Journal of Contextual Behavioral Science ■ (■■■■) ■■■–■■■

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

Please cite this article as: Thompson, B. L., et al. Creating a peer-led acceptance and commitment therapy consultation group: The Portland model. *Journal of Contextual Behavioral Science* (2015), http://dx.doi.org/10.1016/j.jcbs.2014.11.004

Table 1
ACT peer consultation group mission statement.

The purpose of the ACT peer consultation group is twofold

1) To provide ongoing didactic and experiential training in the competent use of ACT with a variety of clinical problems. Certain group members may serve as the senior content experts; however, as participants in the consultation group attend and participate over time, they will be expected to actively present material to others (the see one, do one, teach one model) and take responsibility for the direction of the group. Group members also commit to outside learning in the form of reading books, intentional practice, attending trainings, and/or joining the ACT listserv, as it is impossible to cover every aspect of the model in a two hour monthly meeting.
2) To provide consultation to individuals who are working to apply ACT in their clinical work. This group is for people who are actively using ACT in their clinical work and want to improve their application of ACT principles. Consultation may involve case conceptualization, practicing experiential exercises, role-plays, or discussion of whether ACT is appropriate for a given patient or presenting problem.

Participant agreements

- While not diminishing the importance of other forms of knowledge, we agree that this is an ACT-focused consultation group, not a general consultation group. Thus, we will work to focus the group on the application of ACT principles and work to come back to these principles when the focus wanders.
- Group members agree to hold the content of what others say in the consultation groups confidential out of respect to the attendees and the individuals with whom we work – this is important both with respect to the sharing of difficult clinical cases and for experiential exercises that may occur in the group.
- Group members also agree to practice radical respect for one another and to realize that they are in the "same soup" with one another – just as we strive to do with clients in therapy.
- Discussion of group process is not a primary goal of the group, although if there are issues present in real time in the group that are relevant to the understanding of the ACT model, those can be used as in vivo examples.

Group values

- Creating caring communities (perhaps with as small as two members, like with our clients) where people are supported in living toward possibilities that they may not even see, rather than living out of limiting ideas of how they think life works. We will work to bring this sense of freedom and possibility into this group.
- Lifelong learning and nurturing a "beginner's mind" to remain open to surprise, wisdom, and wonder.
- Openness to alternative perspectives.
- Living a life that is present, open, and authentic.
- Making this work more manifest in our own lives and in teaching it to those who also care to learn about it.

Individual commitments that have been spoken to thus far

- I commit willingly to feeling what I will feel when I model what I know, both verbally and nonverbally, about how to live ACT.
- I will work to shape the group process so that we have a group that doesn't simply talk about ACT, but actually does ACT in our meetings.
- I will work to create an experience of choice in the group, not coercion.
- I commit to valuing the values of those in this group.
- I commit to willingly to experience whatever shows up for me. I am committed to willingly have my discomfort in our group.
- I will bring my full self to the meetings.
- I commit to doing the hard work in life (in addition to during group) that I ask my clients to do each day by showing up fully~not attempting to check my insecurities at the door on the way in
- I commit to be an active and willing participant in the group.
- I will prepare for the group meetings in some way, either preparing a case, a question, or an intention for myself for the meeting.
- I will not buy the story "yeah, but I'm not as real of an ACT therapist as X" as that only serves an avoidance function for me and does not move me towards being the therapist I want to be for the clients I serve.
- I commit to process experiential exercises from an honest personal standpoint and not attempt to separate my own experience from that which "clients" experience.
- I commit to allowing everyone in our group space to experience what they experience – not rescuing others – when painful internal experiences arise in relation to an experiential exercise or discussing challenging clinical work.
- I commit to being open to feedback from the group with a corresponding willingness to ask questions if I do not understand or disagree.
- I plan to use the ACT model consistently during the 2-hour meeting in order to learn new skills and to practice and refine those skills I am familiar with.
- In order to learn, I commit to act, fail, learn and continue to advance my knowledge of ACT.
- I commit to practice risk-taking in both presenting and playing the "therapist role" in our meetings.
- I will appreciate the efforts of all other group members and support them where I can.
- I will respect others and value their contributions.
- I commit to work toward differentiating between that which is ACT-consistent and that which is ACT-inconsistent.
- I commit to asking questions when I'm not sure of something.
- I am committed to offering myself as a resource for the training mission of the group.
- I am committed to making the group a place where I choose to grow and learn about ACT and functional contextualism. I will do this even if my thoughts and feelings suggest otherwise, and will make an effort to be there with patience and compassion.
- I commit to having fun.

means to assess behavioral change, the identification of shared and individual values provides direction and means of assessing whether the consult group process is in keeping with the mission statement. The mission statement helps remind group members of their intentions and is useful in informing and attracting appropriate new group members. Our mission statement and values declaration included three parts: (1) a statement of purpose; (2) participant agreements and group values; and (3) personal declarations of commitments. The Portland Model's complete mission statement can be found in Table 1.

The document begins with a statement of purpose, outlining the overall purpose of the consult group. We looked for a consensus statement that was motivating and common to all group members. Our statement has two emphases: (1) providing ongoing didactic and experiential training in the competent use of ACT with a variety of clinical problems; and (2) providing consultation and support to individuals who apply ACT in their clinical work. In our group, consultation involves case conceptualization, experiential exercises, and role-plays.

The next section outlines shared behavioral agreements and group values. Behavioral agreements focus on commitments to specific behaviors intended to encourage action consistent with the aims of the group. These include maintaining an ACT focus and respect for others, including privacy for what is discussed during group meetings. Group values focus primarily on qualities we want to foster in the group process and include creating a caring

Please cite this article as: Thompson, B. L., et al. Creating a peer-led acceptance and commitment therapy consultation group: The Portland model. *Journal of Contextual Behavioral Science* (2015), http://dx.doi.org/10.1016/j.jcbs.2014.11.004

Table 2
ACT consult group roles.

General roles

Opening Exercise Leader – begins group with guided exercise (≤ 10 min) to help group contact present moment and transition into meeting.
Group Leader – keeps time and maintains structure of the group, keeping group on track throughout meeting.
Process Facilitator – helps group maintain ACT focus. May say nothing during a meeting, or may gently ask members to translate ACT terms other models that come up. May comment on or draw attention to the general process of the group (e.g., unspoken tension) in the service of fostering psychological flexibility among group members.
Transition Leader – writes down unfinished business the group can return to at the next meeting, keeps track of who signs up for roles for next meeting, and sends a reminder email prior to next meeting.

Roles during experiential skills building

Skills Builder – volunteers to practice ACT (e.g., skill, exercise) in front of group and receive feedback.
Assistant to Skills Builder – consults with Skills Builder during exercise at Skill Builder's discretion.
Case Presenter – role plays a client or presents own struggles to provide the material for which the Skills Builder can practice.
Hexaflex Monitor – takes notes on ACT processes demonstrated during experiential skills building and provides up to 5 min of feedback following skill building exercise.

Table 3
Sample meeting outline.

I. Introduction and open time

3:30–3:40 – Opening exercise (*led by Opening Exercise Leader*)

- Opening exercise – can be read from a script or improvised.
  - **Purpose**: For the Opening Exercise Leader, to practice guiding these types of exercises. For the participants, to help them center and orient toward their values. Typically kept to 5 min or less.
  - The group leader takes over at 3:40 pm. If the Opening Exercise leader would like feedback, it is up to that person to leave enough time.
  - *Note*: Opening Exercise Leader **starts** the group and **then** Group Leader takes over.

3:40–4:20 – Open time (*Group Leader takes over and will gently interrupt opening exercise if it runs past time 3:40 pm*)

- *Introductions* (if there are new people in the group – otherwise, skip).
- Review the roles people have signed up for and fill in empty slots.
- If there are new attendees, those assigned to roles relevant to the first half of the meeting describe their roles as they are identified.
  - *Opening Exercise Leader* – leads opening exercise
  - *Group Leader* – keeps group on schedule
  - *Process Facilitator* – keeps group focused on ACT-relevant discussion. Politely requests that non-ACT comments be translated into ACT-relevant language and facilitates psychological flexibility in the group process and members.

- Ask whether there is any leftover business from the previous meeting.
- Set agenda for meeting (e.g., short consultation questions, announcements, questions, theoretical discussions).
- Solicit estimates for the amount of time to devote to each agenda item. Attempt to organize and pace agenda items within the remaining time allotted. *Transition Leader writes down any unfinished business for next meeting.*

II. Experiential skills building

4:20–4:50 – Skills building exercise

- Skills building exercise. Roles include:
  - *Skills Builder* – chooses an exercise to learn/practice in front of the group prior to the meeting
  - *Assistant to Skills Builder* – offers help to the Skills Builder if he/she is stuck or requests feedback at during the exercise.
  - *Case Presenter* – person presenting the case. The details of the case unfold only within the context of the skills building exercise.
  - *Hexaflex Monitor* – pays attention to the core ACT processes (and Creative Hopelessness as appropriate) demonstrated during the skills building exercise.
  - The task of the remaining group members is to silently observe ACT processes at work in the exercise. This is a time to put on your "ACT goggles" and leave any other theoretical modalities at home. It may be helpful to make notes of any questions or comments for the technical discussion.
  - If there is a new attendee, these roles should be described by each person.

4:50–5:00 – **Debriefing** (*Group Leader signals the end of the experiential component of the skills building exercise.*)

- *Participants debrief*: The Skills Builder and the Case Presenter offer reflections on their experience of the exercise.
- Others in the group may choose to share their appreciation and non-technical/emotional responses to what they witnessed (e.g., "I really appreciate your willingness to…"). This is not a time to make suggestions or discuss processes.

5:00–5:05 – **Hexaflex monitor**

The Hexaflex Monitor has 5 minutes to share his or her observations of the ACT processes demonstrated during the skills building exercise and offer any corrective feedback.

5:05–5:25 – **Technical discussion**

Focuses on unpacking the exercise from an ACT perspective. What was ACT consistent? What wasn't? The focus is on what occurred in the exercise rather than on providing consultation on the case. The Hexaflex Monitor may receive feedback as well.

5:25–5:30 – **Role assignments**

Assign roles for the next meeting and wrap-up.

5:30 – (Happy Hour for those interested!)

Please cite this article as: Thompson, B. L., et al. Creating a peer-led acceptance and commitment therapy consultation group: The Portland model. *Journal of Contextual Behavioral Science* (2015), http://dx.doi.org/10.1016/j.jcbs.2014.11.004

community, a commitment to lifelong learning, openness to other perspectives, and bringing the work into our own lives.

The final part of our mission statement consists of examples of individual commitments made by group members. These commitments were intended to help individual members orient to their particular values and unique contributions and to help new members in clarifying their individual values and commitments as they entered the group. Participants made public commitments during meetings and on our local listserv, resulting in a total of 24 individual commitments that were recorded in our mission statement.

After completing the mission statement, a committee was formed to develop a structure that would help the group align with the values and goals established. Each month, the committee presented their ideas to the whole group for feedback. Through this iterative process, the committee developed the structure outlined in the next session.

4. Meeting structure

Our consultation group meets for 2 h and is divided into two parts (see Table 3). Part I of the group provides open space for introductions, announcements, theoretical or conceptual questions about ACT or CBS, and brief case consultation. This part of the group is similar in structure to what might be found in many consultation groups. Part II is focused explicitly on ACT skills building and experiential learning.

4.1. Part I: Introductions and open time

The group begins with a guided exercise. A group member who has volunteered to be the Opening Exercise Leader (Table 2) leads the group in a brief (no more than 10 minutes in length) experiential exercise. Although it typically incorporates some form of mindfulness exercise, the opening exercise can be any time-limited exercise that is oriented towards an ACT skill or embodies the ACT spirit.

Following the opening exercise, the Group Leader takes over and announces which group members have, during the previous meeting, volunteered for each of the roles for the current meeting (see Table 2). If roles remain unfilled for that meeting, the Group Leader asks for volunteers. If new members are present, the Group Leader briefly explains the structure of the meeting and asks attendees to briefly introduce themselves. The Group Leader then elicits agenda items for the remainder of Part I. Typical topics include announcements, demonstration and feedback relating to specific ACT exercises, questions about ACT, and brief case consultation questions.

Throughout this process the Group Leader tracks the time, helps transition members to each agenda item, and facilitates discussion of topics as needed. The Process Facilitator (see Table 2) monitors the group processes to ensure that the group remains focused on ACT, draws attention to relevant ACT processes as they are occurring in the group, and helps support psychological flexibility in the group process. After an hour, the Group Leader helps the group transition to Part II. The Transition Leader documents any unfinished business from the beginning portion of the meeting so that it can be discussed at the following meeting.

4.2. Part II: Experiential skills building

The second half of the meeting typically begins with the Group Leader identifying those members who have volunteered for the requisite roles. We highlight the roles here to clarify how they may deviate from a traditional consult group format. There are 4 roles specific to the experiential skills building portion of the group

- *The Skills Builder* volunteers to practice a specific ACT skill, exercise, or process (e.g., creative hopelessness, Passengers on the Bus exercise, self-as-context, etc.). As the emphasis in our group is on learning and practicing ACT, the focus during the experiential skills building portion is on the development of the Skills Builder.
- *The Assistant to the Skills Builder* is the consultant to the Skills Builder. This person helps the Skills Builder when she/he feels stuck, can offer consultation or guidance, and can offer assistance if the Skills Builder requests.
- *The Case Presenter* presents the clinical material that allows the Skills Builder to practice the ACT skill he/she selected. We have found having the Case Presenter present more personally genuine material (e.g., as opposed to role-playing a client) makes the skills building practice richer and more meaningful. This practice of working with our own struggles is consistent with the ACT assumption that all humans – including therapists – struggle with many of the same difficulties as our clients. To be clear, though, the exercise is for the benefit of the Skills Builder, and there is no expectation that the exercise will be therapeutic for the Case Presenter.
- *The Hexaflex Monitor* attends to the different ACT processes demonstrated by the Skills Builder during the skills building exercise. Using a form (available on the consultation group website and from the authors) with an image of the ACT hexaflex and space for notes, the Hexaflex Monitor takes notes on which various interventions demonstrated in the skill building exercise fit with each ACT process and identifies any interventions that seem ACT in consistent. The Hexaflex Monitor provides feedback on these observations after the exercise.

The experiential skills building exercise between the Skills Builder and the Case Presenter lasts approximately 30 min. The remaining group members quietly observe and do not interrupt the exercise. At its conclusion, the Skills Builder, Assistant to the Skills Builder, and the Case Presenter offer feedback (generally limited to 5 min) about their experiences during the practice. The Group Leader then gives the remaining group members an opportunity to provide any brief and non-technical feedback about what they observed. This often includes expressions of appreciation for the risks the participants took in practicing in front of a group and/or emotional reactions to the demonstration. The purpose of this portion of the meeting is (1) to reinforce people for taking emotional risks in the service of their professional development; and (2) to provide experiential, non-intellectual feedback that can directly shape performance.

The focus then turns to a technical discussion. This begins with the Hexaflex Monitor reporting on the processes and actions observed during the exercise. Following the Hexaflex Monitor's report, the group spends the next 20 min discussing the technical aspects of the experiential skills building exercise, offering ACT-consistent feedback to Skills Builder, and asking questions. As in the skills building exercise itself, the emphasis is on the ACT techniques demonstrated during the skills building exercise rather than offering advice to the Case Presenter.

The final 5 min of the group are dedicated to volunteering for roles at next month's meeting and documenting any unfinished business to return to at the next meeting. The Transition Leader is responsible for recording volunteers, noting any unfinished business, and emailing a reminder about the meeting and list of volunteers the week of the next meeting. To further build cohesion and a sense of community, attendees typically go to happy hour at a nearby restaurant or bar after the group.

5. Common problems & solutions

In keeping with the peer-run nature of the consult group, our aim is for the structure – as opposed to any one individual – to

Please cite this article as: Thompson, B. L., et al. Creating a peer-led acceptance and commitment therapy consultation group: The Portland model. *Journal of Contextual Behavioral Science* (2015), http://dx.doi.org/10.1016/j.jcbs.2014.11.004

keep the group on track. In creating your own ACT peer consultation group, we have found it important to have a structure, whether you borrow from ours' (Table 3) or develop your own. Without structure in our experience, the consult group may stray from its mission statement and lose focus on learning ACT. In this section we highlight common problems we have encountered over the years and have attempted to address in our current model.

5.1. Make the structure explicit and readily accessible

We created written documents with descriptions of group roles and an outline of the structure (e.g., Tables 2 and 3). Once these documents were created, we handed them out in the meeting and made them available on a website for download. The effect was immediate. As soon as we made the structure and expectations clear and accessible, we found participation increased – especially among newer attendees and less experienced ACT therapists. Even individuals attending the group for the first time started to volunteer for roles at the next meeting. Additionally, we made a point to explain each role during meetings when new group members were present.

5.2. Staying on track

With 2 h each month to learn ACT, anything not ACT-related steers the group away from its mission. Someone may have a compelling ethics-related question, for example, but that question is not appropriate for the consult group if it is not directly ACT-related. All attendees contribute towards maintaining the structure of the meeting, but the burden falls to two members in particular – the Group Leader and Process Facilitator.

The Group Leader's role is defined by keeping to the meeting structure. This can feel awkward at times. It may feel uncomfortable to interrupt or end a discussion because there are other items to address. In fulfilling this role, however, the Group Leader is serving the best interests of the group.

The Process Facilitator's role is to ensure a focus on practicing ACT. If the group remains on task throughout the meeting, the Process Facilitator may say little during the entire meeting. When topics stray from the mission statement, however, the Process Facilitator may observe this aloud and gently guide the meeting back on track. This may involve asking an attendee who is speaking from a different model (e.g., Gestalt) if he or she could translate the statements into ACT terms. Here is an example:

Attendee: I experienced a strong sense of counter-transference with a client recently.
Process Facilitator: "Counter-transference" – that would be a really interesting concept to translate into ACT terms. Would you be willing to give it a shot?
Attendee: Okay. Others can jump in, too, if they want.

Additionally, the Process Facilitator helps the group respond flexibly to conflict and maintain alignment with group and individual values. For example, sometimes tension or conflict happens within the group or a member's behavior narrows toward "being right" or avoiding embarrassment. In these instances, the Process Facilitator might skillfully name it and bring it to the group's attention. He or she may reflect on the group's values and wonder aloud how the members may contact their values. The Process Facilitator also has permission to work experientially with some or all of the group members.

5.3. Starting on time

There are a number of reasons a group does not start on time. Unfortunately, not starting on time consistently encourages people to be late. Consequently, we have tried to build in contingencies to encourage a prompt start. In our model, the Opening Exercise Leader – not the Group Leader – begins the meeting. The Group Leader takes over the group 10 min later, and will gently interrupt the Opening Exercise Leader if the exercise goes beyond its allotted time. This arrangement is a little counterintuitive, as most members expect the Group Leader to start the meeting. By having the Group Leader take control of the meeting 10 min into the meeting regardless of when it begins, the Opening Exercise Leader may be more motivated to begin promptly or risk losing time for the exercise. Additionally, this forces the Opening Exercise Leader to be succinct, and to ensure that no part of the group receives less time due to overly long mindfulness exercises or latecomers.

5.4. Emphasis on practicing ACT over case consultation

In an earlier iteration of the ACT peer consultation group, the experiential portion of the meeting typically revolved around cases with which therapists were struggling, often those that were interpersonally difficult or complex. In short, the only opportunities members had to practice their ACT skills were with role-plays of challenging clients. Unfortunately, practicing new skills with a challenging client is not an ideal context for learning, and it is also a recipe for shame and/or humiliation.

It seems obvious in retrospect, but this was a major problem the first 3–4 years of our consult group. The focus on the most difficult cases made it challenging for inexperienced attendees to actively participate, and they usually ended up simply listening or making a brief comment or two at most. Often the only active practice of ACT skills was by a core group of experienced ACT therapists. Practicing with a tough case is intimidating and can interfere with learning, as people are more likely to return to older repertoires of behavior under aversive circumstances.

Another typical pattern was that a case presentation would be followed by a series of brief questions or suggestions for what to do with the case. There was often little coherence to the suggestions or space to follow a particular line of thought. The result was a sort of round robin of suggestions that offered little beyond instructions on what to do next. At other times, clinicians offered reassurance instead – "You're doing the best you can!" – which risks reinforcing experiential avoidance or fusion on the part of the therapist.

In sum, while our core focus was on learning ACT, we were unintentionally falling into a problem-oriented, eliminative agenda rather than a skill-building focus. Consultation often focused on clients that were labeled "difficult" and with trying to help the therapist become unstuck. While there is nothing wrong with this per se, it interfered with the broader goal learning of ACT. While our new structure still includes time to support people working with cases they find difficult (in the first half of the meeting), we focus the second half of the meeting explicitly on experiential learning over case consultation. The Case Presenter is there to provide the raw material to facilitate the development of the Skills Builder. The Case Presenter may or may not benefit from the role-play. By emphasizing experiential learning and structuring how feedback is offered and received, advice-giving, reassurance, and deviations from the ACT focus were reduced.

5.5. Popularity

Once your consult group is up and running, you may encounter another challenge; a successful group can quickly outgrow an optimal size for learning. While this is a luxury problem to have, larger groups can have a suppressive effect on participation and make it difficult for everyone to actively participate. One solution to this problem is to split into smaller groups; in our case,

Please cite this article as: Thompson, B. L., et al. Creating a peer-led acceptance and commitment therapy consultation group: The Portland model. *Journal of Contextual Behavioral Science* (2015), http://dx.doi.org/10.1016/j.jcbs.2014.11.004

however, several members expressed a strong preference for meeting as the whole group for at least part of the meeting. To balance these competing demands, our group developed a policy that if 12 or more members are in attendance, the group meets as a whole for Part I of the meeting and divides into two smaller groups for Part II. Meeting together in Part I helps maintain group cohesion and allows for communication across the entire group. The smaller groups in Part II help to promote more active participation among members.

6. Conclusion

Development of the Portland Model was linked to a vision of a group that fostered both professional ACT skill development and a strong sense of community among those seeking to build ACT skills (e.g., Johnson et al., 2013). Through years of trial and error, this growing community was able to develop a structure that has allowed us to more fully accomplish these aims. We began our revision process by identifying and making explicit our values as a group and as individual group members. Those values and the commitments associated with them, in turn, led us to develop a structure that would better support learning and community. In order to address barriers that we found interfere with learning in previous iterations of our group, we developed a structure designed to empower group members to take a more active role in their own learning, rather than passively deferring to perceived "experts," and to maintain focus on more experiential modes of learning (i.e., learning by doing) such as role plays, experiential exercises, teaching (vs. listening), and being in the client role. The structure helps keep the group on track and maintain its ACT focus during each meeting without any one individual (e.g., de facto leader) consistently guiding it. Having refined this process into a structure with which we are happy, we share the results of our experience with others in the hope that it may inspire them to start or refine their own groups and learn from our process.

References

Johnson, W. B., Barnett, J. E., Elman, N. S., Forrest, L., & Kaslow, N. J. (2013). The competence constellation model: A communitarian approach to support professional competence. *Professional Psychology: Research and Practice*, *44*(5), 343–354.

Luoma, J.B, Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An acceptance & commitment therapy skills-training manual therapists*. Oakland, CA: New Harbinger.

Tryon, G. S. (1983). The pleasures and displeasures of full-time private practice. *Clinical Psychologist*, *36*(2), 45–48.

Please cite this article as: Thompson, B. L., et al. Creating a peer-led acceptance and commitment therapy consultation group: The Portland model. *Journal of Contextual Behavioral Science* (2015), http://dx.doi.org/10.1016/j.jcbs.2014.11.004