Supervising Trainees in Acceptance and Commitment Therapy for Treatment of Posttraumatic Stress Disorder

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Abstract

Acceptance and Commitment Therapy (ACT, Hayes, Strosahl, & Wilson, 1999) is a behaviorally based intervention designed to target and reduce experiential avoidance and cognitive fusion (holding the thoughts in one's mind to be literally true) while at the same time helping clients to make powerful life enhancing behavioral changes that are in line with their personal values. As a therapeutic approach, ACT is specifically used to help clients come into contact with an experiential sense of knowing, rather than relying too heavily on verbal knowledge. That is, clients are taught to see themselves as a context for ongoing experiential events that include all things occurring inside the skin, emotion, thinking, memories, and bodily sensations, without excessive verbal involvement and control. The goal is to reduce experiential avoidance and move toward meaningful life paths, or more generally, to help the client who has fallen into rigid way of thinking and behaving to become more psychologically and behaviorally flexible.
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Introduction

Clients in ACT are generally led through several stages of therapy that are designed to bring them to a place where they can make healthy life choices, rather than being blocked by believing that negative emotional and mind content must be eliminated or changed before positive action can be taken. In the first stage of ACT, clients are asked about the many ways in which they have tried to eliminate or change what is evaluated as negative memories, emotions, and thoughts and how successful these attempts have been, especially in the long run. When the various change efforts are listed and described, it is generally discovered that these strategies ultimately don't work. *Control of priv*ate events is then explored as the second stage of therapy. Here it is pointed out that attempts at control can actually prolong the experience or paradoxically cause the experience to be intensified. *Willingness* to experience is then offered as the alternative to control. Willingness is made possible by pointing to the sense of "self" that experiences but is not any single experience. For instance, one may have a memory or a feeling that lasts for a period of time, but it soon passes and another experience is there to be noticed and felt. The quality that is being created here is one of being able to observe mind and body as ongoing presence rather than discrete instances of thinking or feeling. This is created through a series of experiential exercises, metaphors, and interventions that help the client come into to contact with this observing sense of self, this is seeing one's "s*elf" as context,* - in which *content* is felt, noticed and experienced without any effort to make it be other than what it is, even if it is related to the trauma. Finally, a great deal of work is done on personal *values* and choice. The client is taken through a series of exercises designed to help them clarify the values and the goals important to them, and *choice* is approached as being about action, rather than needing internal experience to be a particular way (e.g. to feel good) before a choice can be made. In sum, the client comes to see him or herself as a whole human being with on-going experience (e.g. thoughts, feelings, memories, bodily sensations) who can choose to live according to personal values as an ongoing process.

ACT with Trauma Survivors

ACT is particularly well suited to treating trauma survivors and initial studies of its use with this population are promising (Walser, Westrup, Rogers, Gregg, & Loew 2003; Follette, Pistorello, Bechtle, Naugle, Polusny, Serafin, & Walser, 1993). Individuals who are struggling with traumatic experiences or who have been diagnosed with PTSD often engage in high levels of experiential avoidance. They actively work to avoid disturbing memories and make numerous and ongoing attempts to rid themselves of unwanted thoughts and painful feelings. That is, they are frequently working to avoid internal experiences and the trauma-related cues that occasion them. Many of the attempts to be rid of these experiences in, and of themselves cause problems. For instance, substance abuse is often used as a way to numb or escape feared emotions or memories, and avoidance of relationships can be a way to escape worries about trust and about being revictimized. Often clients believe that healing from the trauma somehow involves forgetting or getting away from their history of this event, as well as to erase all the emotional and thought processes that accompany the event.

> *The problems with experiential avoidance as a course of action is that (1) if traumatized individuals have feelings that they "cannot have," then, in one sense, there is something wrong; whole parts of their own experience must be denied; (2) humans are very poor in deliberately eliminating automatic emotions and thoughts; and (3) many of the methods that can be used (e.g., avoidance of situations that trigger the thought or feeling) are themselves destructive. On the surface, avoidance maneuvers constitute attempts to be free from painful events. Unfortunately, the very thing survivors are seeking, a sense of wholeness, can be lost in their efforts to avoid private experience (Walser & Hayes, 1998, pg 257).*

This avoidance is targeted as *the* problem from the ACT perspective. Rather than join clients in a fruitless agenda to erase the memories of the trauma or experiences from the past related to the trauma, ACT helps the client make room for their difficult memories, feelings, and thoughts as they are directly experienced, and to include these experiences as part of a valued whole life.

Supervising Trainees in ACT with Trauma Survivors

One of the key requirements of doing ACT competently is to be able to apply ACT principles in your own life. That is, the therapist must be willing to experience his or her own difficult emotions, sensations, memories, and thoughts in order to work in the ACT frame with effectiveness. In the supervisory process then, we work with supervisees to (1) develop a sense of personal wholeness and relate that same sense to the client who is avoiding trauma, (2) focus on acceptance of emotions and thoughts, both as it relates to their own experience and the experience of their clients, and (3) and to assess the cost of avoidance as it is related to personal values while working to help supervisees and clients take action that is consistent with the same. We have found that one of the most effective ways to begin supervision is to have a trainee go through an ACT workshop. Here they can contact the core concepts on a personal level and can experience all of the metaphors and exercises from the perspective of the receiver. It is not necessary that the supervisor be the workshop leader. If attending a workshop is not feasible, the next best step is to have the trainee join the supervisor in a group or individual session as the supervisor works through the protocol. Each of these options should be done in addition to regular supervision hours.

One way to approach the supervision hour is to have the supervisee conceptualize a case from the ACT perspective and then report on that case weekly. Additionally, in ACT, there is a strong emphasis on the function of behavior rather than the form. It is important to have the supervisee understand how the concept of experiential avoidance offers organization to the functional analysis of trauma-related problems, and how it lends coherence to understanding the sequelae of trauma. If the supervisee can learn

to distinguish instances of human behavior that are experientially avoidant and to recognize the costs of the avoidance, then much of ACT therapy can be implemented correctly and consistently. Helping supervisees to identify their client's PTSD-related avoidance occurring both inside and outside of the session can help the supervisee to draw on ACT material designed to bring the avoidance to the client's awareness. There are obvious forms of avoidance such as smoking marijuana every night, or abruptly changing the topic in session, and recognition of these avoidant strategies is fairly easy. However, targeting more subtle forms of avoidance may not only require helping the supervisee to be aware of the client's avoidance, but also helping them to identify their own subtle forms of avoidance. That is, the supervisor should take the opportunity, as appropriate, to point out when the supervisee might be supporting emotional avoidance rather than undermining it. Examples of this include filling time or silences in sessions with continuous talk when the ACT-consistent strategy would be to simply be present with the silence, moving quickly to problem solve or provide comfort if the client tears up, supporting ongoing talk by the client throughout the session while making no effort to determine the function of the talk, leaving a topic too quickly, or when the supervisee spends time describing and intellectualizing as a means to explain the therapy or "figure it out" for the client. In such instances we work with the supervisee to recognize possible attempts to avoid their emotions such as anxiety, and to explore the workability of this avoidance as it relates to the client's struggle and to using ACT. In our supervision we have been interested not only in how the client felt in the session but also how the supervisee felt. We then model acceptance by making all that is felt (including what is evoked by the supervision session) welcome while also working on the goals of treating the client.

One of the places where trainees often struggle is in the implementation of the ACT protocol. Trainees tend to be fairly rule-bound in the initial stages of ACT and can get stuck when a client brings something to therapy that doesn't "match" the current session to be introduced. For instance, one of our supervisees had completed the session designed to help the client identify all of the strategies tried to eliminate or change personal internal experience and had ended the session with a metaphor about "being stuck." Upon return to the next session, although the supervisee was ready to continue with *control as the problem*, the client reported not remembering any of the previous session. At that point, the supervisee felt unsure about what to do and abandoned the protocol – and then worked through the rest of the session by doing what the client wanted to do (talk about problems as a form of emotional avoidance). Two things needed addressing in this instance in the supervision session including looking to see if experiential avoidance was present in "not remembering" for the client, and to see if the supervisee was engaging in emotional avoidance in abandoning the protocol. Here, the supervisee was encouraged to check back to the previous session to see if forgetting (which could be created in multiple ways - like the client "checking out" during the session) was yet another strategy to avoid painful material. The supervisee could was then encouraged stay with the first core component, helping the client to further contact what hasn't worked, rather than abandoning the protocol. The supervisor would also want to check with the supervisee to see if he was avoiding internal experience (e.g. anxiety, not knowing, fear of negative evaluation) when he made the shift from ACT to doing what the client wanted to do. As the supervisor, you can work directly with experiential avoidance, helping the supervisee to stay connected to the goal of the client's session, *with* the anxiety or the experience of not knowing, rather than trying to escape or control those internal experiences. In addition, working with the trainee to understand the bigger picture of how mindfulness and present moment processes are integrated with values and committed action can often help to guide trainees in being flexible with the protocol.

Another area of difficulty with implementing the protocol occurs when supervisees become overly concerned about doing the therapy "wrong." There are ways in which fairly large mistakes can be made, giving messages of control mixed with acceptance or being in a "one-up" position, for instance. However, mistakes can be worked with in an open and compassionate fashion. We work directly, as supervisors, to point out messages of control and to point to the problem of language (see Hayes, Barnes-Holmes, & Roche, 2001) as a human problem, not a client problem. We discuss our own personal

mistakes and model how to address mistakes in therapy. Additionally, we work with the supervisees to notice the thoughts of "getting it wrong" while again, asking them to *be with* the feelings of anxiety and make a commitment to follow the ACT approach. We focus on doing this in a fashion that functions well for the purposes of therapy. It should be noted that this fear of making a misstep when first learning ACT is not experienced only by trainees. Even very experienced clinicians have reported a similar fear when first doing ACT, a sense that one could do something "wrong." This is not surprising given that many clinicians have been both culturally and professionally trained to approach troubling thoughts, feelings, etc., from a "fix it" stance—letting clients "have" these experiences and refraining from sending control messages can feel quite foreign. In other words, clinician's sense, quite correctly, that they could easily do or say something in the session that is ACT inconsistent. Helping new ACT providers and trainees identify and work with this concern is an important function of supervision.

As mentioned, a central tenet of ACT is that the therapist is also working from a stance of experiential acceptance. Although trainees tend to quickly grasp this idea conceptually, in practice it can be quite challenging, especially when control or avoidant strategies are subtle. For example, one supervisee quickly grasped the key components of ACT and efficiently helped co-lead an ACT therapy group through the protocol. However, at the very end of the therapy, where clients (and therapists) are asked to stand before the group and to maintain eye contact without speaking (i.e., to just be "engaged and present" in the *stand and commit exercise*), this supervisee remained coolly collected although the supervisor could sense that she found the exercise quite difficult. While understandable, this is an example of experiential avoidance that can undermine the therapeutic process. It is likely that the group also sensed the supervisees' unwillingness to be uncomfortable, this following their own, far less poised experiences with standing in front of the group. Aside from supporting the idea that poise is the goal rather than willingness to "have what one has", a potential growth experience was lost. That is, the supervisee and the group may have experienced a powerful moment in therapy had she been willing to have (and openly experience) her anxiety.

In another example, one supervisory session was spent working with a supervisee who had self-disclosed information during her session with her client that was not relevant to the session. This supervisee shared that it was important to her to be authentic in her personal and professional life. We worked with her to disentangle whether she valued authenticity for authenticity's sake, or if authenticity was to be used in the service of other values (e.g., intimate relationships, establishing trust). If an additional value is faithfulness to the ACT therapeutic process, then thoughtfulness around self-disclosure is required – not just authenticity for authenticity's sake. Further, in examining her internal process more closely, the supervisee realized that the "authenticity" in this case was actually about not wanting her client to perceive her in a certain way. Her self-disclosure was actually a control strategy, aimed at reducing her own anxiety about being perceived as somehow superior to her client.

As can be seen in these examples, a crucial aspect of ACT supervision is the creation of an open and willingness-based atmosphere. Towards this end, supervisors model by sharing their own uncertainties or experiences in therapy, and assist supervisees to do the same. When working on particular challenges that arose during the session, supervisees are often asked whether they were avoiding some experience such as anxiety. We have also found role playing, wherein the supervisor or another supervisee plays the therapist, to be a powerful tool in ACT supervision. We recommend that role playing be a standard part of supervision as it is a great tool for learning the therapy and provides an opportunity for the supervisor to model ACT interventions and metaphors. Occasionally, the role plays lead to a specific area of experiential avoidance that is being enabled by the supervisee. This then presents an opportunity for the supervisee to work on willingness and how it may be applied in the therapy with the client.

Finally, we model in supervision the kinds of things we would like to see happening in therapy. We encourage compassion for self and the client, especially when searching for instances of avoidance and the personal costs associated with the avoidance. We openly work on willingness to experience and commitment to personal values. This includes discussion about personally held values about therapy and about being a therapist. As we are using ACT to develop psychological flexibility in the client, we are also working to create psychological flexibility in the trainee, both in their own lives and in the use of the therapy.

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