ACT Meets Mental Health Recovery: Development and Evaluation of an ACT-based Training for Peer Specialists

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Introduction

Within the Department of Veterans Affairs (VA), Peer Specialists (PSs) are individuals who have achieved success in their own recovery from mental illness or problematic substance use. They are employed by the VA to connect with, inspire hope in, and support Veterans who are in earlier stages in recovery. PSs are part of the Recovery Model of mental health and substance use, which shifts the focus of treatment beyond symptom management to cultivating hope, empowerment, social inclusion, and personal meaning. Based on their own experience, PSs help their peers via individual and group work to clarify recovery goals, learn and practice effective coping skills, monitor their progress, and reintegrate into the community.

Currently, PSs receive a 1-week (40-hour) training, which covers the Recovery Model, phenomenology of common mental illnesses and substance use disorders, crisis management, communication skills, group facilitation skills, sharing their recovery story, motivational interviewing, and problem solving (Harrington, 2011). While the training includes a 5-stage theory of the recovery experience, the other components of the training are not integrated into this theory in a coherent, thoughtful way. A theoretical framework that organizes these training components and other techniques around these 5 stages could therefore be useful to PSs in helping Veterans advance through the stages.

Acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012) is a broadly applicable, empirically supported theoretical approach to helping individuals enact meaningful changes in their lives. ACT fits well with the Recovery Model, as both approaches emphasize the pursuit of meaningful action in addition to decreasing the impact of difficult internal experiences. Both approaches also seek to reduce self-stigma by helping clients experience themselves as whole human beings rather than giving their lives over to stigmatizing labels.

In consideration of the contribution ACT theory could make to the PSs' work, as well as the good fit between ACT and the Recovery Model, we developed and evaluated a training integrating ACT theory into the 5-Stages of Recovery, which was delivered over 8 weekly 45-minute sessions.

Method

Participants

The 12 PSs at the VA Long Beach Healthcare System participated in the training. The services in which they were employed included Mental Health Intensive Case Management, Inpatient and Outpatient Psychiatry, Psychosocial Rehabilitation and Recovery, Housing/Homelessness, and Substance Abuse. Because one PS resigned during the training, 11 completed pre- and post-training assessments. These 11 PSs attended 6-8 sessions (M = 6.9). The training occurred during the PS's regular weekly supervision meetings, and they received Continuing Education Units for their participation.

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ACT in Stages Training Protocol

Sessions were structured as follows: (1) brief mindfulness exercise, (2) review of previous material and practice assignment, (3) experiential exercise and/or presentation of metaphor, (4) didactic training, and (5) discussion of how techniques (that are new or already in PS's repertoires) may fit into the theory presented.

Session 1 introduced the 5 Stages of Recovery (Deegan, 2008):

1. **Impact of Illness**: The person is overwhelmed by the disabling power of the illness
2. **Life is Limited**: The person has given in to the disabling power of the illness
3. **Change is Possible**: The person is questioning the disabling power of the illness.
4. **Commitment to Change**: The person is challenging the disabling power of the illness.
5. **Actions for Change**: The person is moving beyond the disabling power of the illness.

Session 2 addressed the role of experiential avoidance in Stage 1 and presented acceptance as an alternative.

Session 3 explored the role of fusion with self-as-content (e.g., a sick "story" of oneself) in Stage 2, and presented defusion as an alternative.

Session 4 reviewed and expanded on acceptance and defusion as two ways of being open.

Session 5 explored the role of self-compassion in moving on from Stages 1 and 2.

Session 6 examined the role of self-as-context and present moment awareness in Stage 3.

Session 7 addressed the role of personal values in choosing recovery goals in Stage 4.

Session 8 underscored the importance of building long-term patterns of consistent committed action in Stage 5.

Outcome Measures

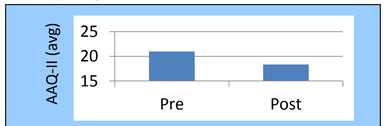
PS's completed the following questionnaires pre- and post- training.

1. The **Acceptance and Action Questionnaire-II** (AAQ-2; Bond et al., 2011) is a measure of experiential avoidance.
2. The **Personal Values Questionnaire** (PVQ; Ciarrochi, Blackledge, & Heaven, 2006), Work/Career Domain assesses work-related values.
3. The **Recovery Attitudes Questionnaire-16** (RAQ-16; Borkin, et al., 1998) measures attitudes about recovery.
4. The **Peer Specialist Confidence Questionnaire** (PSCQ) was developed specifically for this project and measures the degree to which the PS's feel they have a useful theoretical framework to guide their work.
5. The **Maslach Burnout Inventory-Human Services Survey** (MBI; Maslach, Jackson, & Leiter, 1996) measures 3 aspects of job-related burnout: Emotional Exhaustion, Depersonalization, and lack of Personal Accomplishment.

Results

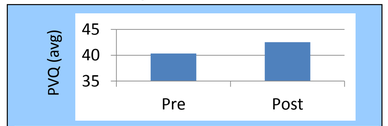
Paired samples t-tests were conducted to evaluate pre-post changes on each variable. No significant results were found.

1) Experiential Avoidance



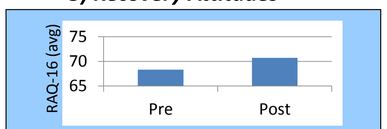
A non-significant reduction in experiential avoidance was observed.
t (10) = 1.42, p = .19; Cohen's d = 0.43, a small effect

2) Values



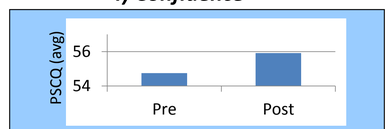
A non-significant increase in values was observed.
t (10) = -1.76, p = .11; Cohen's d = 0.53, a medium effect

3) Recovery Attitudes



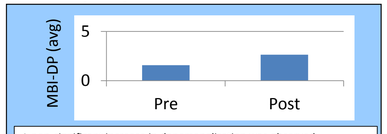
A non-significant increase in recovery attitudes was observed.
t (10) = 1.23, p = .25; Cohen's d = 0.37, a small effect

4) Confidence



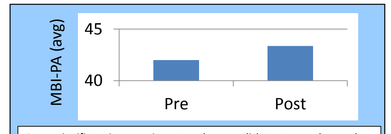
A non-significant increase in confidence was observed.
t (10) = -.747, p = .47; Cohen's d = 0.23, a small effect

5) Depersonalization



A non-significant increase in depersonalization was observed.
t (10) = -1.57, p = .15; Cohen's d = 0.47, a small effect

6) Personal Accomplishment



A non-significant increase in personal accomplishment was observed.
t (10) = -.809, p = ..434; Cohen's d = 0.24, a small effect

7) Emotional Exhaustion (MBI-EE, avg) increased from 12.25 to 13.55. This increase was not significant, t (10) = -.53, p = .60. Because Cohen's d = .15, indicating no effect, these data were not graphed.

Discussion

While no significant pre-post differences were observed, small to medium improvements were observed in experiential avoidance, values, recovery attitudes, confidence, and personal accomplishment. Because the small sample size limits power, it uncertain whether the absence of significant findings reflects a true lack of effects. In addition, the absence of a control group makes it difficult to know whether the changes observed are due to the intervention or other factors, such as history or demand characteristics.

Interestingly, a non-significant small worsening was found in depersonalization, however it is again difficult to know whether this reflects a true effect.

Satisfaction with the training seemed to be high for most of the PSs, as evidenced by their informal self-report. This suggests that this training could be feasible as a means of providing PSs with a theoretical framework to guide their work.

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