiding discomfort as much as they are seeking out pleasurable experiences.

Once the purpose of substance use has been clarified (feeling free to use whichever term seems to capture ideas – escape, self-medicate, control etc.), you should write it on paper or a flipchart. You should then proceed to elicit examples of the psychological content that have noticed they have been avoiding with substance use.

Each psychological experience should be written on individual pieces of paper and placed in a bin. This physical metaphor conveys that client is the container of their experiences (the bin), and they hold these experiences (the paper).

Facilitators should refrain from screwing up these pieces of paper to distinguish them from later additions. This helps draw out the distinction between clean and muddied discomfort.

During this part of the exercise, the facilitator will need to work with the client to clarify the distinction between external events and internal reactions. Instances of fusion can be evident, where clients are responding to a world structured by thought rather than the world as directly experienced.

For example, if a client states they drink when their partner is being unreasonable, the facilitator might ask, *"Could you give me an example of what your partner is doing when you're having the thought 'they're being unreasonable'?"*

This response highlights the distinction between the partner's actions, and the client's thoughts about those actions. For this client, fusion leads to the perception that their partner's behaviour and 'unreasonableness' are one and the same thing.

Where a client suggests they drink to 'deal with arguments', inquire about how that person feels when they have arguments, and to note it as such (e.g., *"so when you have an argument, you feel angry and frustrated, lets write anger and frustration down and place that in the bin. What happens to anger and frustration when you drink? What happens in that relationship over time?"*).

You should take a genuinely curious and compassionate approach to this discussion. Aiming to model acceptance of whatever content shows up, and validating how clients have been responding to it (e.g., *"It makes sense why you drink in this moment. Who wouldn't want to not feel this stuff – to empty the bin? I'm curious, though, what your experience says about the way things work out when you try to not feel this stuff. What have you noticed?"*).

ATTENTION!

This exercise is a great opportunity to connect with other ACT processes

Adapt it!

Assess whether the client will find the physical bin helpful – if not, then this does not have to be used

Adapt it!

This is an important exercise, but may feel long for some clients – consider completing this over 2 sessions, or allow the client to take it away to think about before completing it in one session

Validate

Be sure to validate and discuss the client's substance use without judgement

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Difficult Thoughts and Feelings are Normal

Note for facilitators: **There are 2 exercises in this section. Please offer both to the client and assess which would be most useful.**

Exercise 1: Thank You, Mind[2]

For Facilitator to say to Client:

Your mind is always busy, working every moment to do its main job, which is to help you survive. Your mind is always on the lookout for danger and more than willing to point it out to you. Your mind is constantly making judgements about what's good or bad for you. Your mind keeps a running commentary on events to try to explain why everything that happens to you happens.

But, sometimes, the mind goes overboard and finds danger when there isn't any. It can make painful judgements or explain things in a way that makes us feel ashamed or wrong.

One way to respond to these thoughts is to thank the mind for its efforts.

As each painful thought shows up, try to use the mantra "Thank you, Mind, for that thought", and then let it go.

This exercise can be done as a long sequence of thank-yous! "Thank you, Mind, for that 'fear' thought… Thank you, Mind, for that 'I'm bad' thought… Thank you, Mind, for that 'judgement' thought", and so on.

Adapt it!

Phrase this exercise in a way that best resonates with the client – it does not need to be a script

Exercise 2: Little Kid [4]

You will need:

- **Paper**
- **A pen**
- **An envelope**

Instructions for Facilitator: This exercise can be emotive and powerful. As such, facilitators should consider the timing of this exercise for clients and ensure they are fully willing to engage in the exercise.

Facilitators should settle the client into a present-moment exercise where, initially, they focus on present moment experiences.

ATTENTION!

Some clients may find this exercise uncomfortable for various reasons – provide the option of using a Safe Word where appropriate

Facilitators should be aware of signs of distress

Ensure a rapport has been developed before completing this exercise

Explain the exercise to the client before completing it

Facilitator to guide Client through Present-Moment exercise:

Imagine that there is filing cabinet in front of you containing all the memories of your life. I am going to now invite you to open the draw and flick back through memories to a time when you were younger – this should not be a trauma memory or anything particularly difficult, just a neutral memory. Pull out a photograph of yourself at this age wherever you were around that time and look at the little kid, your younger self, in this memory; and notice any felt sensations, emotions, or thoughts that show up.

Imagine that you can pour your consciousness into this little kid and experience the world as it is through their eyes. Try to look at the place in or outside the place you were in around that time and notice any thoughts, emotions, or felt sensations in the moment.

Take yourself to the place you would have felt most comfortable and go there as the adult 'you.' Then, see the little kid walk in.

Look at the little kid and notice details, such as what you are wearing, the expression on your face, etc.

Then, provide an opportunity to take a self-compassionate stance toward their own history, thoughts, emotions, and sensations. For example, by saying:

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Taking a look at this little kid, and acknowledging all the pain, suffering, difficulties, wrong choices, and struggles this kid will have to go through to be where you are today, here and now. Knowing that you can't save that little kid from those experiences. And, taking a moment to offer some words of wisdom to this little kid, about how to walk through this history of yours. Not saying this out loud, but kind of speaking to this little kid knowing they can hear you.

Leave some time for the client to engage in this self-compassionate act before moving toward eliciting values and commitment:

And if you could see inside this little kid and acknowledge what this kid really wants from life: be it safety, love, friendship, acceptance, whatever, see if you can just acknowledge that. And, seeing if this is important to you too, here and now. Exploring whether you could give this to yourself as a gift in your actions over the coming days and weeks. And seeing if you can work through to a place where the answer to this is a 'yes,' a commitment to take a stand for something that was important then, that is important now, and guides you into shaping a future that is meaningful to you.

Facilitators should gently lead the client into a few minutes of present moment awareness before ending the exercise.

Following the exercise, inquire into the client's experience of the exercise:

- *What stood out to you in this exercise?*
- *What was your experience of looking at your history from this perspective? Was there harshness in how you treated your younger self, or a kinder stance?*
- *What about the gift to yourself, and this little kid, what stood out there? What might that look like if you were to take a stand for that?*

Following this exercise, you should provide paper, a pen, and an envelope to the client.

The client should be invited to write a letter to themselves in the third person - from the perspective of being a kind, compassionate friend.

They can be encouraged to include what they have learned, or felt was useful, from participating in the ACT treatment.

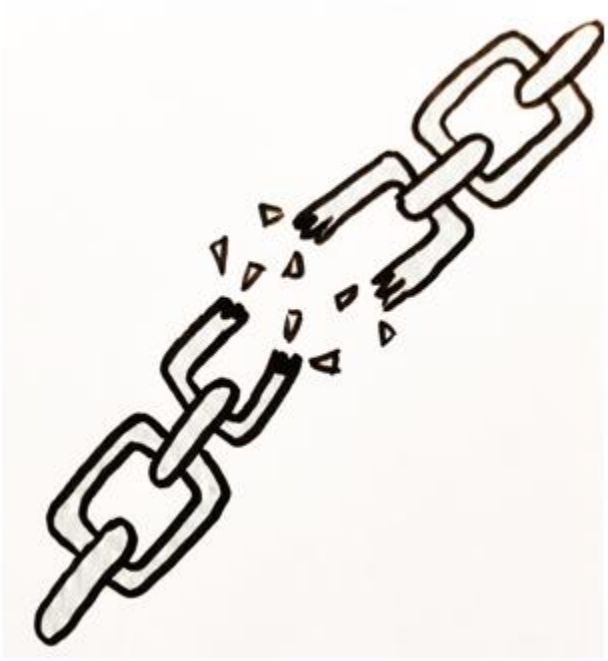
These letters should be completed *without* sharing their content with the facilitator. This point should be made explicit from the start of the exercise.

Once completed, letters should be placed in the envelope, sealed, and the client should write their address on the front.

The facilitator should keep the letter and post it 15 weeks later.

Whilst the content of the letter should remain private, facilitators should inquire about the experience of writing the letter itself.

Session 4: Experiential Avoidance



Session 4: Experiential Avoidance

Note for facilitators:

In session 4, there are 3 exercises to choose from. Only one needs to be discussed. Please consider which would be most appropriate for the client. Here is some guidance:

Exercise 1: May be most suitable if the client likes to reflect on worksheets between sessions

Exercise 2: May be most suitable if the client prefers visual information and videos, followed by a discussion

Exercise 3: May be most suitable if the client finds it difficult to sit for long periods or thinks more literally

Exercise 1: Feeding a Stray Dog Metaphor[4]

You will need:

- **A copy of the exercise summary for the client to take home**

Information for facilitators: The feeding a stray dog metaphor offers a useful summary for clients. Highlighting that by trying to gain control of the dog, we progressively lose control. And the harder we try, the less possible the desired outcome becomes.

Facilitator to say:

This exercise is going to help us to understand that by trying to gain control of difficult thoughts and feelings by doing x, y, and z, we actually lose control. And the harder we try, the less possible it is to get the outcome we want.

So, I'd like to offer a thought about what might be happening here. Here's an example. Imagine that you have this stray puppy turn up at your house one day. It's quite sweet to begin with, but it does make this annoying yapping noise at times. We find that, when the dog makes this annoying noise, feeding the dog some food makes it goes quiet. We gain some control over the dog. But, by feeding the dog, we find the dog starts coming round a little more often, and having eaten, it's gotten a little bigger, louder, and stronger.

So, when the dog comes round the next time, you feed it to keep the noise down. Once again you get control over the dog's annoying behaviour. But the dog turns up more often, and as the dog gets bigger and bigger, it expects to be fed; it learns that baring its teeth and looking big and mean makes us more likely to feed it. Then, it seems to find its own corner in the house and sets up home. So, more and more you find yourself in the kitchen preparing its food, trying to control this dog from barking and showing its teeth. Our efforts to control the

dog end up with the dog controlling us. Might our attempts to control our unwanted thoughts, feelings, and urges be like this?

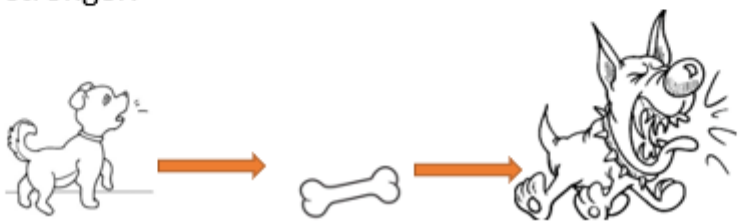
Instructions for facilitators: Debrief client's reflections on the metaphor and what that might suggest about how to deal with cravings, thoughts of using, and / or unpleasant emotions.

Useful questions are:

- *If feeding the dog hasn't worked to keep it quiet, what else could we do? (be careful around responses that suggest getting rid of the dog, getting rid of the dog is trying to control it, which is just more feeding)*
- *How might you go about teaching the dog that barking doesn't result in getting you to feed it?*
- *If you weren't just feeding the dog, how else might you interact with it?*

Summary Sheet

When we want to stop the dog yapping and making noise we feed it because it quietens down. However, the dog ends up in control. As we have been feeding it, it has gotten bigger and louder and stronger.



When we want to stop our difficult thoughts and feelings, we do things such as use drugs and drink alcohol. However, the drugs and/or alcohol end up in control. They no longer stop the difficult thoughts and feelings and we keep having to use even more drugs or alcohol.

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Exercise 2: Quicksand Metaphor: There is an alternative to struggle[5]

You will need:

- **A downloaded version of the video (https://youtu.be/z6JpdCtPr0Y)**

Adapt it!

The client may find it difficult to think of things 'on the spot' – feel free to provide prompts

Facilitator to say: *We have a problem here – your mind tells you to do what doesn't work, because it can't see anything else to do.*

It would be like if you were caught in quicksand. Naturally, you'd try to get out. But almost everything you've learned about how to get out will cause problems in quicksand. If you try to walk, jump, climb, or run, you just sink in deeper because you end up trying to push down on the sand.

If you struggle, wiggle, push with your hands, or crawl, you sink in deeper. Often, as people sink, they get panicky and start flailing about, and down they go.

In quicksand, the only thing to do it to create as much surface area as possible, to lay out on the quicksand, and get everything you have in full contact with it.

It's like that. We need to get everything you have in full contact with what you've been struggling with, but without more struggle.

Facilitator to show the video.

Instructions for facilitators:

- Ask the client what they do to cope when they struggle (this may include using alcohol or substances, behaving in particular ways, etc.)
- Is this like when we try to struggle our way out of quicksand?
- Do they do it in the hope that their difficult thoughts and feelings will go away?
- Does it actually result in further struggle? (i.e., using substances to cope leads to more problems?)
- Emphasise that by learning to connect with our difficult thoughts and feelings can help to reduce how much we struggle with them

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Exercise 3: Holding Something Heavy[5]

You will need:

- **A "heavy object" – this should be a bag with a strap full of heavy items**

Adapt it!

If you feel that the language used in this exercise will be too complex / perceived as patronising / etc. please consider being flexible with the terminology and choose what works best for the client

Facilitator to say: *One thing you can practice between now and next session is to try to become aware of how BPD / EUPD / substance use actually looks when it shows up and how your struggle with it really looks. See if you are willing to notice what shows up and if you can notice all the things you normally do: all the strategies you use when thoughts, memories, feelings, or other internal experiences related to your trauma show up. Getting a sense of what unhelpful strategies are for you is important because even if you stop using them, you will probably find that old habits are so strong that you are using them again only instants later. We will likely have to stop using unhelpful strategies many, many times.*

Note for Facilitators: The heavy object or what is inside of the bag represents the client's unwanted internal experiences. Using a bag allows us to play with the term "baggage". Moreover, it has a strap that can really facilitate carrying the pain while keeping it close.

When asking questions in the next section, take time over this and create a discussion between yourself and the client as they reposition the bag.

Facilitator to say: *Does it ever seem that although your mind tells you to push away from the pain, this increases the pain, makes it stronger? Let's try something if you're willing.*

I'm going to invite you to hold the bag close to you and then to slowly hold it with one hand further and further away. Remember, you don't like this stuff, and so your mind may tell you to keep it as far away as possible. Really notice the effort required to push it away. You'd like to just drop or get rid of this stuff, but you've tried that for a long time, and it doesn't seem to be possible. Holding it away from you kind of works, but for how long? What are the costs? Can you keep it up? Are you able to do anything else while you carry it in this way, or does this solution take all of your energy and focus?

Now, what about if you held it close, in a different position? What is that like? Does it free you up to do something else with your hands? The object has not changed, but your ability to carry it while using your attention and energy on other things has likely changed. Notice that being willing to hold the object, which represents your unwanted "stuff" closer to yourself increases workability.

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Session 5: Difficult Thoughts and Feelings

Session 5: Difficult Thoughts and Feelings

Part 1: Staying with Difficult Thoughts

Note for facilitators:

There are 4 exercises to choose from and you may wish to do more than one. As guidance:

Exercise 1: Is verbal and may be best for those clients who prefer to receive information verbally. It also requires the client to think of a mildly upsetting recent memory.

Exercise 2: Is verbal but has an accompanying visual handout.

Exercise 3: Is a physical exercise and may be preferred by those clients who benefit from more experiential exercises.

Exercise 4: Involves the use of videos and discussions about those videos.

Exercise 1: Choosing to Feel[3]

ATTENTION!

Before doing this exercise, consider the therapeutic relationship you have with the client – if you have less of a rapport, choose another exercise

ATTENTION!

Before doing this exercise, assess the client's current frame of mind. How are they today? If this is a "bad day", consider another exercise

Information for facilitators: This exercise helps clients notice how control strategies for their emotional experience are ineffective and actually create more restrictive behaviour. This teaching point focuses on a core process in ACT: acceptance.

Briefly share with clients that as much as we wish it were the case, we don't have control of feelings in a given moment.

You may want to ask clients the following: "Can you tell yourself to be happy? Can you be sad in this moment? Or can you tell yourself to be angry?"

Finally, ask clients: "How did it work?" Some clients may show a facial expression of happiness or sadness, but explain to them that those are overt behaviours, not necessarily emotional states they can control.

Here is a reality to share with the clients: we feel what we feel, and learning to have fleeting, overwhelming, and unpleasant feelings that come up with requires a particular skill – choosing to feel. This is a core inner skill in response to emotional states when putting values into action.

Information for facilitators: This exercise demonstrates through experience how the client can choose to sit, open up, and get in contact with a feeling – any feeling.

Invite the client to sit in a comfortable position and make themselves as comfortable as possible. If they prefer to stand, that's an option, too. Then read the suggested script:

Facilitator to provide a description of the exercise: *This exercise involves either closing your eyes or focusing on a spot on the floor or wall and paying attention to your breathing.*

I will not ask you to think about anything very distressing or traumatic, but I will ask you to think of a mildly upsetting memory.

Then I will guide you through paying attention to your feelings, bodily sensations, and urges.

Facilitator to say: *For the next couple of moments, I'm going to invite you to either focus your gaze on a single point in the room or to close your eyes, and gently focus your attention on your breathing. Pause for two or three minutes.*

Next, bring into your mind a mildly upsetting moment from last week. I don't want you to think about anything related to significant distress or trauma, just something that was mildly upsetting. And for a couple of moments, notice what happens in your body.

Pay attention to the sensations that come up while holding this memory in your mind. See if you can name the feelings that come along.

Notice their intensity, the thoughts that show up in your mind, and even the go-to actions.

What do you feel like doing? Do you have any urge to suppress or run away from this feeling? If so, see whether you can make some space for it and allow it to be there.

See if you can notice the life of this emotion – how it changes naturally, and how maybe a new sensation comes its way.

Information for facilitators: Gather the client's observations, appreciate them, and do your best to convey that the options of engaging in quick fixes, avoidant responses, and quick gut reactions are always available for clients as much as the choice to feel an emotion, as uncomfortable as it is, when it matters.

ACT is not about forcing clients to be in discomfort (that's called torture!); it's about learning to be in contact with those distressing feelings when it matters as a choice!

Exercise 2: Acceptance of Emotions[3]

ATTENTION!

Before doing this exercise, consider the rapport you have with the client – if you have less of a rapport, choose another exercise

You will need:

- **A copy of the 2-page visual handout for clients**

Facilitator to provide a rationale for the exercise: *This exercise is done to help us to connect with difficult feelings and make room for them.*

This is important because if we can work to get comfortable with feeling uncomfortable, then we can accept those feelings are there while still doing the things which are valuable to us.

Facilitator reads: *I invite you to sit upright in your chair with your back straight and your feet flat on the floor. Most people find they feel more alert and awake sitting this way, so check it out and see if this is the case for you.*

You can either close your eyes or fix them on a spot in front of you, whichever you prefer. Now take a few slow deep breaths, and really notice the breath flowing in and out of your lungs.

Now quickly scan your body from head to toe starting with the top of your head and moving downward. And notice sensations you feel in your head, throat, neck, your shoulders, chest, abdomen, arms, hands, legs, and feet.

Discussion Point: *How does that feel?*

Now zoom in on the part of the body where you're feeling whatever your emotion is most intensely. This could be anxiety, worry, anger, frustration, boredom, or another feeling.

Observe the feeling closely as if you're a curious scientist who has never done anything like this before. Observe this sensation carefully. Let your thoughts come and go and keep your attention on the feeling.

Notice where it starts and where it stops. Learn as much about it as you can. If you drew an outline around it, what shape would it have? Is it on the surface of the body or inside you, or both? Where is it most intense? Where is it the weakest?

If you drift off into your thoughts as soon as you realise it, come back and focus on the sensation. Observe it curiously. How is it different in the centre than around the edges? Is it a

light or heavy feeling? Moving or still? What's its temperature? Are there hot spots or cold spots? Notice the different elements within it. Notice that it's not one sensation. There are sensations within sensations. Notice the different layers.

As you're observing this feeling, breathe into it. Imagine your breath flowing into and around this feeling, breathing into and around it. As you're breathing into this feeling, it's as if in some magical way all the space opens up inside you. You open up around this feeling. Make space for it. Expand around it, however you make sense of that.

Breathing into it and opening up around it. And see if you can just allow this feeling to be there. You don't have to like it or want it; just allow it, just let it be.

Discussion Point: *Is there anything that you have noticed? How does that feel?*

Observe it, breathe into it, open up around it, and allow it to be as it is. You may feel a strong urge to fight with it or push it away. If so, just acknowledge the urge without acting on it, and continue observing the sensation.

Don't try to get rid of it or change it. If it changes by itself, that's okay. If it doesn't change, that's okay too.

Changing or getting rid of it is not the goal; your aim is to simply allow it to let it be. This feeling tells you some valuable information. It tells you that you're a normal human being with a heart. It tells you that you care that there are things in life that matter to you.

And this is what we humans feel when there's a gap between what we want and what we've got. The bigger the gap, the bigger the feeling.

Discussion Point: *How are you doing?*

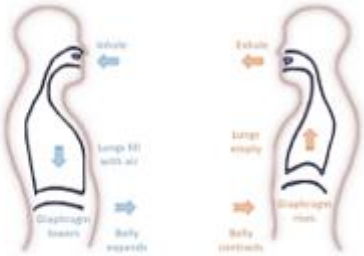
For the last few minutes, start to notice your arms and legs, your head and neck, and notice that you're in control of your body, regardless of how you are feeling.

And just move them around a little to check that out for yourself. And then stretch a little bit, notice yourself stretching.

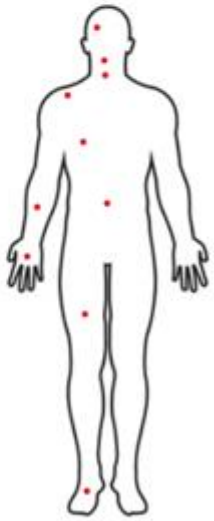
Open your eyes, look around, notice what you can see. Notice what you can hear. Notice that there's not just a feeling here.

There's a feeling here inside a person, inside a room, inside of a world that has opportunity.

Sit up straight, with your feet on the floor - Get comfortable



Notice your breathe going in and out of your lungs



Scan your body

Head, throat, neck, shoulders, chest, abdomen, arm, hand, legs, feet

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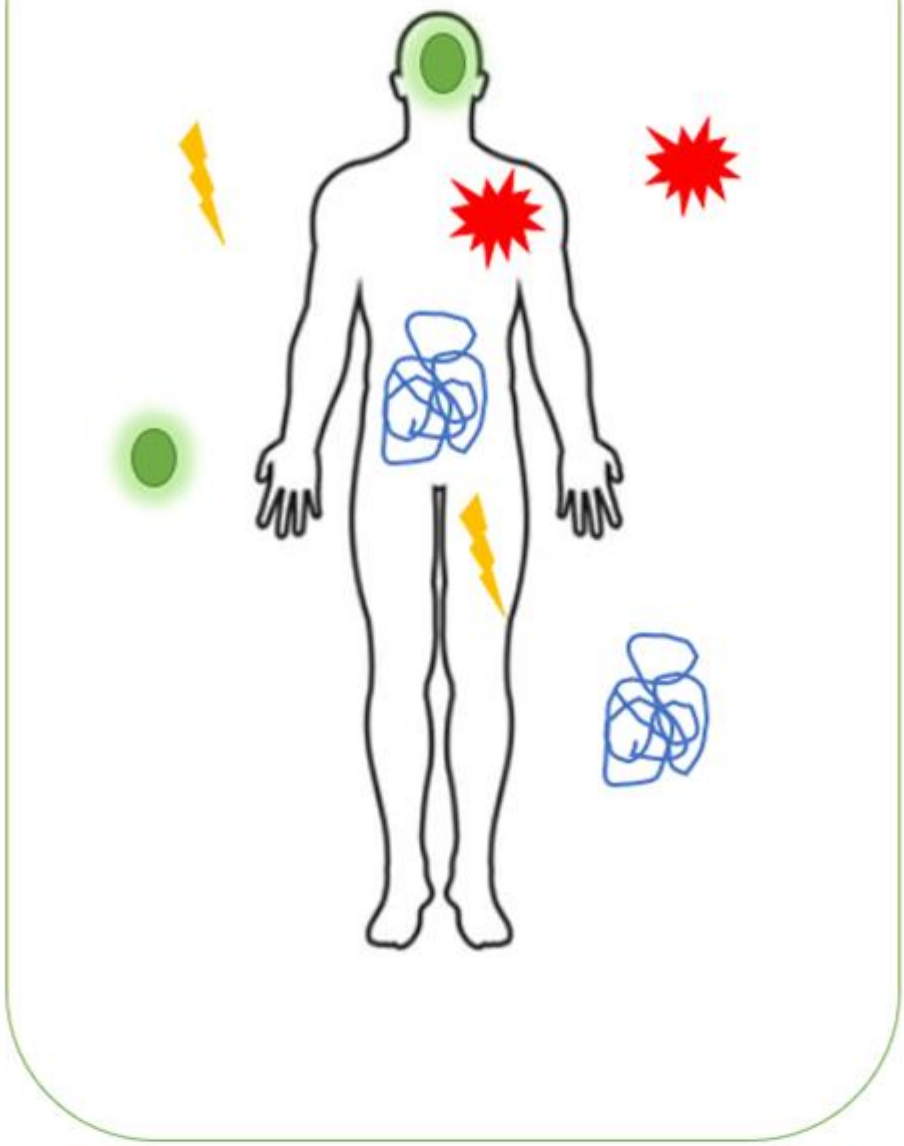

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Exercise 3: Tug of War with a Monster[5]

You will need:

- **A piece of paper with a hole drawn on it – this is your "bottomless pit" which will be placed between you and the client**
- **A rope (or an alternative, e.g., a scarf)**
- **Post-it notes and pen**

Information for facilitators: Acting out this exercise requires a rope. By now, clients will hopefully have gained awareness that their thoughts and emotions can invite them into actions that move them away from their values.

The tug of war with a monster metaphor is a useful way of illustrating this.

It also provides clients with repetition of key aspects of this treatment: Acceptance of thoughts and emotions paradoxically allows greater behavioural control.

The facilitator takes the role of the monster (which represents the difficult thoughts and feelings the client experiences).

Facilitator to say: *Let's imagine your struggle with these thoughts and emotions like being in a tug of war with a monster.*

In between you and the monster (me) is this bottomless pit. Let's think about some of those thoughts and feelings, write them on post-it's and put them in the pit. [Spend time doing this with the client].

So, when this monster (me) makes itself known, it throws out the rope and you catch it. You get into a struggle with this monster. It seems like, through lots of effort, if you could pull this monster into the bottomless pit, you will have won. You won't get to see that thought again, and you can get on and move in directions that are important to you.

But this monster is pretty strong and the harder you pull the harder it pulls. And what's worse, you can feel like you're getting pulled closer to this bottomless pit, so you pull harder and the struggle goes on. If your experience says we can't win the war here, what can you do in this scenario?

Information for facilitators: If the client doesn't offer the idea of dropping the rope, facilitators can gently guide them to consider this option.

Reflection on the metaphor should highlight the idea that 'dropping the rope' with thoughts doesn't get rid of the unwanted thought (the monster is still there), but reduces the discomfort associated with the struggle itself.

Exercise 4: Demons on a Boat / Passengers on a Bus[1]

You will need:

- **Downloaded versions of the 2 videos (links provided below)**

Demons on a Boat: Demons on the boat - an Acceptance & Commitment Therapy (ACT) Metaphor - YouTube

Passengers on a Bus: Passengers On A Bus - an Acceptance & Commitment Therapy (ACT) Metaphor - YouTube

Information for facilitators: This exercise is aimed at bringing all ACT core processes together into a single exercise. Complete this exercise experientially. Encouraging the client to connect with it by asking questions throughout so that they can project themselves into the metaphor.

Facilitator to read: *Keeping committed to our values, as you know, is often not easy. It's often a choice to do something in spite of your mind telling you the reasons why you shouldn't or despite what you may be feeling at the time. We also need to notice that there is effort involved in keeping committed to our values and that there are costs to not following through with valued commitment. This video is to help us think about this some more.*

Facilitator to play video

For the Demons on a Boat metaphor:

- Discuss the video after it has played with the client. What did they take from it?

Points to consider:

- The demons are the client's difficult thoughts and feelings
- The client wants to do what they value – this is represented by the man in the video wanting to go to shore
- Every time the man goes to shore (which is what he wants to do), his difficult thoughts and feelings pop up (the demons)
- The question facing the client is: can they see that it is possible to get to shore (do what they value) and really and fully do that while the demons are there? They can welcome the demons even if they don't like them and they say horrible things. The client does not have to like the demons and what they do or say. Their opinion of the demons if different from their willingness to have them around.
- The client could decide that the demons are not welcome, that they need to put up a fight and struggle to get rid of them. But as soon as they do that, they have to give up what they value (go back to sea and be lonely). This is a lot of work without really getting anything they want.
- We can choose to welcome the difficult feelings and thoughts (the demons) even though we don't like them.
- What has the client's experience been like with not being willing to have difficult thoughts and feelings?

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- How has their struggle with their mental health improved their quality of life? What have been the costs to their values of buying into unwanted thoughts and urges?
- Has their struggle and use of alcohol / drugs allowed them to pursue the things they value?
- From your discussions with the client, does it seem that something in particular as a barrier? A demon? How could they approach things differently so that it would not throw them off of following through with their valued actions?

For the Passengers on a Bus metaphor:

- Discuss the video after it has played with the client. What did they take from it?

Points to consider:

- The passengers are the client's difficult thoughts and feelings
- The client wants to do what they value – this is represented by the bus driver wanting to drive down roads that encourage him to "follow his dreams" and "take a chance"
- Every time the man goes down one of these roads (which is what he wants to do), his difficult thoughts and feelings pop up (the passengers start saying horrible things to him)
- One of the passengers (the lady with glasses) appears to be helpful at first – but she is also wanting him to do as the passengers say which stops the bus driver from driving down the roads he wants to go down
- The question facing the client is: can they see that it is possible to drive down those roads (do what they value) and really and fully do that while the passengers are there? They can welcome the passengers even if they don't like them and they say horrible things. The client does not have to like the passengers and what they do or say. Their opinion of the passengers if different from their willingness to have them around.
- The client could decide that the passengers are not welcome, that they need to put up a fight and struggle to get rid of them (by doing what they say). But as soon as they do that, they have to give up what they value (go back to driving where the passengers tell him to). This is a lot of work without really getting anything they want.
- We can choose to welcome the difficult feelings and thoughts (the passengers) even though we don't like them.
- What has the client's experience been like with not being willing to have difficult thoughts and feelings?
- How has their struggle with their mental health improved their quality of life? What have been the costs to their values of buying into unwanted thoughts and urges?
- Has their struggle and use of alcohol / drugs allowed them to pursue the things they value?
- From your discussions with the client, does it seem that something in particular as a barrier? A passenger? How could they approach things differently so that it would not throw them off of following through with their valued actions?

Part 2: You are separate from your feelings and thoughts

Note for facilitators: Please aim to complete Exercise 1 and then either Exercise 2 or Exercise 3.

Exercise 1: The Inner Voice[3]

ATTENTION!

This exercise may be difficult for those who do not speak fluent English, as some of the idioms may not exist in other language – consider other exercises if relevant

Facilitator to say:

Today we are going to talk about our inner voices in relation to 4 important points. These are:

1. *Our inner voice's tendency to create associations,*
2. *Its natural ongoing activity,*
3. *The natural evolution of the inner voice as a "danger detector", and*
4. *The protective function of the inner voice.*

The inner voice's natural tendency to create associations:

From the time we are born our inner voice learns from our experiences, and because of language, it constantly forms associations with the millions of experiences we have had in our lives. It doesn't matter how old we are – our inner voice always has and always will do this.

If I ask you to complete a sentence: "Keep your friends close, and your…" what does your inner voice say? [it will say "enemies closer"]. *And what if I say, "There's no place like…"* [they will say "home"]. *These are examples of how our inner voice will hold onto these learned associations our entire lives, even when we don't want them or when these associations have nothing to do with what we are doing.*

Discussion point: *Does that make sense? What do you think about that? Can you think of any experiences you have had that remind you of other experiences you have had?*

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The natural ongoing activity of the inner voice:

If we pay close attention to our inner voice, we will find that it is constantly chattering in the back of our mind about all types of things. It doesn't ever have a day off. It's on all the time – comparing, analysing, evaluating, planning – and we don't have control over what shows up in our mind, in the same way we don't have control over what shows up on the screen on our TV.

Discussion point: *Does that make sense? Do you ever find yourself comparing things? Or planning? O analysing?*

The natural evolution of the inner voice as a "danger detector":

Our ancestors were exposed to all kinds of threats and dangerous situations. These included things like bad weather, challenging territory, wild animals, or enemies within or outside of their group.

To survive, they had to be able to keep track of what could go wrong and what went wrong. So, in order to stay alive, our ancestors constantly relied on their inner voice telling them, "Watch out, that could be dangerous; watch out, that looks similar to what you went through before".

Over time, the inner voice evolved as a "danger detector" and even now, continues to do this, even though we're not living under prehistoric conditions anymore.

For example, people scared of having a panic attack might pay constant attention to any changes in how their body feels, whether it's their heart beating fast, butterflies in their stomach, having a dry mouth.

Our emotions go to things like fear, and the inner voice does its job and comes up with thoughts like, "Is this a panic attack? Watch out, it could be one of those moments!"

Discussion point: *Does that make sense? Do you have any thoughts about it?*

The natural protective function of the inner voice:

Because our ancestors were constantly in danger, their inner voice, as a danger detector, was in charge of protecting them from all potential threat or danger.

These days, our inner voice is doing exactly the same thing; protecting us from being hurt. So, with the person who was struggling with panic attacks, their mind is just naturally protecting them.

Discussion point: *Does that make sense? Do you have any thoughts about it?*

Exercise 2: Eyes On[1]

ATTENTION!

Consider risk as well as whether this exercise will do what it is aimed to do – If doing the exercise increases risk or the client would not benefit from it, choose another exercise

ATTENTION!

Consider neurodivergence and / or cultural difference for this exercise – would this be distressing or socially unacceptable? If so, choose a different exercise

Information for facilitators: This exercise can be powerful for clients because it involves emotional exposure that supports the acceptability of whatever shows up.

The thoughts, feelings, beliefs, etc. of clients should never be invalidated or challenged by the facilitator. This is essential because it models the proper relationship for the client to have towards their experience.

The issue is not the content of their thoughts, feelings, memories, or urges; it is what they choose to do with it.

Facilitator to say: *This exercise is all about getting some practice with being willing to experience difficult thoughts and feelings.*

As a part of that, it involves us having eye contact because this usually brings up unwanted thoughts and feelings.

The challenge is to keep eye contact even though those difficult thoughts and feelings show up. It won't be an easy exercise, but no harm will come to you.

This exercise can be challenging in certain ways, so we'll take it slow and we will practice several times. All I ask is that you do your best to notice what feelings, thoughts, and urges come up and see if you can just have these, without reacting automatically, even if only for a moment or two.

When a thought or feeling or urge show up, just say to yourself, "I just had a thought about…and fill in the blank," "I am feeling…and fill in the blank," and when you have the urge to do something just notice the urge, but choose not to follow it, even if just for a moment.

If you are willing, let's begin by sitting across from each other, and look at each other's eyes and make eye contact.

Now watch what arises and see if you can just make note of what thoughts, feelings, and urges come up but be willing to have them without automatically averting your gaze.

If your mind tells you to do something other than keep eye contact, just make a mental note of it.

The point is not to grit and bear it, but to take a breath, notice the feeling or thought, and breathe out, continuing to make eye contact with me. If this exercise becomes too

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challenging, you can turn away for the moment, but then see if you can come back and return to looking at me. Just tell yourself what you notice while continuing to choose to keep eye contact with me.

Information for facilitators: [If the client turns away or moves back, normalise their difficulty and then invite them to come back to the exercise.]

- If the client struggled with the exercise, repeat it, sitting further apart and making intermittent eye contact (facilitator breaks away and then comes back).
- Tell the client you will be doing that and provide the rationale that this takes practice, small steps, as the client is learning a new skill that is difficult.
- It is hard to keep eye contact with someone. The facilitator should also share their thoughts, feelings, and urges during the exercise.

Facilitator to say:

- *What sort of things came up for you during the exercise?*

Exercise 3: Observer[1]

ATTENTION!

Please be aware of the client's past trauma – you will be asking for memories from childhood, adolescence, and adulthood – these can be happier memories

ATTENTION!

During this exercise, please assess for signs of distress

the client may also find it helpful to have a "safe word"

ATTENTION!

The client may wish to engage in this exercise, but it still may cause distress – consider harm reduction after completing the exercise

Information for facilitators: The observer exercise is designed to help clients make experiential contact with a 'self' separate from the content of experience.

It is an eyes closed exercise which invites a variety of different psychological content so that the consistent place where that content has always been experienced (i.e., self-as-context).

Facilitators should engage the client in an eyes closed mindfulness exercise aimed at noticing present moment experiences for a few minutes.

Facilitator to say: *I am now going to invite you to take part in an exercise which is about noticing your thoughts, feelings, and urges. It's like the you that sees you.*

I will ask you to think of a memory, but I want to make it clear that this can be any memory – it can be happy, neutral, or mildly difficult. However, it should not be a distressing or trauma-related memory.

So now I want you to close your eyes or fix your gaze on a spot in the room and pick a memory from last year. When you have a memory raise a finger so I know when to carry on.

Now that you have a memory, I want you to step into that memory and get behind the eyes of the you that was there. I want you to think about what you can see. What can you hear? How do you feel? What do you feel?

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Notice who is noticing these things. Notice the part of yourself that is noticing this. in some deep sense, the you that was there then, is here now.

Notice how your body has changed and grown and that sometimes you are ill and sometimes you are healthy....but notice who notices that physical self...and although you have a body, you are also not that body.

Notice how over the years emotions come and go, sometimes happy, sometimes, anxious, sometimes not feeling anything much....but notice who notices these emotions...and that although you have emotions, you are not your emotions.

Notice roles in your life...even being in the role of client or group member right now...but who notices this role...although you have roles, you are not those roles.

Notice how at one time you had few thoughts, thoughts and beliefs have changed and grown. But notice who notices this...although you have thoughts, you are not those thoughts.

Instructions for facilitators: Repeat the above procedure for two more memories – one from their teenage years and one from their childhood. Each time, have the client notice who is noticing, and to notice the part of themselves has always been there.

Clients should end the exercise with a return to mindful awareness of the present moment for a few minutes.

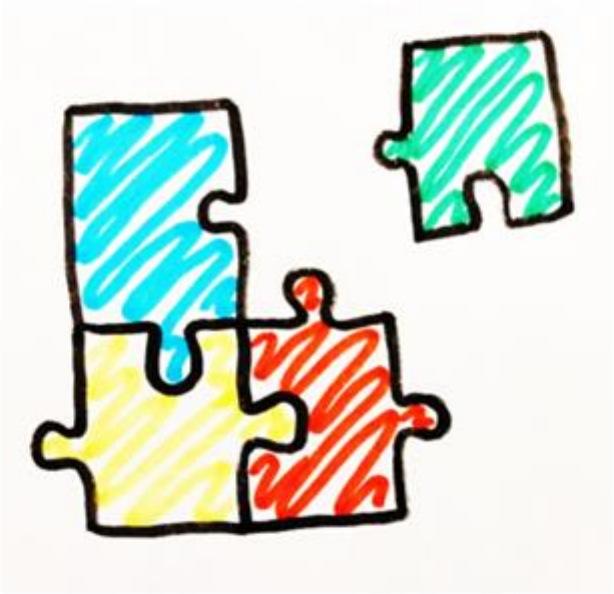
Following the exercise, invite the client to reflect on their experiences of the exercise, reinforcing where appropriate the distinction between the '*noticer*' and the '*noticed*'.

Facilitator to summarise: *There is a part of you that is bigger than the cravings, thoughts, emotions, and urges you struggle with. Furthermore, it is not damaged by those experiences.*

This means, that when we experience a difficult thought, emotion, or urge, there is a part of you that is notice who's noticing that experience, to step back into board level – the observer self – and make room for that experience.

Then ask, what is the most workable action I can take, right here and right now? And then, take those experiences along for the ride.

Session 6: Thoughts are Not the Whole Person



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Session 6: Thoughts are Not the Whole Person

Note for facilitators:

Exercise 3: May be particularly useful for clients who engage in negative self-talk.

Exercise 1: I Can't Lift my Arm[1]

Adapt it!

Be aware of the delivery of this exercise – in particular, consider whether the client will find it patronising and adapting it to maximise the benefits for them

Facilitator to say: *If you're willing, let's try something right now. At the moment I am having the thought that you might think that what I am about to suggest we do is silly. However, I think that it could be helpful and so I am going to allow that thought to be there and still try something that might be helpful.*

I'd like you to repeat a phrase silently to yourself, just say to yourself "I can't lift my arm." Say it over and over again in your head a couple of times… keep saying it in your head and while saying it, lift your arm up… So, you can lift your arm even though your mind says you can't. You could do this with all sorts of words, like "I can't go in there," "I need to get out of here," "I can't handle this."

You could do this with all sorts of thoughts, like "I can't go in there" while managing to go into a place, or "I need to get out of here" while staying there, or "I can't handle this" in a difficult situation that you are working to solve.

Facilitator to discuss after the exercise is complete: *How did that exercise feel? What this exercise tries to get across is that even though our mind sometimes puts out thoughts that we cannot do something, it does not mean that we can't do it. Our thoughts can lead us to consider behaving in different ways, but we don't have to pay attention. Are there any thoughts that your mind puts out?*

Of course, the specific situation is important. For example, if you are not physically safe in a place, then do not go into or stay in it. But if your mind is telling you that you cannot do something, recognise that as a thought and remember that you can do things even when your mind tells you otherwise.

Exercise 2: Leaves on a Stream[2]

ATTENTION!

Before doing this exercise, consider the rapport you have with the client – if you have less of a rapport, consider choosing another exercise

If you decide a practical element would be helpful for the client, you will need:

- **A picture of a stream / a model of stream with water**
- **Paper leaves**

Information for facilitators: This exercise provides the client with an opportunity to practice stepping back and looking at thoughts, rather than from them. It is also practice at noticing when they have been 'hooked' by a thought (experientially *in* the thought, rather than looking *at* the thoughts floating on a leaf in front of them).

Firstly, facilitators should provide an explanation of why they are inviting the client to take part in this exercise.

Facilitators should help the client centre into the present moment and bring their awareness to the ongoing flow of experience. If done verbally, the client can complete this exercise either with their eyes closed, or with their gaze fixed on a spot in the room.

Invite the client to imagine sitting on the bank of a river, with a slow-moving stream in front of them, and leaves floating past. With this image in mind, instruct the client to simply watch for thoughts.

When they notice a thought, instruct them to *catch* that thought and place it on a leaf out in front of them so that can look *at* it. If the client finds a leaf with a thought on is getting stuck, they should allow it to be there until it moves on.

The intention is not to get rid of the thoughts, but to allow them to come and go at their own pace.

The client should be advised to let the thought float by in its own time. And, meanwhile, look for the next thought to show up, catch, put on a leaf, and watch float past. They should continue this exercise for at least five minutes.

Facilitators should also invite the client to notice when they find themselves immersed *in* a thought rather than looking *at* it. If this happens, they should take a moment to see if they

have been 'hooked' by that thought, and are 'buying into' the literal truth of its content. If this should happen (highly likely) they should notice it, place that thought on a leaf, and continue with the exercise.

Following the exercise, facilitators should debrief the client's experience of the exercise.

If you are using the version where the client wishes to use paper leaves, ask the client to write their thoughts down on each leaf or offer to write for them. The client can choose to move the leaves down the stream, or ask for the facilitator to do this as they watch them and complete the exercise.

Exercise 3: Card Carrying[3]

You will need:

- **A piece of card / client smartphone**
- **A pen**

Facilitator to say: *This exercise gets the thoughts out of your head and onto a card that you carry with you. Get some card and put it in your pocket so that you'll have it with you as you go about your daily routine. If you don't want a card with words on, you could have one with pictures. If you don't want a card at all, you could use voice notes (if you have a phone that does them) or just say these things to yourself in a mirror.*

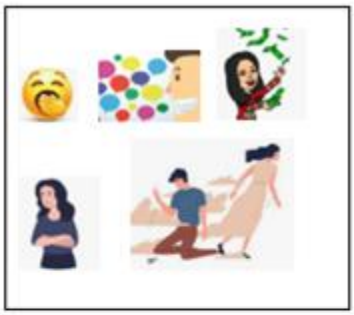
Another option is that we could write on a card in the session and either throw it away when we're done, or I can keep hold of it and you can look at it in our sessions together. The idea of this exercise is that when a particularly troubling thought occurs to you, write it down on the card. When the thought returns, tell yourself, "I don't have to think about this, it's on the card".

Example:

I'm Brian. I'm twenty-two years old. I used the card-carrying technique after a weekend trip with my new girlfriend, Sally. I had been nervous about everything going smoothly and us having the perfect time. Whenever Sally seemed distracted or quiet, I had thoughts that she was bored or angry with me. I worried about spending too much or too little money, wanting to give just the right impression of being neither a cheapskate or a spendthrift. I tried to keep a conversation going every moment, which led me to blurt out some things about my old girlfriend that perhaps would have been better left unsaid.

On Monday, my mind was rehashing the weekend so constantly that I couldn't concentrate. Monday night and Tuesday I carried a card around. Here is what my card looked like by Tuesday night:

I'm boring
Talked too much
Stupid about money
Offended her somehow
She thinks I'm weird
She'll dump me
Blabbermouth



Having this card in my pocket helped me disconnect from my difficult thoughts about my unworthiness and ineptness around women in general, and Sally in particular.

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Exercise 4: Milk, milk, milk[5]

ATTENTION!

Before doing this exercise, consider the therapeutic relationship – if this is damaged in some way, choose another exercise

Adapt it!

Be aware of the delivery of this exercise – it can be difficult for people – feel free to be daft / silly with it!

Instructions for facilitators:

Facilitator to say: *At the moment I am having the thought that you might think that what I am about to suggest we do is silly however, I think that it could be helpful and so I am going to allow that thought to be there and still try something that might be helpful.*

Say "milk" - what came to mind when you said that?

Instructions for facilitators: Explore various functions (e.g., something you drink, something cows produce, something nice, something you put on cereal, etc.).

Facilitator to say: *OK, so let's see if this fits. What shot through your mind was things about actual milk and your experience with it.*

All that happened is that we made a strange sound – milk – and lots of these things showed up. Notice that there isn't any milk in this room. None at all. But milk was in the room psychologically. You and I were seeing it, tasting it, feeling it – yet only the word was actually here.

Now, here is the exercise if you're willing to try it. The exercise is a little silly, and so you might feel a little embarrassed doing it, but I am going to do the exercise with you, so we can be silly together.

What I am going to ask you to do is to say the word "milk" out loud, rapidly, over and over again and then notice what happens.

Are you willing to try it?

Instructions for facilitators: Say "milk" over and over again for 1-2 minutes, and periodically encourage the client to keep it going, keeping saying it, or to go faster.

You can also invite the client to say this in a higher or lower-pitched voice, or in silly voices (consider your therapeutic relationship with the individual client).

Debrief what happened as the functions disappeared and only a sound remained. You may want to ask specific questions, such as:

- *What did you notice as you said the word over and over again?*
- *Did this change the meaning of the word 'milk' that you had when we started thinking about it?*

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- *What does this tell you about other thoughts you might have, like words you might use about yourself?*

You may also wish to say:

Milk is a fairly neutral example. If it feels okay to, I would invite you to do the same about one of the words you have used about yourself, such as [insert word used by the client, such as 'failure']. Repeat the exercise using this word.

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Session 7: Not Distracting Ourselves from Unwanted Thoughts and Feelings

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Connecting with the Here and Now

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Session 7: Not Distracting Ourselves from Unwanted Thoughts and Feelings

&

Connecting with the Here and Now

Part 1: Not Distracting Ourselves from Unwanted Thoughts and Feelings

Note for facilitators: Please complete the exercise with all clients.

Exercise: When You're Triggered, FACE[3]

You will need:

- **2 FACE cards for the client to take away with them**

Facilitator to say: *We're going to shift from practising acceptance and defusion in situations we remember to doing it in real life. When you're hit suddenly by difficult emotions, we encourage you to use a response called "FACE" which is an acronym for:*

1. *Feel*
2. *Accept*
3. *Call thoughts a name*
4. *Express intention*

These are all things you've practiced before, but now it's time to do them as you are triggered. The first step is to open yourself to the emotion. Running away has bruised your relationships. The best thing to do is observe the feeling and find words to describe it.

Next, accept this experience. A difficult emotion has shown up in your life, and it will run its course. It is weather that will exist for a while in your sky. Let this feeling be what it is. Make room for it.

As thoughts show up, give them a name: ***"I'm having a judgment thought… I'm having a scary thought… I'm having a failure thought… I'm having a "why" thought (trying to explain why things happen").*** *Make up your own labels. And abbreviate the label if that feels better (worry thought, bad thought).*

The last step of FACE is to express your intention. Based on your values, what actions have you committed to in this relationship? if you could be the person you want to be, what would you do right now? Then do it.

Notice how FACE gives you an opportunity to expose yourself to feelings and defuse from thoughts as they show up. We know this isn't easy, and there will be triggering situations where you fall back into old patterns of thinking and feeling.

One way to increase the likelihood of using FACE is to create reminders. Put a FACE sign up on your bathroom mirror, in your pocket, by your bed, or anywhere else you will see it regularly. Let these reminders help you stay aware of your commitment to FACE.

Here's an example from a client who has used this before:

I decided to use FACE, initially, with situations that came up in this group I belong to. I find that people there frequently hurt me. The next time I was triggered, I actually used it. I watched the feelings (hurt, worthlessness) and thoughts (judgments, "why" thoughts). Then, instead of withdrawing, I acted on my intention to clarify the other person's motivation in saying what he or she said. I was pleased with myself and then I promptly forgot to use FACE. I got triggered a number of times, once to the point where I flew out of a meeting and considered quitting.

Three weeks went by. I was about to visit my dad, and I thought about FACE again. The man drives me nuts – opinionated, full of advice, critical. This time I decided to use the FACE card.

Notes for facilitators:

- Encourage the client to take a card and put it somewhere they will see it regularly (for example stuck to a mirror)
- Encourage the client to put a card in their purse / wallet
- If the client has a smartphone, they could also write it in their notes, have it as a picture in a file or as a background
- Give the client the opportunity to practice this during the session

Card:

FACE

Feel

Accept

Call thoughts a name

Express intention

Part 2: Connecting with the Here and Now

Note for facilitators:

The client may choose to use all of the following four exercises, and all should be suggested. However, if the client would like to choose one or two:

- **Exercise 1 (SOBER Breathing):** May be more useful for those who like verbal information and something to look at between sessions.
- **Exercise 2 (Focusing on Activities):** May be more useful for clients who struggle to find opportunities to connect with the present moment.
- **Exercise 3 (Focusing on Walking):** May be useful for clients who struggle to sit still in sessions. If the client is not mobile, this can be adapted for them.
- **Exercise 4 (Focusing on Conversations):** May be useful for clients who struggle in their interactions with other people.

Exercise 1: SOBER Breathing[5]

You will need:

- **A copy of the "Client Summary" for the client to take away with them and / or look at during the session**
- **A copy of the "SOBER Card" for the client to take away with them and / or look at during the session**

Facilitator to say: *We want to begin to bring a specific practice into our lives in a way that can help us cope with daily challenges, stressful situations, triggers, etc., while not reacting in a way that isn't in our best interest.*

This is an exercise that you can do almost anywhere, anytime, because it is very brief and quite simple.

Often when we are triggered by things in ourselves, such as pain, or in our environment, we tend to go into "automatic pilot," which can result in us behaving in ways that are not in our best interest.

This is a technique that can be used to help us step out of that automatic mode and become more aware and mindful of our actions.

Just to note also, that the fact that this exercise is called "SOBER breathing" is not an expectation for you to get sober – it is just the first letters of each of the steps put together to help us remember the name of the exercise.

The steps are:

1. ***Stop** – Stop or slow down right where you are and make the choice to step out of automatic pilot by noticing this moment.*

2. ***Observe*** *– Now shift your attention from the "story" of what's happening to you, to your internal experience. Observe what is happening in your body, your emotions, and your thoughts.*

3. ***Breathe*** *– Gather your attention and focus simply on the sensations of breathing.*

4. ***Expand*** *– Expand awareness again to include a sense of the whole body and the situation you are in.*

5. ***Respond*** *– Now notice that you can respond with mindful awareness. Notice how this is different from reacting automatically.*

Let's try this now. You may either close your eyes or keep them open.

1. *The first step is to stop, stepping out of automatic mode.*

2. *The next step is to observe what is happening in your mind and body right now. What is your experience in this moment? What sensations do you notice? Is there any discomfort or tension in your body? What thoughts are present? What emotion might you notice and where is that in your body? Just acknowledging that this is your experience right now.*

3. *So, now you have a sense of what is going on right now in this moment. Now gathering your attention, focusing attention on the breath, the rise and fall of the abdomen, moment by moment, breath by breath, as best you can.*

4. *And the next step is to allow your awareness to expand and include a sense of your entire body. Holding your entire body in this softer, more spacious awareness.*

5. *Sensing that this is a place from which you might be able to respond to any situation with more awareness.*

And then, when you are ready, very gently just allowing your eyes to open.

What did you notice about this experience if anything?

Summary

STOP

- Step out of automatic mode

OBSERVE

- What are you experiencing?
- What sensations do you notice?
- Any discomfort or tension in your body?
- What thoughts are you having?
- What emotions are you feeling?
- Where is that in your body?

BREATHE

- Pay attention to your breathing
- Your stomach rising and falling

EXPAND

- Expand your focus to your whole body
- Hold your body in this softer, bigger awareness

RESPOND

- This is a place where you can respond while keeping focus

S – Stop

O – Observe

B – Breathe

E – Expand

R - Respond

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Exercise 2: Focusing on Activities [3]

Adapt it!

You may feel that not all of the items on the list are relevant for the client (i.e., maybe they do not garden, etc.) – this is okay – just edit the list and choose the items you feel will be of most benefit

You will need:

- **Anything that would help the client practice the exercise (for example, food or drink)**
- **A copy of the list for the client to take away**

Note for facilitators: Please provide the client with the opportunity to practice at least one item on the list during the session

Facilitator to say: *Focusing on what we do and noticing every moment is not just about watching what we are experiencing inside. It's something you can learn through ordinary activities that you do every day. Instead of doing them in the usual distracted fashion, you can perform these tasks with full awareness.*

This is an important skill as it helps us to focus on the here and now, and recognise the thoughts and feelings we have.

Here are some examples:

Focusing on dishwashing: noticing the warm water, the slippery soap, the hard edges of dishes and utensils, the sound of the running tap.

Focusing on walking: noticing the pressure of your steps (perhaps counting them), the sway of your hands, the shifting balance, the sights, sounds, and smells.

Focusing on gardening: noticing the cool feel of the soil, the tug while you are pulling weeds, the thrust of pushing in a trowel, the smell of flowers.

Focusing on bathing or showering: noticing the sound and feel of the water, the slippery soap, the shifting sensations as water sprays on various parts of your body.

Focusing on eating: start with a snack or a light meal. Noticing the texture or temperature of the food, the smell and taste, the sensation of lifting a fork or spoon.

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Focusing on drinking: noticing the liquid in your mouth, the temperature, the viscosity, the smell and taste, the feelings in your throat and stomach, the texture and weight of the glass or cup.

The goal, of course, for focusing on activities is to stay with your sensory experience. If thoughts or other private events come up, you can note them while returning your attention to your five senses.

Focusing on one or more activities each day strengthens the skill of self-observation. It helps you learn to notice your experience – moment to moment – and to accept the experience for what it is, without judgment.

We suggest starting by focusing on one or two activities this next week and committing to a specific time to do them. And then add one new activity each week thereafter until you are focusing on four to five activities each day.

Note that you don't need to take a lot of time with these activities. Rather, they are brief opportunities to be here, now.

Example

I'm Sam. I was sceptical about whether focusing on activities would be of any value to me. I chose 'focusing on drinking' as my first activity, using my morning coffee for the exercise. I began by simply holding the mug, feeling its warmth in my hands. Then I felt the steam on my face and noticed the aroma. As I began to drink, I felt the sensation of each sip, the sudden heat and bitter taste in my mouth.

Sometimes I'd lose concentration and start thinking of things I had to do that day. And I'd realise I had drifted off and then would go back to the smell and taste. I actually enjoyed the coffee more when I paid attention.

During the second week, I added 'focusing on a shower' and 'focusing on walking' the 20 minutes to the shop. So, I was focusing on these three activities in the morning – and that's when I started to see a change. I was calmer and more aware at the same time. I was settled inside myself, yet super aware of what I was feeling and doing, I felt awake.

Exercise 3: Focusing on Walking[5]

Adapt it!

If it is not possible for you to do this physically with the client, consider doing this over the phone, or via a Recovery Connector

This can be done outside or in the corridors of the service

If you or the client has mobility issues, you can adapt the exercise to include, for example, arm exercises

Troubleshoot

Plan sessions to give the best chance of facilitating where to go with clients – there may be places that are more comfortable than others for them to go

Information for facilitators: There are several ways to practice focusing on walking. As with each of the practices, this exercise is best led from experience. The facilitator might narrate the process they are engaging in while focusing on walking themselves.

Focusing on walking or other movements can be led as a formal, structured practice ("lifting, placing, shifting") or as a more open awareness of the whole process allowing a curious, even childlike quality (What is it like to walk / move in this way? What do the feet / arms feel like as they move? Notice all the muscles it takes to move the leg / arm). The facilitator might suggest imagining walking for the first time, as though having just dropped into this human body; and our job is just to observe it as it walks.

Clients might experiment with different speeds. To begin with, one might walk at a pace that is slower than usual, to give oneself a better chance to become fully aware of the sensations of walking. Once clients feel comfortable, walking slowly with awareness, they might experiment with walking at faster speeds. If agitation or restlessness arise, it might be helpful to begin walking faster, with awareness, and to slow down naturally as the mind settles.

Focusing on walking can be done "formally," in one's home or an appropriate outdoor area, or "informally," outside or in public, in day-to-day life. The practice can be a way to check in as one moves through the day. While walking to get somewhere, one might practice the "4 Modes" by noticing how the body feels, then shifting to awareness of sounds, then to the experience of seeing, then to the breath. Or one might simply stay with physical sensations of walking.

Often people feel awkward, silly or self-conscious while doing this exercise. Awareness of these reactions, too, is part of the practice. It can be helpful to include all of this when leading the exercise, encouraging clients to notice whatever arises including any thoughts they are having about the exercise, or feelings of embarrassment or silliness, and then focusing again on the experience of walking.

When possible, lead the client through the initial instructions, and then have them move into a larger area to practice on their own for a while. We encourage clients to pick a short

length of ground, and walk the length of that course, turn, and walk back in the opposite direction. The idea is to experience just walking versus trying to get somewhere. In certain settings it is not possible to walk back and forth or leave the room to practice, in which case we might stay in the room and walk in a circle.

Walking Exercise

Facilitator to say: *For this exercise we will have our eyes open. Begin by simply standing with your knees soft and arms just resting comfortably at your sides. Letting your focus be soft, maybe just resting on the ground a few feet in front of you. Now bringing your awareness to the bottoms of your feet, sensing the physical sensations of your feet contacting the floor and the weight of your body supported by your legs and feet.*

Allow your weight to shift very gently over to the left side, so that the left leg is bearing the weight and the right leg is light. Feeling how the left leg becomes "full" and the right sort of empties out. Now shifting the weight back to centre, noticing how the body knows where that is. Maybe noticing if there are any urges to shift to the other side. Now, allowing the weight to shift to the right, transferring the weight onto the right leg.

Now very slowly taking a step with the left leg, staying with all the sensations as you do this. Feeling the left heel come off the floor, the muscles contracting, the joints moving. Placing that foot down on the floor in front of you and allowing the weight to shift a little onto that foot. Pausing here for a moment. Noticing if there are any urges present – maybe to move the right leg.

And then moving the right leg – lifting the heel, moving the leg forward, placing the heel then the whole foot on the ground, then shifting the weight forward onto the right leg.

Continuing in this way, lifting the leg, moving it forward, placing it on the ground. Walking in this way, being aware, as best you can, of physical sensations in the feet and legs, and of the contact of the feet with the floor. Keeping your gaze directed softly ahead. You might label the movements of each step as a way to focus your attention: "lifting, moving, placing."

Now, try shifting the attention to different modes of experience. You might start with physical sensations in the body, or even just the bottoms of the feet. Then, when you reach the end of your path and need to turn around, pause and shift attention to sight. As you walk, bring your attention to the experience of seeing. When you reach the end of your path or a place where you need to turn around, take that opportunity to shift again, this time to sound. As you walk, bring your attention to the sounds, to the experience of hearing. Then when you are ready, shift to the sensations of breathing (or smell, if you are outside).

Arm Movement Exercise

Facilitator to say: *For this exercise we will have our eyes open. Begin by simply sitting with your knees soft and arms just resting comfortably at your sides. Letting your focus be soft, maybe just resting on the ground a few feet in front of you. Now bringing your awareness to your hands, sensing the physical sensations of your arms contacting the sides of your body.*

Allow your left shoulder to move upwards if this is comfortable, so that your left shoulder moves closer to your ear, and let the right arm stay where it is. Feeling how the left shoulder becomes "full" and the right sort of empties out. Now shifting the left shoulder back to where it was in the centre, noticing how the body knows where that is. Maybe noticing if there are any urges to shift to the other side. Now, allowing the right shoulder to move upwards towards your ear and then slowly back down again.

Now very slowly moving the left arm upwards, staying with all the sensations as you do this. Feeling the left arm move from your side, the muscles contracting, the joints moving. Placing that arm back to where it was. Pausing here for a moment. Noticing if there are any urges present – maybe to move the right arm.

And then moving the right arm upwards – lifting it up to the ceiling, moving it forward, and placing it back down.

Continuing in this way, lifting the arm, moving it forward, placing it back down. Moving in this way, being aware, as best you can, of physical sensations in the hands and arms, and of the contact of the arms with the rest of your body. Keeping your gaze directed softly ahead. You might label the movements of each step as a way to focus your attention: "lifting, moving, placing."

Now, try shifting the attention to different modes of experience. You might start with physical sensations in the body, or even just the tips of your fingers. Then, pause and shift attention to sight. As you move, bring your attention to the experience of seeing. When you have finished, take that opportunity to shift again, this time to sound. As you move, bring your attention to the sounds, to the experience of hearing. Then when you are ready, shift to the sensations of breathing (or smell, if you are outside).

Exercise 4: Focusing on our Conversations[3]

Facilitator to say:

I would like you to begin observing specific conversations. It is useful to do this, as we often get caught up in difficult interactions with other people. When we focus in on these conversations with other people, we can learn what is actually happening and consider doing things differently in the future.

Choose one conversation you'd like to focus on each day. The simplest way to do this is by making the choice in the morning – after thinking about who you're likely to see in the next twelve hours. At this point, don't choose problem people or interactions where you might get upset.

Here are the guidelines for focusing on our conversations. While the conversation is underway try to notice:

- *Your thoughts (including judgments and assumptions about the other person)*
- *Your emotions (enjoyment, sadness, boredom, irritation, and so on)*
- *The other person's tone, posture, and facial expression.*

The goal of focusing on our conversations is to observe the boundary or intersection between you and the other person. Your thoughts and feelings belong to you. They are reactions, not facts. They are just your experience. The facts are what you observe about tone, posture, and facial expressions – and the literal words chosen by your conversational partner. The ways you interpret, be it words, tone, expression, and posture, are your thoughts. They are not real or necessary as they live inside of you.

Each day, as you experience a few moments of focusing on your conversations, separate what you observe using your senses from your private experience of thoughts and emotions. Knowing the difference between what you see and hear and what you think, and feel can make a big shift in how you respond to people.

Example

I'm Robin. I've struggled with anger towards my family. Here's what I noticed after experimenting with focusing on my conversations for a week. I stayed away from doing this with problem people, but even so, I was getting irritated and was noticing a lot of thoughts about how people don't act right. There were lots of judgments. And while this was going on, I noticed, on the other side, people smiling, having a friendly tone, just blathering away about something or other.

And I was feeling this gap between what was going on inside of me in terms of what I was thinking and feeling, and what seemed to actually be going on with these other people. It's as if there were two different conversations – the one they were having and the one that I was thinking about. And now, after a week of paying attention this way, I realise how often this happens.

Session 8: Noticing Being Hooked Away

Session 8: Noticing Being Hooked Away

Note for facilitators: Please encourage the client to participate in both exercises.

Exercise 1: Dropping Anchor[3]

Facilitator to say: *When distressing and overwhelming emotions show up, sometimes they come so quickly and strongly that it's like we're being kicked, stomped on, or knocked down to the floor. Naturally, we get hooked on them and forget that we can have those feelings instead of them having us.*

So, the skill of dropping anchor is about grounding ourselves in the moment in which we experience overwhelming or distressing emotions.

It's about noticing when we get hooked on these difficult feelings, and once we notice it happening, we can try to stay in the here and now instead.

Let's practice. This is something that takes some practice, so it's okay if we don't get it the first time, this isn't a quick fix.

For the next moments, press your feet against the floor as hard as you can, as a way to anchor yourself, and intentionally slow down your breathing.

Pause for a couple of seconds. You can even place your hand on your stomach or chest to notice the quality of your breathing.

Information for facilitators: After gathering the client's reactions, tell them that now we'll practice dropping the anchor as a skill when dealing with a troublesome situation they're encountering. Here are the basic directions for this activity that you can modify to fit your style:

- As the client continues to stand up, invite them to think for a moment about a challenging encounter they had last week where they experienced overwhelming or distressing emotions.
- After selecting a situation, invite the client to imagine that encounter for a couple of moments, and notice and name the feelings, sensations, and go-to actions that come along with it. For example, the may say, "I'm noticing the feeling of…" (Pause for a couple of moments).
- Gently, encourage them to drop their anchor. They can press their feet against the floor as hard as they can, slow down their breathing, kindly place a hand on their body, or slowly balance their body from front to back to bring themselves into this moment.
- Next, invite them to focus intentionally on three different objects in front of them and silently notice their qualities while they continue to press their feet and slow down their breath.

After this exercise, ask clients to sit down and then ask for feedback. Highlight the process of contacting their experience as it is, as an overwhelming feeling that shows up, and while they intentionally struggle, they also bring themselves back to the present: right here, right now (instead of starting an emotional reaction chain). Lastly, clarify to the client that when

they practice dropping anchor, after slowing down their breathing and acknowledging their struggle, their task is to focus on the external world, whether that's focusing on the person talking to them, their surroundings, or things they see, hear, or smell.

Explain to the client that the purpose of this skill is to help them bring themselves back into the present moment when they're getting hooked on intense feelings and the emotion is taking over. Grounding themselves in the moment won't make the emotion go away, but it will give them a moment to pause, centre, and check what really matters in that moment. Lastly, this skill is not about running away and quickly escaping from overwhelming emotions, it's about learning to notice when they're getting hooked on those feelings, letting go of the struggle with their internal experience, and giving themselves an opportunity to learn to live their values in challenging moments.

Contextualising why, how, and when to use the 'dropping the anchor' skill is important, so you're not just teaching a technique.

You may wonder, why is contact with the present moment important? Here is a brief response: if we pay attention, more often than not, we'll notice that we're hooked on the stuff produced by our minds, trapped by intense uncomfortable experiences, fighting distressing sensations, or struggling with strong urges to take action; we just don't notice how absent we are from the present.

8. Putting thoughts on clouds. You can visualise putting your thoughts on clouds and then watching them drift away. Or you may prefer a different image, such as carriages on a train passing by, balloons floating away in the sky, or leaves being carried away on a stream.
9. Objectifying, or thinking of thoughts as physical objects. Imagine what physical characteristics your thought might have – size, colour, texture, shape, density, consistency, weight, flexibility, temperature, and so on. This technique is also very useful for disentangling yourself from emotions and other internal experiences.

10. Physically letting go. As thoughts arrive, rotate your hand so your palm is facing down and imagine the thought dropping out of sight.

11. Card carrying. In this defusion technique, you carry a card with you and write down thought monsters as they come up. Then, whenever these painful cognitions recur, you can remind yourself, "It's on the card," and let it go.

Review & Ending

Client Reflections

- Ask the client about their thoughts and feelings related to finishing therapy.
- Discuss the client's thoughts and feelings about moving forward with the next phase of their recovery. How do they feel about using the skills from therapy on their own?
- Ask the client for 2 things that have stood out to them as important over the course of therapy.
- Provide the client with an opportunity to write a letter to themselves (as a good friend) – for the facilitator to send to them 15 weeks later.

Facilitator Conclusions

- Thank the client for showing up and doing some great work.
- Conclude by exploring any potential barriers for the future, and plan strategies to allow the client to follow through with committed actions in spite of barriers.
- Reinforce the use of willingness / acceptance and defusion skills in response to barriers to committed valued actions.

Outstanding Actions

- Cover any materials that did not fit into earlier sessions.
- Provide the client with the opportunity to revisit any parts of the therapy.

Onward Referrals

- Explore the need for referrals to other services or relevant signposting.

Treatment Roadmap Exercise

- If the client used the Treatment Roadmap in Session 1, encourage the client to continue to use it to handle challenging situations that show up in day-to-day life.

Reminders

- Encourage the client to try all skills, track how they work, and try them again and again.
- Let the client know that when we have intense feelings, it is natural to feel like throwing skills out of the window, and even though the short-term payoff of doing this may look great in the moment, but we know that in the long-term, it just adds more struggle. Encourage clients to be open and to see what happens when trying one skill with commitment to moving towards their values.

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- Say to clients: Who doesn't make mistakes when trying something new? Who doesn't make bad decisions at times? Take the time to pause, check how workable the thoughts are, practice defusion, and use self-compassion.
- Encourage clients to come back, again and again, to their values, and to continue to connect with what really matters to them!

Additional Resources

1. Values cards
2. High-risk situation cards

Values Cards

RESPONSIBILITY

To be responsible for my actions

SAFETY & PROTECTION

To secure, protect, or ensure my or others safety

SENSUALITY & PLEASURE

To create or enjoy pleasurable and sensual experiences

SEXUALITY

To explore or express my sexuality

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SKILFULNESS

To practice and improve my skills and apply myself fully

SUPPORTIVENESS

To be supportive, helpful, and available to myself and others

TRUST

To be trustworthy, loyal, faithful, sincere, or reliable

KINDNESS

To be kind, considerate, and caring towards myself and others

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LOVE
To act lovingly towards myself and others
MINDFULNESS
To be open, engaged in, and interested in the here and now
ORDER
To be organised
PERSISTANCE & COMMITMENT
To continue, despite problems or difficulties

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RESPECT

To treat myself and others with care and consideration

FRIENDLINESS

To be friendly towards others

FUN & HUMOUR

To find, create, and take part in fun-filled activities

GRATITUDE

To be grateful for myself, others, and life

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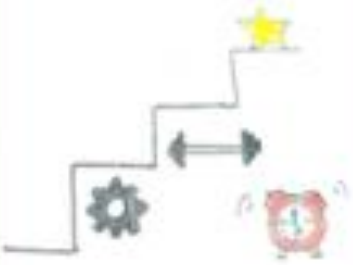
HONESTY

To be truthful with myself and others

INDUSTRY



To be hardworking and dedicated

INTIMACY

To open up and share myself, emotionally or physically

ENGAGEMENT

To engage fully in what I am doing

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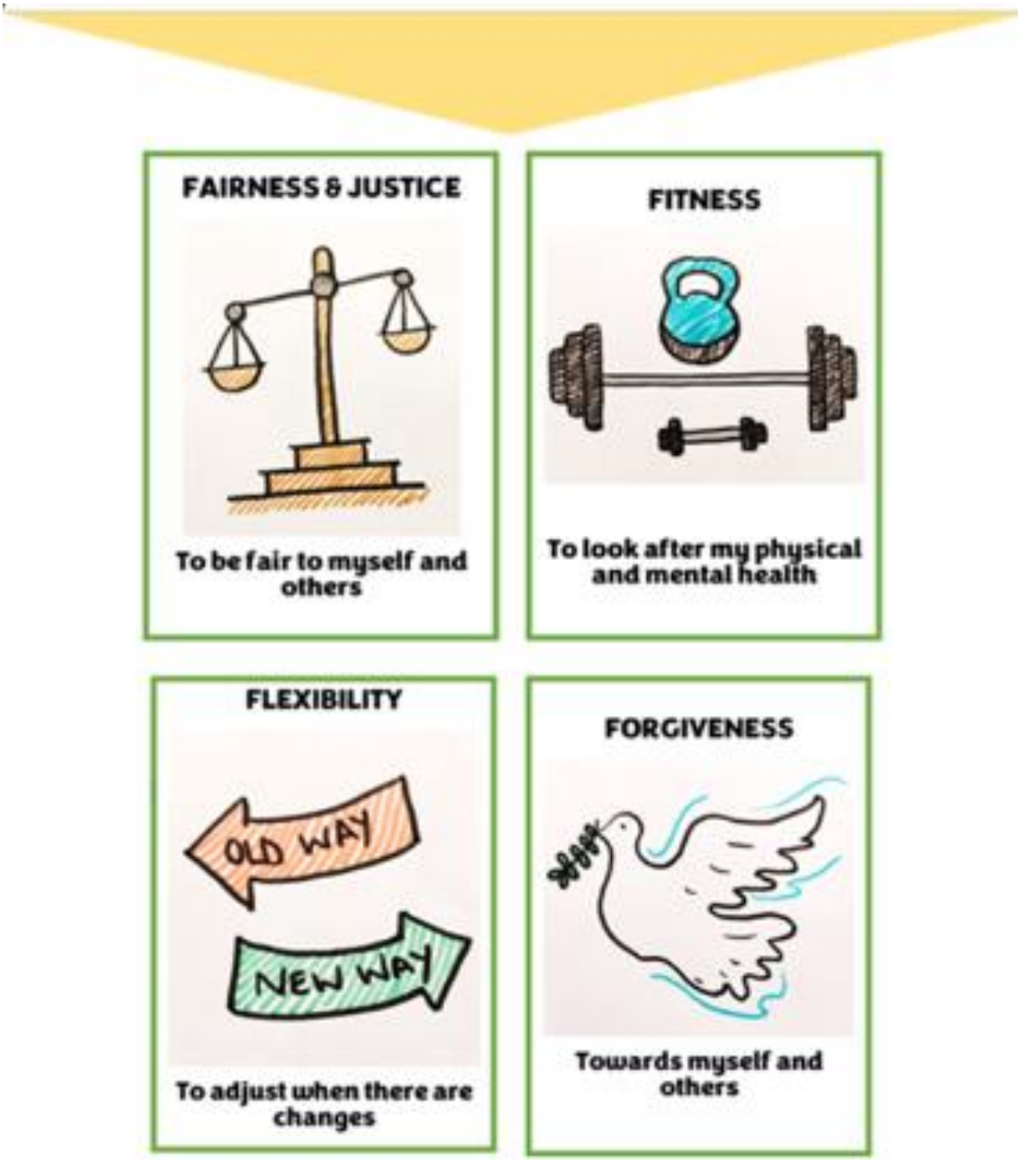
FAIRNESS & JUSTICE
To be fair to myself and others
FITNESS
To look after my physical and mental health
FLEXIBILITY
OLD WAY
NEW WAY
To adjust when there are changes
FORGIVENESS
Towards myself and others

FREEDOM & INDEPENDENCE

To choose how I live

CONTRIBUTION & GENEROSITY

To give, help, assist, or share

COOPERATION

To work with others

COURAGE

To be brave in the face of fear, threat, or difficulty


CREATIVITY
To be creative or innovative
CURIOSITY
To be interested, explore, open-minded
ENCOURAGEMENT
Well Done!
To reward behaviour that I value
ACCEPTANCE
Of myself, others, and life

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ADVENTURE

To explore new experiences

ASSERTIVENESS

To stand up for my rights and ask for what I want

CARING

To myself, others, the environment, etc.

COMPASSION

Towards myself and others

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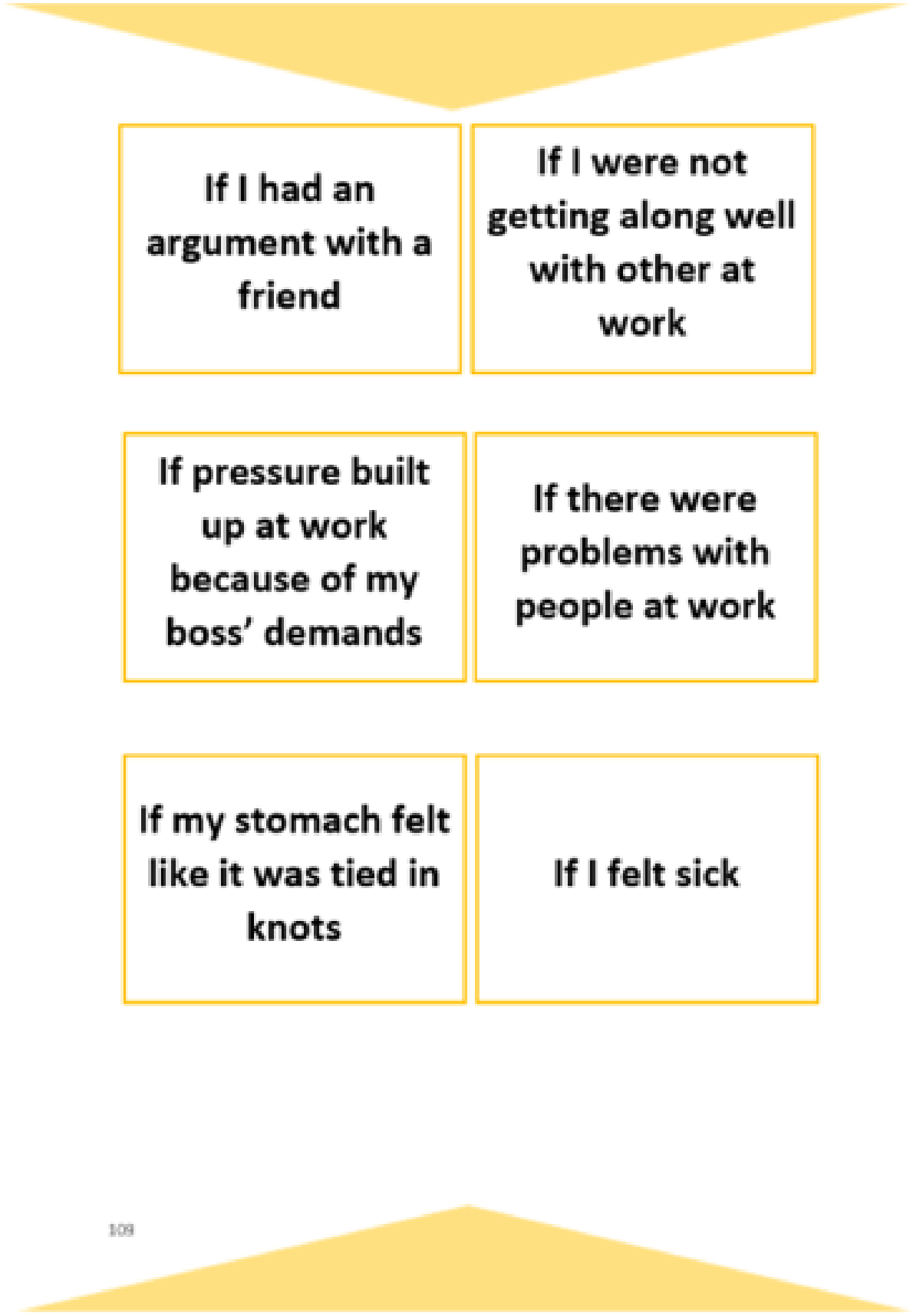
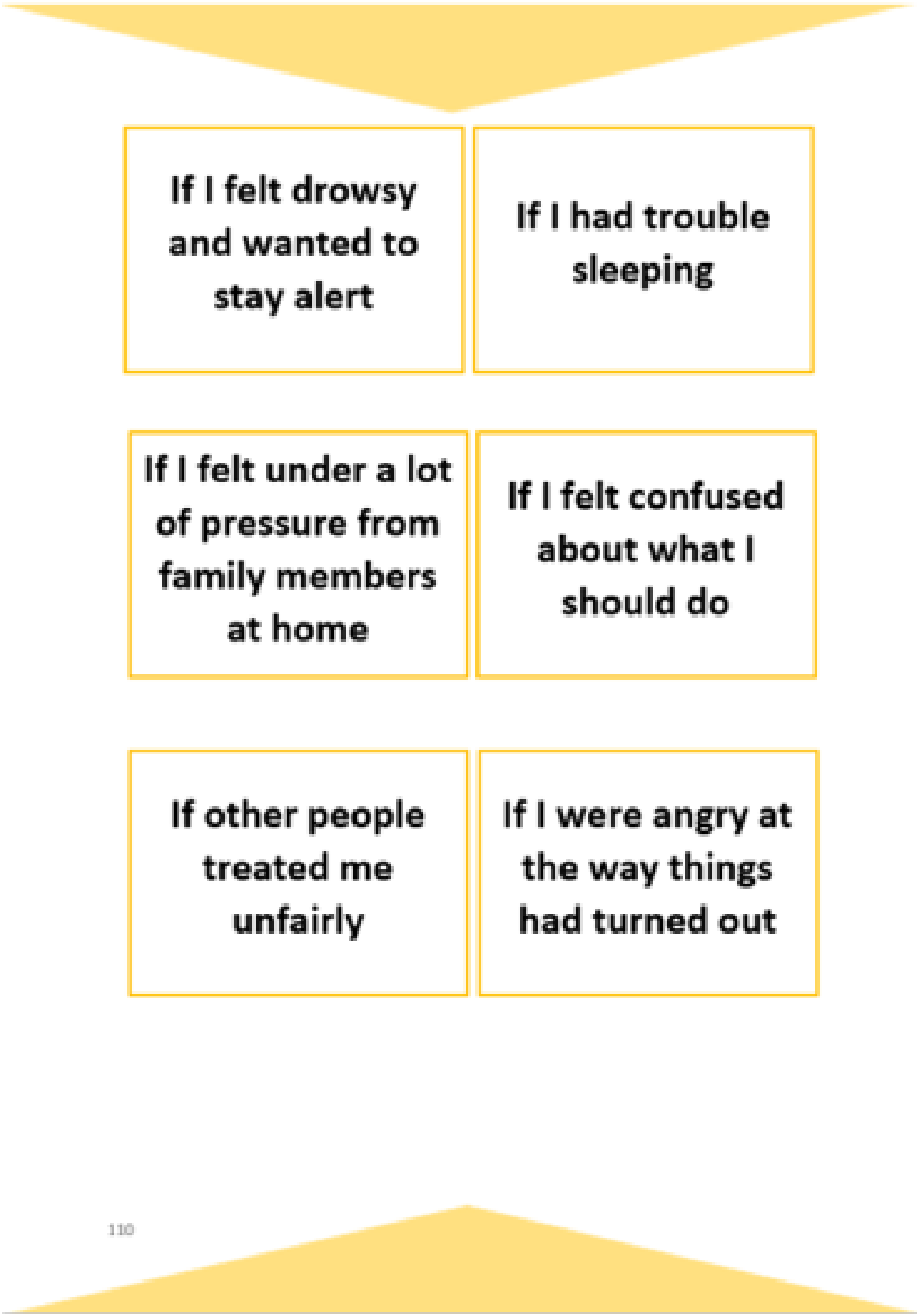
CONNECTION
To do what I am doing fully

High-risk situation cards

If everything were going well	If I felt confident and relaxed
If other people around me made me tense	If someone criticised me
If I felt uneasy in the presence of someone	If other people did not seem to like me


If I had an argument with a friend
If I were not getting along well with other at work
If pressure built up at work because of my boss' demands
If there were problems with people at work
If my stomach felt like it was tied in knots
If I felt sick


If I felt drowsy and wanted to stay alert
If I had trouble sleeping
If I felt under a lot of pressure from family members at home
If I felt confused about what I should do
If other people treated me unfairly
If I were angry at the way things had turned out
110


If I wanted to prove to myself that I could have a few drinks without becoming a drunk
If I started to think that just one drink could cause no harm
If I felt that I had let myself down
If there were fights at home
If I were afraid that things were not going to work out
If other people interfered with my plans
111


If I passed by a shop selling alcohol
If I remember how good it tasted
If I unexpectedly found a bottle of my favourite booze
If I suddenly had an urge to drink
If I convinced myself that I was a new person and could have a few drinks
If I wondered about my self-control over alcohol and felt like having a drink to try it out
112


If I felt satisfied with something I had done
If I were out with friends and they stopped at a bar for a quick drink
If I were enjoying myself at a party and wanted to feel even better
If I wanted to celebrate with a friend
If I were relaxed with a good friend and wanted to have a good time
If other people interfered with my plans

113


If I were in a restaurant and people with me ordered drinks
If I were out on the town with friends and wanted to increase my enjoyment
If I met a friend and they suggested we have a drink together
114

References:

[1] Luoma, J. B., Kohlenberg, B. & Hayes, S. C. (2005). *Acceptance and commitment therapy group therapy manual for self-stigma and shame in substance use disorder.* [Unpublished Manuscript]. The National Institute on Drug Abuse.

[2] McKay, M., Lev, A., & Skeen, M. (2012). *Acceptance and commitment therapy for interpersonal problems.* New Harbinger Publications, Inc.

[3] Meyers, E. C., Hermann, B. A., & Walser, R. D. (2019). *Acceptance and commitment therapy for co-occurring posttraumatic stress disorder and alcohol use disorders in veterans.* U.S. Department of Veteran Affairs.

[4] Woodward, L. (2019). *ACT on your recovery: A fifteen session group work manual.* Association for Contextual Behavioral Science.

[5] Zurita Ona, P. E. (2020). *Acceptance & commitment therapy for borderline personality disorder: A flexible treatment plan for clients with emotion dysregulation.* Context Press.

Acknowledgements:

Thank you to all of the people with lived experience as well as staff who work in services supporting individuals for whom this manual is designed. Your contributions to this manual as part of a doctoral research project were invaluable.

Appendix I: Evidence of Ethical Approval

DPAP Committee

28/04/2022

Supervisor: Anna Tickle

Applicant : Hannah Holland

Project: Project Id Acceptance and commitment therapy for people facing multiple disadvantage and borderline personality disorder: Adapting a talking therapy manual.

A favourable opinion is given to the above named study on the understanding that the applicants conduct their research as described in the above numbered application. Applicants need to adhere to all conditions under which the ethical approval has been granted and use only materials and documentation that have been approved.

If you need to make any any changes (for example to the date or place of data collection, or measures used), an Amendment Form should be submitted. This can be done by the Supervisor in 'Create Sub Form' in the Actions Menu on the left hand side of the page on the on-line system: Select 'Amendment Form'

yours

Professor David Daley

Co-Chair of DoPAP Ethics Subcommittee

Professor Amanda Griffiths

Co-Chair of DoPAP Ethics Subcommittee

Appendix J: Examples of Contextual Questions

1. What did you think about x part of the base manual?
2. What is the nature of your experience in relation to x?
3. What needs does the target population have in relation to x?

Appendix K: Participant Information Sheet for Step Four for Professionals

University of Nottingham
UK | CHINA | MALAYSIA

School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Acceptance and commitment therapy for people facing multiple disadvantage and borderline personality disorder: Adapting a talking therapy manual.

Researcher/Student: Hannah Holland, Hannah.holland@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle, Iwaat@exmail.nottingham.ac.uk

Ethics Reference Number: 2855

We would like to invite you to take part in a research study about the effects of an intervention manual on people facing multiple disadvantage who also have a diagnosis of borderline personality disorder. Before you begin, we would like you to understand why the research is being done and what it involves for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of this study?

We have gathered feedback from both staff and people with lived experience. Using their feedback, we have adapted a manual specifically for this group of people. The study aims to test how acceptable an adapted therapy manual is. The manual is based on an approach called Acceptance and Commitment Therapy (ACT). The study also aims to test whether it has positive effects on how service users approach difficulties, symptoms, quality of life, and substance use. This is a therapy intervention for individuals experiencing multiple disadvantage, with a diagnosis of borderline personality disorder. Those delivering the therapy will also be rated on their adherence to the manual. Should the manual prove an effective tool to create positive change among these outcomes, then it is hoped that the adapted manual could be used by services with this group of individuals. In addition, this study will be written up as a thesis for a Doctorate in Clinical Psychology for the University of Nottingham.

Although the study may not help you directly, the information we get may help us to develop a therapy manual for people facing multiple disadvantage. Taking part will lead to you having training in a therapeutic approach, which may improve your confidence and ability to support service users. Following your participation in this study, further analysis will be undertaken on the adapted manual. This will highlight any future development needed on the manual. It may also lead to research on a wider scale, which could have positive implications for the ways in which services work with individuals who are experiencing multiple disadvantage and who have a diagnosis of borderline personality disorder.

Why have I been invited?

You are being invited to take part because you are a member of staff who has not received formal training in the delivery of psychological therapies, and you work for a service that provides support

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for people facing multiple disadvantage who have a diagnosis of borderline personality disorder. We are inviting three people like you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. You do not have to take part in the study, even if it has been suggested by someone you know. You can keep this information sheet. If you do decide to take part, you will be asked to sign a consent form. You may change your mind about being involved at any time or decline to discuss a particular question. You are free to withdraw at any point before or during the study without giving a reason. If you withdraw, we will no longer collect any information about you or from you, but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally identifiable information possible. Withdrawing from the study would not affect your legal rights.

What will I be asked to do?

If you choose to take part, you will be asked to contact the researcher using the details below to inform her. You will then be provided with a consent form to sign in writing to say you wish to participate.

You will be asked to provide basic demographic information (name, age, gender, ethnicity, occupation) and be trained to use the manual. You will conduct several sessions with one client participant in either your place of work or the service from which the client participant was recruited. It is currently unknown how many sessions you will deliver but it is estimated to be between 4 and 12. Sessions will last between 40-60 minutes. You will then be interviewed by the researcher about the acceptability of the manualised intervention. This will take place either face-to-face or via Microsoft Teams. This interview will be audio-recorded and will take 30-60 minutes.

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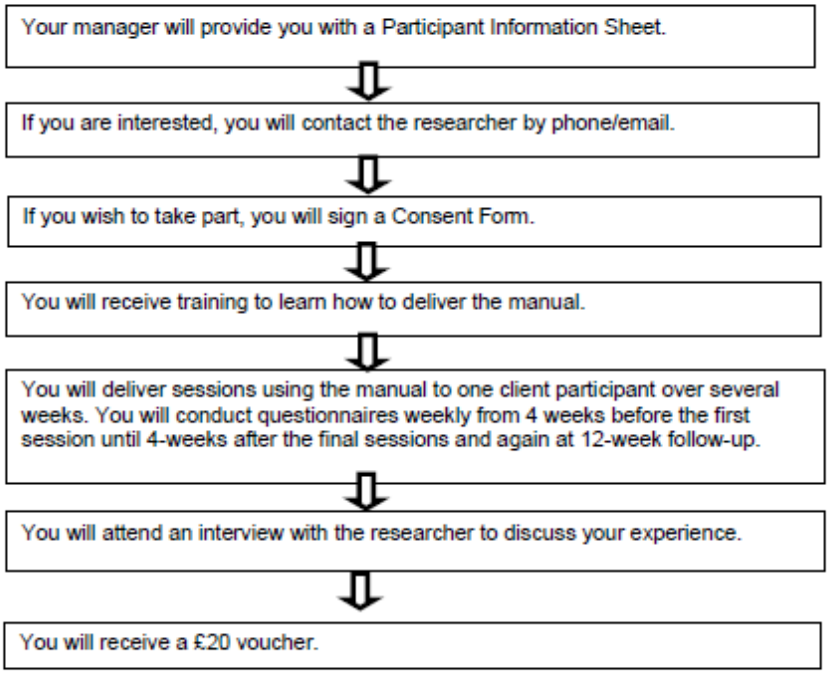
The flow chart below shows what will happen should you choose to take part.



What will happen to the information I provide?

The information you provide will only be accessible to the researcher, their supervisors, and a limited number of the University of Nottingham course staff where applicable. Recordings will be transferred onto the researcher's university and the original will be destroyed. Once transcribed, recordings will be deleted. To ensure that you cannot be identified by name you will be assigned a pseudonym on transcripts. A list linking participants' names and pseudonyms will be stored electronically as a password-protected file by the researcher. Your consent form, demographic information, questionnaires, and contact details will be scanned and stored electronically in password-protected files and the originals will be stored in a locked cabinet. Your personal data will be destroyed 3 months after the completion of the study unless you consent to the researcher retaining your contact details should you wish to receive the study's findings.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the research. This If you join the study, we will use information collected from you during the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the

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Data Controller (legally responsible for the data security), and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data will be kept securely for 7 years. After this time, your data will be disposed of securely. During this time, all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's, and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Should you disclose information about potential risk of harm to yourself or another person, we may report this to the appropriate persons.

The results of this study will be submitted as a thesis for the Doctorate in Clinical Psychology at the University of Nottingham. It will also be submitted for publication in a peer-reviewed journal after February 2023. You will not be identifiable in any report or publication. Should you consent to your contact details being retained, we would be happy to send the results of the research and any publications. If you would like to be informed of the results, please provide consent on the consent form for the researcher to retain your contact details so that they can inform you on completion of the study.

Are there any possible disadvantages or risks in taking part?

We don't expect there to be any disadvantages or risks to taking part. In the unlikely event that it does give rise to any concerns for you, we advise you to consider that, due to the nature of the study there is a chance that you will discuss difficult past experiences. In such instances, the

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researcher will address any concerns directly with you following the interview and will signpost you to relevant services where appropriate.

Data Protection

We will follow ethical and legal practice and all information will be handled in confidence.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere.

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?

If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee adrian.pantry@nottingam.ac.uk who will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health

Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Additional support

If you want additional support with your mental health, you can contact Wellness in Mind for support and signposting: https://www.wellnessinmind.org/; Telephone: 0800 561 0073 '

If you are having thoughts about self-harm or suicide, you can access support from Harmless (https://harmless.org.uk/) or the Tomorrow Project (http://www.tomorrowproject.org.uk/.

Appendix L: Participant Information Sheet for Step Four Clients

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School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

PARTICIPANT INFORMATION

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Acceptance and commitment therapy for people experiencing multiple disadvantage and borderline personality disorder: Adapting a manual through consultation and a pilot study.

Researcher/Student: Hannah Holland, Hannah.holland@nottingham.ac.uk
Supervisor/Chief Investigator: Dr Anna Tickle, lwaat@exmail.nottingham.ac.uk

Ethics Reference Number: 2855

We would like to invite you to take part in a research study about the effects of an intervention manual on people facing multiple disadvantage who also have a diagnosis of borderline personality disorder. Before you begin, we would like you to understand why the research is being done and what it involves for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of this study?

The study aims to test a new therapy manual for people facing multiple disadvantage with a diagnosis of borderline personality disorder, which is also known as emotionally unstable personality disorder. We are specifically looking to test whether it is acceptable and whether it has a positive effect on how service users approach difficulties, symptoms, quality of life, and substance use.

We have gathered feedback from both professionals and people with lived experience of multiple disadvantage and a diagnosis of borderline personality disorder. Using their feedback, we have adapted a new manual. Should the adapted manual prove an effective tool to create positive change among these outcomes, then it is hoped that the adapted manual could be used by services specifically with this group of individuals. In addition, this study will be written up as a thesis for a Doctorate in Clinical Psychology for the University of Nottingham.

We cannot promise the study will help you but the information we get from this study may help others who are experiencing multiple disadvantage and have a diagnosis of borderline personality disorder. Following your participation in this study, further analysis will be undertaken on the adapted manual. This will highlight any future development needed on the manual. It may also lead to research on a wider scale, which could have positive implications for the ways in which services work with individuals who are experiencing multiple disadvantage and who have a diagnosis of borderline personality disorder.

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Why have I been invited?

You are being invited to take part because you are experiencing multiple disadvantage and have a diagnosis of borderline personality disorder. We are inviting three people like you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. And you may change your mind about being involved at any time or decline to discuss a particular question. You are free to withdraw at any point before or during the study without giving a reason. If you withdraw, we will no longer collect any information about you or from you, but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally identifiable information possible. Withdrawing from the study would not affect your legal rights.

What will I be asked to do?

If you decide to take part, you can contact the researcher using the details below to inform her. You may also wish to ask a member of staff at the organisation from which you were recruited to support you to do this. The researcher will then contact you either by telephone or email to discuss the study. You will then be provided with a consent form to sign to say you wish to participate.

You will be asked to provide basic information about yourself (name, age, gender, ethnicity). You will be asked to complete four short questionnaires on a weekly basis for between 4 and 12 sessions. These will be completed during face-to-face sessions with a staff member who has been recruited and trained to use the manual for the purpose of this study. These sessions will take place at the service from which you were recruited. You will be asked by the staff member to complete a set of questionnaires on a weekly basis from four weeks before your first session until four weeks after your final session. You will then be asked to complete these again 12 weeks after your final session. Four weeks after your final session the researcher will interview you. This will be audio-recorded and will last 30-60minutes. During this interview you will be asked for your thoughts in relation to how acceptable you found the sessions, as well as what you felt helped or got in the way of the therapy.

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The manager of the service supporting you/your navigator will provide you with a Participant Information Sheet.

If you are interested in taking part, the manager/navigator will support you to contact the researcher. The researcher will explain the study.

If you are eligible and want to take part, you will be asked to sign a Consent Form.

You will receive several therapy sessions with a staff member who works for a service that supports people facing multiple disadvantage. they will use the manual and ask you to complete questionnaires each week.

Four weeks later you will attend an interview with the researcher to discuss your experience and complete some questionnaires.

Eight weeks later you will be asked to complete questionnaires.

You will receive a £20 voucher

What will happen to the information I provide?

The information you provide will only be accessible to the researcher, their supervisors, and a limited number of the University of Nottingham course staff where applicable. Recordings will be transferred onto the researcher's university OneDrive and the original will be destroyed. Once transcribed, recordings will be deleted. To ensure that you cannot be identified by name you will be assigned a pseudonym on transcripts. A list linking participants' names and pseudonyms will be stored electronically as a password-protected file by the researcher. Your consent form, demographic information, questionnaires, and contact details will be scanned and stored electronically in password-protected files and the originals will be stored in a locked cabinet. Your personal data will be destroyed 3 months after the completion of the study unless you consent to the researcher retaining your contact details should you wish to receive the study's findings.

We will follow ethical and legal practice and all information about you will be handled in confidence.

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If you join the study, we will use information collected from you during the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Nottingham. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security), and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All research data will be kept securely for 7 years. After this time, your data will be disposed of securely. During this time, all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Nottingham's, the Government's, and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information, we will seek your consent for this and ensure it is secure. You will be made aware then if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Should you disclose information which pertains to the potential risk of harm to yourself or another person, we may report this to the appropriate persons.

The results of this study will be submitted as a thesis for the Doctorate in Clinical Psychology at the University of Nottingham. It will also be submitted for publication in a peer-reviewed journal after February 2023. You will not be identifiable in any report or publication. Should you consent to your contact details being retained, we would be happy to send the results of the research and any publications. If you would like to be informed of the results, please provide consent on the consent form for the researcher to retain your contact details so that they can inform you on completion of the study.

Are there any possible disadvantages or risks in taking part?

We don't expect there to be any disadvantages or risks to taking part. In the unlikely event that it does give rise to any concerns for you, we advise you to consider that, due to the nature of the study there is a chance that you will discuss difficult past experiences. In such instances, the researcher will address any concerns directly with you following the interview and will signpost you to relevant services where appropriate.

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Data Protection

We will follow ethical and legal practice and all information will be handled in confidence.

Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (named above) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally–identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx

We would like your permission to use anonymised data in future studies, and to share our research data (e.g. in online databases) with other researchers in other Universities and organisations both inside and outside the European Union. This would be used for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. All personal information that could identify you will be removed or changed before information is shared with other researchers or results are made public.

The data collected for the study will be looked at and stored by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

At the end of the project, all raw data will be kept securely by the University under the terms of its data protection policy after which it will be disposed of securely. The data will not be kept elsewhere

If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the email addresses above.

What if there is a problem?

If you have any queries or complaints, please contact the student's supervisor/chief investigator in the first instance. If this does not resolve your query, please write to the Administrator to the Division of Psychiatry & Applied Psychology's Research Ethics Sub-Committee adrian.pantry@nottingam.ac.uk who will pass your query to the Chair of the Committee.

If you remain unhappy and wish to complain formally, you should then contact the Faculty of Medical and Health Sciences Ethics Committee Administrator, Faculty Hub, Medicine and Health Sciences, E41, E Floor, Medical School, Queen's Medical Centre Campus, Nottingham University Hospitals, Nottingham, NG7 2UH or via E-mail: FMHS-ResearchEthics@nottingham.ac.uk

Appendix M: Consent Form for Step Four Professionals

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School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

Participant Consent

Paper form for face-to-face consent

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Acceptance and commitment therapy for people facing multiple disadvantage and borderline personality disorder: Adapting a talking therapy manual.

Researcher/Student: Hannah Holland, Hannah.holland@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle, lwaat@exmail.nottingham.ac.uk

Ethics Reference Number: 2855

- Have you read and understood the Participant Information? YES/NO
- Do you agree to take part in receiving training in the delivery of a manualised intervention for people facing multiple disadvantage and have a diagnosis of borderline personality disorder, and then deliver eight audio-recorded sessions based on this intervention and an audio-recorded interview four weeks after the final session? YES/NO
- Do you know how to contact the researcher if you have questions about this study? YES/NO
- Do you understand that you are free to withdraw from the study without giving a reason? YES/NO
- Do you understand that once you have taken part it may not be technically possible for us to withdraw your data? YES/NO
- Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected? YES/NO
- Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications? YES/NO
- I confirm that I am 18 years old or over. YES/NO
- If you would like a summary of the research findings, please contact the researcher at Hannah.holland@nottingham.ac.uk and this will be arranged for you.

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Signature of Participant ..... Date .....

Name (in capitals) .....

Signature of Researcher ..... Date .....

This consent form will be stored separately from your contributions to the study. So, your responses in the study will not be identifiable.

14 April 2021

Appendix N: Consent Form for Step Four Clients

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School of Medicine
University of Nottingham
Medical School
Nottingham
NG7 2UH

Participant Consent

Paper form for face-to-face consent

STUDENT RESEARCH PROJECT ETHICS REVIEW
Division of Psychiatry & Applied Psychology

Project Title: Acceptance and commitment therapy for people facing multiple disadvantage and borderline personality disorder: Adapting a talking therapy manual.

Researcher/Student: Hannah Holland, Hannah.holland@nottingham.ac.uk

Supervisor/Chief Investigator: Dr Anna Tickle, lwaat@exmail.nottingham.ac.uk

Ethics Reference Number: 2855

- Have you read and understood the Participant Information? YES/NO
- Do you agree to take part in receiving 8-12 audio-recorded sessions of a new manual intervention, complete questionnaires on a weekly basis for 16-20 weeks and complete an interview with the Researcher four weeks following your final session? YES/NO
- Do you know how to contact the researcher if you have questions about this study? YES/NO
- Do you understand that you are free to withdraw from the study without giving a reason? YES/NO
- Do you understand that once you have taken part it may not be
- technically possible for us to withdraw your data? YES/NO
- Do you give permission for your data from this study to be shared with other researchers in the future provided that your anonymity is protected? YES/NO
- Do you understand that non-identifiable data from this study including quotations might be used in academic research reports or publications? YES/NO
- I confirm that I am 18 years old or over. YES/NO

If you would like a summary of the research findings, please contact the researcher at Hannah.holland@nottingham.ac.uk and this will be arranged for you.

Signature of Participant ..... Date .....

Name (in capitals) .....

University of Nottingham
UK | CHINA | MALAYSIA

Signature of Researcher ..... Date .....
14 April 2021

This consent form will be stored separately from your contributions to the study.
So, your responses in the study will not be identifiable.

Appendix O: Example Questions

1. What did you think about x part of the base manual?

2. What is the nature of your experience in relation to x?

3. What needs does the target population have in relation to x?

Word Count

Journal Paper

Main text = 7,478

References = 1,802

Extended notes = 329

Total = 9,280

Extended Paper

Main text = 19,076

Total Word Count = 28,356

Poster

Acceptance and Commitment Therapy for multiple disadvantage and emotionally unstable personality disorder: Adapting a manual through consultation

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Background

- People diagnosed with Emotionally Unstable Personality Disorder (EUPD) who misuse substances and face homelessness often do not receive treatment due to how services work (e.g., strict appointment times).
- Many treatments are designed without discussions with People With Lived Experience (PWLE)[1].
- This includes therapies, which tend to be delivered by Clinical Psychologists[2].
- Acceptance and Commitment Therapy (ACT) focuses on wellbeing and can be delivered by non-psychologists[3].
- There is limited research into ACT for this population, and what adaptations they need.
- This study aimed to adapt existing ACT interventions for this population with professionals and PWLE.

Method

Stage one: Existing ACT manuals were reviewed to find interventions that be adapted for this population[4].

Stage two: Professionals and PWLE were consulted in two interviews. They rated existing interventions and provided comments. Data was analysed using Framework Analysis[5].

Stage three: The research team developed the adapted manual using guidance[4].

Results

Stage one: Forty-one interventions across five manuals were found.

Stage two: Four professionals and two PWLE were recruited. Three themes were identified: acceptability, facilitators, and barriers.

Stage three: Feedback was used to develop an adapted manual.

Research Aims

- Find existing ACT interventions that could be adapted
- Consult with professionals and PWLE about adaptations
- Develop an adapted manual for use with this population

Discussion

- This is the first attempt to adapt ACT for this population in consultation with professionals and PWLE.
- It offers a tailored therapy for this population by considering acceptability (language, resources, willingness), facilitators (therapeutic relationship, flexibility), and barriers (practical issues).
- The adapted manual can be delivered by non-psychologists.
- Future research should explore feasibility and effectiveness of the adapted manual.

References: [1]Fulfilling Lives. (2020, January 17). *Improving access to mental health support for people experiencing multiple disadvantage.* Fulfilling Lives. https://www.fulfillinglivesevaluation.org/improving-access-to-mental-health-support-for-people-experiencing-multiple-disadvantage-latest-evaluation-report/; [2]Association of Clinical Psychologists. (2020, January 9). *BMA mental health workforce survey: Data from clinical psychologists.* ACP. https://acpuk.org.uk/bma_mental_health_workforce_survey/; [3]Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44*(1), 1-25.; [4]Goldstein, N. E., Kemp, K. A., Leff, S. S., & Lochman, J. E. (2012). Guidelines for adapting manualized interventions for new target populations: A step-wise approach using anger management as a model. *Clinical Psychology: Science and Practice, 19*(4), 385.; [5]Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & B. Burgess (Eds.), *Analyzing qualitative data* (pp. 173-194). Routledge.