

**BEHAVIOURAL AND
COGNITIVE PSYCHOTHERAPY**



**Ameliorating Patient Stigma Amongst Staff Working With
Personality Disorder: Randomised Controlled Trial of Self-
Management vs. Skills Training.**

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Abstract

Background

Patients diagnosed with a personality disorder (PD) are often stigmatised by the healthcare staff who treat them.

Aims

This study aimed to compare the impact on front-line staff of a self-management Acceptance and Commitment Therapy-based training intervention (ACTr) with a knowledge- and skills-based Dialectical Behaviour Training intervention (DBTr).

Method

A service-based randomised controlled trial was conducted comparing the effects of 2-day ACTr (N = 53) and DBTr (N = 47) staff workshops over 6 months. Primary outcome measures were staff attitudes towards patients and staff-patient relationships.

Results

For both interventions, staff attitudes, therapeutic relationship, and social distancing all improved pre- to post-intervention, and these changes were maintained at 6-month follow-up.

Conclusions

Although offering different resources to staff, both ACTr and DBTr were associated with an improved disposition towards PD patients. Future research could evaluate a combined approach, both for staff working with PD patients and those working with other stigmatised groups.

ACTr vs. DBTr for PD staff

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3 *Keywords:* Personality Disorder; Stigma; Acceptance and Commitment Therapy

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5 (ACT); Dialectical Behaviour Therapy (DBT); Training; Acceptance.
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3 Ameliorating Patient Stigma Amongst Staff Working With Personality Disorder:

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5 Randomised Controlled Trial of Self-Management vs. Knowledge and Skills Training.

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7 In the UK, a series of recent scandals has highlighted the way in which the
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9 provision of healthcare services for some groups (e.g., hospitalised older adults;
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11 individuals with severe intellectual disabilities) can sometimes become callous and
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13 inhumane (Francis, 2013; Scally, Chalmers, Fallon-Williams, & Sly, 2012).
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15 Disrespectful treatment is likely to be associated with *stigma*. Corrigan and Watson
16
17 (2002) define stigma as the combination of *stereotypes* (i.e., socially agreed
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19 perceptions of groups of people), *prejudice* (i.e., a negative evaluation of a group
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21 based on stereotypes or past interactions), and *discrimination* (i.e., behavioural
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23 reactions resulting from prejudice).
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29 Because patients with mental health issues are particularly vulnerable to stigma,
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31 attempts have been made in the UK to change attitudes through a national
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33 campaign, *Time To Change*. Unfortunately, results to date are limited: The campaign
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35 achieved only small improvements in the mental health staff's discrimination
36
37 towards their patients over a 3-year period (Corker et al., 2013). Similarly, a training
38
39 intervention aimed at reducing medical students' stigma towards mental health
40
41 patients created only a short-term positive change in their knowledge, attitudes, and
42
43 intended behaviour (Friedrich et al., 2013).
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48 Patients diagnosed with a Personality Disorder (PD) are at particularly high risk
49
50 of experiencing stigma from healthcare professionals. They are often described as
51
52 "difficult": the term appears frequently in the professional literature of, for example,
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54 psychiatric services (Koekkoek, van Meijel, & Hutschemaekers, 2006), nursing
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56 (Lakasing, 2007; Laskowski, 2001) and psychology (Foertsch, Manning, & Dimeff,
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3 2003). The widespread use of this characterization of patients risks creating stigma
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5 towards them (Hinshelwood, 1999), which may undermine their care (Aviram,
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7 Brodsky, & Stanley, 2006; Newton-Howes, Weaver, & Tyrer, 2008). In the UK, for
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9 example, the Department of Health found it necessary to issue policy guidelines to
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11 service providers, requiring that PD is “no longer a diagnosis of exclusion” (NIMHE,
12
13 2003, p. 1).
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17 Stigmatisation certainly harms vulnerable individuals, but there is evidence that
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19 those who hold stigmatising beliefs may also be badly affected. For example, using a
20
21 model-building approach with staff self-report data, Taylor (2011) showed that
22
23 staff’s negative attitudes towards PD patients were associated not only with poorer
24
25 quality interactions (weaker therapeutic alliances, greater social distancing) but also
26
27 with reduced personal well-being (burnout, general health).
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31 Stereotyping and prejudice may be reduced by increasing staff’s exposure to
32
33 ‘difficult’ patients during training, and by using psychoeducational interventions
34
35 (Corrigan, 2004). To this end, Cook, Jonikas, and Razzano (1995) compared the
36
37 impact of a day’s teaching by trainers who had or had not used mental health
38
39 services. Although post-training attitudes to mental health patients were more
40
41 positive for those trained by a service user, no follow-up measures were obtained.
42
43 Miller and Davenport (1996) assessed the impact of a psychoeducational self-
44
45 instruction booklet on psychiatric nurses’ knowledge, attitudes, and behavioural
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47 intentions towards service users. Although the effects were positive compared with
48
49 a no-treatment control group, the study was weakened by the fact that staff were
50
51 not randomly assigned to groups and no follow-up assessment was conducted. Thus,
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53 although both exposure and psychoeducational approaches are plausible, research
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3 support for them is currently limited.

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5 Prejudice and discrimination may also be reduced by developing skills and
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7 enabling staff to work more effectively with their patients. Knowledge and skills
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9 training based on Dialectical Behavioural Therapy (DBT) is of particular relevance to
10
11 PD. DBTr aims to provide staff with a non-judgemental understanding of severe PD,
12
13 based on the Biosocial Theory (Linehan, 1993), together with some behavioural
14
15 strategies to help patients manage their emotions and relationships more skilfully.
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19 Using a qualitative research design, Perseus, Ojehagen, Ekdahl, Asberg, and
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21 Samuelsson (2003) showed that therapists who were trained in DBT reported
22
23 improved attitudes towards their patients. Likewise, in a larger-scale uncontrolled
24
25 study, Hazelton, Rossiter, and Milner (2006) assessed the impact of a 2-day DBT-
26
27 based skills training workshop on 69 mental healthcare staff. Although they showed
28
29 that attitudes towards patients with a PD improved after training, only 24 staff were
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31 available to provide data at 6-month follow-up. Thus, although DBT offers a
32
33 promising approach to changing staff attitudes, research supporting its effectiveness
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35 is currently limited.
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41 In any case, although a DBT skills-training approach has some advantages,
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43 Hayes et al. (2004) have suggested that information and skills alone may not be
44
45 sufficient to improve attitudes in the long term. This, they argue, is primarily because
46
47 staff still need to manage the negative emotional responses and thoughts elicited
48
49 during challenging patient encounters, which are very likely to impact on their
50
51 professional behaviour. Acceptance and Commitment Training (ACTr), an alternative
52
53 self-management approach based on Acceptance and Commitment Therapy (ACT),
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55 uses the principles of acceptance, mindfulness, values, and committed action (Hayes,
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3 Strosahl, & Wilson, 1999) to help staff to manage the private—and often negative—
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5 thoughts and feelings that they experience in working with mental health patients.
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7 Rather than trying to change negative thoughts, ACT focuses on helping thinkers to
8
9 become less entangled or ‘fused’ with them. It teaches the benefits of accepting that
10
11 negative thoughts are inevitable—but that they can pass without the need to judge,
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13 change or act on them. Finally, it encourages developing (or returning to) a strong
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15 reliance on personal values to guide behaviour.
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20 Hayes et al. (2004) compared the effectiveness of ACTr (N = 30), multicultural
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22 training (N = 34), and an educational control (N = 29) in reducing stigma in substance
23
24 abuse counsellors. Compared to the educational control, multicultural training
25
26 reduced stigma post-intervention, but not at 3-month follow-up. ACT, however,
27
28 improved attitudes 3 months after the intervention, and reduced staff burnout.
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30 Further studies, with students as participants (e.g., Lillis & Hayes, 2007; Masuda et
31
32 al., 2007), have suggested that ACTr may be effective in reducing stigma towards
33
34 other marginalised groups. Thus, ACT-based studies are encouraging, but no
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36 research to date has investigated the utility of an ACT intervention in improving
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38 attitudes in staff who work with PD.
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44 To summarise, whereas DBTr seeks to reduce prejudice and discrimination by
45
46 providing staff with knowledge and skills to improve the effectiveness of their clinical
47
48 practice, ACTr aims to provide self-management skills to reduce the impact of
49
50 negative evaluations and strengthen value-driven behaviour. The present study was
51
52 designed as a direct comparison of DBTr and ACTr training in improving staff
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54 attitudes towards PD patients. Both training interventions were delivered in the form
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56 of a 2-day staff workshop. Drawing on Corrigan and Watson (2002), the impact of
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3 training was assessed in terms of changes in staff attitudes (prejudice), factors
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5 relating to behavioural intention and staff-patient relations (discrimination). Factors
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7 relating to staff wellbeing (burnout and psychological distress) were also assessed.
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10 **Method**

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12 The study protocol was approved by the UK National Health Service
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14 Research Ethics Committee (Dorset:06/Q2201/158) .
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17 **Participants**

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19 Participants were health and social care staff working in UK state-funded or
20
21 charitable provision providing services for PD patients. Volunteers who responded to
22
23 internal advertisements offering a free 2-day staff development course returned a
24
25 signed consent form after receiving an information pack outlining the study. Table 1
26
27 shows relevant sample demographics. The sample size (N=100) was based on similar
28
29 published research (Hayes et al., 2004; Masuda et al., 2007).
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36 INSERT TABLE 1 HERE
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40 **Measures**

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42 All measures in this study were self-report questionnaires.
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45 **Primary Outcome Measures.** We used the 35-item Attitude to Personality
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47 Disorder Questionnaire (APDQ; Bowers & Allan, 2006) to assess attitudes of staff
48
49 towards PD patients. Staff perceptions of the quality of their therapeutic relationship
50
51 towards PD patients were measured using the 19-item Helping Alliance Questionnaire –
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53 Therapist Version (HAQ-II; Luborsky et al., 1996). We assessed the degree to which
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55 staff distanced themselves from PD patients using the 7-item Social Distancing Scale
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3 (SDS; Link, Cullen, Frank, & Wozniak, 1987), with all references to 'mental illness'
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5 replaced with 'personality disorder'. All measures had acceptable to excellent test-
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7 retest reliability (alpha = .56 - .84, not available for SDS), and excellent internal
8
9 consistency (alpha = .83 - .94; Bowers & Allen, 2006; Link et al., 1987; Luborsky et al.,
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11 1996; Taylor, 2011).

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14 **Secondary Outcome Measures.** Psychological distress was assessed using the
15
16 28-item General Health Questionnaire, (GHQ; Goldberg & Hillier, 1979). Staff
17
18 burnout was assessed by the 22-item Maslach Burnout Inventory (MBI; Maslach,
19
20 Jackson, & Leiter, 1996), where the Emotional Exhaustion and Depersonalisation
21
22 subscales were combined to create a total burnout score (see Hayes et al, 2004).
23
24 Finally, we used the 7-item Acceptance and Action Questionnaire (AAQ-II; Bond et
25
26 al., 2011) to assess staff psychological flexibility. All measures had acceptable to
27
28 excellent test-retest reliability (alpha = .54-.90) and good to excellent internal
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30 consistency (alpha = .79 - .94; Bond et al., 2011; Sterling, 2011; Taylor, 2011).
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36 **Credibility and Expectancy.** The Credibility and Expectancy Questionnaire
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38 (CEQ; Devilly & Borkovec, 2000) was used to determine the credibility of a described
39
40 training approach and participants' expectations of benefits from it. Two separate
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42 scales are summed to produce a total score, with higher scores reflecting a greater
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44 level of preconceived ideas about the training.
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47 **Procedure**

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49 Participants were randomly assigned to either the ACTr or DBTr conditions
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51 (ISRCTN18382289) by an independent researcher using an online random number
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53 generator (random.org). After randomisation, but before the first training session,
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3 participants privately completed a questionnaire pack. All workshops were
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5 conducted away from staff workplaces at a single UK site.
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7 **Interventions.** Both the ACTr and DBTr training were delivered in workshop
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9 format over two 1-day training sessions, spaced approximately 2 weeks apart.
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11 Workshop group size was limited to approximately 16, so each form of training was
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13 delivered independently three times. Both kinds of training were matched in terms
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15 of workload and were delivered by a team of two Consultant Clinical Psychologists
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17 (mean experience = 19 years). One Consultant Psychologist is a DBT national trainer
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19 (SC) and both (SC and HB) are intensively trained DBT practitioners. Likewise, both
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21 have substantial recent experience of ACT training and therapy and one (SC) was a
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23 member of the ACT International Training Committee.
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28 **Acceptance and Commitment Training (ACTr).** Based on Hayes et al. (2004),
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30 the focus of ACTr was the improvement of staff's self-management skills. We
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32 adapted content to address PD-specific concerns, but retained the underlying
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34 principle that good practice depended on staff's ability to manage their private
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36 experiences. The intervention was designed to help staff (a) mindfully notice their
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38 negative thoughts, emotions, and action urges towards their PD patients, without
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40 acting on them, and instead (b) be guided by their work-related values. Although
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42 part of the course was didactic, the majority of it consisted of group and individual
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44 experiential exercises, designed to assist participants in utilising ACT techniques
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46 (acceptance; mindfulness; cognitive defusion) to change their relationships with
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48 their thoughts.
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53 **Dialectical Behaviour Training (DBTr).** In contrast with the ACTr program,
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55 DBTr provided staff with knowledge and skills to incorporate into their clinical
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3 practice. Drawing on Linehan (1993), training involved both experiential group and
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5 individual exercises, and didactic presentations. The validation component of DBTr
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7 taught participants how to validate their patient's experience; the change
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9 component taught behavioural formulation of target problems and identification of
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11 DBT solutions.
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14 Both protocols are described more thoroughly in Taylor (2011), and on
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16 request from the first author.
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19 On the first training day, after initial orientation, participants completed the
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21 CEQ. The two days of training followed, at the end of which staff again completed
22
23 the questionnaire pack. Follow-up data were collected by mail 6 months later.
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26 **Qualitative follow-up interviews**

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28 Three months after training, all participants were invited to discuss both the
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30 positive and negative aspects of their workshop experience. Fifteen participants
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32 volunteered (mean age = 45.8 years, 13 females): eight had attended ACTr (seven
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34 females); seven DBTr (six females). Fourteen staff provided usable data. Their
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36 demographic characteristics suggested the final sample was representative.
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38 Experience working in a mental health setting ranged from 4 to 20 years (M = 11.0
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40 years), and duration of work with PD patients ranged from <1 to 12 years (M = 6.2
41
42 years), and duration of work with PD patients ranged from <1 to 12 years (M = 6.2
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44 years).
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48 Two researchers who had not been involved in the training conducted semi-
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50 structured interviews based on seven open-ended questions. Interviews were
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52 recorded and transcribed for data-driven thematic analysis (Joffe & Yardley, 2003)
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54 which continued iteratively until no further themes emerged.
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57 **Results**

Missing Data and Analysis Strategy

Figure 1 shows the participant flow through the trial. Of the 100 participants that attended at least one day of training, all completed pre- and post-intervention measures. Loss to follow-up left 33 participants in the ACTr group and 24 in the DBTr group. All analyses were completed on an *intention to treat* basis using Linear Mixed Models (LMM) based on all available quantitative data. Each dependent variable was examined using a factorial Group (DBTr vs. ACTr) x Time (pre-intervention, post-intervention, follow-up) LMM.

Baseline Analyses

Independent t-tests showed no significant gender differences and no significant group differences on any of the measures, including CEQ. Pearson's correlations showed that age and a higher caseload of PD patients were associated with worse therapeutic relationship. In analysing outcome data, these work-related variables were entered as covariates in the LMM analyses. Table 2 shows the descriptive statistics for all questionnaire measures for both the ACTr and DBTr group, across all three time points.

INSERT TABLE 2 and FIGURE 1

Primary Outcomes

A LMM analysis of attitudes towards PD patients revealed a significant main effect of time, $F(2, 63.76) = 8.79, p < .001$ but no significant Group x Time interaction. Pairwise comparisons showed that, compared to baseline, attitudes towards PD patients were significantly improved post-intervention ($p < .001$) and at

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3 follow-up ($p = .002$) in both groups. Likewise, LMM analyses uncovered significant
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5 main effects of time for therapeutic relationship and social distancing ($F(2, 64.47) =$
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7 $11.20, p < .001$ and $F(2, 65.45) = 12.10, p < .001$, respectively), but no significant
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9 Group x Time interactions. Pairwise comparisons with baseline showed that both
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11 therapeutic relationship and social distancing were significantly improved at post-
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13 intervention (both $p < .001$) and this improvement was maintained at follow-up in
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15 both groups ($p = .005; p = .001$, respectively).
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19 **Secondary Outcomes**

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21 A LMM analysis of distress levels revealed no significant main effects or
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23 interactions. In the case of burnout, however, LMM analysis identified a significant
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25 main effect of time, $F(2, 66.24) = 4.70, p = .012$, and a Group x Time interaction, $F(2,$
26
27 $66.24) = 10.23, p < .001$. Pairwise comparisons showed burnout increased in the
28
29 ACTr group between baseline and post-intervention ($p < .001$) before returning to
30
31 pre-intervention levels at follow-up, but for the DBTr group it did not change
32
33 significantly over time. Psychological flexibility followed the same pattern as
34
35 burnout. LMM analysis revealed a significant main effect of time ($F(2, 70.33) = 6.27,$
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37 $p = .003$), and a significant Group x Time interaction ($F(2, 70.33) = 6.65, p = .002$).
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39 Pairwise comparisons showed the interaction was the result of a significant decrease
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41 in flexibility for the ACTr group between baseline and post-intervention, ($p < .001$)
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43 which was no longer evident at follow-up. The corresponding comparisons were not
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45 significant for the DBTr group.
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52 **Thematic Analysis**

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54 Themes specific to ACTr and DBTr were identified to a high level of inter-rater
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56 reliability ($kappa = 0.80$). ACTr participants emphasised the emotional impact of
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3 working with PD patients. They noted that ACTr was emotionally exposing and
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5 challenging, but that these experiences were worthwhile and helpful. For example,
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7 the personal disclosure encouraged by the training fostered a sense of humanity and
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9 community within the group. Participants reported that, after training, they had a
10
11 greater awareness of their thoughts, emotions, and action urges, both with regard to
12
13 their PD patients and in their daily lives outside work. In contrast to the ACTr group,
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15 DBTr participants focused on how services dealt with PD patients, rather than on
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17 their personal reactions to them. They reported that DBTr fostered a connection
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19 with other participants but this reflected a shared professional approach to their
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21 work. Likewise, they described the training as intellectually challenging. DBTr group
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23 members reported that, after training, they had a sense of reassurance about their
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25 professional role, but they made little mention of personal impact.
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31 Discussion

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33 To our knowledge, this is the first RCT of staff training interventions aimed at
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35 reducing stigma towards PD patients, a group widely regarded as “difficult” (e.g.
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37 Koekkoek et al., 2006). We compared the impact on front-line staff of two training
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39 interventions, one focusing on the role of intra-psychic processes in cognitive and
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41 emotional self-management (ACTr); the other on knowledge and skills-based
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43 processes in patient management (DBTr). Primary outcomes were changes in
44
45 attitudes towards PD patients, and staff-patient relations (therapeutic relationship;
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47 social distancing) following training; secondary outcomes related to measures of
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49 staff wellbeing (distress, burnout, and psychological flexibility). Any differential
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51 effects of the training approaches would have produced significant group x time
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53 interactions in our LMM analyses, but these effects did not emerge except for
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3 burnout and flexibility (see below). Thus, the two interventions could not be
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5 differentiated from each other in terms of primary outcomes. Importantly, however,
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7 each of these measures revealed a main effect of time, indicating that training was
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9 associated with improvements in attitudes, therapeutic relationships, and social
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11 distancing, and that these benefits were sustained at 6-month follow-up.
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15 On secondary outcomes, however, the effect of training was less clear.
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17 Distress did not change with training, but both burnout and psychological flexibility
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19 showed a group x time interaction, explicable in terms of poorer outcomes for the
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21 ACTr group immediately after training which were not sustained at follow-up. There
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23 were no such changes in the DBTr group for either measure.
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27 These results are important in that they demonstrate that staff working in a
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29 variety of settings can benefit from relatively brief training interventions designed to
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31 improve their ability to manage working with PD patients. Training was sufficient to
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33 produce not only a sustained reduction in staff's self-reported negative attitudes
34
35 towards patients, but also a corresponding improvement in their self-reported
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37 therapeutic relationships and social distancing. Such changes may be expected to
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39 produce benefits for the PD patients themselves, whose care could be compromised
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41 by negative attitudes.
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45 Unfortunately, the improvement in staff's reported capacity to work with PD
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47 patients was not mirrored by improvements in their own personal functioning (i.e.,
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49 distress, burnout, and flexibility). Although Taylor (2011) has shown an association
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51 between negative attitudes towards PD patients and negative outcomes for staff,
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53 training-produced attitude change was insufficient to reduce these outcomes. This
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55 may reflect a dose effect (more or improved training would be required) or a
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3 measurement sensitivity issue (indicators of wellbeing may not reflect changes). In
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5 fact, both burnout and flexibility showed a differential but unsustained rise post-
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7 intervention following ACTr, which was not mirrored following DBTr. These effects
8
9 may have arisen because ACTr's focus on staff processes evoked strong emotions,
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11 which were initially experienced as challenging and disruptive. The interviews
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13 conducted 3 months after training supported this interpretation.
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17 Qualitative analysis of interview data indicated that the different training
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19 approaches impacted on participants in different ways. ACTr respondents
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21 emphasised that the training influenced their personal thoughts and emotions
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23 towards their patients, their action urges, and their sense of shared humanity. In
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25 contrast, DBTr respondents focused on the impact training had on their professional
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27 role. These themes mirror the different foci that the interventions adopted towards
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29 staff-patient relations: self-management in ACTr vs. patient-management skills in
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31 DBTr.
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35 DBTr, based on a leading evidence-based treatment for PD, focused on giving
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37 staff tools for understanding and dealing with PD patients' difficulties. In contrast,
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39 ACTr made little reference to patients' difficulties; rather, it focused on staff's
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41 professional values and their management of the private experiences triggered by
42
43 their work. The fact these two approaches had comparable outcomes is therefore
44
45 noteworthy, particularly because the qualitative analysis suggested that the
46
47 processes involved in change differed markedly. If both approaches have merit for
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49 different reasons, staff training that combines elements of both could be usefully
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51 trialled. One additional and timely research direction would be to evaluate ACTr and
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3 DBTr approaches in other care specialties where staff attitudes may sometimes
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5 compromise the quality of care.
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8 Although we have shown that brief training is associated with improvements
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10 in attitudes towards, and perceived relations with, PD patients, some limitations of
11
12 the study are apparent. Methodologically, the absence of a control condition for
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14 non-specific effects limits our confidence regarding how useful either training
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16 condition was compared to none at all. Although the possibility exists that the
17
18 effects observed were entirely non-specific, this seems unlikely given (a) the results
19
20 of the qualitative analysis, in which participants' reports reflected processes of
21
22 change that were specific to the intervention they had received and (b) the longevity
23
24 of the effects, which were still apparent 6 months after the training. There are, in
25
26 any case, some difficulties in eliminating the possibility that training effects are non-
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28 specific unless a training method known to be inert or ineffective is used as a
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30 control. This approach, however, raises some ethical and practical questions, in part
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32 because of the pressures on services and staff time. It was for this reason that we
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34 opted for a comparison of treatments we believed to be active. Future research
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36 might consider adding a waiting-list control condition, but this could incur selective
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38 attrition because participants who are less enthusiastic about training may drop out
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40 during the waiting period.
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47 A further consideration is that, because participants were volunteers, their
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49 attitudes towards PD patients were not extreme. Staff who hold the most negative
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51 views may be less likely to volunteer for training programs aimed at tackling these
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53 difficult feelings. A study in which attendance was compulsory would, however, raise
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55 substantial ethical issues and, in any case, it would be difficult to fully engage staff
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3 who were reluctant to attend training designed to promote positive attitudinal
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5 change.
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8 Another limitation arose from the fact that attrition was high at follow-up in
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10 both conditions. Future research could use a larger sample to increase statistical
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12 power and incentivise completion of follow-up measures. It would also be useful to
13
14 reduce reliance on staff self-report, for example by obtaining data on staff-patient
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16 interactions, through observation or patient report. This would mitigate the risk of
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18 social desirability bias in staff self-reports. Although our questionnaires were
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20 completed anonymously, future research could measure social desirability bias
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22 directly and, if necessary, treat it as a covariate.
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27 A final consideration relates to the initial negative effects on flexibility and
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29 burnout in the ACTr group. This may reflect the evocative nature of the intervention,
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31 because we obtained post-intervention assessments immediately after training. The
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33 qualitative analysis confirmed that ACTr was emotionally challenging. Further
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35 programmes could 'soften' the ACTr protocol to reduce the immediate challenge
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37 presented, without compromising its self-related focus. This approach has been used
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39 successfully in organisationally-based ACT interventions (Flaxman & Bond, 2006).
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44 In conclusion, this trial paves the way for future research to establish more
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46 firmly the mechanisms by which ACT-based and DBT-based interventions work to
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48 reduce stigma, an issue of pressing concern in contemporary healthcare. We can
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50 envisage a research program, conducted across a variety of healthcare specialties,
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52 that explores the impact of brief stigma-focused interventions, based on self-
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54 management or skills-based methods—or an amalgam of both approaches. The
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56 results of such a program could help ameliorate the critical problems faced by hard-
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ACTr vs. DBTr for PD staff

pressed services in attempting to maintain a culture of compassionate care.

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Table 1

Demographic Data for Participants in Both Interventions

	ACTr		DBTr	
	<i>n</i>	Mean (SD)	<i>n</i>	Mean (SD)
	Range		Range	
Age	49	41.80 (10.96)	46	41.52 (12.26)
		23 - 59		21 - 67
Gender (Female <i>n</i> and (%))	47	42 (79)	44	36 (77)
Relevant Work Experience (Years)				
Mental Health (general)	48	9.51 (7.51)	45	10.11 (7.74)
		<1 - 25		<1 - 36
Personality Disorder	46	6.06 (6.52)	41	6.54 (6.88)
		<1 - 25		<1 - 36
Number of PD patients currently seeing (median)	51	2 – 5 patients	47	2 – 5 patients
Service (<i>n</i> and (%))				
NHS Inpatient Services		9 (17)		4 (9)
NHS Outpatient Services		19 (36)		12 (26)
NHS A & E		0 (0)		1 (2)
Social Services		4 (8)		2 (4)
Housing Services		10 (19)		8 (17)
Administrative		2 (4)		0 (0)

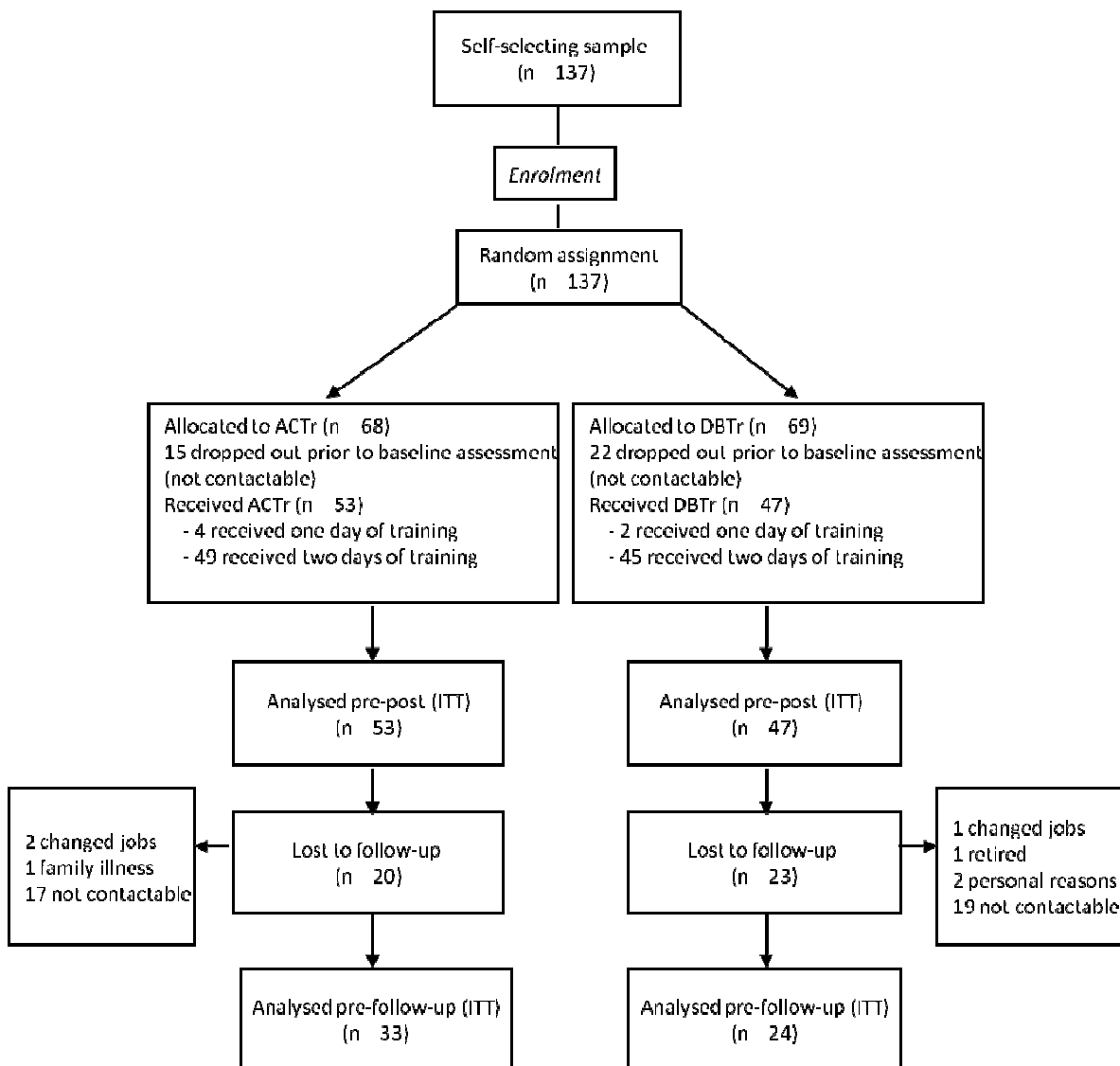
Table 2

Mean Scores (Standard Deviations) for Questionnaire Measures in ACTr and DBTr Groups At All Time Points

	ACTr						DBTr					
	n	Pre	n	Post	n	6 f/up	n	Pre	n	Post	n	6 f/up
		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)		Mean (SD)
APDQ	49	137.9 (17.09)	47	142.23 (16.93)	30	142.05 (20.52)	45	143.49 (18.74)	45	151.17 (16.93)	23	147.96 (15.31)
HAQ-II	45	80.01 (9.32)	48	81.68 (8.38)	31	82.45 (9.47)	42	78.92 (8.06)	45	82.67 (6.47)	23	81.78 (7.83)
SDS	49	12.02 (3.62)	48	10.25 (3.30)	31	10.97 (3.66)	42	12.00 (4.07)	43	11.09 (4.05)	23	9.65 (4.43)
MBI	50	19.74 (10.89)	49	26.20 (12.91)	33	20.94 (14.35)	44	21.91 (12.85)	46	20.46 (10.95)	21	24.00 (12.60)
GHQ	53	17.51 (8.45)	47	17.30 (7.94)	33	21.27 (13.37)	44	18.28 (7.90)	45	16.82 (7.09)	23	17.04 (7.71)
AAQ-II	50	38.44 (5.70)	50	35.34 (6.68)	33	37.85 (6.76)	43	39.40 (5.75)	45	39.04 (5.38)	22	38.95 (4.70)

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Note. Higher scores indicate less stigma (APDQ), better therapeutic relationship (HAQ-II), and more psychological flexibility (AAQ-II). Lower scores indicate less social distancing (SDS), less burnout (MBI), and less distress (GHQ).



Note. ITT = Intention to treat

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