

# **‘It’s Knowing That There’s Other People and They’ve Accepted It’: Patients’ Experiences of an Acceptance and Commitment Therapy Group Intervention for People with Neurological Conditions**

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## **Abstract**

Individuals living with neurological conditions often face chronic issues including motor and sensory impairments and cognitive deficits. These challenges can lead to significant psychological difficulties, including anxiety, depression, and post-traumatic stress. Acceptance and Commitment Therapy (ACT) is a psychotherapeutic approach which aims to enhance psychological flexibility and acceptance while promoting behavioural change. Although ACT groups have shown promise in supporting individuals with neurological conditions, the evidence on patients' experiences of attending them is sparse. This project explored the experiences of individuals with a range of neurological conditions who had attended ACT group sessions as part of routine clinical practice, with the aim to refine future iterations of the intervention and enhancing patient care. Ten individual qualitative semi-structured interviews were carried out and the data were analysed thematically. Three overarching themes emerged from the analysis: 1) Initial Barriers to Group Attendance and Engagement; 2) Building an Environment of Acceptance; 3) Developing an ACT toolkit. Overall, the results showed that the ACT group intervention led participants to develop stronger emotional connectedness, better knowledge of their difficulties, more effective psychological skills, and different mindsets regarding their condition. Implications for the refinement of future ACT groups, neuropsychological service development, and clinical practice are discussed.

**Keywords:** Acceptance and Commitment Therapy; ACT; Group Intervention; Peer Support; Neuropsychology; Qualitative; Thematic analysis

## Introduction

Neurological conditions are disorders which affect an individual's nervous system (Bazargan-Hejazi et al., 2021). In the UK, one in six people are living with at least one type of neurological condition, with 600,000 new diagnoses annually. Among these, common conditions include stroke, multiple sclerosis, traumatic brain injury, epilepsy, brain tumours, tension-type headaches, and neurodegenerative conditions (Englot et al., 2016; Feigin et al., 2019), all of which carry substantial economic and social burden. The socioeconomic impact and incidence of neurological conditions are expected to increase due to the aging global populations (Deuschl et al., 2020).

Globally, neurological conditions are considered the leading cause of disability (Feigin et al., 2020) and often result in long-term physical consequences, including chronic pain and fatigue (Borsook, 2012), nutritional and respiratory problems (Aquino et al., 2021; Halliday et al., 2021), mobility issues, (Cattaneo et al., 2020) paralysis (Armour et al., 2016), and sensory deficits (Kran et al., 2019; Li et al., 2021). Alongside physical disability, individuals with a neurological condition can experience cognitive impairments in domains such as processing speed, language, memory, executive functioning, attention, and social cognition (Durand et al., 2018; Goitia et al., 2020; Hwang et al., 2019; Severiano e Sousa et al., 2022). Psychological distress is also prevalent, with evidence suggesting higher rates of anxiety and depression (Chan et al., 2021; Khedr et al., 2020; Lima et al., 2021), post-traumatic stress (Hütter & Kreitschmann-Andermahr, 2014), panic disorders (Sharma et al., 2022), and suicidal risk (Erlangsen et al., 2020) compared to healthy controls with no neurological conditions.

These issues can lead to significant psychosocial impacts, such as inability to work, lack of independence, reduced perceptions of control, stigma, and social withdrawal (Eccles et al., 2023; Gil-González et al., 2020; Perepezko et al., 2019; Riechmann et al., 2019; Tombini et al., 2020; Zarotti et al., 2024), ultimately resulting in poorer quality of life (Gandy et al., 2021). Psychological difficulties are often stronger detractors of quality of life in these populations than the impact of physical impairments (Simpson et al., 2021; Zarotti, Dale, et al., 2022). Consequently, there is a strong emphasis on developing psychological interventions to optimise recovery and rehabilitation for people with neurological conditions (Aterman et al., 2023; Essat et al., 2020; Kossi et al., 2024; Rae-Grant et al., 2011). Among these, psychotherapeutic approaches have often been trialled

to address psychological difficulties by targeting unhelpful behaviours, cognitions, and emotions (Dale et al., 2022; Fernie et al., 2015; Lai et al., 2019; Simpson et al., 2021). One notable approach is represented by Acceptance and Commitment Therapy (ACT; Robinson et al., 2019).

ACT adopts a non-pathologizing view to mental health, holding that psychological challenges are inherent to the human experience (Graham et al., 2016). ACT is a third wave cognitive behavioural therapy that promotes psychological flexibility by helping individuals to 'unhook' from difficult thoughts, feelings, and sensations whilst supporting them to commit to values-based action, which in turn enhances quality of life (Hayes, 2016; Hayes et al., 2006). More specifically, ACT aims to alleviate distress and enhance well-being through six processes (Zhang et al., 2018): 1) cognitive 'defusion', a concept which aims to reduce the impact of difficult or distressing thoughts by changing the way people relate to them; 2) acceptance, which involves leaning into uncomfortable feelings rather than coping via experiential avoidance (i.e., escaping or otherwise altering unwanted private thoughts, feelings, and memories and the contexts that elicit them; Kingston et al., 2010); 3) 'self-as-context', which allows people to be an objective observer of their emotional and cognitive processes; 4) Contact with the present moment; 5) personal values, which people are helped to identify; 6) committed actions, which are promoted in alignment to values.

The implementation of ACT has been highlighted as especially beneficial for neurological patients due to its emphasis on enhancing activity and participation (Dindo et al., 2017). Evidence supports its effectiveness in addressing challenges associated with numerous neurological conditions, including epilepsy, brain tumours, Parkinson's, motor neurone disease, and multiple sclerosis (Alipour, 2019; Gould et al., 2024; Kangas et al., 2015; Zarotti, Eccles, et al., 2022; Zarotti et al., 2021). Similarly, positive outcomes have been reported for ACT as a group intervention in these populations.

For instance, 'Valued Living After Neurological Trauma (VaLiANT) – an 8-week group programme combining elements of cognitive rehabilitation and ACT – showed significant improvements in subjective well-being and anxiety in people with brain injury (Sathananthan et al., 2022).

Nonetheless, much of the extant evidence relies on quantitative methods (Ben-Zion, 2017; Foote et al., 2023; Han et al., 2021; Niu et al., 2022), while qualitative studies have so far been sparse (Ben-Zion, 2016; Large et al., 2020). A noticeable example in this regard is represented by the qualitative analyses for the VaLiANT study, which highlighted meaningful changes such as higher feelings of connectedness, sense of self, and belonging, as well as increased reported use of daily strategy (Sathananthan et al., 2024).

The current scarcity of qualitative studies on this topic poses a considerable limitation, as understanding the experiences of individuals undergoing ACT within the field of neurology could enhance existing interventions and the development of novel ones. Furthermore, exploring the application of ACT groups in a non-condition specific way is crucial considering the current financial pressures and issues surrounding service wait times and lack of inclusive care which are currently faced by the National Health Service (NHS) in the UK (Greener & Powell, 2024) as well as healthcare similar systems elsewhere (Doetsch et al., 2023). In this article, we present the experiences of individuals who attended an ACT group for various neurological conditions in an NHS Trust in the North-West of England. The primary aims of the project were to evaluate the integration of the intervention within routine clinical practice, refine future iterations, and ultimately improve patients' care quality.

## **Materials and Methods**

### **Design**

A service evaluation was designed based on qualitative methodology (Creswell & Poth, 2007). Semi-structured interviews were carried out to explore the subjective experiences of individuals who attended two iterations of an ACT group intervention for neurological conditions within an NHS Clinical Neuropsychology Department in the North-West of England. More specifically, the following evaluation question was addressed: *what are patients' experiences of attending ACT groups to address psychological difficulties across multiple neurological conditions?*

## **Participants and Recruitment**

A convenience sample of patients with neurological conditions was recruited from the host NHS Trust. Patients' referrals were triaged by qualified clinical psychologists within the Clinical Neuropsychology Department to consider their eligibility for groups, based on their diagnosis. Those identified as eligible were invited to attend as part of their routine clinical care. A minimum of three participants was required for the group iterations to be carried out, while no maximum number was set. Attendees were invited to participate in semi-structured interviews following the conclusion of the final group session in each iteration.

## **ACT Group Intervention**

The ACT group intervention was carried out by a Consultant Clinical Neuropsychologist (KM), supported by a Senior Assistant Psychologist (HD). Each session took place at the host NHS Trust. Two iterations of the groups were carried out from October 2022 to December 2022 and from February 2023 to April 2023. The content and delivery modalities of the intervention remained the same across both iterations.

Each iteration consisted of eight 2-hour sessions, each featuring a different ACT-informed focus. Sessions 1-6 were carried out on a weekly basis. A 2-week break was then included between Session 6 and Session 7, to allow the participants to practise skills and strategies discussed up to that point and apply them to their daily lives before meeting again with the clinician. Session 7 was carried out on an individual basis to allow for a personal review and to plan next steps. A further break of two months was included after Session 7 before participants met for a reunion (Session 8). Sessions 1 and 2 were carried out in-person, Sessions 3-5 were carried out remotely (via Microsoft Teams®), and Sessions 6-8 were again carried out in-person.

Since the population consisted of individuals diagnosed with a neurological condition and potentially cognitive impairments, specific adaptations were made available to help people retain the relevant information. Examples of these included providing booklets of all session content, scheduling additional optional telephone calls with clinicians if needed, and providing coaching to facilitate the use of technology for remote virtual

sessions. Homework tasks were also sent via email. Table 1 summarises the topic of each session.

### **Data Collection and Analysis**

Individual semi-structured interviews were offered to all attendees after completing the group sessions. These were carried out by a male doctoral level Academic and Clinical Psychologist (NZ) who had not been involved with the delivery of the group sessions or with the participants' care prior to interviews. Interviews were conducted in person at the host NHS Trust or remotely, depending on the participants' preference, in December 2022 and February 2023 – i.e., within a month from the end of each iteration.

The interview content was formulated through a combination of relevant literature, clinical expertise, and previous piloting with similar populations (Storey et al., 2024). The final version, agreed by all authors through iterative discussions, was structured into six sections, covering the following topics: a) Initial Information & Motivation, b) Group Format, b) Structure & Accessibility, c) Content d) Engagement, e) Outcomes. The full interview schedule is available as Supplementary Material.

Interviews were recorded and transcribed verbatim. The anonymised transcripts were then imported and organized into the NVivo® qualitative data analysis software, where thematic analysis (TA) was conducted by two Senior Assistant Psychologists (AS and HD) under the supervision of NZ, following the guidelines outlined by Braun and Clarke (2017).

The analysis started with a process of data familiarisation, whereby the transcripts were extensively read over several weeks to generate ideas for potential themes. This facilitated the identification of codes, which were then linked to emerging themes within the dataset. The initial themes and codes were subsequently reviewed to ensure consistency across the dataset. A thematic map was created, featuring titles and descriptions for each theme, which was then cross-checked against the dataset.

A critical realist epistemological stance was assumed throughout the analysis, through which the participants' subjective experiences were conceived as being as meaningful as physical and behavioural phenomena (Sayer, 2000). To ensure credibility, transparency,

and reliability, open discussions were also held among team members at various stages of the analysis (Nowell et al., 2017). While TA allows for both inductive and deductive approaches (Braun & Clarke, 2006, 2023), a more inductive approach to the analysis was considered appropriate in this instance in order to allow participants to share any opinions on the groups without forcing a focus on specific elements (e.g., ACT principles). This was also reflected by the general structure of the interview schedule (see Supplementary Material).

### **Ethical Considerations**

The present project was approved and registered as a service evaluation by the Research & Innovation Department of host NHS Trust (REF: 23HIP31). All patients provided full written consent, and all audio recordings and transcripts were anonymised.

### **Results**

In total, 13 patients attended the ACT group (six from the first iteration, seven from the second). Of these, 10 agreed to participate in the interviews, while three were lost to follow-up. The final sample consisted of six females and four males, with a mean age of 45.9 years (range 25-61). Half of the participants had a brain tumour, while other neurological conditions included epilepsy, stroke, and chronic hydrocephalus. The interviews lasted approximately 36 minutes on average (range: 25-47). Based on the participants' preference, half of the interviews were carried out remotely (i.e., via phone and Microsoft Teams), while the other half occurred face-to-face.

Following data familiarisation, 23 preliminary codes were produced. Upon revision, the final code list was decreased to a total of 12. Three overarching themes emerged from the data which aligned uniquely with the topic of the analysis. Of these, Theme 1 concerned participants' narratives on more general aspects of attending a group intervention (e.g., barriers and facilitators), while Theme 2 and Theme 3 revolved more around ACT-specific topics (e.g., connectedness, acceptance, defusion).

Although data saturation was not a specific aim in this project due to the adoption a convenience sample (Guest et al., 2006), some information redundancy was observed in



the last three interviews. Each theme is described below, along with supporting quotes from the participants. Figure 1 illustrates the final thematic map.

### **Theme 1. ‘We’ve All Had Sort of Quite Disturbing Issues’: Initial Barriers to Group Attendance and Engagement**

The first theme derived from the data revolved around barriers participants encountered in both attending to and engaging with the sessions. Participants shared observations recognising disparities in the way others interacted, with some wondering whether this may feel disempowering for some:

*The people who participated less... I don’t know [...] I guess there, there may be some people who didn’t feel they could contribute as much. (Participant 9)*

*I think we all engaged in a different way yeah. (Participant 10)*

Consequently, some participants perceived their group experience to be affected by other participant’s engagement, as it affected their ability to engage actively:

*I think it was just one person who just spoke a lot [...] so I think they just kind of took over the group a lot, so I think other people didn’t speak as much... so, I feel like maybe I would’ve got a lot more out of it if they weren’t so overpowering. (Participant 5).*

Some participants elaborated on their preference for groups smaller than six or seven participants (i.e., the number in our two iterations). This manifested as a reluctance for interaction and self-disclosure, possibly elucidating why certain individuals contributed less. For example, some experienced feelings of discomfort in the presence of unfamiliar people, while others acknowledged their neurological condition to have a direct impact on their ability to tolerate groups:

*Since my stroke I’ve struggled with um, being in a group of people. My friends, you know, I can only really deal one-to-one or, you know, if the three of us are having a conversation, I could cope with that, but I worried about that. (Participant 2)*

While this theme appeared to relate more to attending a psychotherapy group in general, some findings could also be viewed through an ACT-informed lens. For instance,

experiential avoidance, an ACT-congruent target, appeared evident with some participants as they expressed a wish to avoid experiencing more difficult thoughts and emotions in a group context:

*Initially, when I thought 'oh, are you willing to go in a group with other people?'. You think, well I'm not going to answer all these, you know, I don't know if I'm comfortable saying... you know, very personal things from my thoughts in front of other people. So, I probably did have some trepidation in relation to that. (Participant 9)*

This process was further reported by others, who found groups difficult to navigate, justifying their hesitance with the experience of strong emotions or concerns of being judged:

*Fear, shame, you know, it's not pleasant to have to talk about unpleasant things and to face them. (Participant 8)*

*I was just a bit, a bit anxious, you know, going into a group [...] what people will think of me. (Participant 3)*

By virtue of sharing their difficulties living with their conditions, participants acknowledged feeling affected by other peoples' lived experiences, recognising that they all faced distress stemming from their neurological diagnoses. Indeed, while establishing relatability can be challenging in the presence of differences, encountering similarities also posed its own set of challenges. For some, these similarities were distressing, as they triggered their own mental health difficulties:

*It was a little bit upsetting because everybody- we've all had quite bad you know we've all had sort quite disturbing issues happen to us and it was, you know [...], it was set off triggers in my own issues. (Participant 7).*

Finally, some participants reflected on other aspects of their life which prevented them from being able to commit time to engaging in interventions. This also enabled them to reflect on factors contributing to the maintenance of their current difficulties, such as family commitments and concurrent mental health difficulties which were acknowledged as barriers to accessing psychological support:

*As a grown up and as a mum of two kids at different ages as well, like teenager and a toddler, it's hard. [...] There is so many things, and until that is up I can't even, I don't feel like the therapy is going to help me at the moment. (Participant 4)*

*I tried to get a balance of the two... a [neurological] condition and my mental health. (Participant 2)*

## **Theme 2. 'We Could Relate to One Another in Some Way or Shape': Building an Environment of Acceptance**

Despite the issues described in Theme 1, participants also expressed several factors which allowed them to have a positive experience while attending the ACT group intervention, which formed the core of Theme 2. This appeared related to feeling accepted by both the group facilitators and other group members, with participants feeling that, when a stance of acceptance was fostered, it had a positive effect on their engagement, even in those who had previously expressed ambivalence around interacting with groups of people:

*When I met [Clinician] I just [...] got a comfortable feeling and then you can feel the room, can't you? (Participant 7).*

*I felt more at ease after speaking to [Clinician] and knowing the numbers would be smaller than a huge group and when I said I struggle interacting a lot and, you know, with more than a few people. [...] I went to the first session, and I enjoyed it and well, then I looked forward to going each week. And like I say, I miss it now so it was very helpful. (Participant 2)*

Furthermore, support from group facilitators appeared beneficial for those who felt unsure while navigating the group sessions and at times required brief individual assistance, which in turn appeared to enable some participants to feel as though the process was person-centred:

*[Assistant] offered me a phone conversation with [Clinician] [...] and sent me extra information when I got a bit stuck, so I felt that was personalised as well as being in the group, so it wasn't "one size fits all". (Participant 6)*

The facilitators' support appeared to encourage openness and active participation in group discussions while respecting the participants who may be more reserved. As a result, it seemed to promote trust among the participants and their peers, despite it being an unfamiliar atmosphere to them:

*It wasn't one way; it was very much conversation with [Clinician] and [Assistant] and we could just share. Just a very good atmosphere to share in. (Participant 2)*

*The people were quite open and honest, which I think was nice [...]. 'Cause you are dealing with strangers, aren't you. And it's quite a sensitive subject [...], and you've been quite honest with your feelings, and I think it's nice that people trusted you and you could feel trusted in that room. (Participant 7).*

In a group context, acceptance (as the opposite of experiential avoidance) involves embracing all the psychological experiences of living with a neurological condition, without judgement or action. This seems to also be part of the group experience in terms of how participants related to each other. Participants highlighted the value in group interaction which encouraged a sense of relatedness as they recognised the benefit of having opportunities to talk to people with similar lived experience. This was shared despite diagnoses being different, suggesting that many difficulties were transdiagnostic:

*I found that group interaction was... was a huge part of the session because we could relate to one another in some way or shape or form but also talk about the information given to us. There was plenty of opportunity to do that. (Participant 2)*

*They have similar conditions, so it was nice to be able to talk to somebody in the same boat. (Participant 10)*

Engaging with peers who shared similar experiences of managing neurological conditions provided validation and a sense of normalcy, ultimately alleviating feelings of isolation and embarrassment. This appeared to allow people to practise another acceptance-related process – i.e., 'unhooking' from unworkable thoughts about their experience being invalid in some way or of being or negatively judged by others:

*The reality is, you know, your experience is valid and when you hear from other people who have similar limitations you don't feel as isolated. (Participant 8)*

*I feel if I had a seizure with them [other participants], I'd feel okay. I wouldn't feel embarrassed, you know. But if I was to have one [a seizure] [...] with my brother-in-law, my sister-in-law, you know, I've known for twenty-two years now, I'd feel embarrassed. [...] They [other participants] know what it's like. (Participant 1)*

### **Theme 3. 'You're Learning How to Deal with It': Developing an ACT Toolkit**

The final theme revolved around the strategies the participants felt they had developed over the course of the ACT intervention, and which seemed to promote their emotional wellbeing by providing them with effective coping skills and practical resources – i.e., an 'ACT toolkit'. This appeared to be associated not only with the group programme itself, but also from the shared experience with other participants:

*I think there's a benefit from that shared experience, because you're learning how to deal with it and new processes, and how to cope. (Participant 9)*

During the intervention, participants were learning to adopt a present moment focus and cognitive defusion respectively as new techniques in the everyday life, tied directly to exercises and practices adopted in the group programme:

*The separation from the thoughts. [...] I have to remind myself that 'I'm having the thought that'... and then whatever the thought is. So, that's been helpful. (Participant 8)*

In turn, this process appeared to spark in others a desire to emulate those effective coping strategies, such as choosing to do value-driven activities more mindfully:

*I've never really done anything like that [mindfulness] before. [...] You know, if one of us was saying that they were having a bad day, what they would do. [...] A guy used to say that he used to go for a walk before work and clear his head and, you know, you'd say 'oh yeah, you know what, that's a good idea and, you know, I know how you feel, and I would do something like that!' (Participant 7)*

A further important element in the participants' ACT toolkit appeared to be an increased understanding of their own values. For instance, sharing lived experiences allowed some to reflect on their personality and acknowledge traits which had particular value to them,

such as honesty, self-care and personal growth. In turn, this acknowledgment appeared to promote goal setting and committed action:

*The values activity for me was really really useful, because it's not something I've ever done before. [...] And also, to know that values aren't... you never achieve them, it's something you work towards. I found that quite interesting. (Participant 8)*

*For example, she [other participant] was very helpful. She was saying about work and she was saying like... she told them [their employer]... it took her a bit longer. [...] Then when I went back to work, I was just honest with them, I told them, I was like... I explained the situation, what's been happening. Whereas in the past I didn't and I just kind of did more, took more responsibility and everything, so I think I did get more out of it. (Participant 5)*

*This whole self-knowledge and growth, those are big values to me, they're really important to me. But I've learnt more, you know, I've grown more, I have more self-knowledge just from these few weeks of the group. (Participant 10)*

Another relevant experience participants reported was represented by the way their cognitions changed as they unhooked from difficult thoughts, refocusing on more workable decisions, and moving from them – all central elements of an ACT exercise called the 'Choice Point' where participants purposely chose 'towards moves' whilst also moving towards acceptance of realistic limitations:

*I didn't know about Choice Points before. I think having that knowledge is really useful because in the moments when you do check yourself, when you think 'ah-ah, okay what... is this a good idea? am I making the right decision? should I be staying home and rest rather than driving the children to their friends?' I can just say no to them and it's not the end of the world. So, Choice Points! (Participant 8)*

*We spent the next weeks working towards how you can make those choices and how you can come to incorporate and accept things in your life, you know, what strategies and tools you could use. (Participant 10)*

Openness in discussing their conditions appeared to signal acceptance and improve psychological flexibility among the participants throughout the whole duration of the

group. In addition to feeling encouraged by their peers to acknowledge their challenges, some also saw acceptance as a valuable source of comfort as they navigated their distress:

*I understood from the beginning that it was to do with accepting a condition that you're living with. [...] So, when after the first session, when I was reflecting on what I had...' what did I expect?' I did this on the way home. 'What did I get out of the group? 'Was it right for me?' With every intention of going back the next week, and I realised that it is. 'It is gonna be helpful'.*

*It's knowing that there's other people and they've accepted it... that's the main thing what I've got from this group, meeting people and listening to way they handle theirs. (Participant 1).*

*I've realised that they've... they've come to accept their conditions so I should just accept mine. (Participant 3)*

*When it hits me at home and I'm... I'm in a low mood, a really low mood [...] it's okay to feel low that day. (Participant 4).*

Finally, the participants showed an ongoing commitment to using their 'ACT toolkit' in their everyday life not to change internal experiences (i.e., thoughts, emotions, sensations), but rather to alter the way they engaged with them and therefore reduce the distress they cause and the power they have over their lives:

*The ACT Group was more like 'it doesn't matter what there might be, whatever thought or memory or anything like that is in the past, the way you're going to deal with it is the same'. I hadn't thought about it in that respect, so that was good. (Participant 9)*

*I've got some books on mindfulness since the group, and I read those in the evening now. It makes you step back and just think about what you're doing and why you're doing it. (Participant 7)*

*The metaphors in particular struck a chord with me, because I use them a lot. I find it's an easy relatable discourse to explain a situation that otherwise is difficult and then the techniques going along. [...] Because I write. I can't write journals or diaries,*

*but I'll write my feelings in kind of metaphors and so that was something that I took home with me. (Participant 2)*

*[The group] hasn't stopped the thoughts. However, I'm definitely trying to have a bit of distance from them. [...] I've actually used it with my children. When my children get cross or angry, I say to them 'it's gonna pass, you're not angry now about what happened yesterday so when you're in the moment just remember it's just a thought, it will pass'. So, I've used that to help my children as well, which is obviously an unintended consequence but a useful one! (Participant 8).*

## **Discussion**

This article explored the subjective experiences of attending an ACT group intervention for people with different neurological diagnoses. To our knowledge, no study has been published so far on this topic. A series of individual semi-structured interviews were conducted with 10 participants and analysed thematically. Three overarching themes emerged from the data: 1) Initial Barriers to Group Attendance and Engagement, 2) Building an Environment of Acceptance, and 3) Developing an ACT Toolkit.

The first theme highlighted the initial barriers affecting participants' engagement in group sessions, including different interaction styles, fears, and reluctances associated with experiential avoidance, busy schedules, and concerns about triggering others or being triggered by shared worries. These findings are consistent with previous literature adopting both qualitative and quantitative methods in other health conditions. For example, anxiety, shame, and anger are known obstacles to group participation in psychiatric patients (Shay, 2021), while, in the context of neurological conditions, stigma has been highlighted as a barrier to accessing support (Evetts et al., 2021; Gandy et al., 2018). A study exploring reasons for group non-attendance in psychiatric patients also found that individuals contributing too much or too little to the group can negatively impact all attendees (Dilgul et al., 2018), while other life commitments were found to be a barrier for group attendance in tumour patients (Mallya et al., 2020). In addition, as mentioned above, experiential avoidance is intended within ACT theory as the opposite of acceptance – i.e., a process of escaping from or modifying thoughts, feelings, and memories perceived as unwanted as well as the contexts that may elicit them (Kingston



et al., 2010). With regards to this, our findings appear consistent with other qualitative evidence where experiential avoidance was highlighted as a specific barrier to engagement with therapy (Tursi et al., 2022), coupled with evidence showing that ACT interventions can help decrease levels of experiential avoidance in general (Na et al., 2022; Zakiei et al., 2021).

The second theme focused on the factors that helped establish an environment of acceptance and openness to all aspects (positive and negative) of living with a neurological condition through interactions between group facilitators and participants. Acceptance in ACT theory involves a posture of active curiosity, interest, and deliberate exploration of the whole range of feelings, memories, bodily sensations, and thoughts (Hayes et al., 2012). Key elements mentioned by the participants in this regard included fostering a sense of relatedness, learning to trust peers, receiving support from group facilitators, and the recognition of not being alone. These findings appear to resonate with literature involving a range of neurological conditions. With regards to loneliness, a qualitative study exploring the effectiveness of peer support in stroke survivors outlined the importance of recognising shared challenges (Christensen et al., 2019), while relatability was also recognised as an important facilitator of adjustment in a study exploring experiences of ACT group interventions in people with stroke (Large et al., 2020). Previous evidence also recognised the pivotal role played by group facilitators in providing a space for participants to discuss important topics while also managing group dynamics (Ben-Zion, 2016). In addition, qualitative investigations involving people with acquired brain injury found that increased trust and being with “someone who had been there” (Kersten et al., 2018; p. 8) can be essential factors in terms of building peer relationships in a group (cf. ‘in the same boat’ in our findings), and getting to know peers may allow group participants to feel as if they were gaining strength (Sathananthan et al., 2024).

Finally, the ‘ACT toolkit’ participants felt they had acquired through the group intervention and through shared experience formed the core of the third theme. Specifically, these skills included greater awareness of one’s thoughts as well as essential ACT techniques involving finding different ways of responding to emotions and thoughts, increasing acceptance, focusing on the present moment, and living by one’s values. Consistently with this, a study exploring an ACT-informed pain management group found

that ACT led to greater openness towards thoughts and acceptance of living with chronic pain (Aymerich et al., 2022), and similar findings were observed following ACT groups for people living with multiple sclerosis (Ben-Zion, 2016) and stroke (Large et al., 2020). Additional qualitative evidence also supported the effectiveness of ACT groups in shifting thought patterns in people with psychosis, leading to increased cognitive defusion and acceptance (Shi et al., 2023). With regards to sharing knowledge, literature exploring the outcome of ACT in stroke survivors has highlighted learning from each other as playing a pivotal role in increasing confidence, awareness, self-esteem, and alignment to values while asking for help (Starling, 2019). Similarly to our 'ACT toolkit' findings, sharing experiences in a group has also been reported to support adjustment in people with acquired brain injuries in the form of exchanging "knowledge and tools" (Lexell et al., 2013; p. 8) along with a theme of obtaining a "fuller toolkit for life with brain injury" (p. 9)

### **Implications for Clinical Practice**

Based on the findings outlined above, a number of relevant implications for clinical practice may be drawn. First, personal preferences and preconceptions around psychotherapy can act as a barrier to attendance or engagement with group interventions. Being sensitive to these issues may therefore be beneficial when triaging patients for group interventions. For instance, in response to this the host NHS Trust of this project developed additional paper and digital resources to allow prospective attendees to gain a better insight into the structure and content of the intervention. Plans to film an 'advert' for the ACT group are also being considered, enrolling previous group attendees to share their experiences and potentially dispel any concerns.

Furthermore, adopting some of the principles of ACT (such as exploring participant values) may be important throughout the stages of triaging as a way to reduce initial barriers to group engagement by attempting to ensure more appropriate matchmaking across participants. Similarly, some group dynamics, such as tendencies to under or over-contribute, were found to have a potentially relevant role in the way an intervention is delivered. Thus, clinicians may need to consider whether contributions appear unbalanced during sessions and whether prompts or allocated speaking times may be necessary.

In addition, our findings highlighted the importance of building an environment of acceptance despite potential cognitive, behavioural, and emotional diversity within a diverse neurological sample. This originated from the observation that, despite the wide range of different diagnoses, the intervention enabled emotional connectedness among participants, who were able to share knowledge and lived experiences. This highlights potential clinical implications in terms of accessibility and acceptability – i.e., ACT group interventions are not only acceptable and feasible with people with neurological conditions, but they also do not need to be disease-specific. In turn, this may result in further clinical implications such as reduced waiting times for appointments and greater consistency across service provision. However, clinicians who wish to implement similar interventions should also consider the results of this service evaluation regarding group facilitators being open, approachable, and encouraging with regards to active group participation.

### **Strengths, Limitations, and Future Directions**

The main strength of this project is that it highlights the importance of utilising ACT groups for neurological populations to provide skills that people can use in their real lives but also help them grow by sharing their own experience and enhancing self-acceptance. Another key strength of this project lies in its focus on a topic which is neglected in literature – the subjective experiences of individuals living with a wide range of neurological conditions who participated in an ACT group intervention. By adopting qualitative methods, the project not only gave participants a platform to express their thoughts and feelings, but also uncovered crucial subjective factors involved with attending an ACT group which may go overlooked with quantitative approaches. In addition, the fact that the interviews were carried out by a clinician who was not involved in the delivery of any of the group sessions (NZ) may have reduced the impact of social desirability and stimulated more honest conversations (Bergen & Labonté, 2019). A further strength was the promotion of inclusivity as the group was not condition-specific and participants were provided the option to attend either in person or remotely.

Nonetheless, a number of limitations should also be noted in this project. First, this was a service evaluation involving a population of individuals under the care of a specific NHS Trust in the north of England. Thus, future evidence should be based on studies aiming to

generalise findings. Second, due to the nature of self-selection and voluntary participation, it is possible that our participants may have chosen to take part due to having a positive outlook on psychotherapy. However, this was at least partly mitigated by the finding that some of the participants retained negative preconceptions around group psychotherapy (cf. Theme 1). Finally, a lack of age diversity was noted in the individuals included in this project. Therefore, future studies should explore the subjective experiences of attending ACT groups for people with different neurological diagnoses by recruiting more comprehensive, diverse, and representative samples drawn from this population.

### **Conclusions**

To our knowledge, this was one of the first projects exploring the subjective experience of individuals attending an ACT group intervention for people with different neurological conditions as delivered by a Clinical Neuropsychologist and co-facilitated by an Assistant Psychologist. The results highlighted that the group intervention provided patients with emotional connectedness and knowledge through shared lived experiences. More specifically to ACT, participants acquired new skills in adopting greater psychological flexibility in terms of managing thoughts, accepting their difficulties, and living a more values congruent life which triggered a shift in perspective and mindsets surrounding their condition. Additional quantitative and qualitative evidence, involving more comprehensive and representative samples, is warranted to provide further insight into the effectiveness of ACT group interventions for people living with neurological conditions.

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### **Declarations of Interest**

The authors have no conflict of interest to declare.

## Data Availability Statement

Data available on request due to privacy/ethical restrictions.

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**Table 1***Support group session topics*

Session	Topic	Content
1	Introduction, Choice Point, and Identifying Values	Group introductions to allow for rapport building. Participants were encouraged to share their experiences of living with a neurological condition. ACT was introduced as an approach to group therapy. Participants then began identifying individual values and participated in discussions of 'away' and 'towards' moves.
2	Bringing Yourself Back to The Moment	Group discussions led by a Clinical Neuropsychologist to begin to bring awareness to our thoughts, explore the thought-feeling link and why we have difficult emotions. Introduction to mindfulness, including what is is, , dispelling the myths and the benefits.
3	Getting Present	Group discussions led by a Clinical Neuropsychologist exploring mindfulness and mindfulness related activities (such as leaves on a stream video, mind full or mindful).
4	Defusion/De-hooking Skills	Exploring the illusion of control as a group , led by a Clinical Neuropsychologist. Group exercise looking at identifying workable and unworkable thoughts. Learning how to unhook from unworkable thoughts using various exercises (i.e. "I'm having the thought" exercise, the Unwanted Party Guest metaphor and Hands as Thoughts exercise).
5	Dropping the Struggle	Introduction to acceptance and 'leaning into' difficult thoughts / feelings / sensations , led by a Clinical Neuropsychologist. This included discussing the struggle switch, quicksand metaphor and walking in the rain metaphor.
6	Review and Future Plans	Summary of all weeks with a focus on the choice point, group exploration of goal progression alongside potential barriers the participants faced in achieving goals, led by a Clinical Neuropsychologist. The group then explored ways to overcome barriers to achieving goals via problem solving,

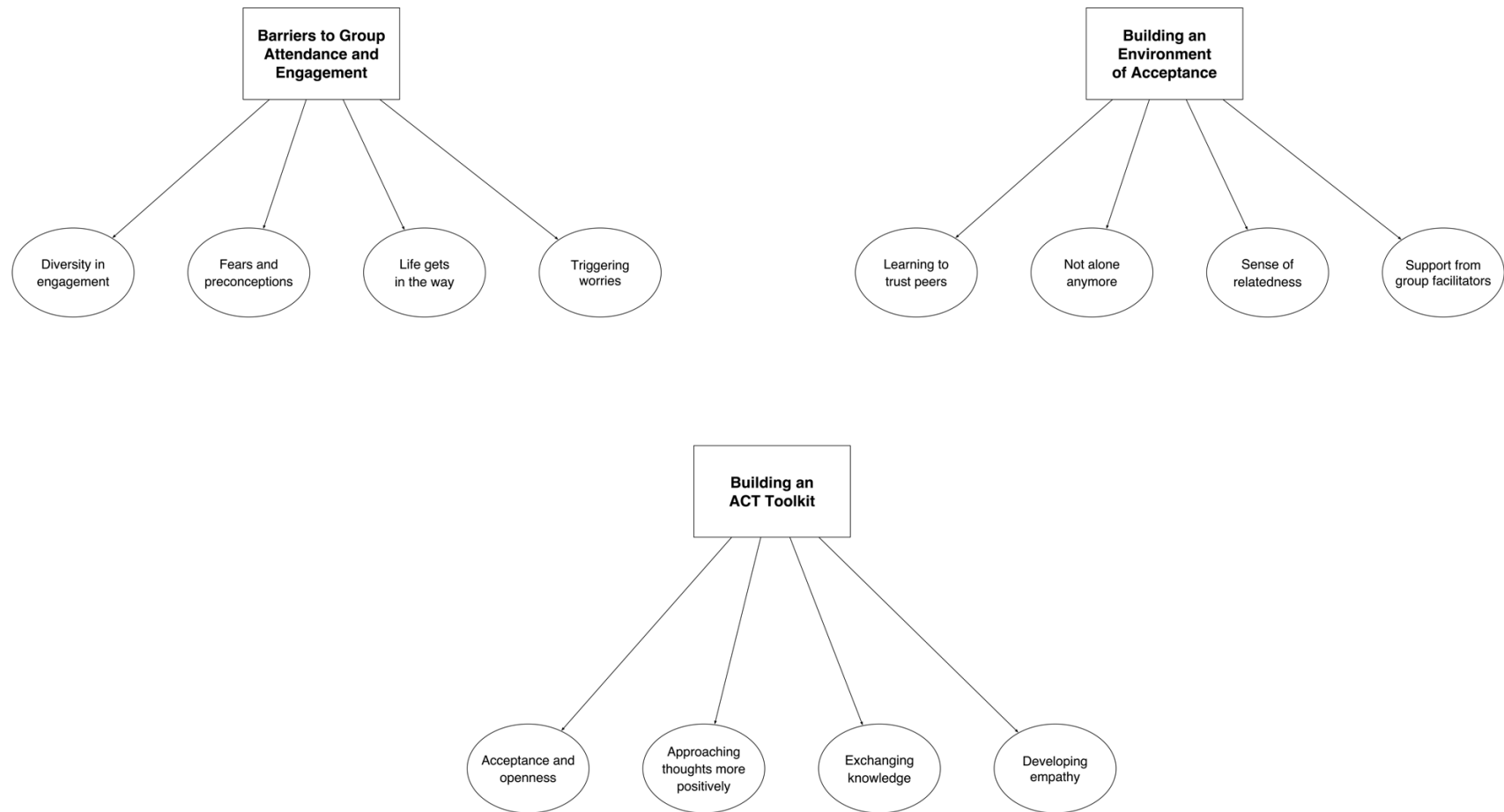


7	Individual Review	Participants were invited for a one-to-one review with a Clinical Neuropsychologist, regarding their future plans for treatment and to explore any residual unmet need(s). Participants were also encouraged to feedback their experience of the group. Outcome measures were also reviewed.
8	Reunion	A reflective space was provided to act as a summary of the group and to allow participants to review and share their progress. This was led by a Clinical Neuropsychologist and co-facilitated by the Assistant Psychologist.

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**Figure 1**

*Final Thematic Map*



Alt-Text: Tree-shaped diagrams illustrating the three main themes and the relative codes from the thematic analysis.