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**Acceptance and Commitment Therapy:  
Applications for Educational Psychologists working with Schools**

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## **Acceptance and Commitment Therapy: Applications for Educational Psychologists working with Schools**

### **Abstract**

Guidance for schools from national organisations regarding the promotion and enhancement of psychological wellbeing implies a moral imperative for Educational Psychologists to promote effective, evidence-informed, whole-school approaches for school staff, students and parents. With its transdiagnostic approach and considerable body of empirical literature, Acceptance and Commitment Therapy (ACT) – a mindfulness-based Cognitive Behaviour Therapy model underpinned by a functionalist account of human language acquisition – is presented here as a coherent psychological model that has the potential to support schools in developing such practices. Three ways of applying ACT within educational contexts are discussed to provide a flavour of the potential utility of the model: supporting school staff wellbeing; targeted interventions for children and young people; and a potential universal application, through the development of an ACT-based Personal, Social and Health Education curriculum.

### **Introduction**

Acceptance and Commitment Therapy (ACT) is a modern form of Cognitive Behavioural Therapy (CBT) that places central emphasis on the use of acceptance and mindfulness practices in order to move toward a more values-consistent pattern of living (Hayes, Strosahl & Wilson, 1999, 2012). The ACT model is considered transdiagnostic. That is to say, it assumes that human suffering is common to all, not just to those experiencing clinically significant or diagnosable mental health conditions. Accordingly, evidence-based applications of the ACT model to improve psychological wellbeing extend across a wide range of mental health diagnoses and into various other areas of human effectiveness, such as work and sporting performance (see Hooper & Larsson, 2015 for a review).

ACT is underpinned by a contemporary functional account of human language processes known as Relational Frame Theory (RFT; Hayes, Barnes-Holmes & Roche, 2001). From an

RFT perspective, language and cognition are the result of continually learning and deriving relationships between different stimuli and events in a particular way. This is something people do with increasing complexity from early childhood through interactions with our social environments. For example, a parent might point to a bike and say the word “Bike”. Later, the parent might do the same, but then say “Can you say ‘bike’?” and respond to the child’s rough approximation of the word with a reinforcing consequence such as praise, hand-clapping etc. In this example, two stimuli – the two-wheeled object with a seat and handle-bars and the spoken word “bike” – are trained as being related in a particular way: in RFT terms they are in a *frame of equivalence*.

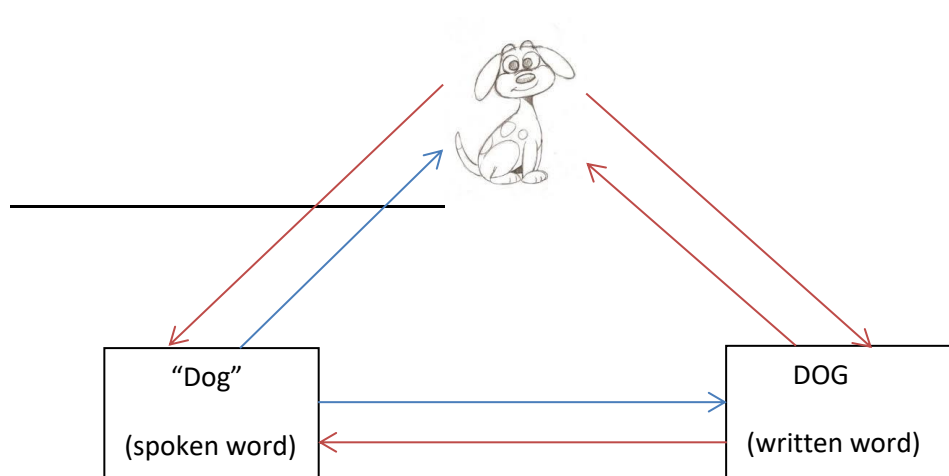
Frames of equivalence are just one type of relational frame. Other types of frames include:

- Distinction: a house is different to an apartment
- Opposition: light is the opposite of heavy (or dark)
- Comparison: Dave is taller than Tom
- Temporal: morning comes before night
- Perspective: I-You, Here-There, & Now-Then

The early research efforts that led to the emergence of RFT began in the 1980s, with a team of researchers led by Professor Steven C. Hayes. The group’s ultimate aim was to build upon the work of Murray Sidman’s Stimulus Equivalence Theory (see Sidman, 1994, for a full discussion) to develop a basic, data-driven, bottom-up account that could explain the full richness of human language processes, grounded in functionalist psychological principles. Sidman’s work on stimulus equivalence provided empirical evidence of the ways in which language-able humans can combine and reverse learned relationships to generate new relations without any explicit training. For example, if a language-able infant is taught that the spoken word “ball” is equivalent to a round object that we kick to one another, and that the spoken word “ball” is also equivalent to the characters *b, a, l & l* on a page in that order, she can derive with no additional training that the characters *b, a, l & l* on a page in that order are equivalent to the round object.

Figure one, below, illustrates this derivation process, which includes both combining and reversing relations to form novel relations that are not directly learned. In this figure, the blue arrows represent directly learned/taught relationships (there are two in this particular relational frame) and the red arrows represent the derived relations. So in this example, when just two relationships are taught, four additional relations are acquired for free (i.e. without the need for additional teaching). This relatively simple example can help to illustrate the incredible generative power of human language.

Figure 1: An example of how equivalence relations can be derived from learned relations



At first sight, it can seem quite clear that this human ability confers upon our species huge advantages and, of course, this is true. For example, we can make meaningful reference to objects and events even when they are not physically present (e.g. a toddler is able to ask mummy for a drink when the bottle is out of sight in mummy's bag). However, having language at our disposal is not all rosy! Imagine the student who starts secondary school and, on the first day, sees a distressed student get locked in a cupboard in her tutor room. It is entirely possible, under these circumstances, that the young person derives from this experience the verbal rule *if I go to school, I will get locked in a cupboard*. The unit of language *going to school* may now be in an equivalence class with a verbal statement that has an already existing aversive function: *getting locked in a cupboard*. What can ensue as a result is a pattern of school-refusal and, more broadly, a narrowed and restricted pattern of behaviour that limits life experiences and opportunities.

Whilst Sidman's work on stimulus equivalence (as one specific relational frame) was ground breaking, it did not provide an explanation of the full richness of human language. For example, it did not provide an explanation of human language as being constantly situated in novel spatio-temporal perspectives (i.e. we always talk from the ever-changing position of *I, here now*). Neither did it explain (explicitly at least) how other types of relational language classes emerge, such as the comparative frames and hierarchical frames detailed above. Rather, this emerged from the early empirical work that Hayes and his colleagues carried out, which led to the advent of RFT (Hayes et al, 2001).

One very significant finding from the empirical work on the nature of relational frames is that once a particular frame emerges (is learned), this relation is robust and enduring (Hayes et al., 2001). This has significant implications for the application of the ACT model that distinguishes it from traditional CBT. Specifically, a primary aim of traditional CBT is to identify dysfunctional or irrational thoughts and beliefs and then to change them or replace them with more adaptive and helpful ones. From this stance, once maladaptive and irrational cognitions have been modified, the client will be more psychologically healthy and more able to pursue effective and fulfilling patterns of behaviour.

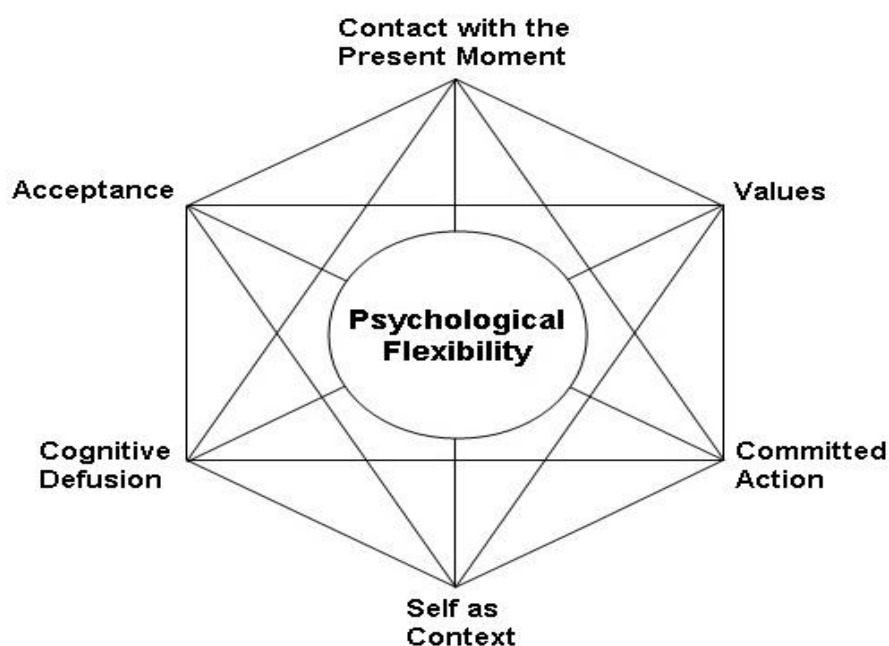
However, the empirical RFT literature suggests that humans do not appear to be able to replace one cognition (i.e. one relational frame) with another in this way. Once something is learned, we can't simply *remove* it. Indeed, we may find the very cognition or belief we are trying to change is evoked when bringing to mind the preferred alternative. For example, I might try to tell myself that I am more than capable of getting the new job I am thinking of applying for, but each time I try to keep this thought in my mind, other thoughts, like *I'm just kidding myself* or *the other candidates will be far stronger than me* might increase in frequency and intensity.

Rather than engaging in attempts to change or eradicate unwanted or unhelpful cognitions and beliefs, the ACT practice framework, informed by RFT, aims to help the client learn to relate differently to such cognitions. Specifically, clients are supported in learning to respond to such "unhelpful" cognitions in more flexible and less literal ways, to reduce the negative impact they have on behaviour. In short, the aim of ACT is not to change the form

or frequency of irrational thoughts or painful emotions, but rather to reduce the extent to which such inner experiences exert an unhelpful influence over behaviour.

To this end, ACT interventions target six core psychological and behavioural skills, which are summarised in the Hexaflex Model (see Figure 2, below).

Figure 2: The ACT Hexaflex



The six processes shown in Figure 2 can be viewed as an interrelated set of psychological and behavioural skills that can be developed in the service of improving one's psychological wellbeing and personal sense of meaning and purpose in life. All ACT work, whether in groups or through the one-to-one therapeutic relationship, in clinical or in non-clinical settings, is focused on developing these skills (Hayes et al, 2004). The core processes can be defined in the following ways:

- *Acceptance* is the practice of being open to all aspects of your experience, including unwanted or painful thoughts, feelings and bodily sensations. While most people do not want to have painful experiences, a willingness to have them at times is an essential part of what is required to live the life one truly wants to live.



- *Defusion* means to get some healthy distance from our cognitive content, to take thoughts less literally and to recognise them as distinct from the person (the observing self) experiencing them. Defusion is a helpful skill for improving psychological wellbeing because it loosens the impact that certain thoughts, particularly unhelpful or unwanted thoughts, can have on our behaviour. For example, if I believe the thought '*I could never run a marathon*' to be literally true, it is likely to function in such a way that I will engage in avoidance-behaviours as regards running a marathon (e.g., I would not sign up, would not start training etc.). However, if I can notice this thought, as it emerges, as a thought and nothing more, I can exert greater and more conscious choice over what I do in response to it.
- *Contact with the present moment* is roughly synonymous with the practice of mindfulness, which means to "*Pay attention on purpose, in the present moment, and non-judgementally to the unfolding of experience*" (Kabat-Zinn, 2003, p.145).
- *Self-as-context* is perhaps the most difficult core process to define in ACT. This is because it is, by definition, non-verbal and so is not, strictly speaking, amenable to verbal definition. Self-as-context is not the labels and description that one might attribute to oneself (termed *self-as-content* in ACT). Neither is it the ongoing experiences that a person is able to label and talk about (termed *self-as-process* in ACT). Rather, self-as-context is the ongoing and stable observer perspective that experiences the world from a particular point-of-view. It is the "I" or "me" that persists as transient experiences - such as thoughts, feelings, and bodily sensations - arise, stay a while, and then pass away again (Hayes et al., 1999).
- *Values* in ACT are understood as being personal qualities – such as kindness, playfulness or integrity – that an individual most wants to express in their actions. Such values are highly personal to the individual and they function as reinforcers for patterns of behaviour that are values-consistent (Wilson & Dufrene, 2009).
- *Committed action* means to engage in particular actions, and toward particular goals, that are consistent with one's personally-chosen values, even when doing so might be difficult or challenging at times.

Collectively, the development of these six areas of skill result in increased Psychological Flexibility, which is the defining concept of mental wellbeing and behavioural functioning at

the centre of the ACT model. Psychological Flexibility is technically defined as contacting the present moment as a conscious human being and, based on what the situation affords, acting in accordance with one's chosen values (Hayes, Strosahl, Bunting, Twohig & Wilson, 2004).

The ACT model has been successfully and effectively applied within a range of contexts (Hooper & Larsson, 2015) and many of these contexts are relevant for school communities. We now consider three examples of school-based ACT applications.

### **Three Examples of School-Based ACT Applications**

#### *School Staff Wellbeing*

The UK's Health & Safety Executive (HSE) reports the prevalence rates of educators' absence from work due to work-related stress as 178 per 10,000 workers, averaged over the period of three financial years, from April 2013 to March 2016 (report available from [www.hse.gov.uk/statistics/](http://www.hse.gov.uk/statistics/)). With the average prevalence rates across all industries at 123 cases per 10,000, this suggests teachers and other educators are at significantly greater risk of experiencing work-related stress than most workers. Indeed, even within professional occupations, teaching and educational professionals are statistically among the most vulnerable, with only welfare professionals and nursing professionals showing higher prevalence rates of stress-related absence from work over that same period of time. It is not surprising, then, that guidance for schools on promoting psychological wellbeing from Public Health England (PHE, 2015) and The National Children's Bureau (Weare, 2015) emphasises a whole-school approach, including a core focus on psychological support for school staff.

Over the past decade or so, a number of intervention studies have shown that ACT-based skills training in workplace settings results in significant improvements in employees' mental health (e.g., Bond & Bunce, 2000; Brinkborg, Michanek, Hesser, & Berglund, 2011; Cerith, Frude, Flaxman, & Boyd, 2017; Dahl et al., 2004; Flaxman & Bond, 2010a,b; Frögéli et al., 2016; Jeffcoat & Hayes, 2012; Lloyd, Bond, & Flaxman, 2013). Given this encouraging research, there has been growing interest in applying similar interventions to help improve the wellbeing of teachers and other school staff.

Some initial studies have demonstrated the benefits of delivering ACT programmes in such settings. In the U.S.A., for example, Biglan et al. (2013) found that ACT-based workshops for special education staff led to significant increases in psychological flexibility, mindfulness skills, and self-efficacy. Similarly, a U.K.-based study by McConachie et al. (2013) has showed that an ACT workshop delivered over one full day (with an additional half day refresher a few weeks later) led to significant reductions in psychological distress among staff working with individuals with intellectual disabilities and challenging behaviour. Further, a large trial (N = 236) by Jeffcoat and Hayes (2012) evaluated the use of an ACT self-help programme for teachers and other school staff in the US. This study showed that personal engagement with ACT processes and exercises led to significant reductions in depression, anxiety and stress. As has been found in other ACT studies, these improvements in staff mental health were associated with increased levels of psychological flexibility.

Flaxman, Bond and Livheim (2013) provide a manual for psychologists and other practitioners wishing to implement ACT-based group interventions within workplace settings. This manual, which is the product of research developed over several years (e.g., Bond & Bunce, 2000; Bond & Hayes, 2002; Flaxman & Bond, 2006, 2010a & 2010b), outlines a three-session training programme for staff and also discusses a range of other delivery formats. More recently, Flaxman and his team were funded by the British Academy to adapt the programme for delivery to UK school teachers. This more recent ACT programme is delivered over four training sessions, typically delivered over four consecutive weeks. The training has now been delivered in several schools across the UK, and has also been successfully delivered to a wide range of other occupational groups, including central and local government staff, professional dancers, and healthcare (e.g., NHS) workers. The training is particularly designed to help staff become more aware of their own personal values (i.e., the personal qualities they most want to express in their own behaviour), and learn how to use those values as an increasingly prominent guide to action in daily life. It is noteworthy, however, that this adapted version of the original three-session intervention detailed in Flaxman et al. (2013) is still in the evaluation stages and an analysis of the outcome data is pending.

We suggest that a key role for practicing EPs as regards the use of ACT to promote and enhance school staff wellbeing would be two-fold. Firstly, it is suggested that practicing EPs could deliver such group-based stress-management interventions to groups of teachers, Learning Support Assistants (LSAs) and Senior Leadership Teams (SLTs). In relation to this, in some instances, EPs may benefit from additional ACT training and supervision as part of their individual Continuing Professional Development (CPD) journeys. Secondly, EPs could play an active role in evaluating the impact of ACT stress-management interventions. In our experience, undertaking this second strand of activity can often be helpfully done in partnership with local universities' psychological research groups.

### *Individual and Group Interventions for Young People*

A meta-analysis of the application of ACT with children and young people published relatively recently (Swain, Hancock, Dixon & Bowman, 2015) identified 202 empirical papers in the literature. Swain and colleagues identify considerable methodological limitations within most studies, including a) that some studies did not target all (or even most) skills detailed in The ACT Hexaflex and thus were not full-blown ACT interventions, b) a low number of studies were designed as Randomised Control Trials (RCTs) or, more broadly, with any kind of control group and c) many studies did not include any psychometrically validated measures. These limitations to the existing empirical evidence regarding the application of ACT with children and young people have been identified elsewhere (e.g. Hagarty, 2017).

In spite of these limitations, of the studies identified by Swain and colleagues, 20 met their inclusion criteria for further analysis. These 20 studies addressed problem areas such as chronic pain, obsessive compulsive disorder, challenging behaviour, anxiety, autism, tic-related disorders, depression, sexualised behaviour, stress, attention deficit hyperactivity disorder and post-traumatic stress disorder. 75% of the ACT interventions examined in this meta-analysis were delivered using a one-to-one format. The remaining 25% were delivered in group format.

Although examination of the studies revealed considerable variability in terms of methodological rigour, the overall findings were very encouraging. This was particularly the

case for situations involving depressive symptoms, tic-related disorders and high-risk sexualised behaviour.

Also of note was the potential utility of ACT as a model to support better management of stress for young people. In a report commissioned by the National Union of Teachers (NUT), Hutchings and Kazmi (2015) argue that high-stakes testing, such as GCSE exams, has a range of negative effects on students, including excessive levels of anxiety and stress. Encouragingly, Livheim et al. (2014) reported significant reductions in students' stress-levels after an eight-session group-based ACT intervention as compared to a treatment as usual (TAU) wait-list control group within a school setting.

More traditional CBT-based exam stress management interventions have also yielded impressive findings with GCSE students. For example, Keogh, Bond and Flaxman (2006) reported significant improvements in measures of mental health and stress levels, as well as improved GCSE grade outcome for a CBT intervention group compared with a control group. Given that the ACT model, when informing stress-management interventions, has performed well in comparison to traditional CBT-based stress management interventions within adult populations (Bond & Bunce, 2000; Flaxman & Bond, 2010a), the utility of its application in times of high stress for teenaged students in schools, such as during exam preparation, seems promising. As such, we would suggest that a helpful role for practicing EPs, in this context, could be to deliver to GCSE students group-based exam-stress management interventions, such as the protocol described by Livheim et al. (2014).

A further targeted application for the ACT model in schools, the delivery (and also the supervision) of which EPs could play a key role in, relates to support for students experiencing high levels of anxiety. Research into the utility of ACT-based interventions for children and young people experiencing such problems is currently at an early stage (though initial findings are encouraging). However, there now exists a considerable body of empirical literature on the beneficial effects of ACT on anxiety among adult populations. By 2015, ten empirical studies with ten or more participants (reporting data from 457 participants in total) reported positive outcomes on quality-of-life measures through ACT-based therapeutic interventions for anxiety (see Hooper & Larsson, 2015, for a full discussion).

In addition to the above potential applications, the use of ACT for supporting students presenting ongoing challenging behaviour (often underpinned by anger and the perception of threatening circumstances) is an area worthy of further exploration. U.K. government statistics show that the percentage of students who have been permanently excluded, across all school-types (primary, secondary and special schools) rose from 0.6% over the 2013/14 academic year to 0.7% over the 2014/15 academic year. Further, there has been an increase in permanent exclusions of primary-phase children from 0.1% over the 2010/11 year to 0.2% by the 2014/15 year (Department for Education, 2016). Many of these permanent exclusions will have resulted from incidents of aggressive and unsafe behaviour fuelled by feelings of anger and threat.

The ACT model sees the emotional experience of anger not as a problem in itself, but rather as a natural response to feeling under threat that is essential for human survival and thriving (Eifert, McKay & Forsyth, 2006). The potential problem lies not in the experience of anger itself, but more in how one relates to, and responds to, this experience. As such, ACT-based interventions for anger-related problems focus on a) acceptance of, and habituation to, the experience of anger, b) development of awareness of one's anger-experience and anger-response and c) the enactment of target-behaviours that are consistent with one's own personal values and valued life-direction (Eifert et al., 2006).

We would note that, as has been expressed by Hagarty (2017), there is cause for proceeding with caution regarding the application of ACT with children and young people. However, the methodological issues identified within the existing empirical literature do not, we would argue, imply that EPs should avoid practicing, or recommending the use of, ACT in schools. The development of an evidence-base for ACT with children and young people is in its early stages (17 of the 20 studies in the aforementioned meta-analysis were published within the last 10 years, for example) but these initial findings are very encouraging. As such, we suggest EPs could usefully take the stance of practitioner-researchers, delivering (and supporting the delivery of) such interventions and collecting appropriate psychometric (and other) data to evidence impact.

*A Personal, Social & Health Education (PSHE) Curriculum*

Dixon (2013) reports on the initial outcomes resulting from a one-year ACT-based life-skills curriculum in a U.S. elementary school (six years to 13 years of age). The curriculum included both universal components, which all students accessed, and more intensive and targeted components, accessed only by students experiencing specific difficulties, such as additional emotional and/or behavioural problems. The common thread running through all components was the teaching, modelling and reinforcement of language and behaviour consistent with the six core skills detailed within the ACT Hexaflex model (see Figure 2, above). The method of delivery, however, did vary according to the skill component, or components, being targeted.

Dixon (2013 & 2014) describes an array of techniques and session-plans designed to teach core ACT skills. For example, in one lesson, children designed their own personal Hexaflex. This included arts-based activities in which children were taught explicitly each of the six parts of the Hexaflex and then asked to draw themselves engaging in the various different core skills. Students were invited to keep their personal Hexaflex at their desk for the rest of the school year, thus providing a visual prompt for individual students regarding the importance and usefulness of the six core wellbeing-skills.

Szabo and Dixon (2016) provide some recommendations for psychologists, therapists, councillors or pastoral leads wishing to pursue the implementation of ACT practices within schools. They emphasize the need for school staff to commit to related practices; the need for a sound understanding of the school culture and context on the part of the ACT trainer; a willingness to work creatively and proactively in the face of inevitable initial resistance; the opportunity for implementers to have formal opportunities to learn – both intellectually and experientially – about ACT; the need for careful adaptation of pedagogies and approaches according to the size, age and type of class/group; and the need for careful consideration regarding adaptation of resources and materials, such as the use of specific and relevant metaphors, which are a key aspect of ACT work.

Although currently lacking full empirical evaluation, there are other potentially useful and relevant practitioner resources to draw upon in developing an ACT-based PSHE curriculum. For example, Porosoff and Weinstein (2017) outline 21 lesson plans for teachers and other educators to use within classrooms. These lessons, designed primarily for children aged 10

& 11 years of age, all target one or more of the six core processes in the ACT Hexaflex. A particularly appealing feature of this resource is that it has been rebranded in order to make it more accessible and engaging for children. Porosoff and Weinstein (2017) present their version of ACT processes through their EMPOWER Model, with seven core processes mapping approximately onto the original six processes in the Hexaflex:

- *Exploration*: Becoming curious about one's values
- *Motivation*: Making values the reason for acting
- *Participation*: Creating opportunities to enact values
- *Openness*: Sharing genuine values
- *Willingness*: Serving values even when doing so is hard
- *Empathy*: Treating others according to one's values
- *Resilience*: Treating oneself according to one's values

Research into the potential universal application of ACT, and other models derived from ACT, is certainly in its infancy. However, Dixon (2013) does report on some encouraging whole-school findings from his initial study, including improved overall attendance rates, attainment grade outcomes and improved scores on measures of psychological wellbeing. In the same report, Dixon discusses the results of more targeted ACT interventions within the same school. For example, he reports reductions in the frequency of a range of concerning behaviours from pre- to post- exposure to an ACT intervention for a small number of students presenting behavioural concerns. The implication here is that the ACT model may lend itself well to strategies that promote and enhance wellbeing practices in schools both for universal practices as well as for certain types of targeted and individualised practices.

There are two potential advantages to delivering ACT-based curriculums of this sort within the school context. First, it provides an excellent opportunity to shift ACT work from a primarily clinic-based (small-group or individual) delivery format into a universally accessible life-skills curriculum within a context that all – or the vast majority of – children can access. Doing this increases the number of individuals who have the opportunity to learn core skills that have been found to enhance psychological wellbeing. Second, the school context is one that people access in the earlier stages of their lives. As such, the delivery of ACT in



schools provides an important opportunity for preventative work, and for early intervention, to promote and improve children's mental health and wellbeing.

While Dixon's work is perhaps the most extensive, empirically documented threading of ACT into entire school systems thus far, other related work is emerging. Hayes and Ciarrochi (2015) describe a version of the ACT model, adapted specifically for work with children and young people. The DNA-V (Discoverer, Noticer, Advisor – Values) model informs a range of techniques and approaches for teachers, school councillors, learning mentors and other educational professionals to help promote psychological wellbeing. Although this model is yet to be tested rigorously within schools, many of the techniques described within it are supported by evidence of improved wellbeing and psychological flexibility among teenaged cohorts outside of the school context.

At this juncture, it is worth pointing out the Department for Education's intention to make relationship education, as a core part of Personal, Social & Health Education (PSHE) curricula, a statutory requirement for schools from 2019, through an amendment to the Children and Social Work Bill (2017). Whilst the development and implementation of social and emotional learning programs in schools have been a focus of the Department for Education for a number of years (e.g. Social and Emotional Aspects of Learning; DfE, 2006), the change to statutory status for aspects of PSHE curricula is significant. With its clearly outlined and skills-based model of psychological wellbeing, EPs could play a core role in the development and implementation of a PSHE curriculum with the ACT model at its core. Whilst PSHE programs that draw upon a plurality of psychological models and approaches may have the benefit of being able to take the best-evidenced approaches from a broad array of existing techniques, a key drawback of such theoretically pluralistic interventions is that educators can become confused about which particular wellbeing skills need to be taught. For example, following a medical or symptom-reduction model, a given technique may implicitly or explicitly endorse the need to find ways to reduce anxiety. Conversely, following a resilience-based model (we would consider the ACT model to fall broadly within this camp) a technique may encourage bravery and persistence, combined with self-compassion, in the face of anxiety. With a single psychological model informing all activities, assuming it is sufficient in its scope for application, potential confusions of this sort would be less likely to arise.

## **Summary and Concluding Remarks**

To date, the ACT model has been applied across a wide range of contexts and to a wide range of issues, both within and beyond mental health diagnoses. As discussed, there is now a sizable body of evidence supporting the utility of the ACT model as a guiding framework for interventions to promote and enhance wellbeing in the workplace. It is suggested that a useful trajectory for EPs would be to explore the application of ACT within schools, pre-school settings and colleges to help support staff wellbeing.

In addition to promoting staff wellbeing, a number of targeted ACT interventions for children and young people have been designed to address a range of psychological wellbeing issues. However, there is valid criticism of the varied methodological quality of many studies in this area, including the fact that only a handful of studies have been formatted as RCTs. Accordingly, there is a useful role for EPs in developing, delivering, supervising and evaluating targeted ACT interventions within school contexts and also in building upon the existing empirical literature in this area. This work could perhaps be most effectively undertaken in partnership with university-based research groups and other academic bodies.

The development of PSHE curricular activities based on the ACT-model represents an emergent area worthy of further development. Some initial work, including material and lesson-plan development, has already been undertaken and a feasible and sensible next step would be to develop and evaluate a full, ACT-informed PSHE curriculum that has a clear developmental progression from start to finish. It would be useful for EPs to contribute to both the development and evaluation of such a curriculum. It would also seem sensible for this undertaking to be informed by a variation of the ACT model that has been designed specifically for work with children and young people, such as the EMPOWER Model (Porosoff & Weinstein, 2017) or the DNA-V Model (Hayes & Ciarrochi, 2015).

As a concluding remark, it is worth noting that the three themes relevant to educational psychologists' practice discussed in this article are not an exhaustive list. There is also potential utility of ACT as a model to support parental wellbeing and effective parenting practices (e.g., Blackledge & Hayes, 2006; Brown, Whittingham, Boyd, McKinley & Sofronoff, 2014; Whittingham, Sanders, McKinley & Boyd, 2013) and as a model to inform professional

coaching for school leaders and other educationalists (e.g., Blonna, 2011; Oliver, Hill & Morris, 2015).

## References

- Biglan, A., Layton, G., Jones, L.B., Hankins, F. M., & Rusby, J. C. (2013). The value of workshops on psychological flexibility for early childhood special education staff. *Topics in Early Childhood Special Education, 32*(4), 196–210.
- Blackledge, J., & Hayes, S. (2006). Using acceptance and commitment training in the support of parents of children with diagnosed autism. *Child and Family Behaviour Therapy, 28*, 1-18.
- Blonna, R. (2011). *Maximise your coaching effectiveness with acceptance and commitment therapy*. New Harbinger Publications, Inc.
- Brinkborg, H., Michanek, J., Hesser, H., & Berglund, G. (2011). Acceptance and commitment therapy for the treatment of stress among social workers: A randomized controlled trial. *Behaviour Research and Therapy, 49*, 389–398.
- Brown, F., Whittingham, K., Boyd, R., McKinley, L., & Sofronoff, K. (2013). Improving child and parent outcomes following paediatric acquired brain injury: A randomised controlled trial of Stepping Stones Triple P plus acceptance and commitment therapy. *Journal of Child Psychology and Psychiatry, 55*, 1172-1183.
- Bond, F. W., & Bunce, D. (2000). Mediators of change in emotion-focused and problem-focused worksite stress management interventions. *Journal of Occupational Health Psychology, 5*, 156–163.
- Bond, F. W., & Hayes, S. C. (2002). ACT at work. In F. W. Bond & W. Dryden (Eds.), *Handbook of brief cognitive behaviour therapy*. Chichester, England: Wiley.
- Dahl, J., Wilson, K. G., & Nilsson, A. (2004). Acceptance and commitment therapy and the treatment of persons at risk for long-term disability resulting from stress and pain symptoms: A preliminary randomized trial. *Behavior Therapy, 35*, 785–801.
- DfE (2017). Policy Statement: Relationship Education, Relationships and Sex Education, and Person, Social, Health and Economic Education. Available at [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/595828/170301\\_Policy\\_statement\\_PSEv2.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/595828/170301_Policy_statement_PSEv2.pdf)
- Dixon, M. (2013). Don't stop believing: Journeys school. *Behaviour Analysis in Practice, 6*, 23-24.
- Dixon, M. (2014). *ACT for children with autism and emotional challenges*. Carbondale. IL: Shawnee Scientific Press.

- Eifert, G., McKay, M., & Forsyth, J. (2006). *ACT on life not on anger: The new acceptance and commitment therapy guide to problem anger*. New Harbinger Publications, Inc.
- Flaxman, P. E., & Bond, F. W. (2006). Acceptance and commitment therapy in the workplace. In R. A. Baer (Ed.), *Mindfulness-based treatment approaches*. San Diego, CA: Elsevier.
- Flaxman, P. E., & Bond, F. W. (2010a). A randomised worksite comparison of acceptance and commitment therapy and stress inoculation training. *Behaviour Research and Therapy*, *48*, 816–820.
- Flaxman, P. E., & Bond, F. W. (2010b). Worksite stress management training: Moderated effects and clinical significance. *Journal of Occupational Health Psychology*, *15*, 347–358.
- Flaxman, P. E., Bond, F., & Livheim, F. (2013). *The mindful and effective employee: An acceptance and commitment therapy training manual for improving wellbeing and performance*. New Harbinger Publications, Inc.
- Frögéli, E., Djordjevic, A., Rudman, A., Livheim, F., & Gustavsson, P. (2016). A randomized controlled pilot trial of acceptance and commitment therapy (ACT) for preventing stress-related ill-health among future nurses. *Anxiety, Stress and Coping*, *29*(2), 202–218.
- Hayes, L., & Ciarrochi, J. (2015). *The Thriving Adolescent: Using acceptance and commitment therapy and positive psychology to help teens manage emotions, achieve goals, and build positive connections*. New Harbinger Publication, Inc.
- Hayes, S., Barnes-Holmes, D., & Roche, B. (2001). *Relational Frame Theory: A post Skinnerian account of human language and cognition*. Kluwer Academic/Plenum Publishers.
- Hayes, S., Strosahl, K., Bunting, K., Twohig M., & Wilson, K. (2004). What is acceptance and commitment therapy? In S Hayes & K Strosahl (Eds.) *A practical guide to acceptance and commitment therapy* (pp. 1-30). New York: Springer.
- Hayes, S., Strosahl, K., & Wilson, K. (1999) *Acceptance and commitment therapy: An experiential guide to behaviour change*. New York: Guilford Press.
- Hayes, S.C, Strosahl, K.D., & Wilson, K.G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd edition). New York, NY: The Guilford Press.
- Health & Safety Executive (report available from [www.hse.gov.uk/statistics/](http://www.hse.gov.uk/statistics/))
- Hooper, N., & Larsson, A. (2015). *The research journey of acceptance and commitment therapy (ACT)*. Palgrave Macmillan.

- Hutchings, M., & Kazmi, N. (2015). *Exam factories? The impact of accountability measures on children and young people*. National Union of Teachers.
- Jeffcoat, T. & Hayes, S. C. (2012). A randomized trial of ACT bibliotherapy on the mental health of K-12 teachers and staff. *Behaviour Research and Therapy*, 50, 571-579.
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present and future. *Clinical Psychology: Science and Practice*, 10(2), 144-156.
- Keogh, E., Bond, F., & Flaxman, P. (2006). Improving academic performance and mental health through a stress management intervention: Outcomes and mediators of change. *Behaviour Research and Therapy*, 44, 339-357.
- Livheim, F., Hayes, L., Ghaderi, A., Magnusdottir, T., Högfeltdt, A., Rowse, J., Turner, S., Hayes, S. C., & Tengström, A. (2015). The effectiveness of acceptance and commitment therapy for adolescent mental health: Swedish and Australian pilot outcomes. [\*Journal of Child and Family Studies\*, 24\(4\), 1016–1030.](#)
- Lloyd, J., Bond, F. W. and Flaxman, P. E. (2013). [The value of psychological flexibility: Examining psychological mechanisms underpinning a cognitive behavioural therapy intervention for burnout.](#) *Work & Stress*, 27(2), pp. 181-199.
- McConachie, D., McKenzie, K., Morris, P. G., & Walley, R. (2014). Acceptance and mindfulness-based stress management for support staff caring for individuals with intellectual disabilities. *Research in Developmental Disabilities*, 35(6), 1216-1227.
- McCracken, L., & Yang, S. (2008). A contextual cognitive-behavioural analysis of rehabilitation workers' health and wellbeing: Influences of acceptance, mindfulness and values-based action. *Rehabilitation Psychology*, 53, 479-485.
- Oliver, J., Hill, J., & Morris, E. (2015). *Activate your life: Using acceptance and mindfulness to build a life that is rich, fulfilling and fun*. Constable & Robinson Ltd.
- Porosoff, L., & Weinstein, J. (in-press). *Empower your students: Tools to inspire a meaningful school experience*. Bloomington: Solution Tree.
- Public Health England (2015). *Prompting children and young people's emotional health and wellbeing: A whole school and college approach*. PHE, London.
- Sidman, M. (1994). *Equivalence Relations: A Research Story*. Boston Authors Cooperative.
- Swain, J., Hancock, K., Dixon, A., & Bowman, J. (2015). Acceptance and commitment therapy for children: A systematic review of intervention studies. *Journal of Contextual Behavioural Science*, 4, 73-85.

- Szabo, T., & Dixon, M. (2016). Contextual behavioural science and education. In R Zettle, S Hayes, D Barnes-Holmes & A Biglan (Eds.) *The Wiley Handbook of Contextual Behavioural Science*. John Wiley & Sons.
- Waters, C. S., Frude, N., Flaxman, P. E., & Boyd, J. (2017-in press). Acceptance and commitment therapy for clinically distressed healthcare workers: Waitlist controlled evaluation of an ACT workshop in a routine practice setting. *British Journal of Clinical Psychology*. Available for early view:  
<http://onlinelibrary.wiley.com/doi/10.1111/bjc.12155/full>
- Weare, K. (2015). *What works in promoting social and emotional wellbeing and responding to mental health problems in schools? Advice for schools and framework document*. National Children's Bureau.
- Whittingham, K., Sanders, M., McKinley, L., & Boyd, R. (2013). Stepping Stones Triple P and acceptance and commitment therapy for parents of children with cerebral palsy: Trial protocol. *Brain Impairment*, 14, 270-280.
- Wilson, K., & Dufrene, T. (2009). *Mindfulness for two: An acceptance and commitment therapy approach to mindfulness and psychotherapy*. New Harbinger, Inc.