A reflection on the value of Acceptance and Commitment Therapy for promoting good mental health in the workplace: a service user perspective

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Biographical note

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Abstract

Many people with mental health issues are workless; despite this, good quality work is often promoted as beneficial for wellbeing. In this article I explore my personal reflections about managing my experiences of mental distress in the workplace, whilst working as a senior lecturer in social work in the UK. The potential of Acceptance and Commitment Therapy (ACT) to support the improvement of my mental wellbeing in the workplace is discussed alongside the central role of the therapist in delivering this intervention. The opportunities ACT offers to support a person with mental health issues to manage the impact of mental health symptoms in the workplace are highlighted, and its potential for wider implementation across mental health services is considered.

Keywords:

First person narrative, mental health, workplace, mental wellbeing, Acceptance and Commitment Therapy

Funding details

No funding was received to undertake this study

Disclosure details

The author reports no conflict of interest

Introduction

Mental ill-health impacts on the effective performance of people in the workplace (Stevenson & Farmer, 2017) and its effect on the UK economy is significant (Monitor Deloitte, 2017). In 2017, a report revealing that over 300,000 people who experience mental distress leave their jobs each year because of poor mental health (Stevenson & Farmer, 2017) was showcased on UK news (BBC, 2017). The reported cost to the UK economy of £33bn–£42bn each year (Monitor Deloitte, 2017) shocked many British residents; moreover, similar experiences for people with mental health issues are likewise reported in the USA (National Alliance on Mental Illness, NAMI, 2018). Furthermore, in the UK between 30% and 50% of people with schizophrenia are capable of work but only between 10% and 20% are in employment (Lelliott et al., 2008). Although some people with mental health issues are in managerial or senior positions, most are in 'elementary' jobs, for example cleaning and labouring, or are in skilled trade occupations (Lelliott et al., 2008).

Although it is important to acknowledge that experiencing wellbeing at work is important for all workers (What works for wellbeing, 2017 a), in this article I reflect on my experiences encountered as a person with mental health issues in the UK in managing mental distress in the workplace. The area addressed in this article is little investigated and I wrote this first-person narrative with the hope that it will illuminate understanding of the importance of providing high quality work for a person with mental health issues and underline the potential of psychological interventions in enabling both myself, and possibly the wider mental health service user community, to access work.

Background

High quality work can often promote wellbeing and good mental health (Lelliott et al., 2008; Stevenson & Farmer, 2017). The World Health Organisation defines wellbeing as being able to realise one's potential, cope with the normal stresses of life, work productively, and contribute to one's communities (WHO, 2017). Although many people with mental health issues have wanted to work, historically they have been seen as incapable of working (Lelliott et al., 2008; Welfare Reform Act, 2012). However , with the implementation of the recovery approach in mental health services in the UK, it has been acknowledged that people with mental ill-health can lead both meaningful lives and achieve effectively in society beyond the life limitation caused by their mental ill-health (Leamy et al., 2011; Repper & Perkins, 2003). Moreover, work is often seen as a key part of recovery for many people with mental health issues (Brown & Kandirikirira, 2006; Leamy et al., 2011); although for some, activities other than work, such as activism in service improvement are key elements in their recovery process (Brown & Kandirikirira, 2006; Leamy et al., 2011; Repper & Perkins, 2003).

Working, alone, provides many people with the means for sufficient financial security to fully participate in UK society; without this, many experience social exclusion and poverty (Lelliott et al., 2008; Stevenson & Farmer, 2017). However, despite this, people with mental health issues, who work, may still experience poverty and social exclusion through participating in insecure and elementary work (Backwith, 2015; Royston, 2017) and they may also encounter poor quality work that exacerbates their mental health (Fox, 2011; Lelliott et al., 2008; Royston, 2017). Mental wellbeing, on the contrary, is often predicated by access to high quality work that promotes good mental health and a sense of meaningful identity (Fox, 2011; Lelliott et al., 2008; Stevenson & Farmer, 2017); good quality work consists of a

person's assessments of satisfaction with their work, positive feelings about work (e.g., motivation) and the relative absence of unpleasant feelings about work (e.g., lack of anxiety or worry) (What works for wellbeing, 2017 b). Although unsurprisingly, many people with mental health issues may also be at greater risk of experiencing stress in the workplace, stress is defined as the adverse reaction a person has to excessive pressure or other types of demand placed upon them (What works for wellbeing, 2017b).

Indeed, the reality is that work inevitably impacts both positively and negatively on well-being and people can exist on a spectrum oscillating from thriving, to struggling and being ill and possibly off work (Stevenson & Farmer, 2017). People who experience mental distress need assistance to support them in the workplace, and this choice to work should be founded on the views of the individual, supported by a full assessment of the reasonable adjustments they need under the Equality Act (2010) to perform effectively in the workplace (Fox & Gasper, 2020). This leads to the question of how can we manage the reality of distress for people with mental health issues in the UK workplace?

In addressing this question, firstly I reflect on my own experiences of mental distress and its impact on my working life. Following that, I consider my experiences of receiving Acceptance and Commitment Therapy (ACT) and how being in receipt of this therapy has enabled me to create a new response to incidents of stress and paranoia in the workplace. In this discussion, I focus on describing the core processes of ACT and address its wider potential to positively support people with mental ill health to manage more effectively in their workplace environment.

Reflections on my experiences of mental distress and the workplace

I was diagnosed with schizophrenia 30 years ago at the age of 20 and as part of my ongoing recovery journey I have learnt different strategies to manage my mental distress, which are discussed in more detail as follows. At my initial diagnosis I experienced very intrusive positive symptoms of voices, extreme paranoia and was unable to think clearly or to engage with either work or study. My symptoms have become less distressing and intrusive since my initial diagnosis through the effective strategies I have learned to manage my condition. I choose to take mental health medication every day which is something that plays a large part in keeping me well; if I stop taking medication, I find that I experience both acute anxiety and the positive and intruding symptoms of paranoia that can make me lose contact with the 'real world'. Before receiving ACT, I had also put in place techniques to manage mental distress (described below), which I had learnt from participating previously in two separate episodes of counselling, both using traditional forms of Cognitive Behaviour Therapy (CBT). The first course of CBT took place in 1996 about 6 years after my first episode of psychosis, and the second about 5 years later in 2001.

Prior to receiving my first course of CBT in 1996, I was unable to access any talking therapies through the National Health Service (NHS); however, I did seek to undertake psychotherapy privately from 1990-1991. This therapy centred on exploring my experiences of childhood and the potential connection that this had to the development of a mental health condition. I had a happy childhood and found this focus to be less than helpful, rather more intrusive, and undermining of my identity. I therefore chose to end this intervention after 6 months – and was deterred from seeking further therapy until I was referred for CBT 5 years later.

The traditional forms of CBT taught me techniques to counter my distressing thoughts by using *evidence* to contradict paranoid thinking and to *replace* the negative spiralling thinking with more positive thoughts patterns. This therapy was effective to some extent in enabling me to challenge the destructive cycles of thought, which were always reinforced by the paranoia I experienced. However, the interventions were not entirely successful, and I continued to experience these issues. Furthermore, encountering these symptoms, despite having received the therapy, left me with very low self-esteem and minimal confidence. This sense of poor self-esteem was combined with terrible anxiety that led me to question everything I did and to doubt any possibility of success. It may be perceived as inappropriate in this article to comment on the effectiveness of receiving earlier CBT interventions whilst I am presenting my experiences of ACT, particularly when each intervention occurred decades apart. However, talking therapies, done well, can have a profound impact on people's recovery journeys – I know my experiences did; thus, from my position as an expert-by-experience, it seems appropriate to consider the efficacy of earlier interventions as I reflect on experiences of ACT as part of my recovery journey.

Even today, I still sometimes experience low esteem, minimal confidence, and paranoia, despite receiving ACT. However, to elucidate the journey of learning through ACT, I first detail the strategies I used to manage distress before receiving ACT, and in the following section, describe the changes following the intervention.

An encounter with stress can be for me a visceral and physical feeling often predicated by paranoia – the occurrence is sometimes related to a memory which may lead me to focus on

possible things that were unsaid but I wanted to say, and later misremember as being said. Moreover, when I am unable to connect with an accurate representation of the past, I can ruminate and chew upon that incident as I try to make sense of it. In the context of my workplace, my paranoia always focuses on whether my teaching or work is effective and whether students are satisfied with the service I deliver. I also experience symptoms in my home life related to social contact I have with friends; however, most symptoms are often linked to paranoid thoughts originating from my work life.

A recent example of such an experience of paranoia and negative thinking, was when I was working in the open plan office at the university. I heard two colleagues talking about a module which I lead, and immediately believed that a student had complained about deficiencies in my teaching. I became so worried that I contacted my colleague in the evening when she had gone home, to clarify what she had said – my colleague revealed that there had been no such topic discussed. I had heard something, constructed it into a discussion which had never taken place, and chewed it to develop it into something that only existed in my head. Moreover, open plan environments are very difficult for me and can cause me to develop paranoid thinking, as illustrated in this incident. Thus, I normally work in a small office by myself in another building to my colleagues; this action forms part of the reasonable adjustments I receive under the Equality Act (2010) because of these responses.

This general pattern of thinking, before receiving ACT, and still sometimes post-intervention, leaves me with little confidence about my teaching and can still completely devastate my self-esteem; a situation that has improved after receiving ACT, but which has not been annihilated. Such experiences of paranoia and negative thinking were much more

common before receiving ACT; thus, when undergoing a medication change in 2016, my difficulties became too much to manage, which demanded that I took some action to improve my life, as introduced in the next section.

Experiences of receiving ACT

At the end of 2016, I began to experience sustained and acute stress at work; the overwhelming episodes of anxiety and paranoia leached into all aspects of my identity: as mother, academic, wife and service user. Work became, on the one hand, a function that enabled me to manage paranoia and mental distress by giving me structure, identity, and purpose; but, on the other, it ultimately became the only strategy I could use to manage mental distress. At weekends, I would feel an overwhelming desire to work, and this thirst would not be satisfied until I had undertaken at least three hours of writing or teaching preparation; only this action satiated this obsession. I was exhausting myself and not spending any time with my family.

As a result of increasing stress and symptoms, and the effects of a medication change, I self-referred to the local mental health wellbeing service on the advice of my psychiatrist; this is a service providing psychological support for people with mild-to-moderate mental health issues. The medication change was agreed in consultation with my psychiatrist following increased weight gain and the associated risk of developing diabetes; these issues are side effects commonly connected with the specific medication I took. Experiences of medication choice are discussed elsewhere in Fox (forthcoming).

Initially I had to undergo a brief assessment to decide the best kind of treatment for me. The therapist and I discussed the options and we agreed that ACT would be the most appropriate intervention. There was a long waiting list to access the service, which led to a delay in my treatment; thus, after a wait of eight months I saw a Cognitive Behaviour Therapy (CBT) practitioner who delivered Acceptance and Commitment Therapy (ACT). I received 10 sessions over the timeframe of a year. Initial meetings took place weekly and then became less frequent. The intervention led to me to undertake a process of development and change as I implemented the techniques suggested by the therapist; this began to loosen the grip of work on me and enabled me to recognise my skills and abilities as a lecturer. I began to find other things that I enjoyed doing, despite just working.

In the next section, the potential of this intervention, alongside the skills of the therapist, to support me to improve my wellbeing at work are now explored, and the wider potential of ACT to improve the functional performance of people with mental health issues in the workplace is considered.

Acceptance and Commitment Therapy (ACT)

ACT is a third generation Cognitive Behaviour Therapy (CBT) (Hayes, 2004; Luoma et al., 2007). ACT has been found to work effectively in several different contexts: in reducing positive and negative symptoms in patients experiencing schizophrenia in the USA (Bach & Hayes, 2002), in group work for people experiencing social phobia in the USA (Ossman et al., 2006), and, also in the USA, even in diabetes management (Gregg et al., 2007). In research undertaken in the USA to investigate the usefulness of different therapies in reducing stress in a media company (Bond & Bunce, 2000), it was found that ACT, when

compared with other therapies, improved stress reduction by enabling the acceptance of undesirable thoughts and feelings. Moreover, its effectiveness as a stress-management intervention in the workplace for employees who did not meet criteria for a mental health diagnosis has also been shown in the USA (Donaldson-Feilder & Bond, 2004). Furthermore, its efficacy in supporting people who experience schizophrenia-spectrum disorders in inpatient settings has also been explored in the USA (Gaudiano et al., 2017).

ACT therapists teach a person to build a new relationship with their stressful and negative thoughts and emotions through both mindfulness training and cognitive techniques. The goal of a therapist delivering ACT is both to help a person to reconnect with their values and hopes as these motivate their actions, and to enable them to focus on achieving their objectives rather than on the power of the negative thinking (Hayes, 2004; Luoma et al., 2007). The six core processes of ACT (Hayes, nd) consist of the following:

- Acceptance: the client tries to 'open up' to the negative experiences or feelings and to remain present with them rather than to try to fight them.
- Cognitive defusion: the client tries to recognise that the negative thoughts are just thoughts and to stand back from them objectively and just 'observe' them.
- Contacting the present moment: the client tries to 'be in the now' and focus on the present situation rather than on the power of memories.
- Self as context: the client tries to become 'the observing self' and observe their thought patterns from a more neutral stance so that the negative beliefs lose their power.
- Values: the client identifies what values they see as important and what they wish to achieve.

- Committed action: the client tries to take action to achieve their desired outcomes.

ACT therapists use these techniques, to help a person to *defuse* from unhelpful thoughts by ceasing to confront negative emotions or to waste energy fighting them; the client learns to stand back from the thoughts, observe them and be in the here and now. As s/he disengages from this battle s/he learns *creative hopelessness* when s/he accepts the thoughts*;* this is when the person learns to let negative feelings exist in parallel with their everyday thoughts (Hayes, 2004; Flaxman et al., 2007) and learns *psychological flexibility* as s/he functions without focusing on the negative beliefs. Moreover, throughout therapy, ACT therapists emphasise that these thought processes are part of a healthy cognition (Flaxman et al., 2007) to enable the client to normalise these experiences (Flaxman et al., 2007; Harris, 2009).

Accordingly, the therapist plays an important role in influencing positive outcomes for the client as identified in seminal research by Rogers (1959), who developed person-centred therapy; this technique is still of great currency in social work practice (Murphy et al., 2013). Rogers (1959) highlighted the need for the therapist to show congruence (genuineness) towards the client, and to demonstrate unconditional positive regard and empathy. The essential role of the therapist in supporting the effective employment of therapeutic interventions is also reinforced in later research (Decker et al., 2014; Elliott et al., 2011; Truax & Carkhuff, 1967); and as such, this supportive relationship is a key part of the effectiveness of the therapeutic process.

Although ACT has been evaluated as being effective in different fields, its efficacy is contra-indicated when it is applied to clients whose external situations or behaviours can and should be controlled (Hayes & Pankey, 2004). For example, a person subjected to domestic violence or an abusive relationship from their intimate partner may be encouraged to accept feelings of anger and shame, but should not be encouraged to accept the abusive situation they are in. Moreover, if a person wants to self-harm, or put their physical or mental health or safety at risk, ACT may not be an appropriate therapy for them.

Reflections on the outcomes achieved by ACT

ACT was very effective in enabling me to learn to manage my mental health needs in the workplace. The empathic relationship that the therapist built with me, the interventions introduced through the therapy, and my own 'expertise-by-experience', generated from receiving CBT in the past, and from being an expert in understanding the experiences of recovery (Fox, 2011; 2016), enabled me to implement the techniques suggested by the therapist. ACT helped me to connect my actions with the achievement of values that were important and meaningful in my life. I valued more quality time with my family and wanted to focus less on negative issues at work; moreover, I was willing to take committed action to achieve this.

I established that the strategies I had tried before using ACT had not enabled me to achieve my goals, so I needed a new approach. Before receiving ACT, I had worked so hard to interrupt negative and destructive thought patterns, to distract myself, and to fight negative thoughts. I had previously ruminated over a problem, tried to remember what had been said, and to analyse it for its truth, and then attempted to contradict the negative thought and fight

with it. ACT taught me to stop battling with the thoughts, and to stop trying to definitively ignore them; as I enacted these changes, I began to release the stress. Learning to hold stress lightly and to just 'let negative thoughts be' helped me to experience better work/life balance. When practising these techniques, I would just experience the negative thoughts and allow them to exist, without fighting or contradicting them – I would be in the present with them and observe them; they thus began to lose their power. Applying ACT began to mediate the stress I experienced in the workplace and to improve my functional performance, as well as my quality of life because the thoughts began to lose their power and I was able to 'observe' them without engaging with them.

I began to realise that these thoughts and feelings of paranoia could not hurt me physically, but that they would pass and decrease; moreover, experiencing this realisation was a turning point. I began to replace the cognitive techniques of distraction or active avoidance of negative though patterns in managing the stress with just letting them be. The identification of my values and my active commitment to realising my values made me realise that my daughter needed time in the evenings – not just my work. I began to delay answering emails, and delay responding to my overwhelming sense that I needed to work. Implementing ACT stopped me from evaluating success in the day not just as the productivity in hours of work completed but also the time I spent with my daughter and husband. I also became less obsessed and less concerned about performance at work; these were key objectives I set when I chose to undertake the therapy. I began to release the overwhelming drive to work and find other ways to manage stress, and to find time to spend with my family. Furthermore, being an expert in my own mental health and now understanding the triggers that caused my distress, alongside the support from the therapist, enabled me to apply ACT to improve my wellbeing.

The relationship with the therapist was also central to the success of the intervention as suggested by Rogers (1959), who developed the person-centred approach in therapy. I had trust in the CBT practitioner and faith in her skills. She was confident, engaging, and sought to build an effective therapeutic relationship. Additionally, the CBT practitioner recognised both my expertise as a professional and as a service user. This mutual respect enabled me both to practise the techniques she suggested and to believe that they might work; such feelings are key in any such relationship with a health or social care practitioner, otherwise it has been evidenced as impossible to either commit to or believe in the potential success of the intervention (Decker et al. 2014; Elliott et al., 2011; Truax & Carkhuff, 1967). Such an effective relationship had been experienced with a psychologist that I encountered when receiving a previous CBT intervention; this underlines the importance of a good therapeutic relationship.

In my opinion, it may be difficult for people experiencing acute stages of psychosis to respond to ACT, in comparison to other forms of CBT. ACT requires an ability for the service user to reflect and concentrate and to be able to focus their thoughts to implement these therapeutic strategies, therefore, ACT may be very difficult for those people to practise who are enduring acute symptoms. Despite this, as described earlier, its usefulness as an intervention for people who experience schizophrenia-spectrum disorders in inpatient settings in the USA has also been explored (Gaudiano et al., 2017), suggesting its potential for wider delivery to this group.

Identity and mental health

As a person with a diagnosis of schizophrenia, now a senior lecturer in social work, work gives me an opportunity to structure my day, grow in my self-esteem and develop a professional identity (Fox, 2011; 2016) all of which are essential components of the personal recovery approach (Brown & Kandirikirira, 2006; Leamy et al., 2011; Slade, 2009). Despite the disabling experiences I sometimes encounter in the workplace, my role as a professional gives value to who I am: as a lecturer, a social worker, and an expert-by-experience. Indeed, the professional self is often perceived as being of greater importance than the service user self (Fox, 2011; 2016). As a social work academic, knowledge of the recovery approach (Fox 2011; 2016) and understanding of the theoretical approaches to mental health intervention gave me insight into the ACT techniques I was taught. Additionally, a faith in the efficacy of evidence-based practice gave me belief that the intervention might work; and this encouraged me to practise the strategies that I was given.

Despite recognising the success that I experienced with receiving ACT, and the acknowledgment that work is a central part of my identity and self-value (Fox, 2011; 2016), people who experience mental distress come from diverse cultural, educational, and socio-economic backgrounds; this means that they may have different life opportunities available to them (Lelliot et al., 2008; Stevenson & Farmer, 2017). Therefore, it must be remembered that work may not be something that all service users feel is part of their recovery; and they may feel its impact decreases their wellbeing. Although, despite this caveat, for many, undertaking work, may be something they desire and need support to access because each person's recovery is unique and individual (Leamy et al., 2011) and working may form part of a vision for their goals and dreams.

Conclusion

In this article I have considered my own experiences of mental distress in the workplace. I have presented an account of the success of ACT in supporting me to improve and manage my distress in the workplace. Despite the success of this intervention, I continue to experience stress and paranoia in the workplace, but the spiral of negative thinking and low self-esteem have somewhat loosened. The negative thoughts have lost a lot of their power; they are still there, but more often than before, I can employ ACT techniques: I can observe the thoughts, allow them to pass, and not engage with them. At times, I do have spiralling thoughts which are destructive and damaging, and I cannot stop myself from engaging with them; moreover, I begin to fight with them and analyse each thought - but those moments are fewer. I still implement ACT and practise the skills I have learnt from the CBT practitioner, but they are now second nature and are part of my armoury that helps me to manage the symptoms of mental distress. I still feel a drive to work, but other activities also have value, and I am committed to spending more time with my family.

Moving forward, a greater recognition is needed of the specific needs of people with serious mental health issues both in entering and remaining in work; and even more so, remaining in professional and senior employment. In this this first-person narrative I endorse the potential of ACT, and possibly other psychological support, to increase access to work for the wider mental health community (Bach & Hayes 2002; Flaxman et al., 2007; Harris, 2009; Luoma et al., 2007); although it is recognised that not all people who experience mental distress will want to work.

In this article I validate the need to consider increasing the availability of psychological therapies to improve the functional performance of people with mental health issues in the workplace. Yet, despite this, service capacity to implement psychological therapeutic interventions is limited due to inadequate funding; this serves as a real barrier to many people accessing such services in a timely way. In writing this article I have hopefully provided a small contribution to understanding this issue by reporting my direct experience as an expert-by-experience through the medium of a first-person narrative perspective; this is a topic little addressed in research, and even less considered through the method used in this article.

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