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Acceptance and Commitment Therapy in the Treatment of Co-Occurring Disorders

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ACCEPTANCE & COMMITMENT THERAPY IN THE TREATMENT OF CO-OCCURRING DISORDERS

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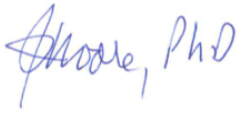

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Abstract

Acceptance & Commitment Therapy is an emerging, contextual approach to psychotherapy derived from Relational Frame Theory. In the present paper, core concepts of ACT are briefly summarized. A total of twelve studies, all published within the last four years, are reviewed. These include meta-analyses on ACT for mental health and substance use disorders, as well as proposed mechanisms of action. Selected recent developments are also reviewed, including studies of ACT in the treatment of mood disorders, personality disorders, and eating disorders, as well as ACT's implications for caregiver and provider self-care. Potential directions for future research are examined, and Appendix A includes an outline of how ACT principles could be integrated into an aftercare program for clients with co-occurring disorders.

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Introduction

Acceptance & Commitment Therapy (ACT, pronounced "act") is a comprehensive, contextual approach to psychotherapy. Though it shares some superficial similarities with more traditional cognitive-behavioral approaches, ACT takes a fundamentally different approach to treatment. These are some of the core concepts that make up ACT, as well as some information on how ACT differs from other models.

The Inevitability of Suffering

Therapists oriented toward ACT take the position that suffering is an inherent element of the human condition. Such therapists take exception to what they call "the assumption of healthy normality" – the idea that "health and happiness are the natural, homeostatic state of human existence" (Hayes, Strosahl & Wilson, 2012, p.5). This is a naturally appealing notion; if negative psychological states can be eliminated, some final victory over suffering may be possible. ACT theorists posit that this is a fundamentally flawed assumption, and that attempts to control, modulate or eliminate negative psychological experiences only increase the sum total of human suffering.

In contrast, the ACT perspective argues for a more nuanced view of the good life. Instead of trying to eliminate suffering – and, in failing, increasing it – individuals can learn to live a present and meaningful life centered on committed action towards sincerely-held values. ACT is a system of treatment to help clients achieve such a life.

The Problem of Problem-Solving

Acceptance & Commitment Therapy draws its philosophical and neurological basis from Relational Frame Theory. It has been proposed by linguists and neurologists that human

consciousness cannot be a simple matter of information processing; there must be inherent qualities that structure this information into what we would call cognition (Pinker, 2002). Relational Frame Theory proposes that the capacity to relate different stimuli in the environment makes up the fundamental building blocks of cognition and language.

It has been argued by (Hayes, Strosahl & Wilson, 2012) that problem-solving is the single most useful function of language, and that this gives rise to a "problem-solving mode of mind." In this mode, the mind compares the current situation with a goal, and noting the difference between the two, continues to seek means of correcting the situation. This is a profoundly useful process when applied to the physical, external world.

When applied to internal experiences, however, this verbal problem-solving process becomes itself problematic. Aversive psychological experiences, rather than being treated simply as experiences, become problems to be eliminated. We eliminate these "problems" by suppressing, denying, or dissociating from them; in this way, our attempts to eliminate suffering actually narrow and cheapen our existence. A central focus of Acceptance & Commitment Therapy is to stop applying this problem-solving mode in situations where it isn't appropriate or helpful. (Hayes, Strosahl & Wilson, 2012)

Similarly, ACT therapists possess, and foster in their clients, a certain healthy skepticism about language. An ACT therapist would not focus on changing an essentially verbal phenomenon in the mind, such as the idea "I cannot live without alcohol." Instead, one would seek to distance oneself from such a thought, understanding that such thoughts will reasonably arise in the mind of an alcoholic client. It is not possible to "unlearn" this idea, but with practice, the client can learn to decouple the thought from behavior (i.e. having a drink).

Creative Hopelessness

Acceptance & Commitment Therapy proposes a radically different idea of mental health. Before a client can begin to work toward what may seem like strange and counterintuitive mental strategies, they must first see how their existing approach has been ineffective. To this end, ACT seeks to create a condition known as "creative hopelessness."

In this exercise, the therapist elicits information from the client via particular questions. What outcome does the client want? What strategies have been tried? How have those strategies worked? And what have these strategies cost the client? By doing so, the therapist gradually illustrates that the client's various past strategies actually fall under one heading – the idea that "control of private experiences equals successful living" (Hayes, Strosahl &Wilson, 2012, p.167). By demonstrating that the client has in fact been doing the same thing over and over again, and that this has not been successful, the therapist induces in the client a willingness to try radical new strategies. Hence, we say that the client is in a state of "creative hopelessness."

The Psychological Flexibility Model

The creators of ACT describe their vision of mental health in the Psychological Flexibility Model. Psychological flexibility is defined as "the ability to contact the present moment more fully as a conscious human being, and based on what the situation affords, to change or persist in behavior in order to serve valued ends" (Luoma, Hayes & Walser, 2007, location 528). This flexibility is based on six core processes, each of which are elaborated on below. It is important to keep in mind that these six core processes are positive skills which clients actively cultivate, not a simple absence of psychopathology.

Present-Moment Awareness. Given the popularity of mindfulness, both in psychotherapy and in the wider culture, present moment awareness is one aspect of ACT likely to be immediately recognizable to the untrained eye. ACT practitioners take the position that life is most meaningfully and effectively lived in the present moment. If a client does not actively practice awareness of the moment, conceptualized notions of the past and future predominate, and present behavior becomes an automated function of past experiences. Hence, mindfulness in an ACT context is not simply a tool for relaxation or stress relief. It is a sort of training by which clients can learn to remain present, moment to moment, in their own lives.

Self-as-Context. Humans beings naturally carry on analyzing their own behavior and, in an effort to understand themselves, construct narratives about who they are. People can tend to become entangled in these narratives, and over time, we learn to serve the narrative rather than our own goals. Hence, the long-time heroin addict may come to think of herself as, fundamentally, a heroin addict; in this context, to stop up using is to give up a fundamental part of oneself. While these stories we tell ourselves may contain a grain of truth, this does not necessarily make them useful to us (Luoma, Hayes, & Walser, 2007).

ACT theorists reject these conceptualized, verbal notions of self, and instead propose the idea of self-as context. This perspective envisions the self not as a single narrative, but as an ever-changing context in which various narratives may have varying levels of truth and value. This self has experiences, but is still separate from them. Divorced from a pre-existing storyline about who they are, the client is then free to choose actions that fit with their most deeply-held values.

Cognitive Defusion. "Cognitive fusion" is a term for when an individual becomes caught up in a thought, and treats it as the literal truth. To cite an earlier example, the chronic alcoholic

may find himself thinking, "I cannot live without alcohol." We know that this is not literally, medically true; but to the individual fused with the thought, it feels like the truth.

Cognitive defusion is an alternative approach. ACT rejects the traditional cognitive-behavioral idea of trying to rid oneself of distorted, negative thoughts. It has been pointed out that nobody has ever identified a cognitive process that could be called "unlearning" (Hayes, Strosahl & Wilson, 2012). It is not necessary to change the *content* of a thought in order to change the behavioral role of that thought (Luoma, Hayes & Walser, 2007). Instead, ACT teaches cognitive defusion – a process whereby a client learns to examine their thoughts *as* thoughts, which may or may not be functionally useful to the client. Here again, by separating thoughts from automatic action, the client can instead make rational choices that advance them toward their goals and values.

Acceptance. From an ACT perspective, a fundamental cause of suffering is experiential avoidance. In response to aversive internal experiences – sadness, anxiety, feelings of inadequacy – we often attempt to control, change, or eliminate the experience, even when our way of accomplishing this is harmful. It may be momentarily helpful, for instance, to defeat one's depression by consuming a large quantity of methamphetamine; in the long run, though, this strategy is untenable. One can try different, healthier means of experiential avoidance, but ultimately, the relationship with the aversive experience must be changed.

ACT thus proposed an alternative position of experiential acceptance. By learning to stop fighting aversive internal experiences, and instead accepting them, one can stop the self-destructive cycle of avoidant behavior.

Values. Much of the Psychological Flexibility Model involves undermining processes that lead to automatic, unskillful behavior. The ACT model instead asks clients to define their values. A value is not a goal, in that it can never be achieved; we are never "done" living our values. As (Luoma, Hayes & Walser, 2007) put it, values are "the linchpin of ACT" (location 616). Presence, defusion, and acceptance are only important in that they "clear the path for a more vital, values-consistent life" (Luoma, Hayes & Walser, 2007, location 627).

Committed Action. It is always tempting to pursue short-term goals – goals like feeling good, avoiding pain, or protecting a conceptualized sense of self come quite naturally, and are often rationalized as a means to pursuing longer-term goals. As (Luoma, Hayes & Walser, 2007) point out, one can spend so much time sharpening the metaphorical axe that one never gets to chopping. ACT theorists propose that, instead of giving oneself over to short-term process goals, one lives a fulfilling, meaningful life by taking committed action toward their values. It will certainly ease the addict's pain to use his drug of choice, but it is unlikely to provide a fulfilling existence – only living in tune with one's values can do that.

Review of The Literature

Since its development in the late 1980's, Acceptance & Commitment Therapy has developed a broad and robust base of evidence. At time of writing, the American Psychological Association has declared ACT to be an empirically-validated treatment. This includes "Strong Research Support" regarding chronic pain, and "Modest Research Support" regarding depression, anxiety, obsessive-compulsive disorder, and psychosis (American Psychological Association, 2016). There is also strong evidence for its usefulness in the treatment of substance use disorders and co-occurring disorders. There is relatively little research on the effectiveness of ACT in the treatment of personality disorders and eating disorders, though the existing research seems to justify further exploration in these two areas.

ACT & Mental Health

At time of writing, the most recent meta-analysis on ACT is (A-Tjak, Davis, et. al., 2015). This analysis examined a total of 39 studies, divided into four categories – addiction (n = 8), depression & anxiety (n = 8), somatic health issues (n= 15), and "other mental health problems" (n = 8). Notably, the research team included 22 studies not included in any previous meta-analysis. They reported that their findings indicated that ACT is as effective, or more effective, than current, CBT-based techniques for anxiety disorders, addiction, depression, and somatic health problems (A-Tjak, Davis, et. al., 2015).

Due to concern about the natural bias toward successful studies – unsuccessful studies may never be published – a "failsafe N" was determined. The researchers determined that, assuming an effect size of 0 in all unpublished studies, some 1100 such studies would have to

exist for the average effect size of ACT studies overall to be reduced to insignificance (A-Tjak, Davis, et. al., 2015).

ACT & Substance Use Disorders

The meta-analysis by (A-Tjak, Davis, et. al., 2015), as noted above, did find that substance use disorders are amenable to treatment via ACT. However, an additional meta-analysis, focused exclusively on substance use disorders, was conducted by (Lee, An, Levin & Twohig, 2015). This more limited analysis, which examined ten studies, found a small-to-medium effect size (k=5) when ACT was used to treat substance use disorders. This finding is in accordance with the results observed in (A-Tjak, Davis, et. al., 2015).

Proposed Mechanisms of Action

Much research has focused on how, specifically, ACT helps clients to change. In an attempt to explain the specific mechanism, (Levin, Luoma & Haeger, 2015) have proposed decoupling – the process of reducing the automatic link between internal experiences and actual, physical behavior. In their literature review on the topic, the team found "preliminary" evidence of such an effect in 44 studies on a wide range of pathologies, including chronic pain, depression, eating disorders, avoidance, anger, anxiety, and self-harm. While cautioning that more replication studies on specific, decoupling-related phenomena were needed, they noted that the strongest available evidence for decoupling was found in relation to substance use disorders (Levin, Luoma & Haeger, 2015).

In particular, there is some evidence that ACT is effective in decoupling substance users from their own negative self-schema, and that this decoupling leads to improved treatment outcomes. A study by (Luoma, Kohlenberg, Hayes & Fletcher, 2012) examined the effectiveness

of an ACT-based group intervention targeting shame in clients with substance use disorders. Compared with treatment as usual, ACT clients showed smaller initial declines in shame, but larger declines at a four-month follow-up. ACT clients had a higher treatment attendance and fewer days of using at follow-up. Notably, the team found clients with higher levels of shame were more likely to be utilizing treatment at follow-up, and that the number of days a client used substances was in turn linked with treatment utilization; the team concluded that the shame-focused ACT intervention was effective "at least in part, through improving treatment attendance" (Luoma, Kohlenberg, Hayes & Fletcher, 2012, p.43).

Further insight is provided by (Trompetter, Bohlmeijer, Fox, & Shreurs, 2015), which explored how ACT treatment reduces psychological distress in individuals suffering from chronic pain. Here, the team zeroed in on "pain-related psychological flexibility" – the ability of sufferers to distance themselves from pain, acknowledging it without permitting it to induce an automatic action on the sufferer's part. This flexibility was found to be a "direct, causal working mechanism" contributing to decreased psychological distress in individuals suffering from chronic pain (p.50).

Recent Developments

Since the publication of (A-Tajk, Davis, et. al., 2015), additional research-controlled trials of ACT have been published. Though they do not substantially alter the level of efficacy determined in (A-Tajk, Davis, et. al., 2015), they do showcase certain novel developments as the ACT research community grows and matures.

Mood Disorders. Depression, one of the most common mental disorders, continues to be a major focus for ACT researchers. Notably, a recent study by (Walser, Garvert, et. al., 2015)

indicates ACT is effective in treating depression and suicidal ideation. This large study (n = 981) zeroed in on two specific factors – experiential acceptance and mindfulness, as measured on the Acceptance and Action Questionnaire-II and Five Facet Mindfulness Questionnaire. Higher experiential acceptance and mindfulness scores were associated with decreased depression symptoms and suicidal ideation - effects that apparently increased over time (Walser, Garvert, et. al., 2015).

Personality Disorders. Acceptance & Commitment Therapy has received comparatively little attention as a potential treatment for clients with personality disorders. Though there are many theories of how and why the various personality disorders develop, it has been suggested by (Young, Klosko & Weishaar, 2003) that all personality disorders necessarily involve an element of dissociation – that is, rather than reacting directly to cues in the environment, the client reacts on the basis of their own rigid schemas. Given its focus on acceptance and present-moment awareness, ACT would seem a productive avenue of research in the treatment of these profoundly challenging cases.

Fortunately, a study by (Chakhssi, Janssen, et al., 2015) has delved into ACT as a treatment for clients with personality disorders who have not responded to previous treatment. In this study, a 26-week group treatment based on ACT was compared with a cognitive-behavioral treatment of similar length. The ACT and CBT groups both experienced small-to-moderate improvements in personality pathology; though ACT was not distinguishably more effective than CBT in this case, the team argued that ACT is, if nothing else, a valid treatment option for this population (Chakhssi, Janssen, et. al., 2015).

Eating Disorders. One largely unexplored area of research for ACT techniques is the treatment of eating disorders. At time of writing, no large, controlled studies of ACT for eating

disorders yet exist. However, a small case-series study by (Hill, Masuda, et. al., 2015) has recently appeared. The study focused on two clients who underwent ten weekly sessions of ACT while self-reporting instances of binge eating. Across both participants, there was a decrease of 2.5 instances per week; strikingly, at both the end of treatment and follow-up, one of the participants no longer met criteria for Binge Eating Disorder. Obviously, no firm conclusions can be drawn from a single case study of two participants; nonetheless, the results hint at a potentially valuable intervention, and the team argued that further research is justified (Hill, Masuda, et. al., 2015).

Co-Occurring Disorders. Much recent research has also highlighted ACT's usefulness in treating co-occurring disorders. A study by (Thekiso, Murphy, et. al., 2015) examined ACT treatment for alcohol use disorder and co-occurring mood disorders. At three and six-month follow-ups, individuals being treated with ACT showed greater cumulative time abstinent, and lower levels of depression and anxiety, than those in the treatment-as-usual (TAU) group.

ACT for co-occurring disorders has also been explored in the context of smoking cessation. For example, (Heffner, McClure, et. al., 2015) studied the use of ACT, in conjunction with nicotine replacement, in the treatment of tobacco users with co-occurring bipolar disorder. Among individuals participating in in-person treatment, 30% remained abstinent at a one-month check-in; individuals participating in treatment via telephone showed a similar level of abstinence (33%) at a one-month check-in. Similarly, (Jones, Heffner, et. al., 2015) studied tobacco users with co-occurring depressive symptoms, and utilized a web-based approach. The team found that tobacco users using ACT were, at a three-month follow-up, more likely to abstain from nicotine (20% vs. 12%) and less likely to display depressive symptoms (45% vs 56%) than did those participating in a control group (Jones, Heffner, et. al., 2015).

Providers & Caregivers. One novel area of inquiry for ACT has been in its use to assist mental health care providers and other caregivers in better accomplishing their goals.

ACT's Psychological Flexibility model has been advanced as a useful construct in understanding how different processes affect self-care among clinical psychology trainees (CPT). The ACT concepts of acceptance, mindfulness, defusion, and values, measured via questionnaire, were studied as predictors of four adjustment variables – life satisfaction, stress, distress, and clinical training satisfaction. Acceptance, values, and defusion were found to have varying influence across these four adjustment variables; most notably, the adverse effects of lower levels of defusion had negative effects across all four variables. Somewhat surprisingly, in light of the existing literature, mindfulness was not found to significantly affect any of the four adjustment variables studied (Pakenham, 2015).

Conclusion

Overall, ACT has a broad and growing base of evidence to support its effectiveness for a wide variety of pathologies. At time of writing, the existing literature demonstrates that ACT is as effective, or more effective than, current CBT-based techniques for anxiety disorders, addiction (including co-occurring disorders), depression, and somatic health problems. It is considered an empirically-validated treatment by the American Psychological Association, with "Strong Research Support" regarding its use for chronic pain, and "Modest Research Support" regarding its use for depression, anxiety, obsessive-compulsive disorder, and psychosis.

There are much more limited indicators that ACT may be effective for eating disorders and personality disorders, and some evidence that the Psychological Flexibility model may be useful in understanding how self-care affects quality of life for mental health care providers. Though the existing evidence does not firmly establish the effectiveness of ACT for eating disorders and personality disorders, it does indicate that these are potentially fruitful directions for future research.

Appendix A: Integrating ACT - Principles of Contextual Behavioral Aftercare

It is widely agreed that, upon the successful completion of a chemical dependency treatment program, clients should complete an additional course of aftercare. Rather than simply ejecting the client unceremoniously into their previous circumstances, aftercare offers the opportunity to help the client ease into life outside of treatment; as they face the difficulties inherent in reintegration, clients can continue to rely on the social support inherent in group therapy, albeit to a reduced extent.

While aftercare is a common component of chemical dependency treatment programs, the research on this continuing care is relatively sparse. A meta-analysis conducted by (Blodgett, Maisel, et al., 2014) indicated that continuing care had a significant positive effect on client outcomes, both at completion of aftercare, and at an eventual follow-up. However, the analysis did not identify any clear, specific moderators of this positive effect. Though there is broad agreement that aftercare is helpful to client outcomes, there is no clear consensus on what constitutes “best practices” in aftercare.

In light of this, it is often reasonable – and certainly easier from a logistical standpoint – to have clients continue in the same environment that they have just completed treatment in. However, it is worth considering that this approach misses an opportunity to broaden the treatment experience. Chemical dependency treatment is often narrowly focused on the cessation of use and prevention of relapse. By integrating ACT interventions and the Psychological Flexibility Model, it is possible to help clients develop a broader framework of how to go forward and live, without mind-altering chemicals or other dangerous forms of stimulus.

Contextual Behavioral Aftercare (CBA) is a possible framework for achieving this vision of what aftercare might be. Over the course of the eight weekly session, it provides psychoeducation on the Psychological Flexibility Model, as well as ongoing social support as the client transitions out of active treatment. In positioning aftercare as being separate from primary treatment, CBA is meant to be in addition to, rather than in replacement of, existing treatment programs – a potentially important factor in winning over existing stakeholders, who may be unwilling to replace tried-and-true approaches.

Sample Group Sessions

Each weekly session of CBA consists of a check-in about challenges encouraged over the previous week; a psychoeducational presentation about one aspect of the Psychological Flexibility Model; and one or more activity designed to demonstrate the aspect explored. Sessions begin and end with brief (3-5 minutes) mindfulness activities, with the intention of helping group members to be present and internalize the lessons of each group. A very broad outline of each session is provided below; all exercises mentioned are taken from *The Big Book of ACT Metaphors: A Practitioner's Guide to Experiential Exercises & Metaphors in Acceptance & Commitment Therapy* (Stoddard & Afari, 2014).

Session One – Introductions. In the group's opening session, the leader works to earn the group's trust, build a minimum of cohesion, and seek buy-in from the group members. Cutesy icebreakers should be avoided; rather, the facilitator can kick things off with a simple and direct prompt. Something along the lines of: "I know you've all been struggling in recovery, because *everyone* struggles in recovery. As you all can attest, early recovery can be a rollercoaster – there are moments of beauty you never anticipated when you were using, and

moments of pain you couldn't possibly have prepared for. So let's start with the latter – what's one thing you're struggling with right now?"

After 45-60 minutes of group discussion (and perhaps a short break), the group leader can shift over to the evening's activity. The facilitator begins with a simple question: "What have you tried?" This is, in fact, an exercise in the ACT concept of "creative hopelessness" – through the resulting discussion, the facilitator demonstrates that clients' past attempts to redress their personal and psychological issues have been based in a fundamental misunderstanding of their own psychology.

Traditional implementations of creative hopelessness file virtually all client strategies under the heading "try harder." For our purposes, past client strategies can be filed under "get more." More money, more sex, more courage, more strength, more love – or, most prominently, more drugs. The facilitator thus creates a teachable moment – the clients have a fundamentally skewed notion of happiness grounded in either satisfying desires or suppressing negative psychological experiences. This notion of happiness will always lead an addict back to their drug, because satisfying desires and suppressing negative stimuli can be most easily accomplished by simply using the drug.

To achieve lasting sobriety, the client must instead develop a new idea of what "happiness" is – a contented, meaningful life congruent with the client's values. If the facilitator can gain a promise from the clients to consider this "other happiness," the real work can begin.

Sessions 2-7: Psychoeducation and Processing. Each psychoeducational session begins with a brief (3-5 minutes) mindfulness exercise, and the same check-in question ("What was tough for you in the last week?"). Answers to the check-in question can lead to further discussion

about how the previous week's lesson was useful, or how it could have been used. Generally, group members should not be permitted to blow off the check-in question and claim that everything is going just fine. ACT is grounded in the simple truth that suffering is inherent in human life, and that it is how we deal with these natural struggles that determines our quality of life. After the check-in question, group members are provided with a psychoeducational presentation on one aspect of the Psychological Flexibility Model.

In session 2, group members learn about *contact with the present moment.* The facilitator should ask the group what they know about the concept of "mindfulness"; group members are likely to respond with a notion of mindfulness based in stress relief or relaxation. The facilitator helps the group to understand that mindfulness is a more direct and vital way of being, rather than a sort of "spiritual aspirin" to be taken only in difficult situations. The facilitator conducts the "Observing Thoughts" exercise, then processes with the group.

In session 3, group members learn about *self as context.* The facilitator asks group members for adjectives they've applied to themselves – first good adjectives, then negative ones. The labels these notions "the conceptual self," then contrasts with the self-as-context – a transcendent, physical notion of oneself that isn't bound up in abstract concepts. The facilitator educates group members on how attempts to live up to a conceptual identity, or to shed one, increase suffering. The facilitator conducts the exercise "Conceptualized Self on Trial," then processes with the group.

In session 4, group members learn about *cognitive defusions.* The facilitator invites the group members to provide examples of past views they've held – views that seemed like truth at the time, but in retrospect turned out to be untrue. The facilitator than elicits ways in which these past views dictated the clients' behavior, and how the clients wish they had acted differently. The

facilitator conducts the "Floating Leaves on a Moving Stream" exercise, and processes with the group.

In session 5, group members learn about *acceptance & willingness.* In this session, group members are first invited to give examples of how they've tried to avoid feelings or thoughts they find aversive. Drug use will no doubt figure prominently, but group members should be encouraged to provide other examples as well. If helpful, answers provided in session 1 can be referred back to. The facilitator educates group members on how experiential avoidance is ultimately unworkable; to illustrate this, the facilitator conducts the "Don't Think About a Puppy" exercise, then processes with the group.

In session 6, group members learn about the ACT conception of *values.* Clients are invited to share with the group what values are important to them. In steering the discussion, the group leader emphasizes the difference between goals and values, as well as the personal and subjective nature of values. The facilitator then conducts the "Prime-Time News Story" exercise.

In session 7, group members learn about *committed action.* Referring back to the values explored in session 6, the group leader facilitates discussion of what specific actions the clients can take toward their values, as well as what pitfalls they anticipated. The facilitator then conducts the "Zorg The Alien" exercise, and processes with the group.

Session 8: Termination. The final session is devoted to ending the group experience in a clear and tidy manner, building compliance with any needed referrals for further therapy, and sending group members out into the world. The session consists primarily of a group discussion about the lessons learned in group, as well as processing the clients' feelings about this chapter of their lives coming to an end.

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