RESEARCH PAPER

The effectiveness of combined therapy on overcompensation coping strategies in histrionic personality disorder patients

A eficácia da terapia combinada nas estratégias de *coping* de hipercompensação em pacientes com perturbação de personalidade histriónica

Seyyedeh Sahar Asgari Ghalebin [1]
Sajad Bashrpour [1]
Seyyedeh Mehsa Mousavi [1]

[1] *University of Mohaghegh Ardabili, Department of Psychology, Ardabil, Iran*

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Abstract

Objective: This study aimed to evaluate the effectiveness of a combination of Schema Therapy and ACT (Acceptance and Commitment Therapy) in reducing overcompensation coping strategies associated with early maladaptive schemas in patients diagnosed with histrionic personality disorder (HPD). **Methods**: A randomized quasi-experimental design with a comparison group was used, involving pre-test, post-test, and a two-month follow-up assessment. Participants were 30 HPD patients selected from three psychology centers in 2021–2022 in Tehran who met the inclusion criteria for HPD diagnosis based on clinical interviews and Millon Clinical Multiaxial Inventory-III (MCMI-III). Patients were randomly assigned to either the intervention or waitlist group. The intervention group received ten 90-minute sessions of combined therapy. MCMI-III and the Young Compensation Inventory (YCI) were used as research instruments. Multivariate analysis of covariance was used to control for pre-treatment differences between the intervention and waitlist groups and to assess the effect of the intervention on the outcome measures. **Results**: The intervention group had significantly lower MCMI-III Disclosure scores and lower YCI levels immediately post-treatment and at the two-month follow-up assessment compared to the waitlist control group. The effect sizes for these comparisons were large to very large, indicating a significant and clinically meaningful improvement in the intervention group. **Conclusions**: The findings suggest that combined Schema Therapy and ACT may be effective in reducing overcompensation coping strategies in HPD patients. The study's limitations included the absence of random sampling in the first stage of screening. Future research should aim to replicate these findings with larger samples and diverse populations.

Keywords: Histrionic Personality Disorder; Schema therapy; Acceptance and Commitment Therapy; Overcompensation Coping Strategy; Quasi-experiment.

Seyyedeh Sahar Asgari Ghalebin
Department of Psychology, University of Mohaghegh Ardabili
56199-13131, Ardabil, Iran
Tel.: +989198087106
E-mail: s.asgari@uma.ac.ir

Resumo

Objetivo: O objetivo deste estudo foi avaliar a eficácia de uma combinação de Terapia do Esquema e ACT (Terapia de Aceitação e Compromisso) na redução de estratégias de hipercompensação associadas a esquemas mal adaptativos precoces em pacientes diagnosticados com perturbação histriónica da personalidade (PHP). **Métodos**: Foi utilizado um desenho quase-experimental com grupo de comparação, envolvendo pré-teste, pós-teste e uma avaliação de acompanhamento de dois meses. Trinta indivíduos foram escolhidos por amostragem por conveniência e, em seguida, aleatoriamente atribuídos ao grupo de intervenção ou ao grupo de espera. O grupo de intervenção recebeu dez sessões de terapia combinada de 90 minutos, enquanto o grupo de controlo estava numa lista de espera. O MCMI-III (Inventário Multiaxial Clínico de Millon-III) e o YCI (Inventário de Compensação de Young) foram utilizados como instrumentos de pesquisa. A análise de covariância multivariada foi utilizada para controlar as diferenças pré-tratamento entre os grupos de intervenção e de espera e para avaliar o efeito da intervenção nas medidas de resultado. **Resultados**: O grupo de intervenção apresentou pontuações na escala de Divulgação do MCMI-III significativamente mais baixas e níveis mais baixos de YCI imediatamente pós-tratamento e na avaliação de acompanhamento de dois meses, em comparação com o grupo de controlo em lista de espera. Os tamanhos do efeito para essas comparações foram grandes a muito grandes, indicando uma melhoria significativa e clinicamente relevante no grupo de intervenção. **Conclusões**: Os resultados sugerem que a Terapia do Esquema combinada com ACT pode ser eficaz na redução de estratégias de compensação excessiva em pacientes com PHP. As limitações do estudo incluem a ausência de amostragem aleatória na primeira fase de triagem. Futuras pesquisas devem visar replicar esses achados com amostras maiores e populações diversas.

Palavras-Chave: Perturbação Histriónica da Personalidade; Terapia do Esquema; Terapia de Aceitação e Compromisso; Estratégia de Hipercompensação; Quási-experimental.

Introduction

Personality disorders are common and chronic mental health conditions affecting approximately 7.8% (95% *CI* 6.1–9.5) of the general population (Winsper et al., 2020). These disorders are characterized by a persistent pattern of maladaptive behaviors and cognitive-affective functioning that deviates from cultural norms and leads to significant impairments in social and occupational functioning (American Psychiatric Association [APA], 2013). Typically, personality disorders begin in adolescence and can lead to significant deficits in at least two of the four domains of cognition, emotion, interpersonal function, or impulse control (APA, 2013; Foster et al., 2014).

Inflexibility is a key indicator of personality disorder, leading to an inability to engage in social and other essential activities. People with personality disorders often fail to modify their behavior or attitudes, even when evidence shows that their methods are ineffective (French & Shrestha, 2021). Histrionic personality disorder (HPD) is one such disorder, classified in cluster B of the DSM-V, which encompasses impulsive, excitable, and dramatic behaviors alongside borderline, antisocial, and narcissistic disorders (APA, 2013). HPD is characterized primarily by intense and histrionic emotional expressions, as well as the use of covert or seductive behavior to attract and maintain support from others. Other traits associated with HPD include inappropriate theatrical and seductive interpersonal styles and a tendency to overestimate the importance of physical appearance and attractiveness to gain attention and validation (French & Shrestha, 2021). Although the prevalence of this disorder is estimated to be 2–3% in the general population, it is more commonly diagnosed in inpatient health clinics, where its prevalence can reach up to 10–15% (Smith & Lilienfeld, 2017). While it is thought to be more prevalent in women than men, this difference may be due to cultural

conditioning of diagnoses rather than actual differences in distribution between the genders (Perrotta, 2019).

One of the most widely accepted etiological theories for HPD is that it has a dual origin: biological and psychological. From a biological perspective, individuals with this disorder are said to have a highly sensitive temperament and may seek external validation to satisfy their psychological needs (Perrotta, 2021). Psychosocially, some individuals may have been praised for their physical appearance by significant others, especially their parents, rather than their skills. Consequently, they may have learned that their body can be used to satisfy their emotional needs. Others may have learned to seek support only through physical complaints, as they received care and attention primarily when they were sick (Perrotta, 2021). As a result, individuals with histrionic personality disorder are often preoccupied with attracting the attention of others as a means of meeting their psychological needs. These efforts to attract attention can become ingrained in their way of life and may be seen as an overcompensation coping style, which is acting as if the opposite of the schema were true.

Coping strategies are the ways in which people deal with life problems, and they are often correlated with defensive reactions and personality traits (Krattenmacher et al., 2013). Coping strategies can be classified into three categories: avoidance, surrender, and overcompensation. People with an avoidance style tend to avoid situations that emotionally threaten them, while those with a surrender style react passively in line with the underlying schema (Young, 1999). Those who have an overcompensation style try to deal with challenges in a pathological and problematic way (e.g., attacking others or seeking approval). In overcompensation strategies, the individual fights against the content of the schema by thinking, feeling, and behaving in exactly the opposite and exaggerated way, as if the opposite of the schema were true, and to avoid the negative schema being activated (Young, 1999; Young et al., 2003). In the case of HPD, individuals may use behaviors such as being excessively social, showing self-confidence, being seductive, telling histrionic stories, threatening suicide, displaying depression, and seeking help as expressions of the overcompensation defensive style to deal with situations in which they are not the center of attention (Ritzl et al., 2018).

Defensive strategies, according to Young's theory of Schema Therapy, are employed to deal with early maladaptive schemas. Schema Therapy integrates the principles and foundations of cognitive-behavioral approaches, attachment theory, gestalt therapy, object relations theory, structuralism, and psychoanalysis into a comprehensive conceptual and therapeutic model (Young, 1999). In the development of maladaptive schemas, an individual's inherent temperament is combined with early negative experiences. In Schema Therapy, early maladaptive schemas are the primary focus of treatment for personality disorders. Early maladaptive schemas are emotional and cognitive patterns of self-harm that are formed in the mind during early growth and development and are often repeated throughout life. These mental patterns consist of four components: emotion, cognition, memories, and bodily feelings (Johnston et al., 2009). There are eighteen types of schemas that fall into five

general categories: disconnection and rejection, impaired autonomy and performance, impaired limits, other-directedness, and over-vigilance and inhibition. These schemas often operate at a deep, unconscious level and contribute to psychological vulnerability. Individuals process environmental stimuli through the filter of these dysfunctional schemas, resulting in maladaptive behaviors (Arntz et al., 2005).

The persistent and repetitive nature of histrionic individuals' problems in their lives is due to the use of confrontational behaviors when their schemas are activated, which can eventually become part of their lifestyle. Schema Therapy aims to reduce the effectiveness of these mental patterns and reinforce acting outside of them. Techniques used in Schema Therapy include interventions that target cognitive processes, behavioral experiments that challenge maladaptive patterns, and the development of a therapeutic relationship (Arntz & van Genderen, 2020). Although Schema Therapy is one of the preferred treatments for personality disorders, it does have certain limitations, such as the high number of sessions required and the cost of treatment, which may make it challenging for some patients to continue treatment. Fortunately, the combination of Schema Therapy and Acceptance and Commitment Therapy (ACT) has emerged as a new, highly effective treatment for personality disorders (McKay et al., 2012). McKay et al. (2012) developed an intervention that uses mindfulness, acceptance, and schema awareness to target interpersonal problems and change maladaptive interpersonal behaviors.

ACT is a third-generation behavioral therapy that emphasizes changing the relationship with cognitions and beliefs rather than changing them. The primary goal of ACT is to increase psychological flexibility, which enables individuals to make practical choices between different options when faced with distressing memories, thoughts, feelings, and desires (Bach et al., 2006). This approach helps individuals to observe and describe their emotional states without judgment and without experiencing secondary emotions such as shame, guilt, distrust, blame, and humiliation. The six main processes of ACT therapy are acceptance, cognitive defusion, present moment awareness, self-as-context, values, and committed action (Hayes, 2013).

Combining Schema Therapy with ACT involves helping patients recognize and understand their maladaptive schemas, as well as learning how these schemas are formed and sustained. This process aims to increase awareness of the maladaptive patterns and promote psychological flexibility by providing patients with tools to observe and modify their automatic thoughts, emotional states, and behavioral responses. The combination of these two treatments has shown promising results in reducing maladaptive coping behaviors associated with personality disorders, including histrionic personality disorder (McKay et al., 2012).

During treatment, patients with HPD may exhibit defensive and confrontational behaviors. Mindfulness skills from ACT are used to help patients become aware of how their schemas influence their perception of relationships and the unpleasant feelings and behaviors that follow (Lev, 2011). Cognitive strategies and schema experiences are combined with ACT to help patients focus on the possibility of starting a new path. The therapist introduces the concept of failure, which is addressed

in ACT to help patients free themselves from the emotional and cognitive bondage caused by schemas. Behavioral pattern-breaking skills from Schema Therapy are used to help patients become aware of the impact of their schemas and to work towards a common goal of eliminating maladaptive coping behaviors. In the next stage of therapy, the therapist helps the patient discover their personal values and create a new path based on those values. The therapist may also use himself and other group members as role models for the patient. The therapist combines interpersonal relationship pattern skills from Schema Therapy with values from ACT to help patients develop a new path that is in alignment with their values. Finally, the therapist must help the patient overcome the pressures of their schemas and commit to their new path, even when it causes suffering. This process involves a combination of therapeutic schema disruption and ACT techniques that support each other (Lev, 2011).

In summary, previous studies have focused on individual therapy approaches, and few studies have explored the potential benefits of combining these two therapies. Thus, our study aimed to address the gap in the literature regarding the effectiveness of combined Schema Therapy and ACT in treating HPD. Our objective was to evaluate the effectiveness of a combined Schema Therapy and ACT intervention in reducing overcompensation coping strategies associated with early maladaptive schemas in patients diagnosed with HPD. Our ultimate goal was to improve the quality of life for individuals with HPD and provide a more effective treatment option for mental health professionals working with this population.

Method

Participants

The participants were selected from patients of three psychology centers in Tehran between 2021–2022. Inclusion criteria were as follows: a) estimated acceptable levels of histrionic personality according to the Millon Clinical Multiaxial Inventory-III (MCMI-III) and clinical interview; b) absence of psychosis, bipolar disorder, and other personality disorders; c) absence of psychiatric disorder due to medical diseases and use of psychiatric drugs; d) no history of hospitalization or electroconvulsive therapy. Exclusion criteria were as follows: a) absenteeism for more than two consecutive sessions; b) recurrence of the disorder and diagnosis of the need for psychiatric services; c) non-participation in one of the evaluation stages.

Initially, the clinical records of 122 patients with a diagnosis of HPD according to the MCMI-III were reviewed. Of these, 58 patients agreed to participate in the clinical project. After conducting clinical interviews again, 30 participants were selected and randomly divided into a waitlist group (n = 15) and an intervention group (n = 15). The participants' ages ranged from 30 to 36 years (M = 32.67; SD = 8.14). Table 1 provides descriptive statistics for the gender, marital status, and education of the participants in the waitlist and intervention groups.

Table 1

Descriptive Analysis of Participant Demographics by Groups

Variables	Categories	Waitlist group		Intervention group	
		n	%	*n*	%
Gender	Female	8	26.7	9	29.9
	Male	7	23.4	6	20.0
Marital status	Single	10	31.1	13	44.9
	Married	5	17.1	2	6.9
Education	Postgraduate	1	3.3	1	3.3
	Diploma	5	16.7	4	13.3
	Bachelor	6	20.0	7	23.4
	Masters	2	6.7	3	10.0
	Doctorate	1	3.3	0	0.0

Measures

Millon Clinical Multiaxial Inventory (MCMI-III)

The MCMI-III was used as a tool to select participants who met the criteria for histrionic personality disorder. The MCMI-III is a standardized self-assessment inventory used to measure various aspects of personality, emotional adjustment, and attitudes among individuals aged 18 years or older who have a level of education of at least eighth grade (Millon, 1994). The MCMI-III includes 175 items, true-false, across 28 distinct scales and is scored based on the following categories: 1) indicators of variability, 2) clinical personality patterns, 3) severe personality pathology, 4) clinical syndromes, and 5) severe clinical syndromes. These categories are consistent with Millon's personality theory and DSM-IV personality disorder diagnoses. The MCMI-III has demonstrated high test-retest validity, with a median coefficient of 0.91, and separate norms have been established for male and female profiles to minimize gender-related effects (Millon, 1994). The average validity of MCM-III was 0.89 for personality scales and 0.91 for clinical disorders. The MCMI-III has been standardized twice in Iran, with the most recent standardization conducted in Isfahan by Sharifi (2003), yielding internal consistency ranging from 0.69 (delusional) to 0.92 (borderline), with an average of 0.84. For this study, we used raw scale scores as they are more appropriate for analyses (Hsu, 2005), and only valid profiles were included in the sample based on the following criteria: the total number of omitted or invalid responses (e.g., both a "yes" response and a "no" response to a single item) was less than 12, the V (validity index) was less than 2, and the raw score on scale X (disclosure) was within the range of 34–178. The Disclosure scale measures the extent to which patients provide an accurate reflection of their self-perception and do not under- or over-report symptoms (Millon et al., 2006). We used this scale to assess the impact of the intervention. Participants

who scored between 60 and 80 on the MCMI-III and met the criteria for a diagnosis of HPD during the clinical interview were included.

Young Compensation Inventory (YCI)

This 48-item scale was used to assess compensation strategies associated with early maladaptive schemas (http://www.schematherapy.com/id114.htm). The items can be categorized into 19 subscales that represent different types of overcompensation for various schemas. Responses are rated on a 1–6 Likert scale (1 = *completely untrue of me* to 6 = *describes me perfectly*), with higher scores indicating a greater tendency toward schema compensation (Young, 1995). All answers with a score of 5 or 6 are considered overcompensatory strategies for emotions that are related to the schemas (Young, 2014). Previous studies have shown that the YCI has good psychometric properties (e.g., Karaosmanoğlu et al., 2013). Data on the psychometric properties of the Iranian version were not available. In Young's study (1995), an exploratory factor analysis yielded a KMO value of 0.79 and a statistically significant Bartlett's level of 71.68 ($p < .001$), explaining 92.5% of the total variance. The YCI had a split-half reliability estimate of .79 and a Cronbach's alpha of .82, indicating good internal consistency.

Procedures

This was a randomized quasi-experimental study that included a comparison group and involved pre-test, post-test, and a two-month follow-up assessment. The independent variables in this study were the combined Schema and ACT therapy, and the dependent variables were Disclosure scores (MCMI-III) and overcompensation levels (YCI). The MCMI-III Disclosure scale and the YCI were administered as pre-test measures. Subsequently, the intervention group received a protocol of ten 90-minute sessions of the combined schema and ACT therapy. Following the intervention, all participants in both groups completed the questionnaires again as post-tests, and a two-month follow-up assessment was conducted. During the treatment process, two individuals were excluded from the intervention group, and three were excluded from the waitlist group.

In the present study, informed consent was obtained from all participants to participate in the sessions, and they were free to withdraw from the treatment at any time. The waitlist group was also informed that if the treatment results were satisfactory, they would receive the same protocol. This study adhered to ethical guidelines and regulations for human research.

Intervention

The intervention involved a group program designed to reduce coping behaviors associated with overcompensation style in patients with HPD. The program was based on the 10-week protocol by McKay et al. (2012) and focused on addressing common schema patterns relevant to interpersonal problems (e.g., abandonment, entitlement, subjugation) using ACT methods (e.g., developing mindfulness skills, clarifying values, cognitive defusion). The program was delivered over ten weeks, with each session lasting 90 minutes. A client handbook containing information and worksheets was provided to participants. The main facilitator was a Ph.D. holder in Psychology, and co-facilitation was provided by a Ph.D. Candidate in Psychology. The facilitators received training in ACT through a one-day workshop and

weekly supervision by the second author, who is a psychologist and accredited supervisor, through the Psychology Board of the University of Mohaghegh Ardabili. To ensure consistency in program delivery, weekly supervision was provided for the duration of the program.

Statistical Analysis

Preliminarily, chi-square tests were used to compare the demographic variables (gender, marital status, and education) between the waitlist and intervention groups.

A multivariate analysis of covariance (MANCOVA) was utilized to analyze the data. Prior to conducting the MANCOVA, the normality of the scores was assessed using the Shapiro-Wilk test, and the homogeneity of variances was also assessed using Levene's test, which indicated that the assumption of homogeneity of variances would be met. The MANCOVA was conducted to examine the effects of the combined Schema therapy and ACT on the dependent variables of Disclosure scores (MCMI-III) and overcompensation levels (YCI), with the pre-test scores serving as covariates. The two-month follow-up assessment scores were also included in the analysis.

The significance level was set at $p < .05$. All analyses were conducted using SPSS version 25.

Results

Preliminarily, the results of the chi-square showed no significant difference between the two groups ($p > .05$).

Table 2 displays the means and standard deviations for the intervention and waitlist groups on the pre-test, post-test, and two-month follow-up of the MCMI-III Disclosure scale and the YCI. At the pre-test, there were no significant differences between the two groups on the MCMI-III Disclosure scale and the YCI measures in terms of MCMI-III Disclosure scores ($t_{(28)} = 0.62$, $p > .05$, $d = 0.23$) and overcompensation levels measured by the YCI ($t_{(28)} = 1.29$, $p > .05$, $d = 0.47$).

Table 2

Descriptives of Pre-test, Post-test, and Follow-up MCMI-III-D and YCI Scores for HPD Patients in Combined Schema Therapy and ACT (Intervention Group) vs. Waitlist Group

Groups	Variables	Pretest		Post-test		Follow-up	
		M	*SD*	*M*	*SD*	*M*	*SD*
Intervention	MCMI-III-D	66.67	8.39	50.22	5.31	35.14	3.83
	YCI	198.47	26.44	145.23	22.74	109.43	16.22
Waitlist	MCMI-III-D	64.83	7.78	65.14	5.75	61.34	5.39
	YCI	186.19	25.54	193.32	23.58	173.48	16.79

Note. MCMI-III-D = Millon Clinical Multiaxial Inventory-III Disclosure scale; YCI = Young Compensation Inventory; HPD = histrionic personality disorder.

The MANCOVA was used to compare the pre-test, post-test, and follow-up scores between the intervention and waitlist groups. Before conducting the MANCOVA, Shapiro-Wilk and Levene's tests were used to check the normality and homogeneity of variances, respectively, and the assumptions were met for the three assessment moments ($p > .05$).

Regarding the Intervention, the results showed that the combined Schema Therapy and ACT program was effective in reducing overcompensation coping strategies in patients with HPD. The intervention resulted in a significant decrease in Disclosure scores on the MCMI-III, $F_{(2, 27)} = 92.47$, $p < .001$, partial eta squared = .74, and YCI scores $F_{(1, 27)} = 53.44$, $p < .001$, partial eta squared = .63, at the post-test, indicating a significant improvement in the intervention group compared to the waitlist group.

These significant differences were maintained at the two-month follow-up for Disclosure scores on the MCMI-III, $F_{(1, 27)} = 91.69$, $p < .001$, partial eta squared = .73, and YCI scores, $F_{(1, 27)} = 51.92$, $p < .001$, partial eta squared = .61.

The effect sizes between groups for the Disclosure scores on the MCMI-III were large for both the post-test (Cohen's $d = 2.70$) and follow-up (Cohen's $d = 5.60$, and the effect sizes for the YCI scores were large for both the post-test (Cohen's $d = 2.08$) and follow-up (Cohen's $d = 3.88$).

Discussion

The present study aimed to investigate the effectiveness of a combined Schema Therapy and ACT intervention in reducing overcompensation coping strategies in patients diagnosed with HPD. The findings of this study showed that the intervention group that received the combined intervention, besides having significantly lower MCMI-III Disclosure scores, had significantly lower YCI levels compared to the waitlist control group, both immediately post-treatment and at the two-month follow-up assessment. The effect sizes for these comparisons were large to very large, indicating a significant and clinically meaningful improvement in the intervention group.

The combination of Schema Therapy and ACT is an emerging intervention, and only a few studies have investigated its efficacy. Previous research on this intervention has mainly focused on its effectiveness in improving borderline personality patterns (Asgari Qhalebin et al., 2021), addressing interpersonal problems of patients with alcohol consumption, and improving therapeutic alliance and schema-focused cognitions in hospitalized patients (McKay et al., 2012).

It is worth noting that histrionic personality disorder is the least researched among all personality disorders in cluster B (Beck et al., 2015). However, the present study's findings are in line with previous research on the effectiveness of Schema Therapy for personality disorders (Bamelis et al., 2012; Jacob & Arntz, 2013; Gol et al., 2019) and ACT for personality disorders (Mazaheri Nejad Fard et al., 2019; Derakhshan et al., 2020; Chakhssi et al., 2015).

According to Schema Therapy theory, early maladaptive schemas and maladaptive coping strategies play a critical role in the development of personality disorders. Therefore, addressing these maladaptive patterns can alleviate the symptoms of the disorder (Young, 1999). In histrionic patients, the acceptance schema is one of the most important maladaptive schemas, in which individuals seek approval and

attention from others, often at any cost (Gol et al., 2019). Consequently, individuals with HPD may engage in exaggerated and theatrical behaviors, such as sexually seductive and provocative interactions with others, constant use of physical appearance to attract attention, vague and cryptic speech, the extreme expression of emotions to compensate for their emotional deficiencies, and a tendency to show intimacy in relationships that may not actually exist, along with constant and excessive influence attempts (Novais et al., 2015). These individuals often lack internal value criteria and feel validated only through the approval of others. The acceptance schema is often an overcompensation for the schemas of emotional deprivation, imperfection, and shame (Young, 1999; Young et al., 2003). Individuals with histrionic personality disorder often have intense emotional needs resulting from feelings of inferiority. As a compensatory coping strategy, they constantly seek to highlight their positive traits to others, using exaggerated and attention-seeking behaviors (Novais et al., 2015).

The therapist's role in the combined Schema and ACT intervention was to restore emotional security to the patient. In this therapy, cognitive and emotional schema therapy techniques were initially used to introduce patients to their active schemas empathically, and then they were explained to them how to implement their overcompensatory coping style. The patients were asked to give examples of this coping strategy in their lives and memories to become familiar with their psychological mechanism. Then, with the help of ACT techniques, patients were helped to accept themselves as they are in the first place, feel the activation of their schemas with the help of mindfulness, and get rid of it through diffusion techniques while identifying their true and personal values. Patients were encouraged to act on their schemas based on their personal values, not based on the values of others, by using behavioral modeling and committing to their own values. Therefore, the high effectiveness of the combined schema and ACT group therapy could be explained by the fact that it targeted the disturbed aspects of the lifestyle of histrionic patients and provided a suitable solution for them.

Limitations and Future Avenues

Despite the promising results of the present study, there are several limitations that should be taken into account when interpreting the findings.

First, the participants were not selected through random sampling in the initial screening stage. This could have introduced bias into the study, as the participants may not have been representative of the broader population of individuals with an HPD. To address this limitation in future studies, it is recommended that a random sampling method is employed in the screening process to ensure the selection of a more representative sample.

Second, the sample size was relatively small, which may limit the generalizability of the results. Future studies with larger sample sizes are needed to confirm the effectiveness of the combined Schema Therapy and ACT intervention for individuals with HPD.

Third, the study was conducted in a specific cultural context, and the results may not be applicable to other cultural or ethnic groups. Future studies should investigate the effectiveness of the intervention in different cultural contexts to assess the generalizability of the findings.

Fourth, the present study used a waitlist control group instead of an active control group, which limits the ability to conclude that the observed effects were due solely to the intervention. Future studies should use an active control group to better assess the effectiveness of the intervention.

Finally, the present study only included a two-month follow-up assessment, and longer-term follow-up assessments are needed to assess the durability of the intervention effects over time.

In summary, while the present study provides preliminary evidence for the effectiveness of the combined Schema Therapy and ACT intervention for individuals with HPD, further research is needed to address the limitations of this study and confirm its generalizability and long-term effectiveness.

Conclusion

HPD is a common personality disorder characterized by the use of overcompensation coping strategies to gain approval from others. This study aimed to evaluate the effectiveness of combined Schema Therapy and ACT in reducing these overcompensation strategies in patients with HPD. The results of this study demonstrated that the combination of schema and ACT therapy might be effective in improving and reducing compensatory behaviors in histrionic patients. Further research is needed to confirm these results and to explore the potential benefits of this intervention in a larger sample size and in different contexts.

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