Journal of Contextual Behavioral Science 4 (2015) 144–150

Contents lists available at ScienceDirect

Journal of Contextual Behavioral Science

journal homepage: www.elsevier.com/locate/jcbs

Creating a peer-led acceptance and commitment therapy consultation group: The Portland model ☆

Brian L. Thompson [a,*], Jason B. Luoma [a], Christeine M. Terry [b], Jenna T. LeJeune [a], Paul M. Guinther [a], Harold Robb [b]

[a] Portland Psychotherapy Clinic, Research & Training Center, USA
[b] Private Practice, USA

ARTICLE INFO

Keywords:
Acceptance and Commitment Therapy
Consultation
Training

ABSTRACT

Regular peer consultation can be an important means to continually develop clinical skills. This paper describes our journey in creating a peer consultation group aimed at helping people learn and practice Acceptance and Commitment Therapy (ACT). Across several years, we have refined and shaped our meeting format, created documents outlining the format and roles, and begun to disseminate this model to others interested in beginning their own ACT peer consultation groups. This paper presents our model for running ACT consult groups, explains the history of it, and provides context for the choices we made in its development.

1. Introduction

The isolation common in practicing psychotherapy is among the most common sources of distress and job dissatisfaction cited by clinicians (Tryon, 1983). For many mental health professionals, peer consultation groups offer both emotional support and learning opportunities that may be lacking in everyday practice. Consultation groups serve many functions for the clinician, including the development and refinement of therapeutic skills, assistance with case conceptualization and treatment, maintenance of ethical standards, and emotional support for the difficult work of therapy.

Johnson, Barnett, Elman, Forrest, and Kaslow (2013) identify 6 core competencies that promote strong relationships among colleagues. These include (a) authenticity and self-awareness; (b) the ability to understand others' perspectives; (c) being able to feel vulnerable and accept feedback; (d) self-care; (e) being able to shift between expert and learner among colleagues; (f) the ability to talk about difficult issues in ways that deepens relationships and encourages competence. They argue that creating supportive communities is a vital way to encourage the development of professional competence among therapists. One of the most common forms of these types of supportive collegial communities is the peer consultation group.

Although consultation groups can be diverse in format, the most common model the authors of this paper encountered was oriented around the presentation of a clinical issue or challenge by one group member while the remaining group members provide solutions or strategies for working with the presenting issue. This model can be quite helpful in certain contexts, but we found this model was less ideal in helping clinicians learn and practice Acceptance and Commitment Therapy (ACT), which was the primary aim of our consultation group.

In this paper, we offer a consultation model that – after several years and revisions – has been helpful in encouraging involvement of new members, providing a safe environment to learn and practice ACT skills, and creating a local community of ACT therapists. We present our model in the hope it may aid other providers in developing their own ACT consultation groups, and that it can foster further discussion about improving the effectiveness of consultation groups as a means for learning therapy skills.

2. History of this model

Formed in 2005, the Portland ACT Peer Consult Group was developed to fulfill two functions: (a) ACT skill development and (b) community building. A core guiding principle of the group was that while learning through discussion and exchange of knowledge

☆*Author's note*: The authors would like to acknowledge all current and former members of the Portland ACT Peer Consult Group, whose consistent display of willingness and valued action have made this group what it is today. We are honored to be a part of such an extraordinary community of colleagues.

* Correspondence to: Portland Psychotherapy Clinic, Research & Training Center, 3700 N Williams Ave, Portland, OR 97227, USA. Tel.: +1 503 281 4852x14.
E-mail address: bthompson@portlandpsychotherapyclinic.com (B.L. Thompson).

http://dx.doi.org/10.1016/j.jcbs.2014.11.004
2212-1447/

is relatively easy and ubiquitous, development of therapeutic skills and flexibility in implementing a therapy approach is better developed through more experiential learning methods (Luoma, Hayes, & Walser, 2007). These methods include practice with feedback, observation of models, and learning through the application of therapy methods to one's self. In short, a central focus was on *practicing* ACT over *talking about* ACT – while also benefitting from the knowledge, feedback, and experience of colleagues. From its inception, the group was grounded in the idea that it would be a place for learning through doing as opposed to learning through discussing.

In addition to this professional development function, the group was created to foster a sense of community, camaraderie, and support among colleagues interested in contextual behavioral science (CBS). At the time of the group's formation, several members had been involved in the larger ACT and CBS community for many years and had admired and appreciated the warmth, support, and openness of this larger community. There was no identified ACT/CBS community in Portland, Oregon at the time. The group was created with the intention of bringing the spirit of the larger CBS community to the local area. Efforts were made to foster a sense of community, egalitarianism, and inclusivity in which all members shared responsibility for the creation, progression, and maintenance of the group.

Although the group was founded on the idea that it would be a true *peer* consultation group – without identified leaders or a structured hierarchy – this proved to be a challenge. Despite the intention to remain a leaderless group, the essential tasks of sending out reminders and coordinating meeting times and locations fell on the two individuals who initially organized the group, resulting in a perception that they were "leaders" of the group. These members served as the contact point for potential new members, hosted the meeting at their office, and sent out emails to coordinate and remind participants of upcoming meetings.

As with many consultation groups, members had a wide range of experience with and exposure to ACT. Without a strong structure in place, the group often turned to more experienced members to answer their questions. The result was that de facto "experts" emerged, undermining the peer quality of the group. Also, because the group had no established structure or method for conducting its activities, direction for the group often came from these more senior members, further cementing their leadership role. In these early months, the group struggled to remain non-hierarchical and egalitarian.

In earlier incarnations of the group, interactions within the groups were less experiential and often deviated from the group's ACT focus. One common scenario was that one participant would ask a question or bring up a clinical issue, and other participants would offer brief suggestions for what the therapist should do, often with little theoretical rationale or without any experiential elements. In order to try to curb these tendencies, the more experienced members tried to introduce experiential modes of consultation such as role-plays or working with the therapist's emotional reactions to client, but these were frequently interrupted with additional advice-giving from other members. As a consequence, most meetings quickly shifted from an experiential emphasis towards more intellectual and didactic suggestions (e.g., "Have you tried X…"), and because many of the group members were relative novices to ACT, many suggestions were not ACT-focused or consistent with the model. As a result, the group had difficulty maintaining a focus on experiential learning of ACT without explicit guidance from particular members. Unfortunately, the direction these leaders and ACT "experts" provided further reinforced the implicit sense of hierarchy and suppressed active participation by other group members.

During the first few years of the group, particular core members made many changes to the group format, but the group continued to struggle with the same challenges. The group was neither fulfilling its original intentions nor embodying the spirit of ACT. In 2009, key members decided to reevaluate and recommit to the original intentions for the group. They asked for volunteers within the group to participate in a process of values articulation and planning.

Over several months, the group collaboratively developed a mission statement (discussed in the following section; also see Table 1) that explicitly outlined the intended functions of the group. In addition, group members generated and committed to numerous personal values statements intended to guide their individual actions in the group. These values statements reflected both the professional development functions and the community building functions of the group.

Defining shared and individual values helped to foster a stronger sense of community, but the problems with hierarchy and a lack of experiential focus remained. As a result, a committee was eventually formed to explore ways to provide a more formal structure that might address these problems. This committee created an outline for the group's structure, identified various roles that could be filled inside this structure, and created forms to support the implementation of this new structure.

An important inspiration for the restructuring and creation of specific roles was Toastmasters, an international non-profit organization aimed at helping members improve various public speaking roles. The idea was to create a structure that would serve the needs of the group, increase involvement of new members, and reduce the need for specific individuals to guide the group. The structure and defined roles were intended to decentralize control of the group, block behaviors inconsistent with the mission statement, and increase opportunities for active participation within meetings.

Over time, the committee refined this structure, frequently asking the group for feedback during consult group meetings. While we anticipate that the group's structure will continue to evolve over time, we feel the current model, which we will call "The Portland Model," has been sufficiently road-tested to share with other professionals who may benefit from our process. Later in this paper we outline the specific structure of this model that we currently use in our consultation groups, including our mission statement (Table 1), a list of group roles (Table 2), and a sample outline of a meeting (Table 3).

We begin below by detailing some of the foundational elements we found necessary to address before working on a more specific group structure. We felt it essential to identify a set of chosen principles/assumptions and values that could ground and guide our work in the group. What follows is a guide for how groups can begin to address more foundational elements, such as the development of a mission statement, participant agreements, and shared and individual values declarations.

3. Mission statement and values declarations

As previously noted, one of the first steps we took when restructuring the group was to generate a mission statement specifying the values and intentions of the group to help guide its development and foster group cohesion. In ACT, values clarification, experiential learning, willingness to accept discomfort, a focus on what is occurring in the present moment, and commitment towards behavioral change are important components of the ACT model (e.g., Luoma et al., 2007). We wanted these processes to also guide our behavior in the consult group. Just as values establish the direction for clients in therapy and provide a