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Using reflexive thematic analysis to explore the guided experience and applied reflection GEAR model as a role complementary co therapy approach in group acceptance and commitment therapy training

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Research Article

Keywords: Acceptance and Commitment Therapy (ACT), co-therapy, group psychotherapy, reflexive thematic analysis, psychoeducation, GEAR model

Posted Date: May 25th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9505300/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

While Acceptance and Commitment Therapy (ACT) is highly effective in group settings and co-therapy is known to enhance therapeutic outcomes, existing literature predominantly focuses on the therapists' perspectives of co-facilitation. There is a significant gap in understanding how clients perceive distinct therapist styles and how these dynamics influence their internalization of core ACT processes.

Objective

This study aimed to explore participants' experiences of a co-facilitated group ACT psychoeducation workshop to understand the impact of dual-therapist dynamics on client learning and to develop practical guidelines for co-therapy collaboration.

Methods

A sample of 8 adult participants completed a 4-week group ACT training program co-facilitated by 2 therapists. Post-intervention qualitative data were collected via semi-structured questionnaires and analyzed using reflexive thematic analysis.

Results

The analysis revealed four overarching themes: perceptions of distinct and complementary therapist styles, the mechanics of effective co-therapy sequencing, synergistic advantages of the dynamic, and the internalization of core ACT processes. Findings culminated in the conceptualization of the GEAR (Guided Experience & Applied Reflection) Model. Participants benefited from a structured sequence where one therapist led experiential activities and the other facilitated reflections and applications.

Conclusions

The GEAR model offers a practical, role-complementary framework for co-therapy ACT.

1. Introduction

1.1. Acceptance and commitment therapy

Acceptance and Commitment Therapy (ACT) is a modern, evidence-based psychotherapy rooted in the traditions of behavioral and cognitive therapies. The overarching goal of ACT is to increase psychological

flexibility, which is the ability to engage in value-driven actions despite experiencing challenging thoughts, emotions, or environmental factors [1]. Through this approach, ACT helps individuals lead more meaningful lives by fostering acceptance, mindfulness, and committed action.

The ACT model identifies six core therapeutic processes that work together to enhance psychological flexibility [1]:

- Acceptance: Actively and willingly making space for painful feelings, sensations, and urges, without trying to change or resist them.
- Cognitive Defusion: Learning to observe one's thoughts from a distance, without getting "hooked" or entangled by them. It is about seeing thoughts as just thoughts, not as objective truths or commands that must be obeyed.
- Present Moment Awareness: The practice of bringing flexible, fluid, and voluntary attention to the here and now, with curiosity and openness (i.e., mindfulness).
- Self-as-Context: Accessing a transcendent sense of self—a continuous and secure "observing self" that is distinct from one's thoughts, feelings, and roles. This provides a stable viewpoint from which to observe one's experiences.
- Values: Clarifying what is most important and meaningful to an individual; what they want their life to stand for. Values provide direction and motivation for behaviour change.
- Committed Action: Taking effective, value-guided action. This involves setting goals that are aligned with one's values and consistently taking steps towards them, even in the presence of psychological discomfort.

By developing skills in these 6 areas, individuals learn to stop struggling with their inner experiences and instead redirect their energy toward building a rich, full, and meaningful life.

Numerous studies indicate that increasing individuals' psychological flexibility through ACT interventions helps reduce stress, anxiety, and depressive symptoms, while improving overall mental well-being [2, 3, 4]. Furthermore, research demonstrates that group-based ACT is as effective as individual therapy [5]. Nevertheless, there is limited research investigating the use of co-therapy in ACT sessions.

1.2. What is co-therapy?

Co-therapy is a well-established concept that was first introduced by Alfred Adler in the 1920s [6]. It refers to a conjoint psychotherapy approach conducted by two or more therapists [7]. While it may not often be used in individual therapy, it is commonly utilized in group and family therapy settings. There are several different modalities of co-therapy, such as the teacher/student (or senior/junior) model, the complementary model (e.g., mixed-gender pairings), and the egalitarian model [8]. The senior/junior model is typically used in training contexts, where the senior therapist demonstrates how to provide counseling to the clients while the junior therapist provides supplementary support. The mixed-gender complementary model can help reduce gender biases within the therapeutic space. Finally, the

egalitarian model often involves a dynamic where one therapist actively engages with the participants while the other observes and reenacts responses, allowing the clients to evaluate their own behaviors.

There are several reasons why therapists may choose to practice co-therapy [6]. First, therapists can learn from each other's techniques and approaches. Second, having two therapists allows for a broader range of perspectives and experiences, which can enhance the therapeutic process. Finally, co-therapy minimizes the risk of emotional and perceptual biases that may arise when a single therapist handles a session alone.

Various studies demonstrate that co-therapy can improve therapeutic outcomes. For example, Youngberg and Ward found that co-therapy, whether conducted by same-gender or mixed-gender therapist pairs, improved client well-being and enhanced interpersonal relationships in couple therapy sessions [9]. Another study reported no significant difference in therapeutic effectiveness between single-therapist and co-therapist approaches in sex therapy sessions, and both were effective in reducing sexual anxiety and increasing sexual satisfaction [10]. Additionally, co-therapy in family therapy has been shown to be as effective as single-therapist sessions [11].

1.3. Existing literature on how 2 therapists work together

1.3.1. The preparation

Existing research suggests five key areas that co-therapists should address during the preparation phase to enhance therapeutic effectiveness [12]. First, therapists must proactively commit to their professional relationship, building mutual trust that serves as a healthy model for clients. Second, discussing role division, expectations, and theoretical orientations before sessions is crucial to prevent in-session conflicts and ensure a unified approach. Third, maintaining open communication allows co-therapists to effectively plan, debrief, and resolve disagreements. Fourth, therapists must actively cultivate an awareness of counter-transference, monitoring their emotional responses toward both the clients and each other to prevent personal biases from interfering with treatment. Finally, seeking regular clinical supervision provides an objective perspective to navigate the complex relational dynamics unique to co-therapy. Together, these five preparatory steps establish a strong, cohesive foundation that maximizes the benefits of the conjoint therapeutic process.

1.3.2. Developing a growth mindset

Co-therapists might encounter various conflicts or disagreements. Viewing co-therapy as an opportunity for personal growth helps enhance the effectiveness of the sessions and protects clients' welfare. Research has identified several benefits to adopting this mindset [13]. First, therapists maintain professionalism by integrating diverse knowledge rather than rigidly focusing on their preferred techniques. This increases their ability to understand differences and fosters openness. Second, whether specific techniques prove effective or ineffective, the experience serves as a developmental process. As a result, therapists become more willing to modify their approaches and adapt to new systems in a co-therapy setting. Third, this mindset enhances generalizability. Since no single technique is a "one-size-

fits-all” solution, integrating different methods by observing other therapist allows therapists to generalize their skills to a broader range of client needs.

1.3.3. Building dialogical qualities

The concept of "dialogical qualities," a term introduced by Hornova, suggests that developing specific interpersonal skills can significantly enhance the effectiveness of co-therapy sessions. These qualities include the therapists' ability to express and receive disagreement constructively, care for the relational space, foster a responsive environment, and remain aware of body sensations among group members [14].

1.3.4. Limitations of co-therapy

Because co-therapy involves two or more therapists in a session, clinical performance can sometimes be negatively affected by social comparison. For instance, some therapists report experiencing anxiety due to feeling observed by their co-therapist, which can hinder their ability to perform effectively [12].

Furthermore, another study identified four distinct therapist styles: active-directive, active-non-directive, passive-directive, and passive-non-directive [15]. In this model, "active" refers to a greater willingness to verbalize, whereas "passive" indicates a lower likelihood of doing so. "Directive" relates to the directness of the interventions used, while "non-directive" focuses more on client facilitation. The author noted that the combination of these styles can either enhance or impede therapeutic effectiveness. For example, if both co-therapists possess an active style, they may struggle to align their therapeutic process, as both may compete to verbalize. Similarly, a non-directive therapist may disagree with the interventions of a directive co-therapist, and vice versa, potentially leading to in-session conflict.

1.4. Research gap and rationale

While existing literature provides substantial evidence for the efficacy of ACT in group settings and highlights the general benefits of co-therapy, a significant gap remains at the intersection of these two areas. Much of the current research on co-therapy focuses heavily on the therapists’ perspectives, such as their preparation, interpersonal dynamics, dialogical qualities, and the potential clashes between their distinct therapeutic styles (e.g., active vs. passive). However, there is a distinct lack of empirical literature examining the participants’ perspectives on these dynamics.

Specifically, it remains unclear how clients experience and interpret the differing styles and roles of two therapists working together, particularly within a group ACT setting. Furthermore, while we know that co-therapist dynamics can enhance or impede general therapeutic effectiveness, there is limited understanding of how this unique dual-therapist dynamic directly influences participants' ability to grasp and apply the core processes of ACT (such as psychological flexibility). Finally, there is a need to translate these client experiences into practical guidelines for how co-therapists can best coordinate their efforts in real-time.

To address these gaps in the literature, this study aims to explore the client experience of co-therapy in an ACT context. The research will be guided by the following questions:

- How do participants perceive and make sense of the distinct roles and styles of co-therapists in a group ACT training setting?
- In what ways do participants perceive the co-therapy dynamic as influencing their understanding and application of core ACT processes?
- Based on participant experiences, how can two therapists best collaborate and align their therapeutic styles to maximize the effectiveness of group ACT interventions?

2. Methodologies

2.1. Research designs

This study employed a qualitative methodology, specifically reflexive thematic analysis as outlined by Braun and Clarke [16, 17]. This approach was ideally suited for this exploratory research, as it allowed for a rich, detailed, and nuanced account of the participants' experiences. The "reflexive" component acknowledges that the researcher is an active participant in the knowledge-generation process. A reflexive journal was maintained throughout the research process to document assumptions, biases, and analytical decisions, thereby enhancing the transparency and trustworthiness of the findings.

The qualitative data collected from the questionnaires were analyzed using the 6-phase process of reflexive thematic analysis:

- **Familiarization**: The data were transcribed and repeatedly read to ensure a deep understanding of their content.
- **Initial Coding**: Features of the data that were interesting or relevant to the research questions were systematically identified and labeled.
- **Theme Generation**: The codes and collated data were examined to identify significant, broader patterns of meaning, referred to as potential themes.
- **Theme Review and Development**: The potential themes were checked against the entire dataset to ensure they were coherent, distinct, and accurately reflected the data. Themes were refined, merged, or discarded during this phase.
- **Defining and Naming Themes**: A detailed analysis was conducted for each theme, clarifying its scope and meaning. Each theme was given a concise and informative name that captured its essence.
- **Report Production**: The final research report was written, weaving together the analytic narrative with compelling data extracts that illustrated the identified themes.

Through this structured process, the data were systematically explored and interpreted, providing meaningful insights into participants' experiences and the dynamics of the co-therapy model in an ACT training context.

2.2. Participants

This study recruited a purposive sample of 8 adult participants from the local community (see Table 1 for more information). The inclusion criteria required participants to be 18 years or older and interested in learning more about ACT. They also had to commit to attending all four sessions of the training workshop and participating in the data collection process. Additionally, participants were required to express an interest in learning skills to enhance their well-being.

Table 1
Participant demographic information

Participant	Age	Gender	Highest Education	Current Occupation	Previous Counseling Experience	Previous Professional Counseling Training
Participant 1	30–39	Female	University	Unspecified (/)	No	No
Participant 2	50–59	Female	Master's Degree	Nurse	No	No
Participant 3	50–59	Female	Master's Degree	Nurse	No	No
Participant 4	40–49	Female	Secondary School	Unemployed	Yes	No
Participant 5	40–49	Female	University	Nurse	Yes	No
Participant 6	50–59	Female	Secondary School	Unspecified (/)	No	No
Participant 7	60 or above	Male	Secondary School	Retired	Yes	No
Participant 8	18–29	Female	University	NGO Project Coordinator	Yes	No

Individuals were excluded if they had previous formal training in ACT, as prior familiarity with ACT concepts could have influenced the study outcomes. Participants with psychiatric history or crisis at the time of the study were also excluded. Furthermore, professional psychotherapists or counselors were not eligible to participate, as their expertise in therapy could have affected the study's focus due to their analytical mindset towards the therapists. However, other types of healthcare professionals (for example, nurses, occupational therapists, speech therapists, etc.) were welcome to participate.

Recruitment efforts were carried out through community notice boards, local social media groups, and partnerships with community centers to ensure a diverse and representative sample from the community.

2.3. Procedures

Before

Before recruitment began, ethical approval was obtained from the Human Research Ethics Committee (HREC) of Hong Kong Shue Yan University (reference number: HREC 25 – 12 (24)). All human-related procedures were performed in accordance with the ethical guidelines and regulations of the HREC of Hong Kong Shue Yan University. The study was advertised via the Bliss & Wisdom Charitable Foundation. Participants completed a DASS-21 screening to screen out individuals with moderate to severe depressive, anxiety, and stress symptoms. All potential participants were provided with a detailed information sheet outlining the purpose of the study, the nature of their involvement, the voluntary nature of participation, their right to withdraw at any time without penalty, and the measures in place to ensure confidentiality. Written informed consent was obtained from all participants prior to their inclusion in the study. No incentives were provided upon completion.

Participants took part in a 4-week ACT training program. Each session lasted approximately 3 hours and was held one week apart. The training sessions were psychoeducational and experiential, facilitated by a co-therapy team. One therapist specialized in counseling psychologist, while the other specialized in nurse. Both obtained ACT certificates and had more than 5 years of experience in ACT.

The content focused on the six core processes of the ACT Hexaflex, offering participants both theoretical understanding and practical exercises to integrate ACT principles into their daily lives. Practical exercises included experiential activities, metaphors, mindfulness practices, and worksheets. In the first session, the co-therapists introduced the overall concept and background of ACT to participants and invited them to share their personal experiences of struggling with thoughts and emotions. The processes of values, acceptance, and defusion were also introduced in this session. In the second session, participants experienced how the processes of present-moment awareness and self-as-context could be used in daily life through multiple mindfulness exercises and reflections. Participants then progressed to learn about the final processes, values and committed action, in the third session. Finally, a comprehensive summary of the ACT processes and their applications was provided in the fourth session.

After the intervention, participants were asked to complete a 45-minute, semi-structured, open-ended questionnaire.

2.4. Co-therapy considerations

Successful co-therapy relies on the deliberate cultivation of the professional relationship between practitioners. To guide this process, Dugo and Beck proposed a comprehensive 9-stage framework

designed to build and sustain a highly functioning co-therapy partnership [18]. The framework begins with establishing logistical and theoretical agreements, the model progressively guides co-therapists through forging a shared professional identity, building mutual trust, and deepening interpersonal connection. As the partnership matures, therapists assess each other's strengths and limitations, explore collaborative opportunities, and engage in reciprocal self-reflection to address blind spots and unhelpful patterns. Growth is then actively integrated into practice, with the framework concluding in a structured closure process that allows for meaningful reflection and healthy professional separation.

Navigating through these 9 stages enables co-therapists to forge a robust alliance that ultimately elevates the quality of care provided to clients. This systematic progression not only deepens the professional connection between the practitioners but also guarantees they remain unified in their clinical methodologies and overarching objectives.

2.5. Data collection

The post-intervention, semi-structured, open-ended questionnaire was designed to explore participants' experiences and perceptions, guided by the study’s research questions.

Sample semi-structured questions included prompts such as:

- "Thinking back over the four sessions, what was your biggest takeaway or most valuable learning?"
- "What were the qualities of Therapist A and Therapist B?"
- "What was your experience having two therapists in the session?"
- "Did you find the similarities or differences between the therapists helpful or unhelpful for your learning of ACT? Please explain why."
- "Overall, do you feel it was more helpful to have two therapists leading the training, or do you think one therapist would have been better? Please elaborate on your preference."

This questionnaire allowed participants to share their perspectives on the roles of each therapist and the overall co-therapy dynamic.

3. Results

A thematic analysis of the participants' feedback revealed 4 overarching themes that capture the experience and impact of the co-facilitated ACT workshop. The findings are presented in a logical progression, beginning with the participants' perceptions of the therapists' individual styles, moving through the mechanics and synergistic benefits of their co-therapy approach, and concluding with the participants' internalization of core ACT processes. Table 2 provides the details of the overarching themes and their extracts.

Table 2
Thematic Progression from Therapist Styles to the Internalization of Core ACT Processes

First Level Theme	Second Level Theme	Extracts (Chinese Original & Polished English Translation)
Perceptions of Distinct and Complementary Therapist Styles *(The Individuals)*	Analytical Guidance vs. Experiential Facilitation	Therapist A: • **Participant 3**: □□善誘善誘帶領學員進入想像空間 (Patiently and systematically guides participants into an imaginative space.) • **Participant 5**: 很善觀 Therapist A 所講的 ACT 理論, 帶點哲學, theoretical得來, 能令我再更加深入去「諗」, 深入去分析自己... (Therapist A's presentation of ACT theory is highly observant and carries a philosophical, theoretical depth. It prompts me to think more profoundly and analyze myself...) • **Participant 6**: 好尊心聆聽每一位學員的心德分享再續步續步提出合理的問題令學員更加了解自己的問題所在, 及時作出□當的指導。 (Attentively listens to each participant's sharing, progressively asking logical questions to help them understand the root of their issues, and provides timely, appropriate guidance.) • **Participant 8**: 認真專注聆聽的風格, 會致力追問大家的背後想法或感受... 是比較沈穩和冷靜分析型。善於整理大家□說話。 (A focused and earnest listening style; Therapist A actively probes for underlying thoughts and feelings. Therapist A is a calm, analytical type who excels at synthesizing everyone's input.) Therapist B: • **Participant 1**: 對於具體驗式的活動印象深刻(巴士上的乘客)... (Deeply impressed by the experiential activities, such as the 'passengers on the bus' exercise...) • **Participant 4**: 帶領體驗之活動, 令學員深刻明白體驗活動帶來嘅重要感受。 (Skilled at leading experiential activities, enabling participants to deeply grasp the emotional impact of these exercises.) • **Participant 8**: 同時擅長說講義, 理論比較多, 似講師... 是幾好令課堂氣氛活躍的導師! (Also adept at explaining the handouts with a more theoretical, lecturer-like approach... Therapist B is an excellent instructor for energizing the classroom atmosphere!)
	Cultivating a Safe, Non-Judgmental Space	• **Participant 7**: 用溫婉的專業用語, 解答學員說出的用語, 及解答問題; (Uses gentle, professional language to address participants' terminology and answer their questions.) • **Participant 4**: 兩位治療師的風格相似地方是願意耐心聆聽學員嘅感受。 (A shared stylistic trait between both therapists is their willingness to patiently listen to the participants' feelings.)

First Level Theme	Second Level Theme	Extracts (Chinese Original & Polished English Translation)
The Mechanics of Effective Co-Therapy Sequencing *(The Method)*	Structured Transition from Experience to Theory	• **Participant 8**: □□□□, -□□ACT□□□, □□□□□□□, □□□□□ (One focuses on theory, the other on practicing ACT, providing more examples to make the concepts more grounded and practical.) • **Participant 2**: □□□□□□□□□□□□□□□, □□□□□□□□, □□□□□□□□□□... (After one therapist leads and analyzes the content, the other supplements it, achieving a perfectly coordinated effect...) • **Participant 5**: □Therapist B□□□□□□□□, □□□□□□□□□□ exercise... □□Therapist A□□□□exercise□□□□theory... □□□ exercise □□□□□□□□ACT theory (Therapist B uses a gentle voice and tone to lead participants through the exercises... Then Therapist A articulates the underlying theories of each exercise... This structure allows us to reflect on the ACT theories we've learned through every activity.)
	Deepening Comprehension through Dual Perspectives	• **Participant 8**: □□□□ppt □□□□□□□□□□... □□□□□□□□□□□□ (Therapist A)□□□□ACT□□□ by 1□1□□□□□ (Simply reading theories from a PowerPoint makes it difficult to apply them to real life... I feel that having someone capable of practical, individualized analysis (Therapist A) deepens my understanding of ACT through 1-on-1 dialogue.) • **Participant 1**: □□□□□□□□□□□□□□□ (Brings diverse perspectives to the participants' shared experiences.)
Synergistic Advantages of the Co-Therapy Dynamic *(The Benefit of the Method)*	Enhanced Group Management and Holistic Learning	• **Participant 1**: □□□□□□□□□□□... □□□□□□□□□□□□□□□□ - □□□□□□□□□ □□□□□□□□□ (The two therapists complement each other... The counseling style encourages participants to reflect on the class content, while the experiential style allows them to internalize the material through activities.) • **Participant 3**: □□□□□□□□□, □□□□□□□□□□□□□□□□... □□□□□□□□□□□□□□ □□□ (Having two therapists together is highly effective; it prevents dull moments and helps manage unexpected situations... They naturally play off each other to steer the group back on track.)
	Mitigating Therapist Bias and Subjectivity	• **Participant 5**: 2□□□□□□□□, □□□□□□□□□□□□, □□□□□□□theory, □□□ □□□□□□□□□□□□□□□□ (Having two therapists is preferable because the workshop consists of diverse learners. If the focus is solely on theory, not all participants may be able to grasp it.) • **Participant 2**: □□□□□□□□□□□□□... □□□□□□□□□□□□□□□, □□□□□□□□□□□□ □□□□□ (Co-facilitation is excellent... A single therapist might become too subjective, and the perspectives introduced might lack objectivity.)
Internalizing Core ACT Processes	Fostering Psychological	• **Participant 5**: □□□□□□□, □□, or exercise, □□□□□□□/□□□□□□□□□□ □□...□□□□□□□□□□/□□, □□□□□□□□□... (Through various

First Level Theme	Second Level Theme	Extracts (Chinese Original & Polished English Translation)
(The Final Outcomes)	Acceptance	examples, scenarios, and exercises, I was better able to understand and experience the 'existence of thoughts'... 'Do not fixate on specific good or bad aspects, but accept the existence of everything'...) • **Participant 6**: □□□□□□□□□□□□□□□ (Learned to accept myself and others, embracing respect and responsibility.)
	Clarifying Values over Goal-Orientation	• **Participant 1**: □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□, □□□□□□□□□□□□□□□□□□□□, □□□□□□□□□□□□□□□, □□□□□□□□□□□□... (Distinguished the difference between 'values' and 'goals.' With this clear understanding, even if I cannot immediately achieve my goals, I can still pursue meaningful actions that align with my values...)
	Anchoring in the Present Moment	• **Participant 3**: □□□outcomes, □□□□□□□□□□□□□□□□□□□□, □□□□□□□□□□□□□□□□□□□□, □□□□□□□□□ (Shifted focus away from outcomes and toward the process. I learned to allow myself to have diverse thoughts; even negative ones have a place and do not need to be forcibly eradicated.) • **Participant 2**: □□□□□□□□, □□□□□□□□□□□□□□... (Learned to live in the present moment and avoid becoming overly fixated on certain things...) • **Participant 8**: □□□□□□□□□□□□□□□□, □□□□□□□, □□□□□□□□□□□□□□ (I am often consumed by thoughts and lose touch with the present. I realized that returning to the present makes it much easier to observe my own thoughts.)

3.1. Perceptions of distinct and complementary therapist styles

The foundational element of the workshop's success was the participants' recognition of the distinct, yet highly complementary, facilitation styles of the two therapists, Therapist A and Therapist B.

3.1.1. Guided experience vs. applied reflection (GEAR)

Participants clearly distinguished between the two therapists' primary modalities, which naturally formed the foundation of what we term the GEAR Model (Guided Experience & Applied Reflection).

Therapist B was recognized for a dynamic role in providing the guided experience. Therapist B was highly effective at "energizing the classroom atmosphere" (Participant 8) and was praised for skill in leading immersive, action-oriented activities, such as the “passengers on the bus” metaphor. Participants noted that the experiential guidance enabled them to "deeply grasp the emotional impact of these exercises" (Participant 4), allowing them to physically and emotionally walk through the concepts before analyzing them.

Conversely, Therapist A was perceived as the anchor for applied reflection, focusing on here-and-now facilitation to help participants internalize the exercises and apply them to real-life settings. Participants noted Therapist A's "focused and earnest listening style" (Participant 8), observing that Therapist A "patiently and systematically guides participants into an imaginative space" (Participant 3) to process their current thoughts and feelings. Therapist A's approach to ACT theory was described as having a "philosophical, theoretical depth" that prompted participants to "think more profoundly and analyze themselves" (Participant 5). By doing so, Therapist A effectively bridged the gap between the guided activities and the participants' daily lives, linking abstract ACT theories directly to their own lived realities.

3.1.2. Cultivating a safe, non-judgmental space

Despite their distinct pedagogical styles within the GEAR framework, both therapists shared a fundamental ability to create a secure psychological environment. Participants emphasized that a unifying trait of both facilitators was their "willingness to patiently listen to the participants' feelings" (Participant 4) and their use of "gentle, professional language" to validate participant experiences and answer questions (Participant 7). This shared foundation of safety was essential for both the vulnerable experiential exercises and the deep, personal reflections that followed.

3.2. The mechanics of effective co-therapy sequencing

The contrasting styles of the therapists were not merely incidental, they were operationalized through a deliberate and highly effective pedagogical sequence central to the GEAR Model.

3.2.1. Structured transition from Guided Experience to Applied Reflection

Participants highlighted a clear structural rhythm to the workshop that bridged practice and theory. The typical sequence involved Therapist B initiating the Guided Experience, using a gentle voice and tone to lead participants through the experiential exercises (Participant 5). This was followed immediately by Therapist A's Applied Reflection, where Therapist A would articulate the underlying theories and allow us to reflect ourselves based on the theories" (Participant 5). This tag-team approach ensured that the concepts were first felt, and then understood and internalized. As Participant 2 described, "After one therapist leads and analyzes the content, the other supplements it, achieving a perfectly coordinated effect."

3.2.2. Deepening comprehension through dual perspectives

This sequencing allowed for a deeper comprehension of ACT principles than traditional didactic teaching. Participants noted that "simply reading theories from a PowerPoint makes it difficult to apply them to real life" (Participant 8). The combination of Therapist B's experiential immersion with Therapist A's capacity for "1-on-1 analytical dialogue" within the group brought "diverse perspectives to the participants' shared experiences" (Participant 1). By actively linking the abstract theories from the

exercises to the participants' own lives, the GEAR model made the concepts highly grounded, practical, and ready for real-world application.

3.3. Synergistic advantages of the co-therapy dynamic

Beyond the mechanics of teaching, the GEAR co-therapy model provided systemic advantages that enhanced the overall group dynamic and safeguarded the integrity of the intervention.

3.3.1. Enhanced group management and holistic learning

The presence of two facilitators allowed for a more holistic learning environment. The dual approach meant that Therapist A's "counseling style encourages participants to reflect on the class content, while [Therapist B's] experiential style allows them to internalize the material through activities" (Participant 1). Furthermore, the co-facilitation model proved highly practical for group management. Participants observed that having two therapists "prevents dull moments and helps manage unexpected situations," noting that they naturally "play off each other to steer the group back on track" (Participant 3).

3.3.2. Mitigating therapist bias and subjectivity

Crucially, the co-therapy dynamic acted as a buffer against individual therapist bias. Participants recognized that in a diverse workshop, a singular approach might fail to reach everyone. As Participant 5 noted, "If the focus is solely on theory, not all participants may be able to grasp it." Moreover, the presence of two facilitators ensured a balanced perspective between lived experience and theoretical application: Participant 2 insightfully pointed out that "a single therapist might become too subjective, and the perspectives introduced might lack objectivity."

3.4. Internalizing core ACT processes

Ultimately, the complementary GEAR modalities, structured sequencing, and synergistic environment facilitated the successful internalization of core ACT processes among the participants, effectively translating abstract psychological concepts into daily life.

3.4.1. Fostering psychological acceptance

Participants reported a significant shift toward psychological flexibility and acceptance. Through the various guided scenarios and subsequent reflections, participants learned to acknowledge the "existence of thoughts" without judgment, learning to "not fixate on specific good or bad aspects, but accept the existence of everything" (Participant 5). This extended beyond internal thoughts to interpersonal relationships, with participants learning to "accept [themselves] and others, embracing respect and responsibility" (Participant 6).

3.4.2. Clarifying values over goal-orientation

The workshop successfully helped participants untangle the concepts of values and goals, a core component of ACT. Participant 1 articulated this breakthrough, stating that by distinguishing the

difference between the two, they realized that "even if I cannot immediately achieve my goals, I can still pursue meaningful actions that align with my values."

3.4.3. Anchoring in the present moment

Finally, participants demonstrated a renewed capacity for present-moment awareness. The intervention helped them shift their focus "away from outcomes and toward the process" (Participant 3). Participants recognized their tendency to be "consumed by thoughts and lose touch with the present," but learned that "returning to the present makes it much easier to observe [their] own thoughts" (Participant 8), ultimately learning to "live in the present moment and avoid becoming overly fixated on certain things" (Participant 2).

4. Discussions

The primary objective of this study was to explore participants' experiences of a co-facilitated group ACT workshop, specifically examining how they perceived the distinct roles of the therapists and how this dynamic influenced their understanding of core ACT processes. By centering the participants' perspectives, this study addresses a significant gap in the existing co-therapy literature, which has predominantly focused on the therapists' points of view. The findings culminated in the conceptualization of the GEAR (Guided Experience & Applied Reflection) Model, offering a practical framework for co-therapy in ACT psychoeducation.

4.1. Making sense of distinct therapist styles: The GEAR modalities

Addressing the first research question, participants did not view the differing styles of Therapist A and Therapist B as disjointed or conflicting. Rather, they perceived them as a highly complementary dyad. Existing literature by Solomon et al. warned that differing therapist styles (e.g., active-directive vs. passive-non-directive) could lead to in-session conflict or impede therapeutic effectiveness [15]. However, our findings suggest that when these styles are deliberately coordinated, they create a rich, multi-dimensional learning environment.

The collaboration of guided experience (leading experiential exercises) and applied reflection (grounding participants and linking abstract theories to real life) effectively showcased the roles of the two therapists, demonstrating that these distinct roles can work exceptionally well together. Crucially, this division of labor was underpinned by a shared ability to cultivate a safe, non-judgmental space. This aligns with the "dialogical qualities" proposed by Hornova, where therapists care for the relational space by offering diverse but unified, responsive environments for the clients.

4.2. Enhancing the internalization of ACT processes

Regarding the second research question, the GEAR co-therapy dynamic directly facilitated the participants' understanding and application of ACT. ACT is inherently experiential and asks individuals to

accept negative emotions rather than fight them, as well as to observe thoughts without getting entangled in them [1]. Teaching these concepts purely didactically often fails, as participants noted that simply reading theories from a PowerPoint is insufficient for real-world application.

The results demonstrated that the sequential tag-team approach: moving directly from Therapist B's experiential immersion to Therapist A's theoretical debriefing, bridging the gap between abstract theory and lived experience. Consequently, participants successfully reported internalizing core ACT processes, specifically psychological acceptance, values clarification, and present-moment awareness. Furthermore, the presence of two therapists mitigated individual biases and subjectivity, ensuring that the diverse learning needs of the group were met, which echoes the systemic benefits of co-therapy outlined by Roller and Nelson [6].

4.3. Practical guidelines: Implementing the GEAR model

Addressing the third research question, the participant data provides a clear blueprint for how therapists can best collaborate. We propose that co-therapists in group ACT settings adopt the GEAR Model, characterized by the following practical guidelines:

- Explicit Role Differentiation: Therapists should divide their roles based on their natural pedagogical strengths. One therapist should take the lead on Guided Experience (evoking emotion, leading metaphors and mindfulness exercises), while the other focuses on Applied Reflection (observing the clients, analyzing the experience, and connecting it to the ACT Hexaflex).
- Sequential Scaffolding: Interventions should follow a structured, predictable rhythm: *Experience* → *Reflection* → *Application*. The experiential lead initiates the activity, and the analytical lead immediately follows up to help participants process the psychological impact.
- Unified Foundation: To execute this model seamlessly, therapists must engage in rigorous preparation. As outlined in Dugo and Beck's framework, co-therapists must forge a shared identity and establish a contract regarding their theoretical frameworks before entering the room, ensuring that their contrasting styles feel coordinated rather than competitive to the participants [18].

4.4. Implications for practice, training, and research

The conceptualization of the GEAR Model from this study offers several vital implications for how co-therapy is conducted, taught, and studied within the context of ACT and broader group interventions.

4.4.1. Practical implications

Clinically, the GEAR Model provides a highly structured and actionable framework for co-therapists running group psychoeducation or therapy sessions. Rather than defaulting to an unstructured egalitarian model where therapists might accidentally compete for speaking time or step on each other's interventions, clinics can intentionally pair therapists based on their natural pedagogical strengths. A therapist who excels at dynamic, energetic facilitation can be assigned the Guided Experience role, while

a therapist with a more philosophical, analytical demeanor can take on the Applied Reflection role. This deliberate division of labor not only enriches the client experience but also reduces therapist fatigue and cognitive overload, as each facilitator has a clear, predictable mandate during the session.

4.4.2. Training implications

For clinical training programs and supervisors, these findings suggest a shift in how co-therapy is taught. Traditionally, training often relies on the senior/junior (observation) model. The GEAR Model introduces a collaborative paradigm that can be explicitly taught to trainees. Training institutions should focus on teaching the "handoff" or transition between the experiential and reflective phases, ensuring trainees know how to seamlessly pass the baton without disrupting the group's psychological safety. Furthermore, training must emphasize the preparation phase (as outlined by Dugo and Beck) and the cultivation of a "growth mindset," ensuring that therapists learn to value complementary differences rather than viewing contrasting styles as a threat to their own clinical competence.

4.4.3. Research implications

This study advances the academic conversation on co-therapy in three key ways. First, it challenges the historically therapist-centric focus of existing literature by demonstrating that clients actively decode and utilize contrasting therapist styles to enhance their learning. Second, the GEAR model adds crucial nuance to older frameworks (such as Solomon et al. [15]) which warned that differing therapist styles might impede effectiveness. Instead, this study posits that deliberate stylistic contrast serves as a distinct mechanism for therapeutic change rather than a source of conflict. Finally, this research bridges a theoretical gap between ACT processes and co-therapy structure. Because ACT requires clients to both actively experience emotions and safely observe them, having two therapists physically embody these distinct roles (experiencing vs. reflecting) provides a live, systemic metaphor for the ACT hexaflex itself. This suggests that the structural delivery of co-therapy can directly reinforce the psychological skills being taught.

4.5. Limitations and Future Directions

While this study provides novel insights and establishes the theoretical framework for the GEAR model, several limitations must be acknowledged. First, the sample size was small (N = 8) and purposive, consisting of community members from a specific cultural context, which limits the broader generalizability of the findings. Second, the study relied entirely on qualitative, self-reported data collected post-intervention, which captures subjective client acceptability but not objective clinical outcomes.

Consequently, this study opens several vital avenues for future investigation. To address the methodological limitations, future research should employ mixed-methods designs and utilize randomized controlled trials (RCTs). Incorporating quantitative measures of psychological flexibility (e.g., the AAQ-II) would help triangulate these qualitative findings and measure the objective efficacy of the GEAR model by comparing it against both single-therapist groups and unstructured co-therapy groups.

Furthermore, longitudinal studies are needed to determine if the benefits of this role-complementary model persist over time. Finally, future research should explore how this model functions across different clinical populations (e.g., adolescents, or individuals with clinical depression) and various cultural contexts to establish its generalizability, as well as investigate how different pairings of therapist styles might further impact client outcomes.

Declarations

Clinical trial number: not applicable

Funding Statement

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Declaration of Conflict of Interest

The authors declare that they served as the co-therapists for the intervention evaluated in this study. To mitigate potential bias, rigorous cross-checking was implemented between the authors during the data coding and analysis process. The authors declare no other conflicts of interest.

Author Contributions

Both authors contributed equally to the conceptualization, implementation, data analysis, and writing of the manuscript.

Acknowledgement

The authors would like to express their sincere gratitude to the Bliss & Wisdom Charitable Foundation (Hong Kong) for their generous support in facilitating this research. Their assistance was instrumental in participant recruitment, provision of the training venue, and logistical coordination throughout the study. This research would not have been possible without their kind collaboration and commitment to promoting community well-being.

Data Availability

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

Use of Artificial Intelligence (AI)

Artificial Intelligence (AI) tools were utilized solely for language polishing and proofreading during the preparation of this manuscript. No participant data or identifiable information was inputted into any AI system.

Ethical approval

Ethical approval for this study was obtained from the Human Research Ethics Committee (HREC) of Hong Kong Shue Yan University (reference number: HREC 25-12 (24)). All human-related procedures were performed in accordance with the ethical guidelines and regulations of the Human Research Ethics Committee of Hong Kong Shue Yan University.

Consent to participate

All participants were provided with a detailed information sheet outlining the purpose of the study, the nature of their involvement, the voluntary nature of participation, their right to withdraw at any time without penalty, and the measures in place to ensure confidentiality. Written informed consent to participate was obtained from all participants prior to their inclusion in the study.

Consent to publish

Written informed consent for the publication of aggregated, non-identifiable data was obtained from all participants.

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