A qualitative exploration into the personal and professional experiences of having a long-term, daily practice of informal mindfulness for third wave therapists

Author: Salena Bhanji

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City University London
School of Social Science, Department of Psychology

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This portfolio is dedicated to my children, Ariadne and Aydin, who inspire me to be more mindful, accepting and compassionate everyday.

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SECTION A:

Preface to DPsych Portfolio

1. Overview

The theme of mindfulness and in particular mindfulness in the 'third wave' therapies runs throughout all sections of this DPsych portfolio. In this overview, I reflect on how this theme developed from my own professional and personal interests in the topic and what I hope to deliver to readers of this portfolio.

I first came across mindfulness a number of years ago upon reading about it in a psychology journal that described mindfulness as an increasingly popular approach in psychotherapy to cultivate present moment awareness, empathy and overall well-being. As a counselling psychologist and as a person, I was immediately struck by how strongly the philosophical underpinnings of mindfulness resonated with my professional identity and my own personal beliefs about working with mental health issues that was largely missing from the medicalised and diagnostic-laden contexts in which I was working. I was also drawn to the constructs of compassion and kindness that were imbued in the approach and seemed to offer the possibility of relating to my own difficulties, in particular my anxiety, in a more mindful and compassionate way.

From this point my curiosity was piqued as I was drawn to reading as much literature as I could find on the subject matter. Unfortunately, I could not find any articles on mindfulness within the field of counselling psychology, however I found much literature within the wider field of psychotherapy and clinical psychology. I attended a number of talks given by experienced mindfulness practitioners, spiritual leaders, Buddhist scholars and His Holiness the Dalai Lama himself. I also attended seminars and conferences that highlighted the role of mindfulness in the current climate of therapy and the evidence base that existed for mindfulness therapies being an efficacious treatment approach for a range of clinical presentations. Through this exposure, I came to be acquainted with the term 'third wave' therapies, which commonly refers to a specific category of therapies that integrate aspects of mindfulness theory with elements of cognitive and behavioural therapies (Hayes, 2004). As the majority of my training at that point had been in CBT, learning about third wave therapies spurred my desire to pursue training in this area. I started by taking a short course in mindfulness meditation as it appeared to be the primary vehicle for mindfulness practice. Whilst I thoroughly benefitted from the meditation practices and tried to practice them regularly, I often struggled and felt overwhelmed by the expectations to practice formal meditation on a daily basis. Thus I found myself drawn more and more to informal mindfulness practices, which spurred further training in Acceptance and Commitment Therapy (ACT) and Dialectical Behaviour Therapy (DBT).

It has been a number of years since I first came across mindfulness and I currently engage in both informal and formal mindfulness practice. There have been a myriad of ways in which my relationship with mindfulness has made a significant personal and professional impact in my life. The personal impacts have included profound personal and spiritual insights, enhanced self-awareness and self-compassion and a much greater ability to bring my attention back to the present moment. Professionally, my mindfulness practice has greatly improved the quality and depth of my empathy and compassion towards clients, my capacity to be present with difficult emotions and my attention to therapeutic process. I've continued training in several other third wave therapies and I have remained connected to the 'third wave' community through attendance at conferences and on-going CPD.

Thus for readers of this portfolio and in particular any future counselling psychology trainees, I aim to provide some insight into the nature and qualities of mindfulness practice and in particular identify how these characteristics have become implemented across third wave therapies. As third wave therapists generally engage in some form of personal mindfulness practice, I'm also quite keen to explore the personal and professional outcomes of this practice and to illuminate how the principles of mindfulness are inherently compatible with the humanistic values that underpin counselling psychology. My hope is that future trainees receive more specific training in mindfulness whilst completing professional training courses and as a result for there to be a much greater presence of mindfulness literature and research that is specifically relevant for counselling psychologists.

2. Research Thesis

My research thesis was largely informed by my interest in the practice of informal mindfulness practice and my desire to contribute some much lacking literature to the field that focuses predominantly on formal mindfulness meditation. I was also keen to highlight how the practice of mindfulness has particular relevance for counselling psychologists based on the shared values between the two fields and the scope for counselling psychologists to potentially benefit both personally and professionally from practicing mindfulness in the third wave.

The specific focus of the thesis is on the personal and professional experiences of having a long term, daily practice of informal mindfulness for third wave therapists.

I carried out a qualitative study using Thematic Analysis (TA; Braun & Clarke, 2006) and interviewed ten qualified and experienced therapists who each practiced one of

three different third wave therapies as their main approach. Each therapist identified that they practiced informal mindfulness daily and that it constituted their main form of practice. To collect data, I used semi-structured interviews to explore various aspects of their personal and professional experiences of informal mindfulness practice and analysed transcripts of these interviews. The analysis process led to the development of six themes. It was found that the long term, daily practice of informal mindfulness led to the qualitative experiences of enhanced wellbeing, heightened sensory awareness and gratitude towards taken-for-granted life experiences. Informal mindfulness practice also appeared to provide multiple contexts for learning how to deal with pain effectively, facilitated the use of self and other in mindful therapy and bridged the divide between "being" and "doing" modes in Western society. A particularly interesting finding was that many third wave therapists, especially those who had more experience meditating, may be practicing a hybrid form of informal and formal practice that incorporated aspects of both forms of practice. These findings had significant implications for the professional practice of informal mindfulness and opened up new avenues for future research in the field.

3. Professional Practice

This piece of work combined a case study with a process report and thus comprised an in-depth examination of a single client's presenting problems as well an interpretative analysis of a transcript that took place in a single therapy session.

The client was a 56-year old female who had presented with recurrent depression and was struggling to come to terms with significant losses in her life. This particular client was chosen for this report as we had established a sound therapeutic relationship and I felt there was much to be learnt from the work we did together and also on the basis that she was the first client that I had begun to use ACT with.

The case study set out her biographical details and a contextualization of her presenting problems in light of her life experiences and offered insight into the progression of our therapeutic process from assessment to formulation and the development of our treatment plan. The process report was based on a transcript from our fourth session and demonstrates how I used mindfulness as an ACT technique for experiencing and being present with her unwanted emotions, defusing from her thoughts and moving towards creative hopelessness. I also used mindfulness interventions to help the client identify the values in her life. These interventions appeared to produce significant therapeutic shifts within the session and allowed the client to show vulnerability in the room, which was always something she struggled

with. This combined report concluded with an evaluation of the work as well an appraisal of my own learning processes in using the ACT model to treat depression.

4. The Critical Literature Review

The critical literature review aimed to review the evidence for three third wave therapies including Dialectical Behavioural Therapy (DBT), Metacognitive Therapy (MCT) and Acceptance and Commitment Therapy (ACT) as treatments for depression with a view to consider how suitable they would be for inclusion within the Improving Access to Psychological Therapies (IAPT) agenda. At present the IAPT agenda operates in accordance with the guidelines set out by the National Institute of Clinical Excellence (NICE), which largely endorses cognitive behavioural therapy (CBT) as a leading evidence-based treatment for clinical depression but has limited inclusion of third wave therapies. The article reviewed a number of quantitative and qualitative studies and identified their main limitations. Suggestions for future research were suggested and a conclusion made on the basis of the existing evidence.

SECTION B:

Research Thesis

A qualitative exploration into the personal and professional experiences of having a long-term, daily practice of informal mindfulness for third wave therapists

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Abstract

The current study presents a qualitative exploration into the personal and professional experiences of having a long term, daily practice of informal mindfulness for third wave therapists. The humanistic, pluralistic and phenomenological focus of this study aims to appeal specifically to counselling psychologists who practice mindfulness in their own personal and professional lives.

The participants included ten third wave therapists who delivered Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT) or Mindfulness-based Cognitive Therapy (MBCT) as their main therapeutic approach. These therapists identified that they practiced informal mindfulness several times a day during various life activities and that it was their main form of mindfulness practice.

Thematic analysis of the semi-structured interview transcripts produced six themes across the data set. Overall it was found that the long term, daily practice of informal mindfulness produced several beneficial as well as some challenging experiences for third wave therapists across their personal and professional lives. Certain factors appeared to mediate these experiences including the therapists' current engagement in formal meditation, the specific third wave therapy delivered and also spiritual affiliations with mindfulness. These findings posed a number of significant implications for professional practice as well as avenues for future research into informal mindfulness practice.

Keywords: informal mindfulness practice, third wave, counselling psychologists, thematic analysis

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List of Abbreviations

ACT- Acceptance and Commitment Therapy

CBT- Cognitive Behavioural Therapy

DBT- Dialectical Behavioural Therapy

MBCT- Mindfulness-based Cognitive Therapy

MBSR- Mindfulness-based Stress Reduction

List of Appendices

Chapter 1: Introduction

This study centres on the experiences of informal mindfulness practice for therapists who both teach it and practice it daily in their own lives. This chapter opens with an overview of how mindfulness is defined and understood in the West and how certain constructs or practices of mindfulness from largely the Buddhist tradition have come to be progressively integrated into various therapeutic traditions in the West. One such therapeutic tradition is that of the 'third wave' as they have come to be known, which integrates various types of mindfulness techniques alongside other existing cognitive and behavioural techniques. In delivering these techniques, third wave therapists are expected to engage in some form of mindfulness practice in their own lives or have some personal engagement with the mindfulness techniques that form part of the therapy. These expectations and their implications are discussed in this chapter. This is followed by a thorough review of the current literature for outcomes of personal and professional mindfulness practice. The chapter concludes with a reflection on how this area of research is relevant for the practice of counselling psychology and an overview of the study's specific aim and objective.

1.1 Mindfulness: its definitions and practices in the West

This section provides an outline of how mindfulness is defined in the West and some of the issues that have arisen from our current understanding. It also explores the distinction between formal and informal mindfulness practices in the West.

1.1.1 Defining mindfulness

The practice of mindfulness has foundations in many spiritual traditions, but most notably in Buddhism. In the Buddhist language of Pali, mindfulness is referred to as *sati*, meaning "to remember" or to be aware that all things exist in relation to other things and thus only have relative value (Sharf, 1995).

Since entering the field of psychology, Kabat-Zinn's (1994) conceptualisation of mindfulness as "paying attention in a particular way: on purpose, in the present moment, and non-judgementally" (p. 4) is perhaps one of the most widely known and cited. This definition implies that mindfulness requires not only present moment attention but also for there to be a certain quality and intention of one's attention. This concept of attributing mindful attention or 'consciousness' with a certain quality is

upheld in Brown and Ryan's (2004) definition that being mindful is where one remains open and receptive to their awareness of events and experiences. Other definitions that appear in psychology or Western literature make reference to paying attention with a stance of flexibility and curiosity as well as with more compassion, acceptance, empathy and detachment and less judgement, worry and prejudice (e.g. Bishop et al., 2004; Dimidjian & Linehan, 2003; Harris, 2009; McCollum & Gehart, 2010; Sanders, 2010). Since mindfulness started appearing more prolifically in Western literature, there have also been a number of issues relating to how well mindfulness is defined and understood, particularly in the field of psychology. Some researchers (e.g. Dimidjian & Linehan, 2003; Davidson, 2010) point out that there isn't a clear operational definition of mindfulness that has led to much ambiguity about what mindfulness is and what it isn't, with it often being confused with subjectively similar strategies such as relaxation. Researchers have also noted that there is a limited shared vocabulary that adds to the difficulty of using language to clarify the different processes or capacities that the term mindfulness refers to, for example, it has been applied to a trait among long-term meditators, an attentional ability for those who have completed a mindfulness based course or a description of a state of mind that results from its practice and effects (Childs, 2007; Brown, Ryan & Creswell, 2007; Hayes & Wilson, 2003). Davidson (2010) notes that these issues are contemporaneous with the relative newness of mindfulness theory and research in Western therapy and are the subject of on-going research and conceptualisation. Another aspect of defining mindfulness concerns the nature of its practice as either formal or informal, which is explored as follows.

1.1.2 Formal and informal mindfulness practices in the West

Mindfulness practice is broadly conceptualised as either *formal* or *informal* (e.g. Batchelor, 1994; 1997; Kabat-Zinn, 1994).

Formal mindfulness is a practice of sustained and all-encompassing awareness of an object, such as the breath or a part of the body generally in the form of mindfulness meditation (Wolf & Serpa, 2015). It is usually done in a sitting or kneeling position or whilst walking with the meditator observing how one's world and self are constructed and connected in the present moment (Gunaratana, 2002). A person engaging in mindfulness meditation can move towards a non-reactive state of mind by simply noticing internal stimulus without becoming involved or attached to it.

Informal mindfulness practices generally involve bringing a quality of mindful attention to the sensory experience of partaking in everyday, single-task activities such as eating, cleaning, patting a pet, taking a shower or any other such activity. Thus informal practices generally do not take extra time, they can be done multiple times during the day when remembered and can be applied to various creative life contexts (Wolf & Serpa, 2015). The *intention* of bringing about detached observation to present moment experiences is considered to be the same in informal mindfulness practice as it is in formal mindfulness meditation, and therefore it is sometimes referred to as informal meditation (Weiss, 2004). However, the distinctive difference between informal and formal mindfulness is the greater degree of concentration on present moment thoughts and sensory experiences *to the exclusion of all else* in formal meditation compared to informal mindfulness where this concentration occurs whilst the person is engaged in other activities (Wolf & Serpa, 2015).

Buddhist theory stipulates that any type of mindfulness practice is based upon four foundations including mindfulness of body sensations, mindfulness of feelings in the moment, mindfulness of attention or state of mind and mindfulness of encounters between self and the world (McCown, Reibel & Micozzi, 2011). These foundations exist and are essential whether one practices mindfulness formally or informally. An example of a formal and an informal mindfulness exercise is shown in Appendix A.
Aspects of mindfulness theory and practice have been integrated in several psychotherapeutic traditions including humanistic, psychodynamic and existential therapies as early as the 1940's as outlined by Barker (2013). However one more recent branch of therapy that teaches formal and/or informal mindfulness skills as a key therapeutic intervention has come to be known as the *third wave therapies*. These are reviewed in the next section.

1.2 The 'Third Wave' therapies

Hayes (2004) coined the term '*third wave therapies'* to identify an emerging group of therapies that emphasized such issues as acceptance, mindfulness, dialectics, values, spirituality, and relationships. In this section is an account of how these third wave therapies evolved within the cognitive and behavioural therapy tradition as well as a theoretical and empirical backdrop to three dominant third wave therapies in the field.

1.2.1 How did the third wave therapies evolve?

Hayes (2004) conceptualised three “waves” within the cognitive and behavioural therapy tradition with the emergence of each new wave successively integrating aspects of the previous wave/s yet delineating distinctive shifts in the theory and techniques used.

The first wave developed in the 1950’s and were based upon the principles of operant and classical conditioning that relied almost solely on observing behavioural variables, predicting what behaviour would arise under particular circumstances and controlling or modifying behaviour using operant principles with the aim of improving psychological problems (Flaxman, Blackledge & Bond, 2011). As a result, a number of brief exposure-based behavioural therapies were developed and found to be particularly effective for the treatment of anxiety and a number of developmental disabilities (Flaxman, Blackledge & Bond, 2011). However these behavioural therapies were found to be rather lacking in the treatment of depression and some theorists began to recognise the need to deal with thoughts and emotions in a more direct way as noted by Rachman (1997).

Thus the second wave therapies begun to grow in the 1960’s and were largely driven by the work of Aaron Beck and the development of cognitive behavioural therapy (CBT), which assimilated cognitive therapy alongside existing behavioural interventions. Specifically, CBT placed cognitions or “automatic thoughts” at the forefront for understanding emotional reactions and placed a chief focus on disputing and changing irrational thoughts (Jennings & Apsche, 2014). Over time, CBT has also become subject to criticism based upon anomalies between the empirical outcomes and theory of CBT. For examples, studies had begun to emerge that showed cognitive interventions added no extra benefit to behavioural therapy or behavioural activation for people with depression (e.g. Hollon, 2001; Dobson & Khatri, 2000). Also cognitive behavioural therapies were commonly being seen as wooden or overly- mechanistic and neglecting to treat the client as a whole person by relying on the assumption that changing a person’s thoughts could be sufficient to bring about emotional and behavioural change (Gaudiano, 2008).

According to Hayes (2004), the third wave began to emerge in the early 1990s with the integration of mindfulness and acceptance approaches together with behavioural and cognitive techniques from the preceding two waves. One of the distinguishing features

of the third wave compared to the first two waves is that third wave therapies attempt to change the *relationship* individuals have with their psychological events rather than trying to change the psychological event itself or paying too much attention to how valid the event is (Hayes, Strosahl & Wilson, 2012). The focus is also on cultivating a certain attitude such as acceptance or kindness towards inner experiences rather than trying to eliminate or diminish them (Baer, 2003). Third wave therapies also focus on the function of psychological experiences within specific contexts and thus are also commonly referred to as contextual behavioural therapies (Hayes, Villatte, Levin & Hildebrandt, 2011). As with the previous two waves, third wave therapies and the integration of mindfulness into the therapeutic arena has also caused concern or caution from some researchers. For example, Dimidjian and Linehan (2003) stated that extracting mindfulness from its spiritual context could actually reduce its full potency when applied as a therapeutic technique or a treatment in a medicalised sense. Similarly, Brazier (2013) highlighted the need for caution in over-popularising mindfulness in the West suggesting that this may lead to "overly grand claims" made of mindfulness that lack the sophisticated understanding and philosophy of suffering as found in the Buddhist traditions.

Hayes' (2004) entire conceptualisation of third wave therapies and how they developed has also given rise to several debates in the field. For example, some theorists suggest that the rapid popularity of the third wave therapies was at least in part due to the growing disenchantment with traditional CBT techniques (e.g. Jennings and Apsche, 2014). Other theorists disagree with this view and state that third wave therapies emerged in their own right and based upon strong theoretical foundations and not as a reaction to paradigm shifts in the field of cognitive therapy (e.g. Larmar, Wiatrowski & Lewis-Driver, 2014). Theorists have also questioned whether third wave therapies are simply an enriched form of the second wave cognitive therapies, whether the techniques used in the third wave differ significantly enough from the techniques used in the cognitive approach and whether they add incremental value in accordance to the paradigm shift they are meant to represent (e.g. Corrigan, 2001; Hoffman & Asmundson, 2008; Herbert & Forman, 2011). On the other hand, some theorists are more inclined to identify the connections across the waves. For example, Dozois and Beck (2011) point out that whilst third wave approaches may hold different philosophical assumptions to CBT, they are largely compatible with and complementary to CBT and it is just the emphasis and balance of change and acceptance strategies that varies across these waves. Also other theorists propose that mindfulness therapies are essentially CBT therapies "with a heart" indicating that the

mindfulness approach of the third wave therapies adds a more human and compassionate quality to existing cognitive behavioural therapy techniques (Dunkley & Loewenthal, 2013; Germer, 2005a; Martin, 1997; 2002)

Against the backdrop of these debates there has been a proliferation of a heterogeneous group of third wave therapies based upon a rapidly mounting evidence base (Kahl, Winter, & Schweiger, 2012). To date, the main third wave therapies identified or therapies considered to include key characteristics of the third wave include Mindfulness-Based Cognitive Therapy (MBCT), Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Cognitive Behavioural Analysis System of Psychotherapy (CBASP), Behavioural Activation (BA), Functional Analytic Psychotherapy (FAP), Integrative Behavioural Couple Therapy (IBCT) and Metacognitive Therapy (MCT) amongst others. Germer (2005a) identified these therapies as either mindfulness-based or mindfulness-informed therapies; the former indicates that the foundation of the therapy is based upon mindfulness practices such as mindfulness meditation whilst the latter represents the therapies that incorporate informal and/or formal mindfulness practices into their treatment approach.

In this study, I chose to focus on the practice of informal mindfulness within MBCT, DBT and ACT for a number of reasons. Firstly, these therapies represent three of the most widely disseminated and empirically supported third wave therapies as identified in a number of literature reviews (e.g. Kahl, Winter & Schweiger, 2012; Ost, 2008; Hayes, Masuda, Bissett, Luoma & Guerrero, 2004). On this basis, I considered that the prevalence of these therapies would make it relatively straightforward to access these therapists. Secondly, these three third wave therapies assimilate informal as well as formal mindfulness practices with varying emphasis depending upon their theoretical underpinnings, thus I assumed that therapists would have a sound understanding of how informal mindfulness differs from mindfulness meditation and could reflect on these differences. Thirdly, there is a professional expectation for therapists of each of these third wave therapies to engage, at the very least, in informal mindfulness skills in their own lives to support the effective teaching of mindfulness in their therapeutic approach. On this basis I considered that MBCT, ACT and DBT therapists would have a spectrum of personal and professional experiences of informal mindfulness practices to reflect upon. And lastly, from a more personal perspective, MBCT, DBT and ACT are the three therapies that I have most knowledge of and/or experience of delivering, which I considered would be helpful in enhancing my ability to extract depth and richness in the interview process.

A theoretical and brief empirical review of these three therapies now follows.

1.2.2 Overview of Mindfulness based Cognitive Therapy (MBCT)

Segal, Williams & Teasdale (2002) developed the MBCT program based on the existing Mindfulness-Based Stress Reduction program (MBSR; Kabat-Zinn, 1979) that was initially developed as an intervention to help patients cope with pain and chronic illness using a combination of mind and body techniques. Segal, Williams & Teasdale (2002) combined the 8-week structure and core mindfulness practices of MBSR with aspects of cognitive therapy to develop a manualised curriculum for MBCT. Unlike MBSR, MBCT was targeted more specifically for clinical populations and in particular to prevent relapse in patients with severe and recurring histories of depression (Crane, 2009).

The mindfulness practice of MBCT relies heavily on formal mindfulness meditation as well as informal mindfulness techniques to develop attentional control skills and cultivate non-judgemental awareness and acceptance of all experiences. The cognitive therapy aspect predominantly involves the ability to decentre oneself from negative thoughts in order to facilitate detachment from these inner experiences, for example, 'I am not my thoughts', (Baer, 2003). In all MBCT techniques, participants are encouraged to reign in their awareness of their body by drawing upon all their senses (e.g. sight, smell, touch, taste) and to draw awareness to their emotions in order to reveal their impermanent nature and to bring an attitude of acceptance and curiosity to all that arises (Crane, 2009; Mardula, 2009). Teasdale (1999) also highlighted the importance of metacognitive insight in the prevention of depression, which refers to the actual experience of recognising that thoughts are transient events in the mind as opposed to metacognitive knowledge, which is merely the factual understanding that thoughts are not reality. This is contrasted to the doing mode in which the person spends more time thinking about what needs to be done and can lead one towards experiential avoidance of difficult material that the person wishes not to come in contact with, which serves to add to their struggle (Crane, 2009).

In terms of empirical support, the most outstanding outcome is that MBCT has been found to be effective in relapse prevention for patients in remission who have had three or more previous episodes of major depression (Segal, Williams & Teasdale 2002; Ma & Teasdale, 2004; Piet & Hougaard, 2011). Subsequent research has also shown how MBCT can be adapted for chronic fatigue syndrome (Surawy, Roberts & Silver, 2005),

oncology (Ingram, 2005), treatment resistant depression (Kenny & Williams, 2007) and residual depressive symptoms (Kingston, Dooley, Bates, Lawlor & Malone, 2007).

1.2.3 Overview of Dialectical Behavioural Therapy (DBT)

Linehan (1993a, 1993b) developed DBT as a treatment for chronically suicidal women who also showed some symptoms of borderline personality disorder (BPD). It is based upon a yearlong, multi-modal program that incorporates weekly individual therapy sessions as well as group based training with the addition of individual skills coaching by telephone when it is needed by patients (Mardula, 2009). DBT developed as a mindfulness intervention independently of MBSR and aimed to synthesize change-based strategies from CBT with acceptance-based strategies from the eastern and contemplative traditions, most specifically from Zen Buddhism that emphasises radical acceptance of the moment (Swales & Heard, 2009).

Dialectical philosophy underpins DBT, which posits that reality consists of opposing forces and synthesizing these forces can result in a different reality that yet again will contain opposing forces and thus propagates a continual process of change (Baer, 2003). The most fundamental of these dialectic forces in DBT is represented by the change and acceptance interface and it is thought that the adoption of both approaches can be more validating for aspects of client's lives that are intolerable and that the mindful acceptance of reality can lead to positive change in the patient's life as much as direct change strategies and consequently reduce suicidal and parasuicidal behaviour (McCown, Reibel & Micozzi, 2011).

Linehan (2001) stresses the importance of having a community even when practicing mindfulness in a clinical setting and thus DBT tends to takes place in a group format both for clients and for therapists with mindfulness skills being taught in a more didactic way than in MBCT. Linehan recognised that many client populations who use DBT would struggle to adhere to extended formal mindfulness practices and thus mindfulness in DBT is instead taught as a set of skills through structured exercises that include informal mindfulness and body scan practices (Swales & Heard, 2009).
One of the primary skills is the development of 'wise mind', which results from the integration of emotion mind and logical mind. DBT also incorporates other mindfulness based skills that are classified as either 'what' skills (i.e. what one does to be mindful) or 'how' skills (i.e. how the 'what' skills are carried out). The 'what' skills include observing the present moment, describing present moment experiences and

participating fully in present moment experiences. The 'how' skills include non-judgementally accepting the experience and the judgement of the experience and attending to one thing mindfully and effectively in any given moment.

Some of the main research findings for DBT support its efficacy and even superiority in the treatment for patients with a diagnosis of BPD and parasuicidal behaviour (e.g. Linehan, Armstrong, Suarez, Allman & Heard, 1991; Linehan, Tutek, Heard & Armstrong, 1994; Koons, Robins, Tweed, Lynch et al., 2001). Other areas in which studies have demonstrated the effectiveness of DBT include substance use for women (Dimeff & Linehan, 2008), binge eating disorder (Telch, Agras & Linehan, 2001), comorbid depression and personality disorders in older adults (Lynch, Morse, Mendelson & Robins, 2003) and depression and anxiety for men and women with BPD (Clarkin, Levy, Lenzenweger & Kernberg, 2007).

1.2.4 Overview of Acceptance and Commitment Therapy (ACT)

ACT was developed by Hayes and his colleagues and is perhaps closest to the first wave in terms of its theoretical foundations in behavioural analysis however unlike behavioural therapy, ACT emphasizes the importance of behavioural and psychological flexibility and overcoming experiential avoidance in the presence of unpleasant emotions or thoughts in order to live according to one's life values (Hayes, 2004). ACT was originally designed as a short-term therapy similar to CBT, but can also be used effectively in-group formats (Flaxman, Blackledge & Bond, 2011).

ACT is embedded within a philosophy of science known as functional contextualism, which emphasizes the importance of predicting and influencing psychological events (e.g. thoughts, feelings, and behaviors) by manipulating variables in their context and thus referred to in the field as a contextual behavioural science (Herbert & Forman, 2011). This philosophical science has its basis in a theory of language known as relational frame theory (RFT), which underpins the contextual application of ACT. RFT proposes that suffering arises when people become embedded in the language or verbalisation of their problems, which can lead to psychological rigidity, cognitive fusion and experiential avoidance (Hayes, Barnes-Holmes, & Roche, 2001). Cognitive fusion refers to the experience of becoming inextricably linked to a thought in one's mind through the language used to describe a perceived problem, which is thought to perpetuate experiential avoidance that can be defined as the maladaptive strategies that one consistently uses to escape inner and outer events that elicit distress (Hayes,

Strosahl & Wilson, 1999). The traditional ACT model referred to as the 'hexaflex' proposes six core processes within which mindfulness is a key skill that is interwoven across each process to help clients to distance from and observe their thoughts and to undermine the influence of verbal networks (Fletcher & Hayes, 2005). The six processes are as follows; '*Acceptance*' processes aim to demonstrate the futility of avoidance or control strategies and also to create opportunities for action; '*Defusion*' processes focus on distancing the thinker from their inner experiences; '*Contact with the present moment'* processes attempt to bring peoples' awareness back to their experiences of life in the here-and-now; '*Self as context*' processes attempt to demonstrate that people tend to fuse with ideas that are based on what they hear most frequently about themselves; *'Values'* processes focus on clarifying the aspects of life that hold most meaning to people; and *'Committed action'* processes aim to establish a pattern of behaviour that helps one to align with their life values (Hayes, Strosahl & Wilson, 1999).

Two of the initial RCTs that supported the efficacy of ACT in its earlier form tested its efficacy for depressed women (i.e. Zettle & Hayes, 1986; Zettle & Rains, 1989). In more recent years RCTs have investigated ACT for a number of clinical and non-clinical problems including chronic pain, (Vowles, McNeil, Gross, McDaniel, Mouse, Bates, Gallimore, & McCall, 2007), anxiety and mood disorders (Forman, Herbert, Moitra, Yeomans & Geller, 2007), depression (Bohlmeijer, Fledderus, Rokx & Pieterse, 2011), psychosis (Bach & Hayes, 2002) and workplace stress (Dahl, Wilson & Nilsson, 2004).

1.3 Exploring the role of mindfulness practice in the lives of third wave therapists

The developers of each of these three third wave therapies recommend that therapists practice some form of formal and/or informal mindfulness practice in their own lives in order to cultivate the qualities of mindfulness and successfully teach mindfulness principles to others (Hayes, 2004; Segal, Williams & Teasdale, 2002; Linehan, 2001). These recommendations are explored in this section.

1.3.1 What are the specific recommendations for practicing mindfulness for MBCT, DBT and ACT therapists?

The stance in respect to the personal mindfulness practices of MBCT is perhaps best exemplified by Segal, Williams & Teasdale (2002) who strongly advocated the critical

importance for teachers of MBCT to have a regular practice of formal mindfulness meditation in order to competently deliver the approach. Whilst this poses a significant personal commitment for MBCT therapists it was largely based on the developers' own failed attempts to teach mindfulness without a personal practice themselves (McCown, Reibel & Micozzi, 2011). MBCT practitioners are also encouraged to engage in informal mindfulness practice in their day-to-day lives.

Unlike MBCT, Linehan (2001) proposes that DBT practitioners are not required to partake in formal mindfulness practice in their daily lives stating that the decision to maintain a personal practice is indeed a 'personal' decision that falls beyond the boundaries of the therapeutic model. Instead, Linehan (2001) recommends that DBT practitioners should gain experiential knowledge of mindfulness through informal practice in context of DBT skills. Linehan (2001) also recommended that occasional formal meditation practice be built into therapists' weekly program, for example, through short mindful meditations at the beginning of each weekly team meeting. Furthermore, Dimidjian and Linehan (2003) stated that DBT therapists would benefit from having close personal contact with mindfulness teachings through a community of fellow practitioners (i.e. clinical consultation teams) or a spiritual teacher in a similar way to the Zen tradition.

Similar to DBT, ACT does not expect its practitioners to have a mindfulness meditation practice in their personal life nor is it a direct recommendation in their professional practice. Harris (2009) pointed out that ACT therapy may or may not include explicit mindfulness meditation practices as it tends to view meditation as one of many methods for developing practical mindfulness skills. Strosahl et al. (2004) highlighted that a core competence for an ACT therapist is their ability to get in contact with the present moment. In order to develop this capacity, an ACT therapist is encouraged to extract principles from the meditative experience and practice them in context of present moment ACT techniques in order to enhance psychological flexibility in their own lives (Harris, 2009; Hayes, 2004).

This outline demonstrates that the suggestions made for formal and/or informal mindfulness practice in therapists' own lives are largely driven by the theoretical underpinnings and therapeutic goals of each third wave therapy. Thus MBCT therapists have the greatest expectation to engage in regular formal meditation and to support this practice with informal mindfulness on a day-to-day basis. It is suggested that DBT therapists practice mindfulness meditation occasionally within a teaching community,

however that they also practice DBT skills incorporating informal mindfulness on a regular basis. Whereas for ACT therapists there are no explicit expectations to practice meditation but it is recommended that therapists practice ACT techniques themselves, which employ informal and formal mindfulness techniques to cultivate present moment awareness and psychological flexibility.

1.3.2 What are the personal and professional implications of adhering to these recommendations?

The existence of these recommendations for mindfulness practice suggests an extension of the more traditional roles and responsibilities of a therapist that transcend the professional sphere and enter a more personal domain.
Furthermore, it could be seen that the personal qualities or skills of the third wave therapist have much greater bearing on professional effectiveness than what is typically seen for other behavioural therapists. For example, CBT therapists would not be expected to practice CBT techniques such as thought diaries or behavioural experiments themselves in order to be seen as effective in teaching CBT.
Thus it is not altogether surprising that much of the literature states that mindfulness cannot be effectively taught to others if the teacher lacks personal experience or understanding of mindfulness him/herself. For example, Dunkley and Lowenthal (2013) state that a therapists' personal practice of mindfulness is essential in teaching mindfulness *in any way* to clients in order to be able to adequately understand the principles and thus effectively teach these principles correctly. Other theorists propose that therapists who do not practice mindfulness may potentially be less effective in dealing with clients' struggles with mindfulness or be lacking in appreciation for their clients' efforts and difficulties in acquiring mindfulness skill (e.g. Lau & McMain, 2005; Hayes, 2004; Dimidjian & Linehan, 2003). It has also been noted that therapists have an ethical responsibility to ensure that their clients' impression of mindfulness can be experienced not only through words but also in the therapists' *being* in the room (Mardula, 2009). A similar point was made by Barker (2013) who inferred that without nurturing mindful qualities within themselves, therapists could compromise the likelihood of mindful encounters in the room with the client and thus not provide the same learning environment as therapists who do practice.

Despite the broad acknowledgment for the importance of mindfulness practice for therapists who deliver mindfulness therapies, a couple of key issues exist. Most notably, for many third wave therapists and MBCT therapists in particular, it may be a

difficult and possibly daunting commitment to set aside time in their personal life to meditate regularly (Crane, 2009). Harris (2009) highlighted that practicing mindfulness meditation could be compared to going to the gym i.e. people know that it's good for them but can often struggle to sustain it regularly in the long term. Thus for MBCT therapists, it is probable that they would be subject to some concern in their professional community if they did not practice mindfulness meditation as regularly as expected of them in their own lives. The other issue relates to the relative lack of status that informal mindfulness practices hold compared to more formal meditation, despite it being the common denominator across the third wave therapies. Whilst guidance on informal mindfulness techniques or short informal meditations appear to be gaining rapid popularity on mainstream mindfulness websites (e.g. www.mindful.org) and readily acknowledge that mindfulness can be cultivated *without* formal meditation (e.g. Boyes, 2013; Wegela, 2010), unfortunately this same popularity has not been observed in the scientific and academic realm. To date, the bulk of the literature on informal mindfulness is still rather lacking or ambiguous and tends to conceptualise its practices as a supplement to mindfulness meditation rather than as a valuable stand alone practice for developing and embodying mindfulness qualities. Kabat-Zinn (1990) also stressed that informal practice cannot replace mindfulness meditation as it can be easily neglected and thus lose its ability to nurture mindful qualities, however there hasn't been much systematic exploration of what informal practice could cultivate if it was nurtured rather than neglected. A related shortcoming is that there is greater difficulty in measuring or quantifying informal practices as they tend not to have set duration or structure in the same way as formal meditation does (Crane et al., 2014).

Thus formal mindfulness meditation is generally seen to be the exemplar of mindfulness practice (e.g. Boyes, 2013; Bermingham, 2015) and the ubiquitous image of people sitting serenely in the cross-legged, lotus position with their eyes closed and their thumbs and index fingers poised in a *mudras* (hand gestures used in meditation) on each folded knee, has very likely come to represent the cultural norm of mindfulness. Considering this, we now turn to the existing literature base to shed some light on what is currently known about the personal and professional outcomes of mindfulness practice. The following section presents a critical review of the relevant evidence that has been found to date.

1.4 Empirical review of the outcomes of having a mindfulness practice

The online City University Library catalogue was used to conduct a literature search of existing outcomes for mindfulness practice from a number of databases including PsycArticles, PsycINFO, PsycTHERAPY and PubMed. As expected, a voluminous amount of empirical data was retrieved and was subsequently narrowed to include the studies that were most relevant to the current research area. The inclusion criteria was that the study was written or translated in English and presented either quantitatively or qualitatively at least one outcome of short and/or long term mindfulness practice in any form i.e. formal and/or informal with general population samples. Thus the current review excluded any study that focussed exclusively on measures of trait mindfulness or neuropsychological outcomes *only*, studies that offered outcomes of mindfulness as part of a treatment package and studies that demonstrated outcomes of mindfulness for very specific and/or clinical physical or psychological health issues.

As my study focuses on both the personal and professional experiences of mindfulness practice, I organised the findings of my review largely into two sub-sections; the first subsection reviews all relevant studies that explore the personal and/or interpersonal outcomes of mindfulness practice across several domains and the second subsection reviews all relevant studies that explore the professional or therapeutic outcomes of mindfulness practice also across several domains. Some of these studies have been included in various reviews (e.g. Davis & Hayes, 2011; Escuriex, & Labbe, 2011; Shapiro & Carlson, 2009, Brown, Ryan & Creswell, 2007; Grossman, Niemann, Schmidt & Walach, 2004), however a number of studies have not been included in any major reviews to date. This review offers a summary of outcomes as well as a critique of how the studies in each domain limit what is known about the outcomes of mindfulness practice relevant to this study.

1.4.1 Empirical review of personal or interpersonal outcomes of mindfulness practice

Through the process of reviewing the literature, there were three key domains that I identified as representing the main personal or interpersonal outcomes for mindfulness practice. These included: (1) enhanced attention and memory capacity; (2) increases in positive affect and wellbeing and reductions in negative affect, emotional reactivity and stress and (3) improved interpersonal relationships. Although some of the studies produced outcomes that overlapped more than one domain, the outcomes of each

study were reviewed in the domain that represented the most dominant outcome so as to avoid repetition.

1.4.1.1 Enhanced attention and memory capacity

Chambers, Lo and Allen (2008) carried out a quantitative study in which twenty participants from the general population who attended an intensive ten day mindfulness meditation retreat were compared with a wait list control group on measures of attention, cognitive style and affect. Their findings were that the meditation group had significantly better working memory capacity and improved ability to sustain attention than the control group. Also the meditation group had significantly higher self-report mindfulness scores, decreased negative affect, fewer depressive symptoms and less rumination compared to the control group. There were several methodological limitations to this study, which included the fact that it was not a truly randomized study therefore it was possible that some participants in the retreat group had certain unmeasured and biasing characteristics in favour of higher levels of mindfulness. Also researchers were reliant only on self-report measures for both groups. The findings were also based on a relatively small sample size of participants who only had short term exposure to mindfulness meditation and may have reported outcomes based on other non-specific factors, for example, enjoying being on a retreat, being in nature or feeling a sense of community at the retreat.

Another quantitative study that used a control group of non-meditators but only focussed on the outcomes of a relatively short-term meditation intervention, was led by Jha and colleagues (2010). These researchers examined the protective effects of mindfulness training on working memory capacity and affective experience in military servicemen returning from service and compared the outcomes to a control group who did not attend the course. The treatment group attended an 8-week mindfulness meditation course and recorded how much formal mindfulness practice they practiced outside of class. Their findings from pre- and post- measures showed significantly greater working memory capacity and more positive affective experiences in the servicemen who attended the mindfulness training course compared to the control group. The researchers concluded that mindfulness meditation could potentially protect the working memory of those in highly stressful situations when it might otherwise fail thereby reducing the chances of cognitive or emotional impairment.

As opposed to examining the outcomes of a short-term meditation intervention, Moore and Malinowski (2009) used an attentional endurance test to investigate attentional abilities and cognitive flexibility in a group of long term mindfulness meditators compared to a non-meditating control group who reported no mindfulness experience. Their results showed that the meditation group demonstrated significantly better performance on measures of attention and also self-reported higher levels of mindfulness. It was found that mindfulness meditation practice and self-reported mindfulness were also correlated with measures of cognitive flexibility and enhanced attentional functioning. This study revealed more about the effects of long term mindfulness practice but was limited in not being clear about how the control group of participants was determined and whether “mindfulness experience” was determined purely based on meditation experience or whether informal mindfulness practices were taken into consideration.

And a quantitative and neuropsychological study conducted by Pagnoni and Clarke (2007) also compared long term, experienced mindfulness meditators with age matched non-meditator control participants on attention performance and grey matter volume in brain regions devoted to attention. Their findings showed greater attentional performance in the meditators compared to the non-meditator control participants however also found that the control group had an age-related reduction in their grey matter volume compared to the participants who meditated. This outcome was similar to that of an earlier neuroscientific study conducted by Lazar, Kerr, Wasserman, Gray, Greve & Treadway et al. (2005) that showed that long term practitioners of mindful meditation had the most grey matter in brain regions associated with attention and sensory processing compared to a matched control group. This study yielded interesting results for how mindfulness meditation may enhance attentional functioning and change the brain, however the researchers pointed out though that theirs was a correlational study and therefore could not imply causation and that meditators may have different brain structures to non-meditators to start off with. Also the study again focussed on the how mindfulness meditation alone rather than other forms of mindfulness can affect attention performance.

All the studies in this section were quantitative in nature and focussed on the outcome of only short term or long-term meditation. Also a few of the studies relied on outcomes from participants who had very limited experience of mindfulness i.e. following a short course or a retreat.

1.4.1.2 Increases in positive affect and wellbeing and reductions in negative affect, emotional reactivity and stress

Carmody and Baer (2008) explored the relationship between mindfulness meditation experience, levels of mindfulness, psychological adjustment, perceived stress and psychological wellbeing in a large non-clinical sample. The participants took part in an 8-week MBSR program and engaged in home practice throughout the intervention. Results on pre- and post- measures demonstrated increased scores for mindfulness and psychological wellbeing and decreased scores for stress. The researchers also concluded that practicing mindfulness meditation leads to increases in mindfulness that can in turn result in stress reduction and improved wellbeing.
This study however only focused on the outcomes of participation in a short-term mindfulness meditation program without follow up measures and thus it doesn't indicate anything about the longer term effects of regular mindfulness practice in any form.

Another quantitative study that also focussed only on the outcomes of short term mindfulness meditation without follow up data was conducted by Schroevers and Brandsma (2010) who wished to investigate whether affect can be improved for a non-clinical sample of participants following participation in a MBCT training course. They found that participants reported a decrease in negative affect but also an increase in positive affect alongside an increased awareness of their everyday activities, an improvement in their observation and attendance to experiences and also a greater acceptance towards those experiences. Mindfulness training and skills were also seen to improve psychological well- being. This was the first study to show that participants were more able to disengage from unpleasant experiences and identify less with unpleasant emotions however the results did not suggest that participants were more inclined to approach these negative thoughts and emotions with openness and curiosity. The methodological weaknesses were that there was no control group, which limits its ability to determine causal factors in the intervention. Shapiro and Carlson (2009) also noted that as the sample consisted of all highly educated participants that limited how results could be generalised to the wider population.

Deviating somewhat from the previous two studies was a quantitative study carried out by Lykins and Baer (2009) who investigated the effect of mindfulness meditation in longer term rather than short-term meditators. The researchers used self-report

measures to compare the meditators against a matched comparison group of non-meditators on constructs expected to be related to mindfulness meditation. They found that the practice of mindfulness meditation was associated with decreased rumination, decreased fear of emotion, increased mindfulness in daily life and increased self-regulation of behaviours, which fell in line with their hypothesis. Specifically for long-term meditators they found higher scores for self-reflection, self-compassion and psychological wellbeing and lower scores on cognitive disturbances, rumination, thought suppression and difficulties with emotional regulation compared to the control group. The researchers highlighted that as it wasn't a longitudinal study the order of these effects couldn't be determined and as the results relied on self- report measures, the meditators could have been biased in terms of reporting the positive effects of their meditation.

Ortner, Kilner and Zelazo (2007) also carried out a quantitative study that compared long-term mindfulness meditators with non-meditators on emotional reactivity and attentional control in different emotional settings. They conducted two studies measuring reaction times to pleasant, unpleasant or neutral pictures with longer reaction times indicating greater levels of interference. Their results suggested that long-term mindfulness meditation practice might reduce prolonged reactivity to emotionally unpleasant material and allow a person's attention to be more centred on present moment cognitive tasks. Also the long term meditators reported higher levels of psychological well-being than non-meditators. This study however only focussed on the attentional differences in those who practiced formal mindfulness meditation and did not use a control group to determine reaction times to those who didn't practice meditation or practiced it infrequently.

A more recent observational study conducted by Jacobs, Shaver, Epel, Zanesco, Aichele, Bridwell et al. (2013) had the same limitation as the first two studies in terms of focusing on the outcomes of a relatively short-term mindfulness meditation retreat. However unlike any of the previous studies, these researchers aimed to use a physiological marker to investigate the link between self-reported mindfulness and resting cortisol release, which can be prolonged when a person engages in ongoing worry and rumination. Participants from the general population (n=57) attended a three- month meditation retreat where they were taught mindfulness skills and how to cultivate an observing and compassionate mind. Pre and post the retreat, the participant' self reported mindfulness levels were rated on a scale and their cortisol levels were measured with a saliva test. The researchers found that participants had

higher self-report mindfulness scores following the retreat compared to before and also found a link between increases in mindfulness and reductions in cortisol levels.
The main methodological weakness was that the study did not employ a control group to ascertain a comparison of cortisol levels, which undermined any inferences the researchers could make about causality. They also didn't provide any follow up data on the longer-term effects on cortisol levels.

Hanley, Warner, Dehili, Canto and Garland (2014) conducted the only study that could be found that investigated the effects of washing dishes as an informal contemplative practice on states of mindfulness, attentional awareness and affect.
They sampled college students (n=51) in both the mindful and control conditions with participants in the mindful condition having to read a passage that highlighted the sensory experience of dishwashing and the participants in the control condition reading a passage on good dish washing technique. The participants had to provide their interpretations of the passage both verbally and in writing before washing 18 clean dishes. All participants completed measures of personality traits, mindful states, affect, well-being and experiential recall before and after the dishwashing activity. Hanley and colleagues found that participants in the mindful washing condition experienced statistically significant increases in positive affect or mental inspiration by 25% and decreases in negative effect or nervousness by 27% on the pre and post measures. The researchers noted that these results reflected a notable experiential shift compared to the control participants where there was no change on the measures. In terms of limitations, the researchers highlighted that it was not clear whether washing dirty dishes in a more natural setting with noise and competing demands would yield the same outcomes. Also this study focussed on the outcomes of a single informal mindfulness intervention and thus doesn't expand what is known about long term, regular informal mindfulness.

Most of the studies in this section offered only quantitative outcomes and relied on the results or self-reported outcomes of either short-term or long-term mindfulness meditation, rather than on informal mindfulness. The only study that specifically focussed on an informal mindfulness practice was also a short intervention for students and thus didn't provide any insight into the longer-term effects of informal mindfulness for more experienced mindfulness therapists.

1.4.1.3 Improved interpersonal relationships

Carson, Carson, Gil and Baucom (2004) conducted a randomized, mixed-method study to evaluate the effects of a mindfulness-based relationship enhancement program. This program was developed to enrich the relationships of couples using practices of loving-kindness, compassion and connectedness and was measured quantitatively on various measures of mindfulness and related mindfulness constructs and qualitatively using analysis of diary entries. The results showed that the couples experienced significant improvements in relationship satisfaction and greater relatedness, closeness and acceptance of one another. Also measures of relationship distress were attenuated. Individual measures indicated that the program had beneficial effects on participants' optimism, spirituality and relaxation and reduced overall psychological distress. These benefits to the individuals and couples were maintained at 3-month follow up. The results from participants' diary analysis showed that greater mindfulness practice on any given day was related to improved levels of relationship happiness and coping with stress. One limitation of this study identified was that the positive effects of mindfulness practice could have also been due to other non-specific factors such as spending quality time with their partner during the short-term mindfulness intervention. Also the use of diaries in this study didn't necessarily indicate the nature of the at-home mindfulness practice and could have provided participants with a purposeful and meaningful activity that in itself may have helped participants to cope with stress.

A qualitative study using grounded theory analysis by Bihari & Mullan (2012) found that a course of MBCT brought about significant changes in the relationships of their participants. Their core finding was that participants reported that MBCT taught them how to relate mindfully to their own experiences, in particular how to become more aware of their tendency to react to distressing interpersonal situations and instead 'respond mindfully'. Participants also reported that mindfulness produced profound changes in their relationships with others and allowed them to avoid repeating painful patterns. Other outcomes included an increased ability to remain present with distress, improved communication, increased empathy and facilitated more constructive rather than frustrating arguments. However this study only showed how participation in a short-term meditation based mindfulness program could produce positive changes to interpersonal relationships rather than longer-term informal mindfulness practice.

The studies presented here offer further qualitative outcomes that evidence the positive effect mindfulness has on interpersonal relationships, both for couples and for individuals within a relationship. However similar to most of the previous studies, the outcomes were only based upon short-term mindfulness meditation interventions.

1.4.2 Empirical review of professional or therapeutic outcomes of mindfulness practice

In the process of reviewing the literature I identified four key domains that represented the main professional or therapeutic outcomes for mindfulness practice. These included: (1) therapeutic presence and mindful awareness; (2) empathy and compassion for client and self; (3) therapist self-care and resistance to burnout; and (4) effect on client outcomes and perceptions. Again, as some of the studies produced outcomes that overlapped more than one domain, the outcomes of each study were reviewed in the domain that represented the most dominant outcome so as to avoid repetition.

1.4.2.1Therapeutic presence and mindful awareness

Nanda (2005) conducted a qualitative study exploring the therapeutic outcomes of mindfulness meditation with eight therapists who hailed from different psychotherapeutic backgrounds including existential, dynamic and integrative therapy. Using a phenomenological, semi-structured interview approach, Nanda (2005) found that therapists who regularly practiced mindfulness meditation in their own lives felt more present and aware of what was emerging in the therapy room, felt a greater capacity to be present with their clients' pain, took a more accepting and non-judgemental attitude towards their clients and were more willing to let go of their personal agendas in the therapy room, compared to before they started practicing mindfulness. Other results were that these therapists reported an overall transformational change in their interactions with clients such that mindfulness meditation led to greater empathy, compassion and openness in all interactions.

A similar, small-scale qualitative piece of research was carried out by Bazzano (2010) who explored the therapeutic outcomes of long-term, mindfulness meditation with four person-centred therapists. Using thematic analysis, Bazzano (2010) found that these therapists reported being more inclined to be present for both pleasurable and difficult experiences with an attitude of curiosity and compassion and also felt less compelled to jump in to rescue clients. In addition, his interviewees stated that their mindfulness was reflected in the quality of the therapeutic relationship i.e. more unconditional, non-judgemental, open and embodied. Both Bazzano's (2010) and Nanda's (2005) studies were limited in related ways, mainly in terms of focussing only on the therapeutic outcomes of mindfulness meditation and not including informal or even mixed

mindfulness practices in their exploration. And although the therapists of both studies were trained and experienced, they didn't necessarily teach mindfulness to their clients and did not have a professional expectation to practice mindfulness in their lives.

One qualitative study carried out by Cigollo and Brown (2011) addressed at least one of those limitations in terms of exploring the therapeutic experiences of various psychotherapists who practiced regular mindfulness as either regular meditation and/or regular informal practices. A central theme that emerged was that their mindfulness practice of any kind brought about a '*being*' presence in the therapy room either overtly or in subtle ways. Participants also noticed positive changes in attention and in their levels of awareness of self, clients and relational processes. They also reported that mindfulness encouraged greater affect tolerance, metacognitive insight and qualities such as non-judgemental acceptance, openness, curiosity and compassion towards their clients. Based on these results, the researchers suggest that regular mindfulness practice can help therapists to internalise the benefits of mindfulness and enhance their capacity to relate to themselves and their clients. Whilst this study included therapists who did not necessarily engage in formal meditation, the study focussed on mindfulness as a general construct and thus the results reflected outcomes that arose from regular meditation in addition to informal mindfulness. On this basis it could not be determined what particular influence informal mindfulness had on the outcomes. Also the psychotherapists interviewed did not necessarily deliver mindfulness interventions to their clients so nothing could be revealed about the professional or therapeutic experiences of teaching mindfulness for these therapists. And lastly, this study only focussed on the therapeutic rather than the personal experiences of mindfulness practice.

Two other studies in this domain explored the outcomes of relatively short-term mindfulness meditation courses and thus were also limited by the lack of attention to longer term, informal mindfulness practices. The first was a qualitative study carried out by McCollum and Gehart (2010) who looked at how a course in mindfulness meditation could affect therapeutic presence and the ability to teach mindfulness to clients. The researchers conducted a thematic analysis of journal entries with Masters level counselling students (n=13) who and found a number of key themes. These included being better able to attend to inner experience, being aware of what happens with clients and acting with awareness rather than reaction, feeling calmer, managing inner chatter, shifting doing mode to more balanced being mode and developing compassion, acceptance and a sense of shared humanity towards the client and

themselves. A further limitation of this study was that the counselling students had very little experience in delivering therapy or teaching mindfulness skills to others. This might have limited how reflective they could have been about the role mindfulness meditation had on their overall therapeutic skills or in relation to therapists with more established therapeutic skills.

Whilst also focussing on the outcomes of a short-term mindfulness meditation intervention, Irving and colleagues (2012) qualitative grounded theory study was slightly different in exploring how mindfulness meditation was perceived to be *personally* beneficial for various health care professionals (n=26). The analysis revealed that the central experience discussed by all participants was the enhancement of mindful awareness e.g. awareness of their own tendency towards inattention or mind wandering, becoming aware of a range of emotions, detached observation, acceptance, mindful communication, self compassion and self care. Participants also discussed challenges to establishing and maintaining a consistent meditation practice, particularly formal practices and found that being in a group allowed important opportunities for modelling from other participants, mutual support, normalization and sense of shared struggle. This study was limited however by the fact that participants comprised a variety of health care professionals including but not limited to therapists who therefore could not reflect on the therapeutic outcomes of the intervention.

These studies provided some valuable qualitative insights however the main limitations were that they mostly focussed on the therapeutic rather than the personal outcomes of mindfulness meditation with the exception of one study that included therapists who also practiced informal mindfulness although it was not clear the extent to which informal mindfulness practices contributed to the study's results. Other limitations included the use of trainee therapists, general health care professionals or psychotherapists who did not necessarily teach mindfulness to others.

1.4.2.2 Empathy and compassion for client and self

This domain includes a number of studies that highlight how mindfulness practice can cultivate empathy and compassion in the therapist, however the focus of each study is mainly on the outcomes of short-term mindfulness meditation rather than long-term informal mindfulness.

Aiken (2006) conducted one of the earliest of these studies that was qualitative in nature and explored whether mindfulness meditation fostered therapeutic empathy in experienced psychotherapists. Therapists went on meditation retreats, engaged in daily meditation and then completed interviews with the researcher. It was found that mindfulness meditation contributed to therapists' ability to feel more empathy towards their clients' pain and suffering and to their own inner experiences (e.g. confusion, frustration). They were also better able to communicate that empathy and help clients become better able to be present with their pain. This study however only explored the experiences of empathy within the context of the therapeutic relationship rather than personally for the therapists and also used experienced psychotherapists as participants.

A mixed methods study by Keane (2013) was similar to the previous in terms of examining the influence of personal mindfulness meditation practice on the therapeutic work of experienced psychotherapists (n=12), however the difference in this study was that the participants had a long-term rather than short-term practice of mindfulness. The quantitative results showed significant associations between meditation experience, levels of mindfulness and self-reported empathy. And the outcomes of the interviews produced specific themes about the qualitative effects of mindfulness meditation such as enhanced attention and self-awareness and an improved ability to be present and attuned to clients. Also meditation helped to internalise attitudes and qualities that had a positive influence on therapeutic work and increased awareness and willingness to be compassionate towards one's own needs for self-care. Some participants also reported that finding time for meditation practice could be challenging. Researchers highlighted that a limitation of their study was that the interviews required therapists to provide retrospective accounts of how mindfulness practice affected their therapeutic experiences, which could have been influenced more by their present rather than their earlier experiences of the practice due to memory biases. Also participants could have been motivated to promote the positive outcomes of a practice that they had invested many years of practice in.

The other studies in this domain tended towards using trainee counselling students as participants. For instance, Shapiro and Izett (2008) also conducted a quantitative study that looked at the effects of mindfulness meditation on levels of empathy for counselling psychology students. The treatment participants participated in a mindfulness meditation course and were compared to a control group on pre- and post-

measures of empathic concern. The researchers found significant increases in empathic accuracy and concern for others' well-being in the students who completed the meditation course compared to the control group. The study also highlighted three key ways that mindfulness meditation can facilitate empathy i.e. by reducing stress, by increasing self compassion and in being able to distance themselves from their own subjective experiences in order to be more observant, accepting and non-judgemental towards other people's experience.

Unlike the previous study, a qualitative study carried out by Schure, Christopher and Christopher (2008) aimed at examining the subjective experiences of participating in a 15-week MBSR program for Masters level counselling students. The students spoke about their experiences of mindfulness training as improving their ability to connect better with clients and feel more empathy and compassion towards their suffering by being more attuned to the present moment rather than paying attention to their own anxiety or their need to fix their clients' problems. This study also revealed that mindfulness meditation enhanced students' ability to deal with strong and threatening emotions, be less defensive or attached to emotional responses and also find more effective ways of dealing with their fears. The study also incorporated mindful body activities such as yoga and Qigong, which resulted in a number of physical and psychological benefits such as greater flexibility, awareness of body, tolerance of physical pain, mental clarity and concentration. The researchers noted that the strength of this study was that it collected data over four years and demonstrated consistent results across all participant cohorts. The limitations included a reliance on self-report data from participants who completed the course and thus may have felt more positively about their experience whereas students who dropped out of the course were not necessarily included in the study, which may have limited insight into alternative or potentially aversive experiences. Also the researchers noted that the course was a requirement for the students, some of whom may have felt pressured to provide positive responses although the class was ungraded. Another possible limitation was that the participants themselves may not have been certain about whether the positive effects were due more to the meditation practice or a result of the physical or relaxing benefits of yoga/ Qigong.

The studies reviewed in this section were a combination of quantitative and qualitative/ mixed methods studies that did provide further evidence for how mindfulness meditation could bring about empathy and compassion for self and others. However the studies tended to over-represent trainee therapists and focussed more on the

outcomes of mindfulness meditation practice rather than looking at the outcomes of long term and regular informal mindfulness practices for experienced therapists who also taught mindfulness to others. Also the studies focussed almost exclusively on empathy and compassion within a therapeutic or professional capacity rather than in participants' own lives.

1.4.2.3 Therapist self-care and resistance to burnout

A study by Shapiro, Astin, Bishop and Cordova (2005) looked at the effects of an MBSR course for health care professionals who participated in a two-hour session once a week for 8 weeks. The results showed that mindfulness meditation could greatly increase health professionals' capacity to look after their psychological health in emotionally demanding environments. Specifically participants reported reduced stress, heightened self-compassion, greater life satisfaction and decreased job burnout and distress following the MBSR course. The study provided positive findings however the results were based upon a short-term meditation course and there were no follow up measures taken, therefore it could not be determined how long-term engagement in meditation or other informal mindfulness practices could affect self care and burnout over time.

These were also limitations of Shapiro, Brown and Biegel's (2007) study that examined how mindfulness meditation could be used to teach self-care to graduate counselling students (n=22). The students were required to partake in an MBSR course that consisted of 3-hour sessions weekly over ten weeks. The researchers compared their pre- and post- results on a number of measures with other students in a control group who didn't participate in the MBSR course. Shapiro and colleagues (2007) found that the course significantly enhanced students' self-compassion, positive affect and levels of mindfulness overall whilst it decreased their perceived stress, state anxiety and rumination. The researchers highlighted that because it was not a randomized study they could not determine what motivational differences existed between the groups and possibly the students who chose the MBSR course may have had more interest in stress reduction compared to the students in the control group who chose alternative courses. Other methodological limitations included the small sample size and possible gender biases seeing that most participants were women.

May and O'Donovan (2007) carried out a quantitative study to look at the relationship between levels of mindfulness, wellbeing, job satisfaction and burnout for experienced

therapists who practiced mindfulness in their personal lives. They used a survey alongside other measures of mindfulness and found that higher levels of mindfulness were correlated with greater life satisfaction, job satisfaction and positive affect and with lower risk of burnout. Their results suggest that higher levels of mindfulness may enhance therapists' wellbeing and effectiveness at work. The researchers also highlighted that the high levels of mindfulness of many participants may have been a product of informal practices as opposed to formal meditation practices but that they had not taken this into account when conducting the study.

All studies in this domain were limited in terms of not producing any qualitative outcomes and only focusing on how mindfulness meditation affected self-care and resistance to burnout.

1.4.2.4 Effect on client outcomes and perceptions

An earlier quantitative study aimed to investigate the effect of therapist mindfulness on client therapy outcomes (Stanley, Reitzel, Wingate, Cukrowicz, Lima & Joiner, 2006). The study used 23 clinical psychology doctoral students who provided manualized, empirically supported treatments to 144 adult clients in a university clinic setting. Their results were based on scales from a survey and showed that higher levels of mindfulness in therapists predicted a lower reduction in symptom severity for clients following their treatment intervention. The findings suggest that mindfulness may interfere with some therapist's effectiveness in terms of delivering manualized treatments as it can distract them from adhering to a manualized format as they may be less able to suspend their attention to present moment experience in order to take a more automatized approach. However as the participants were students it may have also been a lack of experience in delivering manualized treatments that could have contributed to the results or possibly that therapists with higher levels of mindfulness may *prefer* not to work in a highly manualized way as it prevents from being in the moment with the client. Possibly, this outcome isn't necessarily disadvantageous for therapists as it could offer a means to diversify therapeutic skills e.g. to deliver treatment in a semi-manualized fashion that creates space for addressing in the moment processes. Other researchers including Bruce (2006) and Vinca and Hayes (2007) have pointed out that there could have been problems with the accuracy of therapist self-report measures with more mindful people scoring lower on measures of mindfulness because they were aware of the degree to which they were not mindful.

Conversely those who were less mindful may not have realized it and therefore may have been more inclined to rate themselves higher on such measures.

Grepmair, Mitterlehner, Loew, Bachler, Rother and Nickel (2007) carried out a study that also used trainee therapists, however demonstrated quite different outcomes to the previous. The researchers' aim was to find out whether and to what extent cultivating mindfulness in trainee therapists had an impact on the treatment outcomes of their adult inpatient clients (n=124). The participants were randomly assigned to either a non-meditating group or a mindfulness meditation group, which required participants to practice mindfulness meditation for one hour, five days a week for nine weeks. A series of questionnaires were used to determine results. The outcomes were that the patients of the meditating trainee therapists showed overall significantly higher results in terms of positive therapy outcomes and problem-solving perspectives as well as greater symptom reduction on the scales for anxiety, anger/hostility, obsessiveness and paranoid thinking amongst others, compared to the patients of the control group. This was a rather robust RCT in terms of its methodology however the outcomes were dependent upon a relatively short-term mindfulness meditation intervention that did not provide any follow up data, thus it limited what could be known about the longer-term effects of mindfulness or informal mindfulness. Also as the study was only quantitative in nature there was no insight into how the trainee therapists experienced the meditation course or how the clients experienced the therapists.

A study carried out by van Aalderen, Breukers, Reuzel and Speckens' (2012) addressed this qualitative limitation by exploring the role of the mindfulness meditation-based therapist from the perspective of both client and therapist. Trained therapists and their clients participated in an 8-week MBCT course with researchers engaging in interviews, focus groups and observations of both therapists and clients. The main theme from the perspective of the client was that of the therapists' embodiment and ability to model the qualities of mindfulness when teaching the skills. Clients also reported that the course gave them the sense of being able to deal with problems in a more empowering way. The therapists reported non-reactivity as well as feeling like they don't have to fix anymore, less hierarchy and a more human- to- human context that emphasised similarity rather than difference between therapist and client. The researchers noted that group processes seemed to be underestimated by the teachers in the study. And similar to the previous studies, these outcomes were also based on a short-term, mindfulness meditation course and did not provide follow up on the long-

term effects of mindfulness meditation or informal mindfulness for the clients or the therapists.

Whilst these studies offered some mixed results in terms of how mindfulness practice could affect client outcomes and perceptions, the studies were limited in terms of their dominant focus on the outcomes of short-term mindfulness meditation courses.

1.4.3 Summary of the empirical research gaps for the personal and professional practice of mindfulness

The literature review provides much insight into many of the personal and professional outcomes of mindfulness practice across various domains, however critiquing each domain reveals five significant gaps in the research literature.
They are summarised as follows:

The first research gap is the relative dearth of qualitative studies exploring the more subjective and experiential aspects of mindfulness practice in comparison to the current dominance of quantitative studies that have generally focussed on measuring the effects and processes by which mindfulness operates.

The second major research gap pertains to the overriding focus on the outcomes of formal mindfulness meditation. Informal mindfulness was only included in two studies, neither of which focussed specifically on the qualitative experience of practicing mindfulness informally. Thus there is a wide gap in what is known about the outcomes of informal mindfulness practice even though the researchers of two studies explicitly state that future studies would benefit from the exploration of informal-based mindfulness practices as they are likely used by many but tend to be under-reported or unmeasured (i.e. May & O'Donovan, 2010; Cigollo & Brown, 2011).

The third gap relates to the length of time that the effects of mindfulness meditation have been measured. Whilst there were a couple of studies that explored the effects of longer-term mindfulness meditation, the majority of studies focussed on the outcomes of rather short-term mindfulness meditation interventions, such as participating in an 8-week MBSR or MBCT course. Also many of these studies lacked any or sufficient follow up data to measure the degree to which on-going mindfulness practice was needed to sustain these outcomes over longer periods of time. Therefore there is a gap in knowing how the long-term practice of either formal or informal mindfulness can

affect therapists, particularly those who practice mindfulness in both their personal and professional lives.

The fourth gap concerns the nature of participants that have generally been included in studies of mindfulness within the therapeutic field so far. Labbe (2011) suggested that the over-representation of therapists in training in many of these studies could confound our understanding of therapist mindfulness and its impact upon treatment outcomes with a lack of clinical training. Also many of the fully qualified therapists in these studies didn't necessarily deliver mindfulness therapies nor were they expected to teach mindfulness to others, thus there was limited insight into how teaching mindfulness was experienced by more experienced therapists.

And the final research gap concerns the significant lack of research that paid attention to how mindfulness practice affected the therapist personally or holistically. A couple of studies looked at therapists' self care and well-being in respect to burnout however the dominant focus of these studies was on the therapeutic outcomes of mindfulness practice for the therapists as well as their clients.

1.5 The Present Study

1.5.1 How does this study aim to address these research gaps?

The aim of this research study is to qualitatively explore the personal and professional experiences of having a long term, daily practice of informal mindfulness for third wave therapists, which addresses each of the gaps identified in the previous section.

The objective is to carry out a qualitative research study using Thematic Analysis (TA) and to explore how therapists' experiences of informal mindfulness may be implicated in professional practice.

1.5.2 How is this study relevant to the practice of counselling psychology?

Counselling psychology and mindfulness theory share many core values and thus the present study offers much insight into how the values of counselling psychology could be espoused by the personal and professional practice of mindfulness. Furthermore the proliferation of research and dissemination of third wave therapies, which largely incorporate mindfulness-based principles, would appear to hold much relevance for

counselling psychologists, particularly for those who may be struggling to adhere to their professional values whilst providing mental health treatments endorsed by the National Health Service (NHS) in the UK. This section outlines both of these areas of interest.

The qualities of empathy, openness, acceptance, kindness, compassion and non-judgement that can be cultivated through mindfulness practice marry closely with the humanistic values that are fundamental in counselling psychology (Woolfe, Dryden & Strawbridge, 2003; Woolfe & Strawbridge, 2010). James (2009) stated that counselling psychologists aim to espouse these humanistic values by exploring the deeper and more personal meaning of issues and beliefs in context of the therapeutic relationship, which is considered to be the primary vehicle for evoking therapeutic change. Woolfe and Strawbridge (2010) also point out that one of the key differences between counselling psychologists and their clinical counterparts is their inclination towards privileging the therapeutic relationship over and above medicalised or manualized approaches to therapy.

Another shared value is counselling psychology's preference for "being" techniques in therapy (AGCAS Publications, 2006). According to this publication, taking a stance of being allows for greater awareness of shifts in therapeutic process and the flexibility to reflect on these shifts within the therapeutic relationship. As the theory and existing literature for mindfulness demonstrates, the stance of being can be cultivated through mindfulness practice and present moment awareness and also instil 'being' qualities in the therapist. In both fields, the quality of being in the therapist has vast potential to enhance the therapeutic relationship.

Related to the abovementioned focus is the standpoint of pluralism that counselling psychologists tend to adopt as a means of taking a holistic view of the individual, embracing all their complexities and paradoxes in life and inviting these difficult concepts into the therapy room (Blair, 2010; Cooper & McLeod, 2010). Working pluralistically is often at the other end of the scientific or medical spectrum as it allows counselling psychologists to address the diversity in the individual's experiences of suffering rather than seeing the person as needing to be "fixed" or "cured" of their symptoms (Giddings, 2009; Blair, 2010). In mindfulness one is encouraged to embrace acceptance and compassion towards painful experiences even if it means holding contradictory or uncomfortable ideas about oneself. Also in mindfulness theory, experiences of pain are seen to be part of the human condition and proclivities towards suffering rather than seeing it as a separate entity that needs to be changed or cured.

Furthermore the inclusion of both the personal and professional highlights the study's desire to take a holistic approach to understanding the experiences of the third wave therapist and the specific focus on informal mindfulness demonstrates the study's ambition to explore mindfulness practice more pluralistically so that, according to Jordan (2009), valid alternatives to the orthodox practices may be fostered.

Whilst these values are inherent for many counselling psychologists, they also often pose a dilemma or tension in relation to the profession's philosophical roots in the scientific- reflective practitioner model (Woolfe & Strawbridge, 2010). According to McAteer (2010), adherence to this model means that counselling psychologists need to balance their desire to privilege the individual's subjective or individual truths against their commitment to a more evidence based or scientific practice. This can be a very difficult tension to hold considering that scientific practice and evidence-based treatments often tend to medicalise symptoms of mental health and treat them as a disease as stated by Mollon (2009), which seems incongruous with the humanistic values of counselling psychology. Mollon (2009) also pointed out that the guidelines provided by the National Institute of Clinical Excellence (NICE) that govern mental health service provision within the NHS, largely prescribes various CBT treatment protocols as the leading approach for most mental health presentations. Counselling psychologists have tended to view behavioural and cognitive approaches in isolation as rather narrow or reductionist in understanding individuals' experiences (James, 2010). Therefore it is unsurprising that many counselling psychologists in the recent years have criticised the over-reliance on CBT in the mental health services of the NHS as being 'cure-focussed' whilst ignoring the realities and complexities of suffering, objectifying patients into a set of symptoms and focusing on short term measurable outcomes rather than more relevant underlying issues (Rizq, 2012; Giddings, 2009). As a result, it is likely that the proliferation of CBT approaches puts skilled practitioners such as counselling psychologists under threat of losing jobs in the NHS or possibly even leaving the NHS if dissatisfied with their roles, which may also limit employment opportunities or impel a counselling psychologist to remain in private practice.

Considering these dilemmas, it would appear that third wave therapies that integrate the principles of mindfulness and are currently positioned as a form of cognitive behavioural therapy, could offer a viable means for counselling psychologists to strike that much needed balance between being humanistic as well as scientific. Dunkley and Loewenthal (2013) also stated that third wave therapies have a strong potential for mass appeal and have already been prescribed widely on the NHS with future

dissemination likely to increase. Thus the delivery of third therapies and further research in this area could offer counselling psychologists job security in the NHS whilst still having the scope to work in accordance with their professional values.

1.5.3 Research question

What are the personal and professional experiences of having a long-term, daily practice of *informal* mindfulness for third wave therapists?

Chapter 2: Research Method and Procedures

The first part of the chapter offers a theoretical overview and rationale for the choice of qualitative method and decisions made and also highlights my epistemological position as the researcher. The second part of the chapter details the specific considerations made in relation to the research procedures carried out. These considerations pertain to participant sampling, the interview process, the analytic procedure and the steps taken to ensure ethical robustness of the study. The culminating part of the chapter consists of three reflexive statements that explore how my personal, epistemological and methodological positions may be implicated in this study and the measures taken to address any potential impact.

2.1 Overview of theoretical framework and research method

2.1.1 The use of qualitative research

The general aim of qualitative research is to describe the meaning of personal and often complex phenomena, and to gain a better understanding of how individuals make sense of their experiences in the world (Willig, 2008). Smith and Eatough (2006) also mention that some qualitative techniques allow the researcher's assumptions and meanings associated with their research topic to be challenged by their participants. And Ashworth (2003) points out that qualitative research tends to take place in a naturalistic setting with a small group of participants who are thought to share a similar experience. Thus the research findings tend to be rich in detail and embedded in the unique, dynamic context of the individual participant. This type of approach tends to be quite descriptive and highly subjective with the analysis of data allowing for comparisons on how and why a phenomenon occurs across several cases. Some of the drawbacks of this type of approach are that collecting and analysing qualitative data can often be quite time-consuming and involve large quantities of data. Also qualitative data cannot allow the researcher to make a prediction as this type of data is not seen to generalize to other people and settings. On this basis qualitative approaches are not amenable to testing theories or hypotheses however they are generally not used for this reason.

The alternative is the use of *quantitative approaches* that offer a more systematic or empirical approach to measuring or describing a construct or a relationship between two or more variables. Quantitative approaches attempt to demonstrate whether or not

a construct or relationship exists in a large representative sample of people in a variety of settings (e.g. naturalistic or designed) in order to statistically support or reject a hypothesis (Creswell, 1994). Anderson and Taylor (2009) highlight that whilst quantitative research is seen to produce reliable and quantifiable data it also often decontextualizes much of human behaviour and can present findings that lack real world context. Woolfe, Dryden and Strawbridge (2003) also noted that the scientific underpinnings of quantitative research methodologies means that they are less able to allow insight to unfold or for changes in perspective to emerge. Some researchers point out that quantitative research is generally more widely accepted because it offers an objective means of measurement over the more subjective, less generalizable nature of qualitative approaches (e.g. Creswell, 1994).

However it can be seen from the above descriptions that qualitative and quantitative approaches complement each other in many ways and have different philosophies and goals making it almost meaningless to compare them to each other. Carr (1994) made the statement that neither approach is superior to the other; qualitative research is considered invaluable for the exploration of subjective experiences whilst quantitative methods facilitate the discovery of quantifiable data. Also Willig (2008) pointed out that it is useful to use one approach to elucidate the 'knowledge' found in the other. Thus it would appear that qualitative research can often deepen our understanding for a demonstrated relationship in quantitative findings and quantitative research can often test a hypothesis arising from qualitative findings. Approaching this study as a counselling psychologist who has an innate interest in the subjective and inter-subjective experiences of informal mindfulness for third wave therapists and the meanings given to these experiences, it was clear from the outset that a qualitative methodology would be used.

2.1.2 Theoretical framework for this study

A theoretical framework provides a structure for how existing theory, concepts and assumptions about a broader field of knowledge can be used to guide and contextualise a research study within the field (Swanson, 2013). The theoretical framework for this study is phenomenology, which is a branch of philosophical science concerned with the study of conscious experience and how this experience is perceived and understood by those who are experiencing it (Willig, 2008).
Husserl was one of the significant philosophical founders of the phenomenological method and was keen to develop a way in which people could gain a deeper

understanding of their own experiences and identify certain qualities that could be distinguished and appreciated as aspects of a collective experience. To do this Husserl called for people to step outside their 'natural attitude' (Smith, Flowers & Larkin, 2009, p. 12) to everyday experience so that it can be evaluated without pre-conceived judgments and perhaps be understood in a different way. He thought that once people stop to self-consciously reflect on any of their taken-for-granted experiences or objects, whether they are worldly or in the imagination or memory, they are being phenomenological. Husserl also believed that one could increase their phenomenological awareness by trying to understand how these objects present themselves in the individual's consciousness rather than on attempting to give causal explanations or analysing their existence (Nanda, 2009).

Another key figure in this field was Heidegger (1927/1962) who began his career as a student of Husserl's but moved away from what he considered as Husserl's overly theoretical and abstract approach to phenomenology. In terms of comparing their focus, Husserl was concerned with the psychological processes of the individual such as perception, awareness and consciousness whereas Heidegger was interested in exploring the experience of existence itself in terms of how people perceive and make meaning from the activities and relationships in their lives (Smith, Flowers & Larkin, 2009). Heidegger also placed the phenomenology of Being at the centre of his work, which he referred to specifically as 'Dasein' or 'being' in the world, which represented his view that a person always existed in context of a world consisting of objects, language and culture that is also in a constant state of change depending upon the persons point of reference e.g. time, cognitions or environment (Childs, 2007). In Heidegger's view a person cannot be meaningfully separated from their world, which touches upon the phenomenological concept of intersubjectivity defined as the 'shared, overlapping and relational nature of one's engagement in the world' (Smith, Flowers & Larkin, 2009, p17) and highlights that the relation one has to their world is a fundamental part of their person-hood (Larkin, Watts & Clifton, 2006).

Some of the principles of phenomenological theory correspond well with the fundamental principles of mindfulness theory. For instance, Nanda (2009) points out that Heidegger's concept of Dasein or Being-in-the-world resonates strongly with the notion of *being* in mindfulness theory with both approaches positioned to transcend the Cartesian seperatedness by using the conscious awareness of the breath to harmonise body and mind or subject and object. Also the concept of "inter-being" is used in Buddhist theory to define the absence of a separate self from the world and

acknowledges that all experiences of Being-in-the-world are inherently and inevitably tied to other aspects of our worldly existence (Thich Nhat Hanh, 1999).
One distinction however that Nanda (2009) highlights is that thinking and being are not necessarily the same thing in mindfulness theory, rather the state of being *consists of* thinking as well as an embodied awareness of one's thoughts, one's senses and one's knowledge of their existence of body and mind in the world. Thich Nhat Hanh highlights the distinction in a slightly different way by rephrasing Descartes idiom from, "I think, therefore I am" to, "I think, therefore I am not". His meaning as he describes is that Being-in-the-world necessitates consciousness and thinking without consciousness can separate one from their experience of Being in their body and their world (Thich Nhat Hanh, 1998). These distinctions correspond with Heidegger's belief that "real knowledge" arises from an individual's experiences of Being-in-the world and proposed that this knowledge can also become a foundation for science and can contribute to a more adequate understanding of human existence (Childs, 2007; Copperstone, 2009, p. 330). Thus phenomenology and mindfulness theory both appear to uphold the idea that consciousness of one's state of Being is fundamental to acquiring 'real knowledge' of the body, the world and possibly of human existence.

Taking a phenomenological approach to research also supports the underpinning philosophy and practice of counselling psychology. Counselling psychology research places great emphasis on phenomenological perspectives of human experience by giving value to the subjective and multifaceted nature of each individual's knowledge, personal perspectives, assumptions and experiences (Kasket, 2012; Gil-Rodriguez & Hanley, 2011). Counselling psychologist researchers are also able to play the role of a visible, active and interested instrument in the research process, rather than as a detached or neutral observer as conceptualised by Lester (1999). On this basis, it felt like an informed, yet comfortable decision to approach this study from within a phenomenological framework.

2.1.3 Overview of Thematic Analysis (TA)

The qualitative method used in this study was Braun and Clarke's (2006) approach to thematic analysis (TA), which is a method for identifying, analysing and describing themes across a data set. Boyatzis (1998) stated that thematic analysis can be seen as an effective, sense-making approach for reducing, organising and immersing oneself in large volumes of data whilst retaining its context and richness and also offers much opportunity to make in depth interpretation of the research topic.

Braun and Clarke (2006) state that one of the key benefits of using TA is its theoretical and epistemological flexibility in that it is "not wedded to any pre-existing theoretical framework and therefore can be used within different theoretical frameworks" (p. 81). This theoretical flexibility also allows TA researchers to align themselves with an epistemological position that fits with the framework of the study and can occur anywhere along an epistemological spectrum. On one end of the spectrum, TA can be considered a realist method that assumes that participants' language can provide knowledge of and insight into participants' experiences, meaning and reality in a rather direct and straightforward way. On the other end of the spectrum, TA can be a constructivist method that assumes that reality, events, meaning and experiences are a product of various discourses and sociocultural contexts operating within a society (Braun & Clarke, 2006).

Braun and Clarke (2006; 2013) also emphasize the importance for TA researchers to be explicit about their theoretical positions as the absence of this transparency means that the research would typically be assumed to be a realist account of the data. Thus in the context of my phenomenological approach to this study, my epistemological position sits in between the two ends of the spectrum and is that of a *critical- realist*. According to Larkin, Watts & Clifton (2006) this position is reflective of a researcher who believes that the nature of their data is reflective of their participant's reality, however there may be limits to accessing this reality based upon how social contexts impact on the participants' meaning or ability to convey their meaning. Specifically, my position assumes that the data in my TA study conveys the reality of my participants' mindfulness experiences and meanings, however I remain critical of how certain social, cultural or political contexts may affect my access to this reality.

As the researcher however, I hold a relativist ontological position in assuming that my role in the process of gaining access to my participants' reality would in some way be involved in constructing the reality. This may occur in the process of gathering the data and/or interpreting the data, for example, participants may deliver certain variations of their reality depending on how they perceive me as the researcher or the assumptions they make about the nature of data I am asking from them.

In terms of practically carrying out a TA, a researcher can use a range of data sources including interview transcripts, diaries, field notes, audio or digital files or even drawings or photographs, however TA does tend to rely on textual data so any material would generally need to be transcribed or described in some way before analysis of

themes can take place (Mills, Durepos & Wiebe, 2010). Once a piece of textual data is created, researchers need to engage in coding of the data. Coding is a basic analytic process of closely examining the text to seek for important or recurrent topics or relationships in the data and marking these parts of the text with a code or label in order to explain and interpret later down the analytical track (Mills, Durepos & Wiebe, 2010). Alhojailan (2012) points out that the coding process in TA functions to draw connections between various sections of the data and to highlight apparent similarities and differences. In analysing the data set, the researcher is expected to move in a recursive, back and forth fashion between the entire data set, the coded extracts of data and the themes that are being developed and analysed so that the themes are interconnected and have meaning across the data set. Braun and Clarke (2006) recommend that researchers use a thematic map or thematic table to provide a detailed account of all the themes and the data that exemplifies the patterns within the themes.

Braun and Clarke (2006; 2013) also point out that a TA researcher has to make several analytic decisions regarding the how and why of their analytic approach. The types of decisions that researchers need to consider are explored as follows:

Will my TA be inductive or deductive?

Alhojailan (2012) calls attentions to TA also being flexible in terms of whether an inductive or deductive analytic approach can be used in the coding process. In the current study, I chose to apply an inductive, data-driven approach, which is when themes are developed from and grounded in the data and considered to be more characteristic of TA (Mills, Durepos & Wiebe, 2010; Braun & Clarke, 2006). Alhojailan (2012) states that the inductive approach ensures that themes stay linked to the data by firstly creating codes from more discrete data content and using this to move to broader generalizations and interpretations of the data. Braun and Clarke state that if doing an inductive TA the themes can be quite distinct from the questions asked of the research participants and that the researchers would not be trying to code the data according to their analytical preconceptions of what should be expected to arise, however would still need to remain quite reflexive about what these preconceptions are. Furthermore, data-driven approaches are thought to have greater validity as they can offer the researcher greater flexibility and openness to elucidate themes or ideas that are more novel and unexpected (Namey, Guest, Thairu & Johnson, 2008). The opposite approach is a deductive or theoretical approach that is considered to be more analyst-driven. In this approach, the researcher can code and identify themes based on

theoretical constructs they choose to investigate and expect to see in their data. To do this, researchers may code their data items in accordance with an a priori list of themes or theory-driven categories, which may have derived from their research question, interview questions or literature review (Mills, Durepos & Wiebe, 2010). This approach can facilitate comparisons both within and across data items, however tends to be more rigid in terms of how findings are reported.

What counts as a theme?

Braun and Clarke (2006; 2013) recommend that researchers need to consider how to classify a theme and how this will be determined in terms of its prevalence within a single data item and across a broader data set consisting of several data items. They point out that a theme may present a number of times across a data set or may indeed just present once in a single data item, however both these themes may be as crucial as each other depending on whether they capture a central aspect of the data in relation to the overall research question. In the present study, my themes represented patterns of meaning that were prevalent across the entire data set. Establishing prevalence more broadly felt important considering that I had a smaller data set to highlight meaningful patterns. The complexity and depth of my themes developed from grouping together coded extracts that presented unique convergences and divergences in the data.

Will my themes be semantic or latent or both?

Braun and Clarke (2006) identified that themes within a TA can be either semantic or latent or both. The researcher conducting thematic analysis on a semantic level will look for explicit or manifest themes that arise from what the participants have said and not look for anything beyond this. Whereas researchers looking for latent or interpretative themes move beyond purely the semantic level in order to identify ideas, assumptions and conceptualisations that may theoretically underpin the semantic content of the data (Braun & Clarke, 2006). Despite these differences, many researchers in the field note that both semantic and latent levels of thematic analysis require interpretation, however the depth and degree of abstraction differs between the levels (Vaismoradim, Turunen & Bondas, 2013).

Braun and Clarke (2006; 2013) state that more realist accounts of participants' experiences tend to rely on semantic codes/ themes, which require both description of semantic content and its patterns across the data set as well as interpretation of the meaning and significance of these patterns. On the other hand, TA that is conducted

from a constructionist position tends to rely more on latent codes that allow the researcher to move away from the explicit and obvious content of the data.
As a critical realist position was adopted in the current study, which sits somewhere in between these two poles, I chose to integrate semantic and latent coding as both appeared to offer much richness to the overall analysis. There was however a greater emphasis on the semantic coding due to my position being closer to the realist end of the spectrum. The semantic aspects of the themes were based on analysis not only of what the participants said but also the context of how it was said. For example, I was able to analyse the particular language used (e.g. metaphors or prose), the non-verbal parts of speech (e.g. sighs or uhms) and the participants' tone of voice (e.g. exclamations or neutrality). The latent aspects of the themes were developed from assumptions or conceptualisations about the contexts that were possibly influencing how the participants' meanings or beliefs were being construed.

2.1.4 Critiques of TA as a qualitative research method

Many researchers have identified that thematic analysis is an unsophisticated, poorly branded and inadequately demarcated research method that is rarely acknowledged or named in textbooks in the same way that other methods such as grounded theory or interpretative phenomenological analysis are, and thus is seen as merely an analytic strategy rather than a viable, stand-alone research method (e.g. Mills, Durepos & Wiebe, 2010; Braun & Clarke, 2006). Ryan and Bernard (2000) stated that TA is a common process within other analytic traditions however its lack of specificity precludes it from being seen as a method in its own right. Braun and Clarke (2006) argue that many of the popular analytic strategies are essentially thematic in nature but are claimed as something else thus TA should be seen as a versatile method that can be used in various analytic contexts.

Other critiques of TA have been that whilst it is widely used, there is no clear agreement about how a researcher goes about conducting it and also that it lacks explicit guidelines about how to perform the methods involved that makes it difficult for some TA research to be replicated or evaluated for rigour and quality (Sandelowski & Barroso, 2003b; Boyatzis, 1998). However as pointed out by Mills and colleagues (2010), the creative insight that is necessary for inductive TA can be difficult to subject to a formulaic approach. Mills and colleagues (2010) also highlight that interpretivist researchers may also find issue with the analytic process of deconstructing, organizing

and labeling parts of the text as this in itself may detract from the context and interrupt the coherence of the data.

Whilst not an explicit critique of TA alone, when TA is used as a method for exploring participant's experiences, the over-reliance on the use of language as a means for participants to communicate their experiences can be seen as limiting. Willig (2008) posits that language can often precede or construct reality for an individual so that the words one chooses to describe their experience may construct just one version of that experience and consequently the real essence of the experience may get "lost in translation" between participant and researcher. This suggests that an interview transcript for a phenomenological TA may be more reflective of the way in which a participant uses language to describe their experience rather than a way of gaining an understanding of the experience itself. Related to this is the variation in the ability of interviewed participants to use language is a sophisticated way such that they are able to verbally convey texture, richness and nuance rather than offering general accounts or opinions on the phenomena of interest. Grossman (2010) notes however that language is actually one of the key constructs alongside introspection and personal experience that allows one to understand the conscious phenomena that is mindfulness.

Upon reflecting on these limitations, my position as the researcher was that TA remains the most appropriate method for my study. This was on the basis that the lack of acknowledgement or accolade for TA as a distinctly branded methodology in the literature does not necessarily impact on it being a viable and relevant method to use and perhaps is more reflective of it not being well understood or subject to common misconception. Also the absence of prescribed guidelines for carrying out the analysis does not necessarily have to be a limitation or compromise the quality or the rigour of the study if a clear and coherent account of the analytical procedure is provided as well as an astute reflexive account of the methodological approach. As opposed to seeing this characteristic as a limitation, I considered the flexibility of the analytical parameters to be a benefit as it would allow me to pay attention to aspects of the data that felt most relevant and meaningful. As the researcher I also felt that the issues around language were more general for this type of qualitative approach rather than being specific to TA alone. Thus again being clear about how language was used to interpret and construct meaning would be a necessary step for any study of this nature. This may also include transcribing characteristics of the participants' nonverbal communication such as their

tone, inflections, pauses and sound effects, which would provide another source of meaning and interpretation of experience other than words alone.

2.1.5 Other methodological considerations

Methodology: Why TA instead of IPA or other approaches?
One of the leading qualitative research methodologies is Interpretative Phenomenological Analysis (IPA), which is specifically concerned with understanding individual's lived experiences in the world through an exploratory rather than explanatory, circular process of meaning making (Smith & Osborne, 2008).
IPA is underpinned by the theory of hermeneutics that underpins a circular meaning making process whereby the researcher rotates between parts of any data account and the account as a whole. Based on the earlier description given of TA this analytic process is quite similar to the recursive back and forth process of analysis prescribed by Braun and Clarke (2006). IPA is also based upon the philosophical tenet of ideography that refers to the focus on understanding what lived experiences is like from the perspective of a particular group of people (Smith, 1995). Thus in IPA studies there is a commitment to building a deeper understanding of a phenomena of interest that is experienced by a small homogenous group of people within a specific context.

Upon commencing this study, I had originally considered using Interpretative Phenomenological Analysis (IPA), largely because of its phenomenological focus and its dominance in the field of counselling psychology research. However my desire to research the experiences of informal mindfulness practices for a heterogeneous group of third wave practitioners was considered to be more important and meaningful than altering my research question to meet the criteria of homogeneity required for an IPA study. There was however some degree of homogeneity within the overall heterogeneous sample as Braun and Clarke (2013) recommended that homogeneity can be helpful in small or medium sized TA studies in order to detect meaningful convergences and divergences in the data.
Braun and Clarke (2013) also highlighted that whilst there are some procedural differences in the analytical approach of IPA and TA, with IPA's ideographic approach resulting in thematic development occurring earlier than in TA and specifically for each data-item rather than across a data set, the outcomes of an IPA and a phenomenologically-informed TA study can yield very similar results.

Aside from IPA I had also considered other methodologies, however for one reason or another, aspects of their approach or overall philosophy precluded them from being used. One such consideration was Amedeo Giorgi's descriptive phenomenological method that may have been appropriate considering that its philosophical roots are similar to IPA. However upon exploring descriptive phenomenology further it became evident that it is an approach that distinguishes itself from more interpretative approaches as it relies heavily on the interviewer's "empathic immersion" (Giorgi, 2009, p.127) in their participants' *descriptions* of their lived experiences. Thus during the analytical process, theoretical or exploratory interpretations are avoided in order to flesh out the full meaning arising from the descriptions alone but these interpretations may take place later on when considering the implications of the results (Giorgi, 2009). Considering my position that language itself can be limiting in terms of describing experience and that much meaning can emerge from how the interviewer interprets the participant's attempts to make sense of their experiences, I felt an approach that had prescribed a largely descriptive rather an interpretative approach would not satisfy the aims of my study.

Grounded theory (GT; Glaser & Strauss, 1967) is another method used for qualitative research and various aspects of this approach share similarities with IPA and TA in terms of methodology. The purpose of GT is to facilitate the discovery of new information or theoretical knowledge based on categories emerging from a greater scale of data, which means that the research question answered may be significantly different to the initial research interest (Smith, Flowers & Larkin, 2009). This requires the GT researcher to use a particular sampling approach whereby they continue to gather data from participants to create categories until they reach a point of saturation whereby they are no longer discovering new categories of data. One drawback of this approach in relation to the aim of the current study is that the process of generating theory and knowledge through the collection of new data means that the researcher may often need to depart from exploring the characteristics and nuances of the phenomena of interest. As the aim of my study was specifically to gain an understanding of how informal mindfulness practice was experienced by an under-researched group of therapists rather than to generate new theory about the practice of informal mindfulness, GT was not considered to be the most appropriate approach.

Other qualitative approaches include discourse analysis, Foucauldian discourse analysis and narrative psychology, however these approaches seemed to take me away from my primary research interests as indicated in their descriptions below.

Discourse analysis is thought to include discursive psychology (Potter & Wetherell, 1987) and Foucauldian discourse analysis. Discursive psychology is thought to have evolved within the ethnomethodological tradition and is concerned with how meaning is negotiated through cultural discourse or interaction in everyday contexts with a strong interest on the function of language whereas Foucauldian discourse analysis is concerned with the way language can shape and constrain social and psychological life (Parker, 1992). Narrative analysis is another qualitative approach that focuses on the ways that people create and use stories to make sense of the world. Narrative analysis is not interested in whether people's stories are true or not but how they use the stories to represent themselves and the world (Lawler, 2002). Whist these approaches were not the most suitable for exploring the personal and professional experiences of long term, daily informal mindfulness practice in the way I intended, they nevertheless offered the means to study the phenomena of mindfulness in other interesting ways. For example, discourse analysis could be used to investigate how discussions about informal mindfulness in various professional settings could influence therapists' own personal mindfulness practice. Narrative analysis may be appropriate for uncovering the stories that therapists create and use to explain to others how their informal mindfulness practice evolved over time and how it may have come to change their lives.

Data collection: Semi-structured interviews

Semi-structured interviewing is the most widely used method of data collection in qualitative research and considered to be amenable to various means of analysis as well as being relatively easy to organise compared to some other methods (Willig, 2008). This type of interviewing is normally compared to structured interviewing, which is a more rigid pre-coded data collection approach that is frequently used in quantitative research (Willig, 2008). Smith and Eatough (2006) noted that there is a "natural fit" between semi-structured interviewing and qualitative analysis as they offer the researcher an openness to explore issues that are personal, unique or complex in nature and are thus more able to capture a richer understanding of these issues than what a structured interview could offer. Kvale (1996) also noted that semi-structured interviews, as opposed to structured interviews, offer flexibility to the interview process whereby the interviewer is free to probe for more detailed responses or clarification and that the interviewee is encouraged to correct assumptions and provide material that may not be directly solicited.

Semi-structured interviewing also has its limitations. One such difficulty that having a flexible approach can bring to the interview situation is that the interviewer may have

seemingly less control in containing what is spoken about (Smith, 1995). This can make it be difficult for the interviewer to maintain focus on what is being said and its relevance to the topic of interest. On this same point it may also mean that certain probes used for some participants may not necessarily be used with others if the particular topic doesn't arise, which suggests that the interviewer may be missing out on extracting significant information from some participants simply because the specific probes are not on the interview schedule. Consequently, the richness of the data can depend largely on the interviewers' skills and experience of conducting semi-structured interviews. Due to these characteristics, these types of interviews can also be a lengthy and tiring process for both researcher and participant and involve large volumes of data that might feel overwhelming for the researcher to analyse (Smith, 1995). In my attempt to minimise some of these potential drawbacks, I engaged in a thorough process of interview preparation and practice before and during the interview stage. This included preparing and revisiting the interview schedule, conducting practice and pilot interviews and making reflective notes for improving interview techniques whilst listening to recordings. Throughout the interview I also tried to adopt Parker's (2005) position in approaching each interview as an opportunity to explore new and exciting territory and embrace the unexpected with an attitude of openness so that I could remain open and curious towards as many topics as possible without feeling as though I needed to pursue every area in depth. Other popular data collection methods could have included focus groups or the use of diaries amongst others, however I didn't feel that either of these would have provided me with the data I was most interested in. For example, I dismissed the use of focus groups as I was primarily interested in gaining personal accounts from each therapist and I thought that a focus group may pose expectations on therapists to discuss only experiences they felt comfortable sharing with others. In respect to the use of diaries, I was reluctant to ask therapists to engage in what was potentially a lengthy and time-consuming commitment to record keeping and also considered that I may not have the same opportunity to probe for complexity or ambiguity in what they had written.

2.2 Promoting the quality of qualitative data in a TA study

One criticism that has been directed at all qualitative approaches is that they lack the scientific rigour and credibility associated with traditionally, well-received quantitative methods (Vaismoradim, Turunen & Bondas, 2013). Qualitative researchers posit that the quality of qualitative research is an important consideration but that it is necessary for these features to be evaluated differently to that of quantitative research (Willig,

2008). Yardley (2000) offers four principles for assessing the quality of qualitative research that were detailed in Smith, Flowers and Larkin (2009), which are discussed as follows.

2.2.1 Sensitivity to context

The first principle is *sensitivity to context*, which I aimed to address by considering the position that mindfulness holds in the theoretical, empirical and political arena of mental health in the UK. One particular contextual issue concerned how the expectations for mindfulness practice may influence some of the therapists' disclosure in the interview situation. For example, MBCT therapists who do not practice formal mindfulness meditation as regularly as what they feel is expected of them may be more hesitant in discussing their reliance on or preference for informal mindfulness practices. I attempted to be sensitive to what therapists may feel they "should" be talking about by pitching the study as a non-judgemental exploration of how informal mindfulness practices are experienced and focussing less on the expectations of formal meditation. Another area in that I felt sensitivity to context was needed was in ensuring participants that I was interested in their *experiences* of mindfulness, not their knowledge on the subject. This was to deter therapists' from feeling the need to demonstrate their competency in understanding and teaching mindfulness and to ensure that I could collect data that was rich with experiential insights rather than theoretical data.

2.2.2 Commitment to rigour

The second principle is *commitment to rigour* in respect to continued thoughtfulness and diligence towards participants and participants' data throughout all phases of the research. This principle was demonstrated from the outset in terms of selecting a sample of therapists who were sufficiently experienced in mindfulness practice in order to reflect on this experience. Throughout the interviews, rigour was demonstrated in terms of ensuring that participants were comfortable enough in the setting to discuss whatever came up for them, giving participants ample time to reflect on and respond to each interview question and probing further to acquire depth or clarification of nuanced meaning. Following the interviews, I meticulously engaged with each individual account (e.g. by listening to recordings and reading over transcripts several times) and maintained an ongoing reflexive practice.

In terms of rigour in the analytic process, some versions of TA i.e. Guest, MacQueen & Namey (2012), Joffe (2011) and Boyatzis (1998) recommend the use of 'coding frames', multiple independent coders or 'triangulation' of coders and the calculation of inter-rater reliability scores to demonstrate scrupulous analysis. However Vaismoradim, Turunen and Bondas (2013) point out that there is some scepticism about the usefulness of this type of testing when applied to a purely qualitative approach such as thematic analysis. As such Braun and Clarke's (2006) TA takes a more flexible approach and whilst they concur with the idea that it may be helpful for researchers to try coding with other researchers, they don't necessarily agree with the assumption that multiple perspectives result in more precise analysis. On this basis, I engaged in a rather organic coding process that continued to develop as my analysis progressed. I also had to remain quite reflexive through the process to ensure that my own beliefs and assumptions were not directing the coding process.
In respect to maintaining rigour in a TA analysis overall, I closely adhered to Braun and Clark's (2006) 15-point checklist for good thematic analysis (Appendix K).

2.2.3 Transparency and context

The third principle draws attention to *transparency and context* pertaining to the efforts made by the researcher to clearly describe the stages of the research study as well as being able to show that all aspects of the research fit together and can be justified by the context of study. This study upholds this principle particularly in outlining very transparently the reasons why TA was chosen as the most appropriate research method in terms of researching a heterogeneous group of therapists, which was the context of the study. There has also been transparency shown in the following sections of this chapter insofar as outlining how my sampling considerations and other decisions made in the research process were appropriate for the context of studying informal mindfulness practice. Lastly, the reflexivity section in this chapter very transparently conveys my reflections on how my personal, epistemological and methodological positions may have impacted on this study and the steps taken to try and minimise this impact.

2.2.4 Importance and impact

The last principle refers to the *importance and impact* of the study in terms of its ability to deliver something 'interesting, important or useful' (Smith, Flowers & Larkin, 2009, p. 181). Krippendorff (2004) also suggested that the quality of a study can be determined

by whether new insights into a phenomena of interest have been generated and whether this has led to a better theoretical understanding of a given phenomena or informed practical actions or therapeutic practice (as cited in Vaismoradim, Turunen & Bondas, 2013). The importance and impact this study lies in its aim to discover how daily informal mindfulness practices are experienced by therapists who practice it themselves and teach it to others. Also as there is very limited evidence in this area, the impact of the study may be in the generation of interest or further research in this field. It may also impact on professional practice insofar as developing therapists' understanding of informal mindfulness practices and shifting attitudes about what informal mindfulness could offer in both a personal and professional capacity.

2.3 Method and Procedure

2.3.1 Sampling considerations and inclusion/exclusion criteria

Perhaps the most significant sampling consideration was in determining what constituted informal mindfulness practice and how this was differentiated from formal mindfulness practice. To do this I relied on widely used definitions of informal mindfulness in the literature that made reference to bringing an awareness to the full range of sensory experiences that unfold during activities or actions in everyday life with examples including mindful eating, mindful walking, mindful gardening etc. (e.g. Weiss, 2004, www.lucid-living.org). However there were sometimes 'grey areas' between what could be defined as informal and formal mindfulness practices in terms of how they were described by participants. This necessitated more specific delineation of the intention and function of the practice in order to address resultant ambiguity. One example was differentiating "informal meditation", which was sometimes used to describe a meditative like state when fully engrossed in an activity, from shorter forms of "formal meditation" that have become increasingly popular and tend to involve short 3-5 minute bouts of meditation or mindful breathing during the day as a distinct activity in itself. Another example of a grey area was distinguishing *walking meditation*, which is a formal practice in which the person engages in a meditative state whilst walking, from *mindful walking*, which is an informal practice whereby the person aims to bring present moment, sensory awareness to their walking (e.g. crunching of leaves under their feet, the sound of the birds chirping etc.) as part of an everyday activity. A final example involved distinguishing the intent and function of yoga. For some participants, yoga was considered a meditation practice involving focussed concentration on

different parts of the body and the breath. For others, yoga was an informal practice that functioned as a form of relaxation or physical exercise yet facilitated simultaneous mindful awareness of the body. Thus instead of automatically excluding participants who mentioned that they regularly engaged in informal meditation or exercises such as yoga or mindful walking, I attempted to gain mutual clarification of whether the intent and function of their practice could be considered informal. Following these discussions, the exclusion criteria was that their main forms of mindfulness practice were more indicative of formal meditation rather than informal mindfulness as per the literature definitions, regardless if it lasted 5 or 45 minutes.

Another key sampling consideration was to focus on third wave therapists as they comprise a group of therapists who explicitly teach formal and/or informal mindfulness skills to others and they are also expected to have some form of personal mindfulness practice. Thus I considered that third wave therapists would have a sound base of personal and professional experiences with mindfulness upon which they could reflect on. The other aspect of determining this sample was deciding on which third wave therapists would be included. As the study's focus was on exploring the experiences of informal mindfulness, I was initially going to only include ACT and DBT therapists who I thought would be more likely to practice informally rather than formally. However after sending out the initial poster, I was contacted by an MBCT therapist who identified that s/he also had a regular informal mindfulness practice but still practiced meditation on an occasional basis. On the basis of these discussions, I decided to also include MBCT therapists in my study. Thus my exclusion criteria was that the therapist didn't practice at least one of these three therapies as their main therapeutic approach as I still wanted some degree of homogeneity in my sample.

The third sampling consideration was determining how to define *long-term* informal mindfulness practice and its regularity. In respect to regularity, I decided that therapists would need to practice informal mindfulness techniques daily or at least on 5-6 days of the week. I felt this stipulation married well with the expectations for mindfulness therapists to practice formal meditation daily even if just for five minutes (Kabat-Zinn, 1994). Also as the vast majority of the therapists who contacted me practiced mindfulness meditation to some degree, I decided to set a benchmark of meditation practice such that I only included therapists who had an occasional (i.e. once every 2 to 4 weeks or less) or irregular (once every 2 to 4 months or less often) meditation practice. Therapists were also asked to reflect on their engagement in both informal and formal mindfulness practices and needed to subjectively identify that informal

mindfulness practice played the more central role in their lives for at least 2 years in order for it to be considered long term. Therefore I excluded any therapist who either didn't meet these criteria of regularity or length of time or therapists who were unable to subjectively identify informal mindfulness as the most central practice in their lives.

The fourth sampling consideration was choosing qualified third wave therapists who had received some training in the third wave therapy they were delivering as opposed to trainee therapists, who are already over-represented in the literature in this area. I considered that having received training in the therapy would ensure that the therapist was delivering it in accordance to the model and possibly that qualified therapists would have a greater capacity to reflect meaningfully on their professional experiences of mindfulness practice based on their greater longevity in the field. On this basis, I excluded any therapist who was not yet qualified or a chartered member of the main professional societies i.e. the BPS, BACP, BABCP etc. I also excluded any therapist who had not undergone some training in one of the third wave therapies.

A final sampling consideration was the use of a financial incentive to encourage participation. Head (2009) mentioned that paying participants could help to increase response rates, which I considered would be necessary to attract busy therapists. Head (2009) also stated that making payments could be a way of beginning to equalise any uneven power relationships. I considered this a relevant point on the basis that I didn't want to feel obliged to therapists who may need to sacrifice pay or personal time to complete my interview. Thus I offered £50 for participation, which I thought would equate to an hourly rate for a therapy session.

Thus the final inclusion criteria identified trained and qualified MBCT, ACT or DBT therapists who engaged in informal mindfulness on at least five days of the week as their main form of practice for at least two years.

2.3.2 Recruitment process

The recruitment process relied on purposive sampling rather than probability sampling to ensure that I could access participants who met my inclusion criteria and would also be interested in participating in my study. This type of non-probability sampling is often referred to as 'snowballing' (Morgan, 2008). To begin the sampling process I produced a research flyer containing the inclusion criteria, research aim, offer of financial incentive and contact details (see Appendix B) and emailed it to various training and

professional therapy organisations affiliated with any of the three third wave therapies. I also contacted the organisers for two mindfulness special interest groups (SIGs) within London borough NHS trusts who agreed to circulate my research flyer to members of their mailing list. Both approaches were quite instrumental in generating responses and I was contacted by a number of interested therapists. I made arrangements to have phone conversations with each therapist to inform them of my research aims, discuss how they met my inclusion criteria and provide a comprehensive overview of what their participation would entail. Following these conversations, arrangements for the interviews were made in terms of setting dates, times and location.

2.3.3 Pilot interviews

I had asked two therapists who practiced ACT and DBT if they would be willing to conduct pilot interviews for my study and offered the same incentive for participation. I explained that I wanted to assess the effectiveness of my interview questions and practice general interview techniques and therefore they would be asked to provide feedback at the end of the interview. This feedback aided in the clarification of ambiguous interview questions and highlighted how at least one interview question had been influenced to some degree by my own positive experiences of informal mindfulness. Thus the pilot interviews were invaluable considering that one of the core principles of conducting qualitative research is for the interview schedule to be free of biases or agendas of the researcher that may appear to be leading the participants (Cooper, 2009). On this basis, I changed the wording of a couple of questions on my interview schedule to be clearer and more exploratory.

2.3.4 Participants

The study included ten therapists who delivered MBCT (n=3), ACT (n=4) or DBT (n=3), which according to Braun and Clarke (2012) is considered an appropriate number of participants for a medium-sized TA study or for a UK professional doctorate. The MBCT therapists facilitated 1- 2 MBCT groups per week, the DBT therapists also facilitated 1- 2 DBT groups and had between 12- 16 individual DBT sessions per week and the ACT therapists delivered on average 1 ACT group and had between 10-15 individual ACT sessions per week.

The sample consisted of five females and five males including four clinical psychologists, three counselling psychologists and three CBT therapists who had between 5 to 28 years of post-qualification experience. In terms of the ethnicity of this sample, seven were White British, two were Asian Other and one was Black British. Also two therapists identified that they had a spiritual and/or religious connection to mindfulness.

All therapists stated that their experience in delivering their main third wave therapy ranged between 4 to 8 years. Other therapies in their repertoire included but were not limited to other third wave therapies, CBT, person-centred therapy, psychodynamic therapy, schema therapy and interpersonal therapy. In terms of the main setting for delivering third wave therapies, five therapists indicated solely in the NHS, four therapists indicated the NHS and in private practice and one therapist stated only in private practice.

In terms of mindfulness practice, therapists identified that they had between 3 to 6 years of informal mindfulness being their main form of practice with 5 therapists indicating that they previously had a regular formal meditation practice at some point in their lives. All therapists indicated that they engaged in informal mindfulness multiple times during the day (i.e. anywhere between 5 to 15 times a day) and that each time their practice lasted anywhere between a few moments to approximately 50 minutes. Most of the therapists identified that they also currently maintained an occasional (n=4) or irregular (n=4) formal meditation practice with only two therapists stating that they currently didn't meditate at all.

Table 1 below identifies the key characteristics for each therapist according to the inclusion criteria. Pseudonyms were used to protect the anonymity of participants.

Pp. Pseudonym	***TWT practiced and years***	***Regularity of informal mindfulness practice - including examples*** *(*) approximate number of practices a day*	***Regularity of formal mindfulness meditation***	***Years of personal mindfulness practice***
Sharon	ACT 5 years	Daily (2-3) - Mindful eating, mindful play with children, mindful cooking, mindful cleaning, mindful therapy	Occasional- once every 2 weeks 2-3 day meditation retreat 2-3 times a year	9 years (5 years informal as main)
Claire	MBCT 5 years	Daily (5+) - mindfulness driving, mindful housework, mindful family time, mindful exercise, mindful night nursing, mindful living	Occasional- once every 2- 4 weeks 1 day meditation retreat every 3 months	5 years (3 years informal as main)
Liz	DBT 6 years	Daily (3-5) – Mindful walking, mindful eating, mindful body movements, mindful working/ finances, mindful reading	Irregular- 2 day meditation retreat once a year	6 years informal as main
Andrew	ACT 6 years	Daily (5+) - mindful jogging, mindful showering, mindful piano, mindful conflict, mindful eating	Irregular- 2-3 day meditation retreat twice a year	6 years informal as main
Rosanna	DBT 4 years	Daily (3-5) - mindful exercise and walking, mindful talking, mindful eating, mindful showering, mindful arguing, mindful body movements	No formal meditation	4 years informal as main
Mark	DBT 5 years	Daily (4-5) - mindful sport, mindful dog walking, mindful laundry, mindful eating	No formal meditation	5 years informal as main
Steven	MBCT 8 years	Daily (5+) - Mindful diving/ swimming, mindful driving, mindful shopping, mindful time with family, mindful research, mindful therapy	Occasional- 2 day meditation retreat every month	8 years (4 years informal as main)
Neena	MBCT 6 years	Daily (5+) - Mindful running, mindful gardening, mindful parenting, mindful housework, mindful talking, mindful pilates, mindful therapy	Occasional- once every 2 weeks; 2 day meditation retreat every 3 months	6 years (3 years informal as main)
Phil	ACT 8 years	Daily (5+) - Mindful walking, mindful talking, mindful family time, mindful cooking, mindful tea drinking, mindful therapy	Irregular- 2-5 day meditation retreat twice a year	20 (4 years informal as main)
Jeff	ACT 5 years	Daily (4-5) – Mindful exercise, mindful family time, mindful driving, mindful showers, mindful therapy, mindful eating	Irregular- 2 day meditation retreat once or twice a year	5 years informal as main

Table 1: Summary of key mindfulness characteristics for each participant

2.3.5 Interview schedule

My final interview schedule interview consisted of five open and neutral questions. To ease therapists into the interview process without feeling as though their mindfulness practices were being evaluated, I began by asking a more general question on how their mindfulness practice and in particular their informal practice developed in their lives. This was followed by more specific questions that explored how and in what ways their informal mindfulness practice affected them in their personal and professional lives and the ways in which their practice may have changed over time. A copy of the semi-structured interview schedule can be seen in Appendix G.

2.3.6 Semi-structured interview process

The interviews were conducted either in the participants' work places (after hours if they were in the NHS), at City university or in the participant's home over a period of six months. All participants were sent a Pre-Interview Letter (see Appendix C) via email 5 days before the scheduled date to confirm the time and place of the interview and to provide directions if they were coming to meet me at City University.
Upon commencing the interview process, participants were read out a Research Brief (see Appendix D) and given a further opportunity to ask questions. Participants were then asked to sign a Consent Form (see Appendix E) and complete a Participant Monitoring Form (see Appendix F) in order to capture some of their key inclusion characteristics. Participants were also given the £50 incentive before commencing the interview and it was confirmed verbally that the payment was irrespective of them completing the interview or deciding to withdraw their participation following the interview. All interviews were recorded on a digital voice recorder and lasted between 55- 65mins, which is considered to be a reasonable amount of time to extract richness from a semi-structured interview (Kvale, 1996). After the interviews ended participants were asked to reflect on the interview process itself and on any positive or aversive experiences it may have brought up for them. Participants were also given the opportunity to provide feedback on their experience of how I conducted the interview and to add any further reflections that they previously hadn't thought of or didn't want to have recorded. All participants were then read out a Research Debrief (see Appendix H), which outlined why the study was being conducted as well as the researcher's expectations for what the research may reveal and the impact it could have for professional practice. It also included a section on options for further support to ensure safety, which was discussed individually with each participant.

When the participant left, I wrote notes in my research diary on how I felt the interviews went, interesting observations of the participant or of my own experiences and key reflections on interview technique. The digital recordings were uploaded as a file on my laptop and anonymized using each participant's pseudonym and then sent electronically as password protected files to a professional typist. Before receiving the files, the typist was debriefed on the nature of the study and the confidentiality stipulations and was also asked to sign a transcription contract confirming her understanding and commitment to confidentiality. The typist was asked to transcribe all recordings verbatim including vocal utterances (e.g. ums, ahs), any half words, incomplete sentences or laughs. This was to ensure that the text represented the interview as close as possible. A disadvantage of not transcribing myself was missing the opportunity to familiarise myself with the interviews from the outset however the main advantage was in the time it saved, which gave me ample opportunity to familiarise myself with the typed transcripts.

2.3.7 Analytic Strategy

The analytic strategy in developing themes was guided by the framework set out in Braun and Clarke (2006, p.87). What follows is an overview of each suggested step in the framework as well as a reflective commentary on how I carried out these steps in the present study.

1) *Familiarising yourself with the data*: In this initial step the researcher is required to transcribe data if necessary, read and re-read the data and note down initial ideas. As I didn't transcribe all the interviews myself I read the transcript firstly alongside the audio-recording of the interview, correcting any errors in the transcription and noting down my impressions of the participants' voice, tone and non-verbal expressions. I then re-read the transcripts several times after noting down my ideas about what the participants had said and possible explanations for changes in their tone and their expressions. This process was found to be incredibly beneficial for realigning myself with the context of the data.

2) *Generating initial codes:* This next step involves the researcher coding interesting features of the data in a systematic fashion across the entire data set and collating data relevant to each code. As I was conducting an inductive TA whereby my coding and themes were intended to come from the data, I started the coding process by highlighting key features of the data and generating codes across the transcripts. The

codes were determined according to what was actually said about the experience (e.g. “I taste more” or “I don’t need to fix”), how it was said (e.g. with a long pause or a nervous laugh) or any noteworthy concept or idea. This meant that coding was applied to smaller units of meaning (e.g. a participant’s non-verbal expression such as a laugh or sigh) as well as larger units of meaning (e.g. a theoretical comment such as a metaphor lasting 2-3 lines). Overall this was a lengthy and detailed process that required much attention to detail and a recursive back and forth process.

3) *Searching for themes:* This step asks the researcher to collate their codes in order to form potential themes and to start gathering all data that appears relevant to the themes. In this stage of the analysis, I started to check for consistency in how I was developing the themes and how they presented convergences and divergences in the data. Thus I found myself going back and forth between the transcripts, the codes and the themes in order to clarify the validity of the themes.

4) Reviewing themes: In this stage, the researcher generates a thematic map or table of the analysis to check if the developed themes make sense in relation to the extracts of data and the entire data set. I started this process by drawing out a rough thematic map on a large piece of cardboard that was helpful for initially linking the codes and themes across the data set. I later converted this map into a thematic table (see Appendix I) that was more useful for conveying the data in an electronic format. In this table, I included the themes and the extracts of data that showed convergences and divergences. I also produced another table illustrating the prevalence of themes in each item data item and across the broader data set (see Appendix J).

5) Defining and naming themes: In the final step before writing up the analytical report, I defined the themes in regards to the overall story they told about the data and how the data relates back to the original research question. Defining the themes in this way meant that I was able to illuminate key features of each theme as well as reflect on the broader phenomenon of interest.

6) Producing the report: The final stage of analysis was producing the analysis and discussion chapters in which I relied heavily on the thematic table to structure the documentation of my qualitative outcomes. In the analysis chapter, I presented each theme in detail with a broad selection of vivid and persuasive data extracts from each data item with corresponding analytical narrative. In the discussion chapter, I

considered the implications of the key findings from each theme and explored their significance in light of existing literature.

2.3.8 Ethical considerations

Ethical approval was granted by the Department of Psychology at City University following submission of my research proposal and ethical release form (see Appendix L). The ethical considerations that I adhered to in developing this study were guided by the British Psychological Society Professional Practice Guidelines (2005) and the ethical guidance for doctoral studies provided by City University. The ethical considerations made related to informed consent, attendance to participants' experiences including avoidance of harm and managing distress, bringing benefits to participants through the research process and ensuring participant anonymity and confidentiality of data.

In terms of informed consent, all interested therapists received ample information about the study, its aim and what their participation would entail as well as the opportunity to ask questions before agreeing to meet me for the interview. Upon meeting for the interview, this information was reiterated to all participants in a verbal briefing before they signed the consent form and the interview commenced.

Regarding the attention paid to participants' experiences, I followed Lester's (1999) suggestion that in order to gain depth of information or to create a comfortable environment so that participants feel willing to give something personal of themselves, it is necessary for researchers to establish good rapport and extend empathy from the out set. To do this, I enquired into participant's wellbeing and engaged in light conversation upon meeting to make the participants feel comfortable in my presence. Before commencing the interviews, I also gave participants the chance to discuss any recent aversive experience that may affect their ability or desire to participate in the study and to ask any further questions. All participants expressed openness in signing the consent form and confirmed that they were in a state conducive for interviewing. One participant mentioned beforehand that he/she may become tearful during the interview if certain topics arose but that this was part of his/her emotional processing and wouldn't prevent him/her from continuing. This was discussed briefly before the interview commenced and the opportunity to reschedule or cancel the interview was offered again.

Following the interview, I began the debriefing process by asking participants if they wanted to add anything that they felt was important in regards to their experience but hadn't been asked or they hadn't thought about at the time. I then read aloud a prepared debrief that reiterated their rights as a participant and also asked more explicitly about any aversive experiences that may have arose during the interview. Three participants mentioned that recalling painful memories brought up some feelings of grief, sadness or anger, but that they were mild and manageable and that further debriefing was not necessary, however we spoke about what steps they could take if these feelings become more disturbing at a later point. Participants mentioned that they would seek support from their family, friends or colleagues if needed and the debrief offered further options for support.

In aiming to make the interview/ research process beneficial for participants, I gave them the opportunity to provide feedback on how the recruitment and interview process was conducted. This was so that participants would feel as though their experiences of being part of the data collection process were as important as the experiences that they provided in the interview. I had also noticed that two participants released their breath when I turned the voice recorder off and attempted to explore this in the process. It seemed that every participant responded well to this post-interview discussion and were quite open and reflective about their experiences of being interviewed about a topic that they generally spent more time engaging in rather than reflecting on in great depth. All but one participant stated that it was a rewarding and eye-opening experience for them. The one participant who didn't, mentioned that they struggled to verbally articulate their subjective experiences in a way that felt accurate, which was discussed openly and non-judgementally.

To ensure participant anonymity and confidentiality of data, the interview recordings and transcripts for each therapist were assigned pseudonyms so that the typist could not identify the person by name. All research and interview material was kept as password-protected electronic files on my laptop and all hard copies of transcripts or consent forms were kept in locked storage cabinets.

2.4 Statements of Reflexivity

Willig (2008) stated that engaging in the process of reflexivity and ensuring the transparency of all analytic procedures helps to promote the credibility and validity of the research whilst Sandelowski and Barroso (2002) state that “reflexivity is a hallmark of excellent qualitative research” (p222). These researchers point out that in order for reflexivity be carried out with appropriate rigour, the researcher is required to reflect inwards on his/her position as the inquirer, reflect outwards on the multiple contexts that may influence the inquiry and also reflect relationally on the nature of the interaction between him/herself as the researcher with the participants of the study (Sandelowski & Barroso, 2002). In regards to TA studies, Braun and Clarke (2006) recognise the importance of reflexivity particularly for TA studies that are characterised by latent themes. From a counselling psychology perspective, the interpretative role of the researcher creates the specific need for reflexive practice whereby the researcher is expected to openly and transparently reflect on how their personal and theoretical positions on the subject matter could be implicated in the research. Gil-Rodriguez and Hanley (2011) note that reflexivity offers counselling psychologists a means to humanise any process of research or therapy and acknowledges the inherent value of subjectivity in research. Thus in this section I present three reflexive statements highlighting the possible influences my personal, epistemological and methodological positions may have had in this study and the means by which I attempted to reduce their overall impact on the outcomes.

2.4.1 Personal reflexivity

Kasket (2012) suggested that personal reflexivity can entail how a researcher’s personal experiences, beliefs or expectations about the subject matter could be implicated in the research process. Therefore this statement focuses on the potential influence of my own personal and professional relationship with mindfulness and the contexts in which this relationship arose and how this was managed. One of my significant beliefs on this subject matter can be summed up by the idiom: ‘practice what you preach’. In many ways, my impetus to embark on this research study stemmed from my desire to explore the experiences of therapists who in essence were practicing what they preached insofar as bringing some form of mindfulness into their lives whilst teaching it in some way to others. Whilst I wasn’t concerned with the degree to which therapists practiced according to the expectations of their therapeutic modality, I was certainly interested in how this discrepancy was experienced by the therapist if it arose.

The research question also exemplified my commitment to confront culturally- contrived notions of hierarchy between therapist and client, and traverse time-honoured boundaries between therapists' personal and professional lives. For example this study allowed me to explore the ways in which therapists' experiences of mindfulness may be similar to that of their clients' and also explore the potential overlaps between teaching and practicing mindfulness.

Lennie and West (2010) point out that when one explores the deeper reasons why a particular study was undertaken it often implicates involvement of the researcher's self that is challenged in some way by the subject matter and "niggled by a desire" (p.87) to research and understand one's own experiences better. Thus the researcher's own role in the research process can actually constitute some form of personal therapy or opportunity for personal growth (Lennie & West, 2010). This observation resonates quite powerfully for me as I reflect on how this study has been a somewhat indulgent endeavour to understand the shifting role of informal mindfulness in my own personal and professional life. My particular 'niggle' in this study was my desire to validate the value and significance of informal mindfulness practice in my life and in the lives of others especially as I had always felt that informal mindfulness was considered inadequate or not highly respected in the wider mindfulness community unless it was accompanied by meditation. Lastly, I reflect on how my own personal and professional relationship with mindfulness may have been implicated in this study. Lennie and West (2010) also mentioned that crises in a researchers' personal life may not directly impact on the research but may be a process through the study. Throughout the research process, my mindfulness practice waxed and waned as a result of personal and professional challenges and I felt this experience potentially affected how I connected to my participants' data. For example, during times of struggle I abandoned my own mindfulness practice, which made in more difficult to analyse data that revered the practice as it brought up feelings of doubt in my commitment to mindfulness on the whole and thus my commitment to this study. It also compelled me to seek solace in data that reflected the challenges of others to point out that I was not struggling alone. To address this I relied heavily upon being reflexive in my research journal, to my research supervisor, to fellow mindfulness colleagues as well as to family and friends. I found that this process allowed me to remain aware and reflexive about what was occurring for me as a person as distinct from what my role was as a therapist/ researcher.

2.4.2 Epistemological reflexivity

Nightingale and Cromby (1999) point out that engaging in epistemological reflexivity requires the researcher to reflect critically on the research question and the assumptions it makes about the world and how the research process itself can define and limit what knowledge can arise from the study.

To begin, I reflect on the research question and its assumption that mindfulness and in particular informal mindfulness practice can provide personal and professional experiences significant enough for third wave therapists to reflect on in my study. The research question also implies that mindfulness for therapists is not just important for them as professionals to deliver to clients but also as people who exist in the world as humans susceptible to pain and suffering. In context of existing literature, the subtext of the research question also suggests that there is value in all forms of mindfulness including informal mindfulness techniques. One impact of this research question on the study is that it may have self-selected third wave therapists who do not rely on mindfulness meditation in their lives or do not feel the need to practice meditation as often as stipulated, yet still feel that their informal mindfulness is significant enough to discussed and reflected on and these experiences to be validated in the context of an interview. Furthermore, it may have offered these third wave therapists a valuable opportunity to explore their personal experiences and to recognise that these experiences were just as significant as their professional ones. From a counselling psychology perspective, I saw these characteristics of the research question as being critically important to setting broader benchmarks on phenomenological perspectives towards mindfulness practice. I also considered that the exploration of different kinds of informal mindfulness practices would allow me to take a more pluralistic stance towards the phenomenon, which McAteer (2010) points out is a core value in counselling psychology.

My other key area of epistemological reflexivity concerns how the given research process influenced the knowledge that this study produced and how this was used to make sense of the phenomena. Some of my initial concerns were whether participants would be able to recognise and communicate the myriad of ways in which they experienced their daily practice of informal mindfulness in their personal and professional lives and whether I as a subjective researcher would be able to follow the words of Carl Rogers by placing my assumptions to one side in order to let the participants' truths shine through more brightly (Kirschenbaum & Henderson, 1996). Through practicing mindful awareness myself throughout the interview process and analysis and establishing good rapport with all participants, I felt I was able to bring

openness and curiosity to what was being presented even if it did contradict with my own beliefs or assumptions. In many ways, I found myself embracing the contradictions and multiple perspectives that arose from the data and in particular anything that presented a unique or novel viewpoint that I hadn't previously conceived. It was also comforting to make sense of the data that was familiar to me, yet to interpret its meaning in context of the participant's experiences and demographic background. From the stance of a critical realist, I was able to interpret the language and non-verbal communication to explore the complexity of participants' meanings and the multitude of factors that may have influenced the participants' ability to convey the reality of their experience at the time. For example, the relative differences in status and experience of myself compared to some of the more senior practitioners I was interviewing meant that sometimes instead of reflecting on their experiences, some of these participants attempted to explain theoretical concepts or empirical data. This may have been to inform me, to demonstrate their knowledge in the area or perhaps because it may have been more comfortable than sharing particular challenges or vulnerabilities that may have felt uncomfortable at the time. In these situations, the research process allowed me the space to tentatively make these reflections and attributions either as part of the reflexive or interpretative process. As much as counselling psychologists privilege phenomenological approaches to studying human experience as noted by Gil-Rodriguez and Hanley (2011), Kasket (2012) points out that a significant aspect of epistemological reflexivity also involves the researcher examining how other methods may have produced different insights. For example, it could have been interesting to use a positivist or quantitative methodology that compared levels of mindfulness or measures for empathy, compassion or attention for therapists who practice either regular informal mindfulness, regular meditation or have no mindfulness to determine whether different mindfulness practices produce different outcomes. Likewise it would also be interesting to take a social constructionist perspective to explore how discourse in a workplace can influence therapists' attitudes towards the practice of informal mindfulness and its value with or without mindfulness meditation.

2.4.3 Methodological reflexivity

This statement of methodological reflexivity presents an account of the ways in which my position as the researcher may have shaped this study in regards to the research methods and procedure. Thus I aim to consider how my decision making process and approach to participant sampling, data collection and analysis may have affected the

study and highlight the steps taken to address any personal biases as recommended by Kasket and Gil-Rodriguez (2011).

In regards to the participant sampling, I felt my own experiences as a third wave therapist who practiced informal mindfulness on a regular basis were key in shaping the direction of this study. Whilst I was initially only going to sample ACT and DBT therapists who are not required to meditate on a regular basis like MBCT practitioners, I decided to take a more pluralistic standpoint by recruiting third wave therapists from each of these three backgrounds who practiced mindfulness in different ways yet still identified informal mindfulness as their main approach. As well as aligning to my values as a counselling psychologist, adopting a pluralistic stance presented the opportunity to explore the experiences of informal mindfulness from different theoretical and personal perspectives. At some point I had considered including third wave therapists who identified that they practiced informal mindfulness with less regularity, however I decided not to include these therapists on the basis that I didn't believe that irregular informal mindfulness would yield sufficient exposure to the experience of mindfulness in order to reflect on it meaningfully and richly in my interview. Also I assumed that there would be few therapists who would be willing to commit time to participate in an interview on mindfulness if it didn't play a significant role in their personal lives.

In collecting the data, my position as a counselling psychologist and a mindfulness therapist drew me to the use of semi-structured interviews as I believed it would offer me the flexibility to be present with and curious towards the knowledge arising in the moment with the participant. In the data collection process I was initially curious to find out about how the experiences of therapists aligned with my own, in part to validate my efforts and beliefs about informal mindfulness. I recognised the potential for this curiosity to influence the direction and tone of my questioning, for example, by showing excitement towards experiences that were similar to mine. To overcome this, I rigorously reflected on the evolution of my own mindfulness practices and beliefs in my research journal and with my research supervisor in order to gain clarity on my own position in order to understand the position of others.

My approach to data collection was open, curious and non-hierarchical in nature. I also chose to reflect on my participants' subjective experiences of mindfulness as well as their intersubjective experiences in the room so that participants would recognise my genuine interest in their experiences and my efforts to be mindfully present in the interview and respectful of their vulnerability rather than merely asking questions for the sake of completing a research study. I sensed that this open dynamic between myself and each participant contributed to an overall richness of the data collected as many of the participants revealed in the debriefing process that the interview was a therapeutic

experience for them in terms of being given ample space to reflect on the significance of informal mindfulness practice in their lives.

And lastly in conducting the analysis, my own varied experiences of formal and informal mindfulness practice led me to choose a methodology such as TA that could accommodate heterogeneity in the sample and in the forms of mindfulness practice undertaken without losing the scope to produce richly interpretative outcomes. Kasket and Gil-Rodriguez (2011) highlight the value of exploring different perspectives that arise in human experiences and contextualising against a background of human diversity. In my TA analysis, I was able to explore the multiple perspectives of therapists who shared the experience of having a long term, daily informal mindfulness practice in quite different ways and thus had the opportunity to contextualise the possible factors contributing to the convergences, divergences and paradoxes that arose.

Chapter 3: Analysis

The semantic and latent levels of thematic analysis produced six themes that illustrated distinctive yet interconnected patterns of meaning across the data set. The table below outlines the labels of each theme and their definitions[1].

Labels of themes	Definitions
"Wow! This is really life changing!": Daily informal mindfulness practice enhances wellbeing in an unexpected and life changing way	Outlines the various ways in which participants' wellbeing benefitted from their daily informal mindfulness practice in unexpected and life-changing ways, either because they had never practiced any form of mindfulness before or because they had not anticipated that their informal mindfulness practice could be so effective without daily meditation. The unexpected benefits to wellbeing included a sense of calm arising from single-pointed concentration, an ability to respond rather than react to multiple daily stresses and an increased sense of resilience and effectiveness in life. However some participants indicated that whilst their informal mindfulness practice was both beneficial and life changing, it was one of several life tools that had this same effect. It was also found that informal mindfulness was not as life changing or beneficial without some meditation practice for some participants.
"Just brushing my teeth can bring wonder and enchantment to my life": Informal mindfulness heightens sensory awareness and gratitude for taken-for-granted experiences	Highlights the salutary effects of daily informal mindfulness practice on participants' sensory awareness. The specific effects appeared to be sharper and intensified sensory experiences, enhanced intuitive faculties and "felt-sense" sensitivity and a broader repertoire of sensory responsiveness. These sensory phenomena contributed to a deep sense of gratitude for the ordinary activities that elicited them regardless of whether the activities were subjectively pleasant or unpleasant. Subtle divergences arose in the degree to which participants who had more formal meditation practice described or inferred a greater degree of acceptance, kindness or gratitude towards their sensory experiences compared to the participants who had less or no formal meditation practice.
"Any life activity that generates suffering is an opportunity to overcome suffering": Informal mindfulness offers multiple, in vivo contexts for overcoming suffering and dealing with pain more effectively	Focuses on how daily informal mindfulness practices offered multiple situations in which participants could mindfully approach pain and suffering in the moments they arose, which benefitted them both personally and professionally. Participants described how their practice strengthened their ability to embrace acceptance, compassion and loving-kindness towards all experiences and reinforced their stance of detachment and non-judgement towards suffering. Certain challenges were also overcome, which included recognition that acceptance can be a gradual and painful process in itself and that any efforts to minimise pain with excessive daily mindfulness could inadvertently increase the experience of suffering or lead to over-detachment. This personal practice also enhanced therapists' willingness to be present with their client's pain without trying to "fix it" and also helped them to deal with their clients' anger more constructively.

[1] See Appendix I for full thematic table with data extracts

"*Mindful therapy allows the therapist and client to be both human and expert":* Mindful therapy fosters use of self and other for therapeutic connection	Focuses on the descriptions or interpretations of "mindful therapy" as an informal mindfulness practice applied during the activity of therapy itself. In respect to use of self, participants found mindful therapy to be a means of bringing awareness to their own humanity, which became an organic catalyst for developing meaningful, authentic and non-hierarchical therapeutic connections. Mindful therapy was also found to enliven the embodiment of mindfulness qualities and to teach through this embodiment. In respect to use of other, engaging in mindful therapy allowed participants to connect with their clients' life experiences and wisdom and to actively draw these client attributes into the therapy process. Whilst being beneficial, some participants also experienced mindful therapy to be a tiring and exhausting practice that felt qualitatively similar to meditation. Also difficulties arose in determining the extent to which mindfulness of self or other should guide the direction and content of therapy.
"It's like a bridge between being and doing": Informal mindfulness can reconcile the stance of "being" in mindfulness with the culture and beliefs related to "doing" in the West	Highlights the function of informal mindfulness as a "bridge" that merges two seemingly disparate modes of Eastern and Western existence. Several participants experienced informal mindfulness as a practice that accommodates "being *whilst* doing" and thus offers a viable and conducive means to bring mindfulness into their daily lives. Participants also found that their own experiences of informal mindfulness helped them to address common misconceptions, unrealistic expectations or difficulties in practicing mindfulness that are prevalent in the West, which encouraged a more flexible teaching approach. The integration of being and doing during everyday activities did however pose some challenges in respect to the distraction of engaging in the activity itself or the distraction of competing sensory stimuli. There was also concern about how the rising popularity of informal mindfulness practices may serve to dilute or detract from the value of mindfulness meditation and yet still be overshadowed by more dominant change-based protocols in many Western clinical settings.
"If I hadn't had one or the other, both would be weaker": Having both a personal and professional investment in mindfulness can be mutually reinforcing	Defines the mutually reciprocated and reinforcing relationship between personal and professional mindfulness practice. For many participants this involved the seamless integration of daily informal mindfulness into their everyday life as "mindful living", which amplified their experiences of belief and fulfilment in teaching mindfulness to others. On the other hand, some participants also experienced attenuation in their self-efficacy or affective wellbeing if their mindfulness practice suffered or was perceived to be inconsistent in either or both areas of their life. The nature of these mutual relationships however varied across the therapeutic backgrounds or spiritual affiliations of the participants.

Table 2: Labels and definitions for themes

3.1 *"Wow! This is really life changing!": Daily informal mindfulness practice enhances wellbeing in an unexpected and life changing way*

This theme was epitomized in the following quote from Andrew, who started practicing informal mindfulness upon training to be a third wave therapist:

> "It gave me er, a feeling of, 'hey, there's something in this! I'm on the track of something here, this isn't just some, you know, it's not some slightly wacky Eastern spiritual thing you know, but wow! This is really life changing! There's something shifting in, in my consciousness, and I can feel it in everything I do…. now I am here, existing, living… fully!" (p3)

Andrew spoke in a raised and enthusiastic voice conveying a sense of excitement at the life changes that his practice produced yet the exclamations in his quote hint at having overcome some doubt that engaging in mindfulness could have such a significant impact in his life and consciousness. Andrew also seemed to highlight that his initial perceptions of mindfulness as an alternative or purely spiritual practice perhaps made him more sceptical so the outcomes appeared to have a two-fold effect in terms of changing his life as well as shifting his understanding or appreciation for the legitimacy of mindfulness and in particular, informal practice.

Claire offered an equally powerful insight into what the daily practice of informal mindfulness had lent to her life since becoming her main form of practice:

> "It erm, it sort of offered me something different, it was a somewhat different skill, and when it became a significant part of my life, it took me by surprise (pause) …It just feels like this is something that is very, very nourishing for me, in a different way to sitting in meditation (pauses)… It erm, just feels very special (pause)" (p2)

Claire's slow and deliberate manner of speaking and her multiple pauses indicated a reverence for the value of informal practice in her life. Her quote also indicated that there was a subjective difference in how she experienced informal mindfulness practice compared to her meditation and that she hadn't expected to benefit or be "nourished" as much as she had from practicing informal mindfulness every day.

Also true for Phil was that practicing informal mindfulness in his everyday life allowed for greater daily awareness:

> "I started to connect to so many more emotions throughout the day… I didn't even know I could feel so many feelings just making a cup of tea!" (p1)

Phil inferred that informal mindfulness practice enhanced his emotional wellbeing in allowing him to recognise and be open to a greater breadth of emotional experiences in his everyday life. His exclamation also indicated a sense of surprise that even though he used to meditate regularly, it was his daily informal practice that prompted awareness of the changeable nature of his emotions in a simple, everyday task.

Sharon also reflected on the significance of re-establishing an initially tentative connection with mindfulness through her daily informal practice after ceasing her spiritual connection to Buddhism several years prior. She cleared her throat and almost became teary when she said that it made her feel as though her "life is… starting over". The content and emotion embedded in this extract insinuated that the effects of Sharon's reconnection with mindfulness through informal practice were so powerful that it evoked what could be inferred as a *spiritual rebirth* in terms of giving her the opportunity to live with meaning again even though she hadn't fully resumed her meditative practice.

Some participants were more descriptive in outlining the ways in which their informal mindfulness practice brought about these unexpected and/or life-changing experiences through having a single-pointed focus. For instance, Neena stated the following:

> "I only need to switch off my phone, or the TV or erm, close the laptop and just find a way of focusing completely on what I'm doing at the time, it doesn't matter what it is, the cooking, shopping, erm, having a conversation with my partner…giving myself this time just gives me that feeling of 'ahhh' [release of breath]… It just really affects how the rest of my hour or even how the rest of my day will go…" (p3)

Neena's pronounced release of breath signified a release of tension or the feeling of reaching a calm, relaxed state as the result of bringing mindful awareness to one task at a time, which in turn became more meaningful as a result of switching off from other

distractions. The narrative of “giving” herself the time and opportunity to engage in her life in this way suggested that Neena perceived her informal practice as a necessity as well as a way to nourish her well-being.

Liz also spoke about how her informal mindfulness practice reduced stress in terms of knowing what to pay attention to during her day:

> “I’m less full of all the rubbish that’s going on in my head, or at least I respond to it, um, without getting too much into all the arguments in my head … Also, I think probably I’m far less stressed as I’m able to deal with what comes up as it does instead of letting it all build and build to, you know that pressure point where you feel like, ah, I’m about to explode… it all just gets dealt with in a different sort of way that is more helpful” (p2)

Liz indicated that she felt subjectively less stressed as her informal mindfulness practice had changed her responses to unpleasant mental events and stressful situational events. A key experience for Liz seemed to be that instead of reacting to the presence of these mental or physical stressors in her day or trying to eliminate them, she had become more skilled in responding mindfully in each individual situation and continuing to function even if the stress was present.

Other participants mentioned how effective informal mindfulness was in building their sense of resilience and effectiveness in life. For example, Rosanna mentioned that informal mindfulness prevented her from “short-circuiting or breaking down”. And Mark stated:

> “[mindfulness] helps keep my engine going… it’s a kind of useful, useful oil in the engine” (p5)

Interestingly, both of these quotes imbued the effects of mindfulness with a ‘mechanical’ quality that offers longevity and strength, suggesting that daily informal practice could enhance their ordinary human functioning as well as offer a defence to human malfunctioning.

Jeff offered another similar metaphor:

> "Rather than being swept along by a tide of events or emotions, I feel a little bit like, I'm back in the driving seat, I can slow things and I can choose to focus on what is going on right now… on what I'm doing right now… And this helps me to direct my life more effectively" (p3)

This description created a graphical impression of Jeff's mindfulness practice being somewhat of a lifeboat that offered him refuge or safety from events or emotions that might be potentially overwhelming. Jeff's use of self-oriented terms such as "I", "I'm" and "my" suggested a sense of personal empowerment in being able to make a conscious choice to slow things down so that he could respond effectively rather than react to the multitude of forces that were attempting to influence his life.

There were however other reflections on the effects of informal mindfulness practice that appeared less enthusiastic if not more impartial. For example, Liz described the effects of her daily practice as being "a nice surprise" however noted that it was one of many therapeutic skills she used that had a significant impact on her wellbeing and her life in general. And Rosanna mentioned that informal mindfulness was an "effective tool" that she used alongside other useful DBT skills. These descriptions by two of the DBT therapists indicate that whilst informal mindfulness practice had brought about discernable benefits to their lives, they were not necessarily life changing on their own. Rather, their mindfulness practice was part of an eclectic toolbox of skills that were all effective in their own way.

On the other hand Steven stated:

> "…as beneficial and uh, as much as I enjoy the practice [of informal mindfulness], I know I wouldn't be able to go too long without meditation… it's my foundation really, even though it's not often, it, erm, you know, my daily practice wouldn't work in the same way without it" (p1)

Steven's quote had an energy that demonstrated his strong conviction that the benefits of his informal practice were heightened by his meditation practice, even though he had never practiced informal mindfulness without meditation to determine whether it would 'work in the same way'. It is possible that his beliefs about the fundamental nature of meditation or his awareness of my impressions of him as an MBCT therapist in the

interview session could have influenced how he described the relative benefits and status of his informal practice.

3.2 *"Just brushing my teeth can bring wonder and enchantment to my life": Informal mindfulness heightens sensory awareness and gratitude for taken-for-granted experiences*

Neena's quote highlights the essence of this theme:

> "It's about bringing full awareness to the simple things in life, such as brushing my teeth and tasting the mint in my mouth and feeling the foam inside my cheeks and the cool water on my face… it's delightful how just brushing my teeth can bring wonder and enchantment to my life (short laugh)!" (p4)

There was an enthusiasm in Neena's voice almost as if her reflection on this experience reinforced the sense of wonder and enchantment as she uttered it. Her laugh also suggested that Neena found it amusing or thought others may find it amusing that experiencing all the senses involved in brushing her teeth would elicit such gratitude and enchantment.

Claire offered a narrative that conveyed a similar experience:

> "My mother had this fridge magnet that said something like 'thank God for these dirty dishes as they uh (pause)… I can't remember exactly, something like, the dirty dishes meant that we had enough food to eat or we that we didn't go hungry, or something similar to that… On those days when I'm tired and have to wash a sink full of dishes (short laugh), being mindful of what those dishes mean in my life (pause), it helps to becomes less of a chore" (p4)

This extract illustrated how Claire's mindful awareness of the thoughts and emotions that arose in the moment of seeing her sink of dishes seemed to shift her attitude towards doing them i.e. instead of feeling burdened by the prospect of having to perform a chore, her awareness brought about a acceptance and gratitude in her approach towards the task. It also highlighted how specific memories could become cues or reminders for Claire to engage in informal mindfulness during the day.

Andrew highlighted how when mindfully eating, his sense of smell and taste "gets turned up". He stated that this could be either a pleasant or unpleasant experience depending on what he was eating at the time. Mark also commented that when eating an orange mindfully, it felt like he could "hear the juice in [his] mouth". These quotes imply not only an intensification of their senses (e.g. smell, taste, touch), but suggest that mindful eating could result in blended sensory experiences.

Jeff articulated a very similar reflection:

> "…It's like having the world on slow motion and all my senses are amplified, which feels unreal!" (p3)

Jeff's exclamation and his use of the term "unreal" indicated that his sensory awareness brought about a trance-like quality to his everyday experiences that he seemed to enjoy rather than feel disturbed by.

Sharon reflected on how bringing an attitude of loving-kindness and compassion to her daily mindfulness practice of washing her face in the morning could evoke meaningful shifts in her attitude:

> "…Sometimes when I look at my face in the mirror, I feel sad as I, I look at my wrinkles, and, touch my face, and see this and this … Then I can look at these same things that uh, make me sad, and I show them love and kindness, and my face changes! I have wrinkles, yes, but I have a body, and a heartbeat…. I can not be sad when I am being mindful of my heart beat" (p2)

Sharon's quote highlights the transformative nature and necessity of having an accepting and compassionate attitude whilst practicing daily mindful awareness of her body. It also hinted at the possibility that without this attitude, Sharon's practice of sensory awareness could be susceptible to judgement and desires and thus have an adverse effect on her.

On a related note, Steven pointed out how valuable it was for him to be present with and show acceptance and compassion towards more aversive experiences:

> "Actually some of the, erm, (pause) the less relaxed states, actually are more valuable, in terms of being present with them, and accepting the feelings that they bring up, it feels like more progress" (p7)

Steven acknowledged further that having pleasant sensory experiences were "only sometimes a fortuitous outcome" of his mindfulness practice and that he attempted to practice being mindful during more demanding events or activities as much as he did for enjoyable life activities. In referring to his feelings of "progress", it seemed as though it was very important for Steven to know that he could continue to develop and strengthen his mindfulness capacities through more informal mindfulness practices particularly because he wasn't meditating as often.

Daily informal mindfulness was also seen to enhance some participants' intuitive faculties and sensitivity to "felt-sense" experiences. For instance, Phil reflected on an intuitive experience when being mindfully present with his daughter:

> "…it was like hairs pricking the back of my neck… I knew that something had happened at school that day... she was happy and smiling but it was just a fleeting look she gave me that I could have so easily missed if I wasn't being mindful in that moment…" (p8)

Phil appeared quite emotional in talking about this mindful encounter with his daughter, almost as if it was a reminder to him of the importance of being mindful with his family. The intuitive experience Phil described also suggested that being mindfully aware in his everyday life allowed him to connect to his intuitive senses that might not be so easily accessible if his mind was busy or he wasn't paying attention..

Liz also spoke about how informal mindfulness practice helped her to "be in wise mind" throughout the day and pick up on what her body was telling her:

> "…sometimes it's about listening to my gut reaction and following it really… I don't always know if I'm on the right track, but I can get a sense of it in my body" (p5)

This suggested that Liz could access a more felt sense or intuitive insight by tuning into her bodily sensations and then using this insight to make a more knowing decision even in the absence of factual knowledge.

The last finding was that daily informal mindfulness could develop a broader repertoire of sensory responsiveness. Claire illustrated this by stating that over time she had become more perceptive of, and even open to different environmental stimuli even when she wasn't being intentionally mindful. She gave the example of being able to "hone in on auditory sources" like "buzzing, humming or background noise" or able to taste "subtle differences" in her husband's cooking that surprised him when she noticed. This suggested that the effects of Claire's mindfulness practiced generalised into her sense of being rather than only occurring when she was consciously being mindful. The enthusiasm in Claire's tone also hinted that the breadth of her sensory receptiveness was a welcomed and beneficial aspect of her daily functioning.

A somewhat contrary example was provided by Rosanna who described a more adverse experience of practicing informal mindfulness whilst grocery shopping:

> "…so when I'm in Sainsburys, I erm, I sometimes feel bombarded at times by all the colours, sounds, smells…it, erm, can be quite stressful" (p9)

Rosanna's description of her sensory bombardment as unpleasant and stressful seemed to imply that she was attempting to use mindfulness to alleviate unwanted sensory experiences but that it was having the opposite effect. And unlike Claire or Steven, it seemed as though Rosanna's practice of being mindful whilst shopping was lacking in the qualities of acceptance, compassion or even kindness towards her sensory experiences. Also Rosanna did not appear to acknowledge, at least in the moment during the interview, the significance of bringing these qualities to her practice or how they could have potentially altered the shopping experience for her.

3.3 *"Any life activity that generates suffering is an opportunity to overcome suffering":* Informal mindfulness offers multiple, in vivo contexts for overcoming suffering and dealing with pain effectively

Claire expressed how daily mindful living had helped her to develop self-compassion and overcome "self-critical" thoughts about being a full time working mother that were making her feel "exhausted" and "worthless" as a mother. She stated:

> "I constantly practice letting go of all the *judgment* and all the erm, guilt, there is always *so-much-guilt*! It used to suck the joy out of anything I did, as I felt I didn't deserve it because I'm not a good mum… But by bringing this gentle and compassionate attitude to whatever I'm doing, it doesn't matter what it is, I just, I find the judgement and guilt doesn't affect me in the same way … over time, I have found that any activity that generates suffering is an opportunity to overcome suffering and um (pause), that has been incredibly freeing"(p2)

This was an incredibly powerful insight for Claire as conveyed by the intensity of emotion in her tone and her emphasis on the words judgement and guilt. It also strongly highlighted how bringing the qualities of kindness and compassion to her practice of informal mindfulness had had a huge impact on how Claire related to her pain and reduced her experiences of suffering with guilt. Her use of the word "freeing" also indicated that she felt more empowered to liberate herself from her own suffering.

Andrew reflected poignantly on how practicing informal mindfulness helped him to deal with the passing of his mother:

> "I can have my sadness… but that sadness can almost feel (pause) uh, comforting (pause)…? When I can appreciate that I'm human and I've lost something valuable and then look around me and see that everything is impermanent and that's the natural order of things, it changes the pain a little bit... It uh, makes it a bit easier to swallow" (p11)

This felt like a powerful moment in the interview due to the intimate nature of the experience and the wistfulness of Andrew's tone, suggesting that he was remembering or connecting to the emotions attached to his experience in the interview. In mentioning that his sadness could feel comforting in a questioning tone, there was a sense that Andrew was tentative about whether there would be understanding for the seemingly contradictory experience of being comforted by his grief. The other key idea seemed to be that being mindful of everyday events highlighted the organic, universal and inevitable nature of impermanence and perhaps it was this perspective that Andrew gained through daily informal mindfulness that afforded him a means to cope with the intensity of his grief.

A quote from Sharon also illustrated how practicing mindfulness during conversations or arguments with her husband resulted in profound shifts in her marriage:

> "One of the choices is to accept that this is how it's always going to be… it is more liberating than trying to err, deny what's not there (pause). In the past I just deny what I didn't want to face, and it stopped me from moving on and being happy… my denial added baggage in my marriage" (p12)

Sharon highlighted how bringing a mindful and accepting attitude to all interactions in her marriage had been a liberating and healing experience compared to previously denying or evading the unpleasant experiences that arose, even though her acceptance led to an unwanted dissolution of her marriage. There was also the implication that denying her feelings and thoughts prevented her from being compassionate towards her pain, which consequently led to unnecessary and prolonged suffering in terms of remaining in an unhappy marriage.

Other participants described how daily informal mindfulness developed their stance of detachment and non-judgement towards suffering. For example, Rosanna spoke about how she had learned to detach from the suffering that arose from trying to control how her family members felt and behaved:

> "…mindfulness has helped me to realise that I cannot be responsible for what they do or say, I can only be responsible for myself, and my actions, and my feelings… it is my need for control that controls me and makes me suffer, this is on me…." (p7)

Rosanna illustrated this by describing a recent "bad morning" because she dropped the litter tray, which put her husband in a bad mood and caused an argument with her son. Rosanna described that when she drove to work that morning, it was "tempting" to let her resentful thoughts "take over", however being mindful of her experiences in the car i.e. her body on the seat, her hands on the steering wheel and the sun on her face helped to detach from her thoughts by paying attention to her sensory experiences in the moment. Rosanna's narrative highlighted how informal mindfulness helped her to shift her attention to present moment experiences and helped her to detach from her unpleasant or painful thoughts and feelings.

There was also the suggestion that practicing informal mindfulness enhanced Rosanna's ability to recognise and take accountability for how her responses contributed to her experiences of suffering.

Phil discussed a similar idea when he described how his mindfulness practice helped him to delineate pain and suffering as a "clean layer with a dirty layer on top of it". He also added:

> "I think there is something about this approach that, that, stops the prolongation of suffering, you know (pause) ruminating over, why me, kind of questions and stuff like that…I think in the past, the why me attitude, really interfered in my life and took away a lot of pleasure… I think now, practicing mindfulness everyday, I'm much more able to not judge [the pain] or wish for it not to be there…however in certain situations I find that detaching doesn't, you know, lead to acceptance immediately, I still need time to process stuff… yes, time is still the ultimate healer…" (p8)

Phil's quote implied a journey of insight whereby he had to experience how detachment from the 'why me' questions and not judging his pain could allow him to overcome suffering. Phil also hinted at the importance of time in the process, suggesting that overcoming suffering entails both non- judgement of pain as well as an organic process of learning to accept pain over time.

Steven offered a related metaphor to describe how acceptance of his everyday experiences was a multi-faceted experience for him:

> "…[acceptance] almost feels like an onion… I'm pretty accepting of my experiences, but actually there are whole other layers, of not really, you know? So, (pause) yeah, it's like each time you are mindful of anything in your life, it's like you are peeling back those different layers, it's like saying, I don't have to be *fully* accepting of my experiences in this moment' (p11)

The metaphorical onion suggested that Steven sees acceptance as a journey through pain and perhaps requires the shedding of tears that usually accompany cutting through an onion. Furthermore, he seemed to imply that each time he is mindful of

different experiences during the day, he has the opportunity to progress through stages of acceptance rather than it being an all-or-nothing experience. This tied into his comment mentioned earlier about the importance of becoming progressively more mindful through informal mindfulness practice. Steven also suggested that not being fully accepting of some experiences was a reality that he had learned how to accept.

It was also found that any efforts to minimise pain with excessive daily mindfulness could inadvertently increase the experience of suffering or lead to over-detachment. For example, Jeff had spoken about how he used to try bringing mindful awareness to his back pain during various activities in the hope that it would dissipate, however he found that this actually caused the pain to increase. Upon reflecting on this experience, Jeff quipped:

> "I learnt pretty quickly that you can't trick mindfulness into working! (laugh)" (p12)

Jeff's laugh reflected his insight into how the true nature of mindfulness can only be understood and achieved if he was able to release his desires to achieve a certain outcome. His quote also hinted the belief that the practice of mindfulness in itself provides the necessary lessons for understanding what mindfulness is and isn't.

Mark mentioned a similar experience and said that when he first learnt about mindfulness, he thought it would be a beneficial way of enhancing his performance whilst playing sport. He stated that he "threw [him]self" into the practice in order to become more focussed and aware, which had the following consequences:

> "…it became quite obsessive, and frustrating as my performance was, ironically, getting worse!" (p10)

Similar to Jeff, Mark was speaking from hindsight and his quote suggested that he also recognised that the obsessive quality that initially characterised his practice actually had the opposite effect to what he had been striving for. It also implied that over time, Mark had developed a more realistic understanding of mindfulness.

Claire reflected on how mindfulness meditation initially caused her to feel "over-detached" from her world and although she had learnt how to moderate this effect over time, the practice of meditation in "long sittings" still instigated a less intensified form of

over-detachment. Claire contrasted this experience to her informal mindfulness practice:

> "…thankfully I don't experience it as intensely anymore, but I have to admit that I don't have the same experience when I'm living mindfully… watching the news can be hard and it poses um, a *big* risk for over-detachment, for me, because of how I am as a person, but I've learnt how to uh (pause). I really try to be mindful of how I'm feeling whilst watching the news, and try to remain grounded in the moment so that the suffering doesn't overwhelm me …" (p14)

It appeared that the opportunity to practice detachment to intense suffering in discrete periods during the day helped Claire to maintain an emotional equilibrium, which she seemed to have more difficulty to maintain in longer meditation practices. The quote also implied that having some form of context (i.e. in the form of television output) helped her to remain grounded in the present moment.

The practice of daily informal mindfulness also enhanced therapists' willingness to be present with their client's pain without trying to "fix it". For example, Neena offered the following quote:

> "I don't need to band- aid their problems to make them or make me feel better… if I can be with [their pain] without trying to change it or remove it, then I can hopefully show them that it is ok for their pain to exist…." (p11)

Neena's quote indicated that her daily mindfulness practice allowed her to be mindfully present and compassionate towards her clients' suffering without trying to change the experience for them or for herself. Neena also suggested that not attempting to "band-aid" her clients' pain could demonstrate to her clients that if she could tolerate their pain perhaps they too could learn to tolerate their own pain.

Jeff reflected on how being mindful with his children had helped him to recognise his inclination to try and "fix things for others". He mentioned that observing his children's "innate abilities to solve their own problems creatively" and the "joy" that they experienced from active problem-solving, helped him to bring this same detached but

engaged approach to his professional role. He stated that being mindful in therapy helped him to “be more patient” and “resist the urge to leap in”. Jeff also mentioned:

> “My children have taught me how to be a better therapist!” (p8)

This suggested that Jeff’s personal practice of being mindful had some direct effect on his professional abilities.

Lastly the data revealed how daily informal mindfulness helped participants to deal with their clients’ anger more constructively in session. For instance, Liz stated:

> “I can create a space in the session to step away from the anger and, to find more fertile ground, um (pause) but actually to want to do that rather than doing it begrudgingly” (p12)

The idea of stepping away from the hostility seemed significant as Liz wasn’t implying that she was running away or trying to avoid her clients’ anger but rather that she was taking a purposeful step around it in order to be more therapeutic.
It also appeared that this step was coming from a place of genuine nurturance rather than professional or personal obligation.

Mark also said that practicing mindfulness in sessions had helped him to “take a step back and see the bigger picture” and thus become “less reactive to hostility”. This highlighted how being mindful in therapy helped Mark to create a space between the hostility and his initial reaction to the hostility as well as develop perspective for what might be eliciting this emotion in his client. The connotations were that informal mindfulness practice had developed Mark’s effectiveness in dealing with intense emotions.

3.4 “*Mindful therapy allows the therapist and client to be both human and expert”:* Mindful therapy fosters use of self and other for therapeutic connection

This theme reflected how actively practicing informal mindfulness whilst in therapy sessions (or ‘mindful therapy’) opened up avenues for participants to relate to their clients in a more humanistic way and also changed the way they approached their roles as therapists. Claire exemplified this theme in her quote:

> "… it's like mindful therapy allows the therapist and client to be both human and expert, which is rather fortunate for both parties!" (p6)

This extract highlighted how Claire perceived mindful therapy to be beneficial not only for her clients but also for herself as a therapist as it allows her to bring a more personable or accessible side of herself to therapy. By describing the experience as "fortunate", Claire seemed to imply that she was in a rather privileged position in being able to see the value of bringing her whole self into the therapy room and that it would also be advantageous for her clients to feel like they are experts on themselves.

It was also found that connecting with one's humanity in a session or a group and allowing this awareness to influence the process in the room, brings about a deepening of meaningful, authentic and non-hierarchical therapeutic connections.

Phil acknowledged this experience of connection in the following quote:

> "…What my patients hear from me is you know, we're all in the same boat, you're not different from me, erm… You suffer at times, I suffer at times, life can be difficult, it's difficult being human… there's no rigid boundary between us… and this develops their trust in me… I can't come in here and be anything I'm not, sort of thing…" (p14-15)

Phil's tone carried a sincerity, authenticity and openness in acknowledging his own vulnerabilities that was palpable in the interview and thus provided insight into how this attitude might be demonstrated to his clients. He seemed to imply that mindfulness of his own susceptibility to suffering allowed him to connect to his clients' suffering and see it as a characteristic of being human, rather than necessarily treating it as an affliction. Phil also alluded to being more mindful of and placing trust in negotiable therapeutic boundaries, which in a similar way to Claire, appeared to promote more egalitarianism in the therapeutic relationship that has traditionally honoured the expert role of the therapist.

Andrew highlighted a comparable philosophy that evolved from his mindfulness practice:

> "… I take the approach of normalising rather than pathologising human suffering in my patients… I've never been entirely fond of providing diagnoses... " (p9)

Andrew went on to acknowledge that diagnoses were sometimes "useful" for both professionals and patients however they were not always "relevant" and also served to "label" and "objectify suffering into sets of symptoms". Andrew seemed to indicate that his reluctance to conceptualise suffering as pathological was that it served to further entrench his clients in a state of separated-ness, rather than convey to them that their symptoms are an understandable response to a painful life experience, at least in some circumstances. Andrew also implied that his mindfulness practice precipitated a natural departure from depending too heavily on a purely medical model of mental health.

Jeff expressed a slightly different perspective:

> "… And the funny thing is that we are all the same, our triumphs, our struggles, our uh (pause), our insecurities!... I've always found it funny how talking about our mental health issues [as therapists] can still be so uh, taboo (laughs)!" (p10)

Jeff's laugh and his use of the word "funny" hinted at his ironic perception that mental health professionals would have difficulty being open about their own mental health issues and that this may be because of a need to separate themselves from their clients. Jeff also seemed to suggest that mental health practitioners who practice mindfulness themselves might be more able to gain awareness of the humanity inherent in their struggles and thus may be more willing to embrace their vulnerabilities or mental health issues in their roles as mental health professionals.

A quote from Liz illustrated how mindful therapy facilitated therapeutic insight:

> "…If [I'm] there with them and connecting to what they are experiencing in that moment and not trying to be a super-hero, it erm, it feels more meaningful, it's (pause), it feels like a more real, relationship" (p8)

Liz suggested that mindful therapy facilitated presence and attunement with her clients that undermined any inclination to try to save them from their experiences. Liz also indicated that an awareness of what she can and cannot provide to her clients and not trying to provide more than what she is capable of, contributed to the strengthening of and greater authenticity in her therapeutic relationships. There is also the sense that mindful therapy helped Liz to foster courage in being able to acknowledge her limitations rather than labour under the misbelief that she can be a "super-hero".

Steven described how he was more impelled to take a stance of "mutual curiosity" with his patients, whereby he would use his own curiosity to facilitate a more curious mind in his clients, in particular for those who had grown complacent about the pervasiveness of their symptoms in their lives. Steven stated that this created a sense of collaboration rather than, as he put it, "I'm turning the spotlight on you, kind of thing". This statement underscored Steven's efforts to align himself alongside his clients in a similar way to Liz and to use his curiosity as a therapeutic tool to engage his clients more actively in the therapeutic process, rather than questioning them from a detached position.

Another thread in this theme was how practicing mindful therapy enlivened the embodiment of mindfulness qualities and thus allowed participants to use their embodied selves to teach mindfulness to others. A quote from Phil seemed to epitomise this:

> "I'm not having to sell it, 'cos it's sort of selling itself through me!" (p7)

There was a sense of triumph in Phil's expression at being able to bring an embodiment of mindfulness to his therapy work and for it to be an active yet implicit facet of his teaching approach. Phil's quote also hinted at a different meaning implied by his expression of having to 'sell' mindfulness, which suggested that there may be some doubt about what mindfulness can offer as an approach and that some clients may need to observe the qualities of mindfulness in him as a person and teacher in order to appreciate its value.

Similarly Steven reflected on how his "best teaching occurs" when he is able to "embody a mindful attitude" or "embody acceptance" for his clients. In a similar way to Phil, Steven appeared to see greater value or influence in the ability to teach mindfulness through demonstrating its qualities in a context that his clients could relate to and perhaps even try to model in their own lives.

Participants also identified how engaging in mindful therapy brought about a greater willingness to actively draw attributes of the clients, such as wisdom and knowledge through life experience, into the therapy process. This was captured in Neena's description of how mindful awareness in therapy had broadened her perspectives:

> "…So I have much more insight into [my clients'] abilities, in their strengths and their um, their resources (pause)… and I probably spend more time talking about that than I would have done in the past… I ask 'what do you bring to the table already and how can we enhance, nourish and nurture those things within you?'" (p12)

Neena's extract highlighted a deeper respect for her client's personal strengths and personal resources and an understanding of how tapping into these qualities could be a significantly powerful lesson in developing self-efficacy and resilience in her clients, in terms of teaching them how to nourish and nurture themselves.

Sharon spoke about her proclivity to "tap into" her clients' inherent "Buddha nature". She explained her belief that each person had an inherent capacity to develop the nature of the Buddha through the practice of mindfulness, acceptance and loving-kindness. Sharon's quote implied that she saw her therapist role as a way in which she could help her clients identify their existing Buddha nature and could act as a vehicle to develop their capacity for mindfulness and inner wisdom.

Mark mentioned that being mindful in his sessions had sometimes led to moments of personal insight or "epiphanies" that had arisen from his clients' experiences:

> "I've sometimes thanked [my clients] for sharing their truths and their wisdom…I think it's important to let them know that I have taken something away with me" (p10)

This extract conveyed Mark's positive therapeutic intent in conveying appreciation for his clients' wisdom and honesty, however Mark's eagerness to let clients know he had personally benefitted from their openness and/or pain might indicate that he was possibly only extending awareness to *his* experience of the therapeutic process without necessarily considering the potential adverse impact it could have on his clients. This quote also appeared to highlight Mark's difficulty in knowing how to mindfully engage with his clients' insights as a therapist as well as a person in the room.

Whilst being beneficial, some participants also experienced mindful therapy to be a tiring and exhausting practice that felt qualitatively similar to meditation.
This was evidenced for Sharon who reflected on how mindful therapy can feel like a "mini-meditation". Sharon also stated that being mindful in each of her sessions could feel "intense" as she was constantly aiming to be mindful of cognitive, emotional and sensory experiences.

Phil also referenced the experience of intensity:

> "… so when you bring that degree of concentration to each session, and you have a full day of clients, you know, that is quite intense and uh, quite tiring and timeless… I feel like I've meditated without meditating…" (p13)

Both Sharon's and Phil's quotes highlighted the meditative quality of practicing informal mindfulness in therapy on the basis of the various internal events to be mindful of and concentration of awareness on their experiences of being with the client and doing therapy. There was also the implication that mindful awareness is not just applied in one therapy session, but in each session they have.

Rosanna identified another difficulty in determining the extent to which mindfulness awareness should guide the direction and content of therapy. She stated that she still sometimes "struggled" to follow the intended structure of the session in terms of teaching specific skills or theory if she perceived significant in-the-moment processes. To deal with this, Rosanna highlighted her attempts to integrate her clients' present moment processes into the structure of the session. This struggle appeared to highlight a conflict in Rosanna's beliefs about what aspect of therapy should be privileged and how to integrate her mindful awareness effectively into therapy without derailing it.

3.5 *"It's like a bridge… between being and doing":* Informal mindfulness can reconcile the stance of "being" in mindfulness with the culture and beliefs related to "doing" in the West

This theme identified how informal mindfulness can act as a "bridge" that merges two seemingly disparate modes of Eastern and Western existence. Several participants experienced informal mindfulness as a practice that accommodated "being *whilst*

doing" and thus offered a viable and conducive means to bring mindfulness into their daily lives.

Claire stipulated that practicing informal mindfulness during her life activities made it easier to practice more often and in more areas of her life:

> "…Because I'm being mindful in whatever I'm doing, (pause)… I er don't feel pressure um (pause), to ah, slot it in somewhere… I can be mindful at work, I can be a mindful mum, I can be a mindful wife and daughter and psychologist…" (p4)

Claire stated further that she "enjoyed" her daily informal practice as she was able to apply it flexibly during her day and that it affected her family also. It would appear that the adaptable nature of informal mindfulness afforded Claire a sense of freedom from her expectations to practice mindfulness meditation for a certain period of time. There was also the sense that practicing informally integrated seamlessly into significant roles in her life and allowed her to enjoy the practice.

Neena provided a metaphor that illustrated her conceptualisation of informal mindfulness as a practice that benefitted from being *and* doing:

> "I really embraced that idea of sowing seeds as a metaphor … so I can be in my garden, planting and watering and pruning… but I'm not prodding at the seeds all the time to see where they've got to, I'm just letting them grow…. I'm just putting in the work and the time when I can, and what will be, will be… I think I've lost track a little, but what I'm er, (slight laugh) what I'm trying to say is that I can be sowing seeds [sitting on a pillow in my room] or in my garden, my attitude to either will be the same (pause), however I much prefer being in my garden! (laugh)… " (p14)

Neena's metaphor was effective in drawing the parallels between her informal and formal mindfulness practice. The central concept appeared to be that the underlying attitude of mindfulness and acceptance remained consistent across the two practices, however informal mindfulness offered Neena a meaningful context in her everyday life to enact the attitude she was cultivating in her mind and body. Her attitude of "what will be, will be" suggested that her immersion in the activity seemed to diminish any

inclination to judge or evaluate it. The metaphor also seemed to imply that both practices were as effective as each other in the 'growth of the seeds' i.e. in the development of Neena's mindfulness, however she simply enjoyed one form of practice more than the other.

Another aspect of the theme was participants describing how their daily practice of informal mindfulness helped them to address common misconceptions, unrealistic expectations or difficulties in practicing mindfulness that are prevalent in the West, which encouraged a more flexible teaching approach.

For example, Sharon spoke about her difficulty in teaching clients the value of mindfulness practice due to the "very active" culture in the West:

> "We live in a society, that, sees uh, virtue, [is that right?] (laugh) in the *art* of busyness. You know, cramming lives with more and more… there's not the same value for meditation, I mean, of course there is for some, but other people find it more difficult to sit and, uh (pause) just sit… informal mindfulness can help these people, it's like a bridge between both worlds, uh, between being and doing… a stepping stone that opens the door to meditation" (p8)

Sharon's quote suggested that teaching her clients informal mindfulness could be very effective in providing initial exposure to the principles and practices of mindfulness in a form that was less daunting or challenging than meditation. The idea of a bridge hinted at Sharon's perception of informal mindfulness as an integrative practice that brings together Eastern and Western culture. Furthermore, the concept of mindfulness opening the door to meditation indicated that Sharon sees informal mindfulness as a practice to develop appreciation for what mindfulness is and potentially a 'gateway' to meditative practice. Sharon's overall conceptualisation highlighted her aim of distinguishing informal from formal mindfulness practice so that her clients learn the nature and purpose of each.

Similarly, Claire described a "honeymoon stage" that she sees clients go through when they first encounter mindfulness meditation in MBCT, which "gives way to a time of real challenge and difficulty" in maintaining their practice on an on-going basis. She stated that informal mindfulness alongside shorter meditation practices such as the 3-minute breathing space could be a more "tangible" and "less daunting commitment" at least

initially. On this basis, Claire explained that she tries to be “flexible” in how she engages her clients in mindfulness and places emphasis on the value of “starting out with informal practice” for clients who are anxious about meditation. These reflections indicated that Claire’s self-compassion and flexibility towards her own practice had likely influenced how flexible she was in her approach to teaching mindfulness to her clients who were struggling with regular meditation.

Rosanna stated that she often had to remind her clients that mindfulness “is not a pill you take!” but that even informal mindfulness needed to be “worked on daily” and applied broadly in their lives in order to really benefit from the practice. Rosanna also spoke about how many of her clients were “doubtful” about how bringing attention to what they were doing was going to help, particularly if it didn’t eliminate their symptoms. Rosanna stated that she was able to draw upon her own experiences to share with her clients how her expectations of mindfulness had changed over time and that making this adjustment was “part of the process”. Rosanna’s narrative highlighted her willingness to be open about her own learning processes with the aim of providing her clients with a realistic idea of what the benefits and challenges are. Rosanna’s reference to mindfulness not being a “pill” indicated her desire to point out that the effects of mindfulness were not immediate nor are they intended to alleviate symptoms in the same way as medication, but rather mindfulness could only be beneficial through some form of daily practice.

Liz illustrated a very similar experience to Rosanna:

> “I found that when I was open about my own practice, it was so helpful (pause). Some of them were surprised that I practiced and so it felt really important that I didn’t try to glorify it or, or uh, I didn’t want to give them the idea that it was a panacea that could *cure* everything, kinda thing…” (p11)

Liz’s quote indicated that her intention to be transparent about her mindfulness practice was in the service of helping her clients to develop a more realistic perspective that mindfulness was not a cure. She seemed to recognise the gravity that her personal experiences could bring as both a teaching and motivational instrument in her therapeutic approach.

Instead of directly reflecting on his own experiences, Jeff stated that he took a behavioural approach to addressing his clients' initial preconceptions that mindfulness was a "passive" or "complacent" practice. He described setting these action-oriented clients 'informal mindfulness' tasks, many of which he performed in his own life, and asking them to report back on the outcomes. Jeff stated that many of his clients were "surprised" at how much attentional effort was required to be mindful in even short daily activities and some clients even stated that they enjoyed informal mindfulness practice as it allowed for "active processes in the body and the mind". Jeff's reflections highlighted his preference for teaching mindfulness through the facilitation of experience rather than just through theory, so that his clients could correct their own assumptions through their direct exposure to the practice. He also seemed quite confident that taking this behavioural approach would be effective, which perhaps was a consequence of his own learning process.

Phil highlighted a different slant by reflecting on the dichotomous expectations that arose for him in being both a student of mindfulness within a Buddhist/spiritual context and a teacher of mindfulness within a Western/ therapeutic context:

> "On one hand I'm (deep breath; pause) wondering around not really knowing what I'm doing, and er, on the other hand I'm sort of professing competence at this, that and the other, erm (pause) and then again, they're all, they're all parts of me and where I am in my journey" (p13)

Phil's deep breath conveyed a sense of concern about the duality of his roles and the possible incongruity in being both a student and a teacher of mindfulness. The other aspect of Phil's concern seemed to be the expectations that he perceived as inherent in the role of a 'teacher' in any Western discipline, which tends to prescribe to the idea that teaching is analogous with being somewhat of an expert in the field. Phil appeared to embrace this contradictory position with an attitude of acceptance in terms of acknowledging that both roles were part of him and also seemed willing to *hold* the dissonance that it brought up for him. Overall, Phil also seemed to be implying that being a continuing student of mindfulness negated any possibility of him trying to teach it from the position of an expert and that assuming the role of an expert could potentially compromise his clients' trust in him or skew their perceptions of what mindfulness is.

The integration of being and doing during everyday activities were also found to be challenging for some participants in respect to the distraction of engaging in the activity itself or the distraction of competing sensory stimuli.

For example, Mark commented that maintaining a mindful focus on the present moment experiences of an activity could be challenging due to other distractions that arise in the activity. He gave the example of walking his dog, stating that he can be mindful of his "feet on the ground" and the "tug of the leash" and the "cold on [his] face", however he can be distracted if he remembers that he needs to buy dog food or to book a vet appointment etc., which can then become a "stream of reminders or thoughts" for him. Mark stated that he can return to his sensory awareness, but that there sometimes is a "long loop" he needs to follow in his mind before he returns. He also mentioned that the loop could be extended every time he observes something in the environment that stimulates a new stream of thoughts.

Andrew articulated the challenge for therapists to be mindful of present moment experiences that arise in the room when there are other sources of stimuli that compete for the therapists' attention:

> "… there are so many processes to pay attention to…in what is said, what is seen, what is felt…and so many ways we can respond to these processes… we reflect, we ask, we challenge (pause), we theorise… therapists are verbal creatures and we receive ample training in learning how to 'do' therapy but not enough of uh, actually sitting with one's own response to these processes or allowing the patient to sit with what they're feeling…"(p10)

Andrew highlighted how the state of being can be particularly challenging to uphold, as it is not necessarily nurtured in the training process as a particular skill for therapists to have. It also requires the therapist to resist from immediately addressing new processes that arise and perhaps also suspending their attention to them in order to be able to sit with present moment experiences. Andrew's reference to therapists in general and his use of 'we' rather than 'I' implied his perception of this difficulty as being pervasive amongst therapists as opposed to being unique for him.

Steven highlighted a different aspect of dealing with distractions by reflecting on how the activity itself becomes the anchor, in a similar way to the function of his breath in meditation:

> "My mind still succumbs to the same degree of wandering as it does in meditation, but instead of coming back to the breath I, um, it's about returning to my awareness of whatever I'm doing… there's an excitement in following where my mind wanders and then an excitement in coming back to my life…" (p3)

Steven's comment conveyed a sense of delight in the experience of mind-wandering as much as the experience of bringing sensory awareness to the activities in his daily life. And in contrast to Mark, Steven implied an acceptance and kindness towards the distractions as natural punctuations in his mindfulness practice as opposed to feeling frustrated or challenged by them. It also appeared that Steven had developed a conceptualisation of his informal mindfulness practice that mirrored the process of meditation, which brought about a meditative quality to everyday living.

There was also concern about how the rising popularity of informal mindfulness practices may serve to dilute or detract from the value of mindfulness meditation and yet still be overshadowed by more dominant change-based protocols in many Western clinical settings.

For instance Sharon mentioned that it could be easy for people to "fall in love with" informal mindfulness and forget about meditation in the busy culture we live in. Sharon also inferred that meditation could be a more difficult practice to commit to regularly within Western societies.

Mark also stated:

> "…when I say I practice mindfulness, everyone assumes I meditate… they don't really get informal practice but when they hear about it, they think its pretty doable…" (p7)

Mark's quote inferred his experience of having to correct other people's assumptions about meditation being the only form of mindfulness practice. It also highlighted that learning about informal mindfulness could appeal to people who may not be keen about formal meditation.

And Neena offered the following reflection in regards to the focus on doing or changing in many clinical settings:

> "The concept of *being* with patients is not necessarily a shared narrative erm, and there is still a really strong pull towards doing or changing in the culture we work in… And erm, I think it's really hard sometimes to stay true to the practice of being when there is so often the temptation to jump on change-oriented interventions in an effort to be seen as *doing something!* (release of breath)" (p15)

Neena's quote and her release of breath suggested an experience of frustration in having to reconcile mismatched cultural ideologies of being and doing in her professional work. She also seems to suggest that practicing mindfulness offers her insight into the value of being and instils confidence in adhering to acceptance rather than change based interventions when appropriate, even though they might not necessarily be fully appreciated in the culture she works in.

3.6 *"If I hadn't had one or the other, both would be weaker":* Having both a personal and professional investment in mindfulness is mutually reinforcing in therapists' lives

This theme highlights participants' experiences of having a mutually reciprocated and reinforcing relationship between their personal and professional mindfulness practice. For many participants this involved the seamless integration of daily informal mindfulness into their everyday life as "mindful living", which amplified their experiences of belief and fulfilment in teaching mindfulness to others.

For instance, Phil stated that the practice of both informal and formal mindfulness in his personal and professional life felt "extremely satisfying and rewarding". He stated further:

> "If I hadn't had one or the other, both would be weaker. It's more like they're mutually reinforcing" (p15)

Phil's statement implied that his therapeutic and personal practice reinforced each other and were also equally important to him. Interestingly though, Phil reflected on how the absence of one or the other would weaken the effectiveness of the other rather

than implicating that the existence of both boosts his mindfulness capacity. This seemed to infer Phil's averseness to an ego-self or to any suggestion that his personal and professional practice made him *more* mindful as a person.

Claire also reported that over time she found herself "slipping into mindful states" effortlessly and stated that it was her daily informal practice that really cemented the experience of 'mindful living' for her:

> "…mindful living is my reality in a way, and through me, it has become my family's reality" (p5)

Claire suggested that mindfulness was no longer just a practice that she needed to remember but it had become embedded as part of who she was as a person as well as how she experienced and existed in the world. This quote also depicted mindfulness as having a 'contagious' quality in respect to how its practice affected not only Claire but that it had flow on effects to the people in her life.

Sharon stated that teaching mindfulness made her a "better Buddhist" and being a better Buddhist made her a better therapist. She also remarked:

> "I can see myself teaching mindfulness for the rest of my life!" (p6)

Sharon's emphatic statement underscored the sense of fulfilment that teaching mindfulness had for her as well as her commitment to evoke this same feeling in others. There also appeared to be triangulated reinforcement in Sharon's personal, professional and spiritual practice and identity.

Jeff also alluded to a more spiritual connection to his mindfulness practice:

> "I've always had an interest in Buddhism and Buddhist psychology… and I used to, well, I tried to attend meditation retreats regularly before I got married, then I stopped going regularly for many, many years… but bringing mindfulness into my daily life feels like those weekends… it's inevitable in a way, that I got into this field…" (p2)

This narrative highlighted how Jeff's long-term journey with mindfulness had changed over the years having started out with somewhat of a spiritual interest in Buddhism,

which then evolved and broadened into his personal and professional way of life. Similar to Steven, Jeff also alluded to daily informal mindfulness practice and mindfulness meditation producing similar feelings. This suggested that even though the nature and intensity of his meditation and informal practice differed, it ultimately produced comparable subjective experiences for Jeff, at least in respect to his recollections.

These accounts contrasted with more assuaged descriptions that were provided by the two DBT therapists who didn't meditate. For example, Rosanna stated that there was a feeling of "satisfaction" in being able to benefit from her work and use her own learning for the benefit of her clients. Similarly, Mark pointed out:

> "I don't think I would have ever started mindfulness if I hadn't become a DBT therapist" (p1)

Whilst there was certainly appreciation expressed by Rosanna and Mark for the effects of their mindfulness practice in both areas of their life, their enthusiasm and depth of reflection seemed to be qualitatively lacking compared to some of the other participants. The other impression was that mindfulness in their personal life existed as somewhat of a separate entity to the delivery of mindfulness interventions in their professional life. Thus even though there was mutual reinforcement in their personal and professional practice, each form of practice appeared to have a distinct and demarcated function rather than mindfulness having a more global purpose in their lives.

A divergent aspect of this theme was the attenuation of self-efficacy or affective wellbeing that was described as resulting from diminished practice or the feeling that there was inconsistency of practice in either of both areas of participants' lives. Both Andrew and Liz reflected on the effects of diminished practice in their life. For instance, Andrew stated that attending the meditation retreats had become a "tradition" in his family and that he would feel "guilt" and "regret" if he had to miss one. Liz's quote referred to the effects of not practicing informal mindfulness as often during the day:

> "…my aim is to be mindful of at least one thing I do every couple of hours… I guess there is always the odd day that, uh, my practice is (cough) kinda, not as much on track as I would like, and I find that, or

> it feels like my [clients] get the rubbish side of me on those days" (p11)

Both these participants indicated that having a reduced mindfulness practice in any way affected them unfavourably, with Liz indicating specifically that she felt less effective as a therapist if her daily mindfulness practice suffered. These quotes also suggested that rather than practicing mindfulness purely out of professional expectation to do so, these participants had come to appreciate and experience the value of mindfulness practice in its own right.

In regards to inconsistency between personal and professional practice, Neena pointed out that there was "a lot of expectation" to maintain a regular meditation practice as an MBCT therapist and that she used to feel "inauthentic" when she struggled to meet those expectations. Neena found however that the shorter meditations that she could fit into her day as well as informal practices were quite helpful and easier to manage. Over time, Neena stated that the shorter meditations (e.g. the 3 minute mindfulness 'check-in') and informal practices tended to "blend together" during certain activities when she had more time or there was less distraction, such as driving or walking, but when she was time poor she depended more heavily on shorter informal practices during simple activities. Neena also stated that even though she still didn't practice meditation regularly, her "commitment to mindful living" was very important to her and allowed her to feel more authentic by practicing mindfulness in a way that suited her.

Steven offered a very similar experience by reflecting on how his mindfulness practice had gradually changed since the birth of his son, which had impacted his life "in a dramatic way". Like Neena, Steven inferred that his informal mindfulness practices took on a meditative quality in his everyday life:

> "…it still feels like I'm meditating, even when I'm not… it actually feels like life is my anchor, like life has become one big meditation" (p3)

Steven appeared to be alluding to his own conceptualisation of mindful living by highlighting how he felt like he was in a perpetual state of meditation just by bringing mindful awareness of all the different aspects of his everyday life. By stating that life was his anchor, it seemed to imply that Steven felt grounded by his informal mindfulness practice even though he wasn't technically meditating. Steven also mentioned that he attended meditation retreats every month and that if he couldn't

maintain this, he would start to feel “less effective” and “less authentic” as a mindfulness teacher.

Claire offered another interesting angle by stating that at least one of her colleagues was reluctant to participate in the current study, as they did not wish to openly admit that they did not meditate regularly.

These quotes from Neena, Steven and Claire highlighted how having expectations to practice meditation in a particular way had somewhat aversive affects and could potentially produce experiences of shame or stigma. However it always appeared that informal mindfulness practices or living more mindfully helped these therapists to practice mindfulness in a way that felt more authentic and conducive. Another point was that meditating in a community based setting such as a meditation retreat, was significant in keeping them connected with their meditation practice, and that the absence of this connection could bring up feelings of guilt, ineffectiveness or inauthenticity.

From a different perspective, Phil alluded to feelings of shame and guilt that arose in context of how his practice was incongruous with the expectations of his Buddhist community. He stated the following:

> “It’s a bit like coming out of the closet, in a way (laugh)…” (p5)

The term “coming out of the closet” is commonly used in popular culture to make reference to the disclosure of one’s sexual identity as lesbian, gay, bisexual or transgender (i.e. LGBT). The prevalently assumed experiences associated with ‘coming out’ can often include stigma and isolation in the wider community but also liberation in being able to disclose one’s true identify. Thus the use of this term suggested that Phil anticipated that any disclosure about the irregularity of his meditation practice could elicit these same experiences in his community. This highlighted a strong sense of dissonance between his personal and spiritual practice, however not so much in relation to his professional practice. On this basis, it is possible that Phil’s role as an ACT therapist, which does not hold expectations for meditation, remedied and reinforced his informal practice in a way that Phil could not authentically express in his Buddhist community.

Sharon described an entirely contrasting experience whereby she expressed a sense of superiority over her colleagues who did not have a spiritual connection to their mindfulness practice in the same way she did, even though she did not meditate regularly:

> "So many of my colleagues don't practice like I do; I breathe mindfulness 24 hours a day! My colleagues don't appreciate the spiritual aspects… what they get taught on training courses is only a drop in the ocean!" (p9)

It appeared that Sharon's perceptions of the ubiquitous nature of her informal mindfulness practice within a spiritual context lent to the belief that her practice was more effective or even more authentic than that of her colleagues. Unlike Phil who compared his practice to others within his Buddhist community, Sharon's comparison to her work colleagues appeared to enhance rather than diminish her sense of self-efficacy. This quote also seemed to highlight the contradictory presence of an ego-self and a mindful- self, however it is possible that Sharon's use of English as her second language and possibly even cultural differences could have affected her articulation of this experience.

To conclude this chapter, it could be seen that these findings revealed a range of beneficial yet somewhat challenging personal and professional experiences that arose from the participants' long term, daily practice of informal mindfulness.
These findings pose some interesting implications for the practice of informal mindfulness, which are discussed in the following chapter.

Chapter 4: Discussion

This chapter discusses the main findings that arose from the six themes and their implications in light of current literature and theory. This is followed with a review of the implications for professional practice. A thorough reflection of the strengths and limitations of this study is offered and the chapter concludes with suggestions for future research into informal mindfulness practices.

4.1 Discussion of the key findings from each theme

4.1.1 Daily informal mindfulness practice enhances wellbeing in an unexpected and life changing way

This theme yielded a number of interesting findings, the first of which was the beneficial and life changing benefits to wellbeing, which were largely unexpected by the participants. It was quite likely that the experience of being surprised by the benefits of long term, daily informal mindfulness practice derived from the relative lack of recognition for informal mindfulness being effective either as a stand-alone practice or as a main form of practice that is supported by less regular formal meditation. However there is a growing body of literature that cites informal mindfulness as having more potency than what has been traditionally assumed. For instance, informal mindfulness has been stated to be *as* enriching as formal meditation (Siegal, 2010), capable of cultivating awareness and attention in much the same way as mindfulness meditation (Garland, 2015); capable of producing “seismic shifts” in one’s life (Brooks, 2012) and instrumental in having significant impacts on one’s vitality and productivity (Gotwals, 2016).

There are also a couple of noteworthy implications for why participants found their informal practice to be so beneficial to their wellbeing. Firstly, it is possible that this finding resulted from a ‘minimum dose effect’ whereby a certain threshold or minimum amount of mindfulness is sufficient to generate results (Crane, Crane, Eames, Fennell, Silverton, Williams & Barnhofer, 2014). Thus the participants who meditated occasionally or irregularly might have found that any further doses of daily informal practice was effective in boosting the change process that had already been instigated. For the participants who had never practiced any form of mindfulness before, it was quite likely that some mindfulness practice was beneficial compared to no practice, however it is also possible that the long term nature of the daily informal practice

offered a sufficient dose of mindfulness that produced some significant and notable effects. Another way of conceptualising the dose effect may lie in the actual *amount* of practice that all the participants engaged in. The monitoring forms revealed that the participants practiced informal mindfulness five times or more during the day with each practice lasting on average 5-10 minutes, which amounts to approximately 25- 50 minutes of mindfulness practice spread out over the day. Thus even though the type of practice occurs in multiple yet shorter periods of time rather than in one concentrated sitting, the amount of informal mindfulness was comparable to the amount of time that a person might sit in daily mindfulness meditation, which tends to be between 10-60 minutes for the average modern meditator (Siegal, 2010). There is currently no consensus in the mindfulness literature that stipulates what the most significant factor is for mindfulness generating an effect i.e. whether it is frequency or duration or whether it is formal or informal practice (Crane et al., 2014). However the results from this study implicate the frequency and duration of informal mindfulness practice as capable of producing some qualitative effects.

Secondly, the reason why participants found their informal practice to be so beneficial to their wellbeing could be due to the nature of life experiences it produces, for example, the experience of sensory awareness, gratitude, coping with pain and reciprocity, as well as the degree of life engagement that it produces. Thus the practice of informal mindfulness in context of everyday activities could enhance the intensity of these experiences as they are occurring. This implication is supported by Wolkin's (2016) statement that through informal mindfulness practice, one is likely to make the "wonderful and life-changing discovery that there is no such thing as a mundane moment, only mundane states of mind" (no page). Whilst the existing literature outlines how mindfulness meditation may bring about the same or similar benefits, formal meditation tends to be practiced as a distinct exercise that occurs in a secluded physical space from other events in the person's life. This serves to minimise distraction for the meditator but might also deprive them of present moment context for their practice and therefore less likely to benefit from the intensity of awareness in real life situations.

And thirdly, the practice of informal mindfulness could be just as potent as mindfulness meditation in being a conduit for spiritual connection, which was found to be deeply life changing in Cigolla and Brown's (2011) study. The idea of informal mindfulness practice also spurred an experience that was akin to a spiritual rebirth, which suggests that its practice could be as capable of bringing about spiritual experiences or living

with higher meaning or purpose through engagement in everyday activities as mindfulness meditation.

The second key finding in this theme concerned the specific beneficial effects that developed from participants' daily informal mindfulness practice, including a sense of calm arising from single-pointed concentration, an ability to respond rather than react to multiple daily stresses and an increased sense of resilience and effectiveness in life. These effects are comparable to the research outcomes for mindfulness meditation that were outlined in the literature review, however there were a couple of unique aspects.

The first distinction related to the single pointed concentration being directed towards the experiences of partaking in an event or activity as opposed to concentration on the breath, which is the usual focus in mindfulness meditation. The calmness that was reported to arise from mindful engagement in an activity is consistent with the evidence for "flow states" that refers to how complete absorption in an activity can stimulate transcendental experiences and positive affect (e.g., Berkovitch-Ohana & Glicksohn, 2016). An additional explanation for this distinction draws reference to the effects of single-tasking as opposed to multi-tasking on wellbeing. A number of studies have shown that there is a link between multi-tasking and levels of stress and stipulate that rather than save time, the mental depletion involved in carrying out more than one task at a time can actually reduce effectiveness as well as feelings of efficacy, as cited by Woolston (2016). Brooks (2012) also highlighted the benefits of reducing distraction, such as taking one's phone off, in order to completely focus on a task-at-hand. So even though single-tasking may be considered to be inefficient compared to multi-tasking especially in a culture that values rapid and manifold productivity, multiple acts of single-tasking may be beneficial in reducing stress and thus be more effective over the long-term.

And the second distinction was the ability for participants to mindfully respond rather than react to multiple daily stresses *whilst* experiencing the stressful event. The existing evidence points to reduced emotional reactivity as a generalised outcome of practicing mindfulness meditation (e.g. Ortner, Kilner & Zelazo, 2007) however no outcomes could be found for how emotional reactivity could be affected by simultaneous mindfulness practice.

A link between this distinction and the previous was mentioned by Siegal (2010) who stated that stepping out of autopilot in order to bring our full attention to a task at hand

(i.e. single-tasking), could increase the capacity to respond rather than react to stressful events. This could be due to the reduced demand on one's cognitive functioning that increases the likelihood of implementing constructive problem-solving strategies and applying effective communication styles, such as active listening and a gentler tone of speech as pointed out by Wolkin (2016). Carmody (2009) also pointed out that mindfulness practice reduces a person's possessive feelings to control or over-control their internal experiences. Therefore having a long term, daily informal mindfulness practice might facilitate decreased emotional reactivity during stressful events on the basis of enhanced cognitive functioning whilst single-tasking and resultant reductions in feelings of stress. Also informal mindfulness practice during a stressful life event would appear to provide an immediate outlet in the situation itself for uninhibited emotions to be experienced and expressed appropriately and directly rather than accumulate and contribute to a delayed reaction.

The third and last key finding was the observation of discernable variations in how the effects of informal mindfulness were described. Some descriptions indicated that it was *uniquely* beneficial and life changing, some stated that it was comparably beneficial and somewhat life changing and others expressed that it was beneficial but not as beneficial without any meditation. Overall, it appeared as though these variations were in part influenced by the participants' current and previous meditation practice, their therapeutic modality, their life circumstances, their spiritual affiliations or their general perceptions of and attitude towards mindfulness. This suggests that there may be considerable variations in how informal mindfulness is practiced that could produce different effects for different people.

4.1.2 Informal mindfulness heightens sensory awareness and gratitude for taken-for-granted experiences

Two related and equally significant findings arose within this theme. The first finding concerned the specific nature of salutary effects that participants experienced, which included sharper and intensified sensory experiences, enhanced intuition and "felt-sense" sensitivity and a broader repertoire of sensory responses. Several studies in the literature review have certainly identified heightened attention, mindful awareness and greater intuition as outcomes of mindfulness meditation, however there hasn't been a study to date that has specifically discussed heightened sensory awareness as a distinct aspect of enhanced attention. However considering that informal mindfulness practice focuses specifically on bringing *sensory* awareness to daily activities, it is

perhaps not surprising that heightened sensory awareness has not been a distinct outcome in previous studies. Thus it may be the case that informal mindfulness may increase awareness in a different way to formal meditation by directly enhancing the function of each specific sensory system or organ that is dedicated to the five senses (i.e. sight, hearing, taste, small and touch) within the central nervous system. The one overlap between informal and formal practice was in respect to greater intuition or felt sense. In Buddhist philosophy, there is recognition of the mind as a sense-organ, a sense-base or a "sixth sense" that functions in addition to the five senses of the nervous system (Bodhi, 2000b). Thus it would be reasonable to assume that the practice of mindfulness in any form would connect to the mind and strengthen its functioning as a sixth sense. Amaro (2016) also mentioned that with greater practice of being mindful of every aspect of one's life as is done in informal practice, the greater scope there is for faculties such as wisdom and intuition to arise.

The second key finding appeared to be a consequence of the first insofar as greater sensory awareness brought about a deep sense of gratitude for the ordinary activities that elicited them regardless of whether the activities were subjectively pleasant or unpleasant. This finding aligns well with mindfulness theory, which posits that one may experience gratitude when they see things as they really are rather than as one hopes, wishes or expects them to be, which can then change what one hopes or wishes for (e.g. C. Jagaro, 2011). Hagen (1997) stated something similar in that mindfulness practice can bring a sense of "magic" to everyday life as one comes into contact with reality and sees the space between reality and illusion. And one of the researchers involved in the only study that examined the effects of informal mindfulness during a dishwashing task, stated that by simply shifting one's mental attitude and the quality of attention paid to a task, it could undermine the sense of the task being a chore and also offer the task the quality of being inspirational (Hanley, 2015). Interestingly, the research on mindfulness meditation has shown that one can cultivate gratitude in meditation and that gratitude can be felt towards the skills developed from mindfulness practice (e.g. Keane, 2011), however there haven't been any outcomes that have shown that meditation practice directly or unintentionally elicits gratitude in meditators *during* meditation. One reason for this difference may be related to the specific nature and setting of informal mindfulness i.e. it is practiced within the context of one's life and one's living experiences, therefore it is possible that awareness of these life experiences generates appreciation for what they represent to the person in context of their life in general. For example, gratitude was experienced in the act of brushing one's teeth, which would not normally be considered a meaningful activity but could

represent meaningful ideas such as health and hygiene. Alternatively, being mindfully present with one's daughter could be meaningful in itself but also represent important values such as family and relationships. Gratitude was also expressed towards unpleasant or stressful activities, possibly because these experiences provided challenges that could be overcome or because these stressful activities were associated with significant aspect of one's life. Thus in a similar way to meditation, the gratitude that was experienced in informal mindfulness practice might not necessarily arise from the sensory experience itself but for the object or the relationship to the object that one is directing sensory awareness towards.

Another aspect of this finding was that the participants who had more formal meditation practice appeared to mention or infer a greater degree of acceptance, kindness or gratitude towards their sensory experiences compared to the participants who had less or no formal meditation practice. Whilst this effect was subtle, it might imply a differential approach to informal mindfulness practice whereby meditators might engage in informal mindfulness practice with greater awareness and greater capacity to extend qualities such as acceptance or kindness towards their everyday experiences compared to non-meditators.

4.1.3 Informal mindfulness offers multiple, in vivo contexts for overcoming suffering and dealing with pain more effectively

In this theme, one of the main findings was that daily informal mindfulness practices offered multiple situations in which participants could deal with experiences of pain and suffering in the moments they arose. The relevance of context in informal mindfulness practice is again implicated in this finding albeit in distinct ways from the previous two themes.

One distinct implication is that engaging in informal mindfulness whilst in different life contexts could potentially increase the diversity of one's coping repertoire and enhance coping efficacy for dealing with painful or uncomfortable situations in the moment. Specifically, the capacity to cope with painful or uncomfortable feelings that arise in regular meditation can generalise to other situations as pointed out by Kabat-Zinn (1992), whereas in informal mindfulness practice, one might learn how to cope with unique or subtle differences in painful emotions (e.g. grief, embarrassment, rejection, loss or fear) in a myriad of situations.

The second implication is that daily informal mindfulness practice might offer the additional opportunity to benefit from, or be reinforced by the inherent nurturing qualities of the context itself. For instance, it was mentioned that being mindful during gardening facilitated awareness for the pervasive quality of impermanence and transience in nature, which in turn was able to soften the experience of grief. Thus one may benefit from contexts that foster the development of practical coping skills, provide social reinforcement or offer possibilities for goal attainment or comforting experiences, as examples.

An argument that could be made in opposition to these proposals is that informal mindfulness practice during everyday activities, unlike meditation, offers *too much* context that could detract one's full attention to present moment experiences and thus their ability to detach from and cope with painful experiences that arise. Kabat-Zinn (1992) and Linehan (1993b) explain that mindfulness meditation provides prolonged exposure to sustained, non-judgemental observation of distressing thoughts and feelings without trying to escape, which can result in lower emotional reactivity and enhanced coping skills. Grossman (2010) also mentioned that mindfulness meditation cultivates a mindset whereby one attempts over and over to be kind and compassionate to all unwanted experiences. Each of these references emphasize the sustained, enduring nature of attention that can be cultivated in mindfulness meditation, which is generally not seen to be characteristic of informal mindfulness due to its occurrence in environments that might cause disruptions to sustained attention. It may also be argued that informal mindfulness practice and its focus on sensory experiences may not be sufficient or conducive to bring about awareness of deeper cognitive or emotional experiences. This however may not necessarily be the case. The results indicated that informal mindfulness practice was not limited to sensory experiences alone and was capable of facilitating awareness and acceptance towards mental, emotional, spiritual and ethical states, as conceptualised in Barker's (2013) biopsychosocial model of mindfulness. It was also found that informal mindfulness could provide opportunities for sustained and enduring practice as much as it allowed for shorter more intermittent practice, depending upon the nature of the activity and the attitude or intention of the person at the time. To illustrate both possibilities, the act of mindful driving may simultaneously bring about awareness of tightness in one's grip of the wheel, awareness of frustration and awareness of the thought "how dare s/he!" in the moment. This could subsequently elicit an attitude of acceptance and kindness towards each of these mental, emotional and sensory experiences as one was experiencing them. This could be a sustained practice that one engages in

continuously on their journey without trying to escape by doing something else mindlessly (e.g. by listening to music or talking on their phone).

The second main finding concerned how engaging in daily informal mindfulness practice over the long term helped participants to deal with challenges in understanding the true nature of mindfulness and its capacity to overcome suffering. The specific experiences were recognising that acceptance was a gradual and potentially painful process and that any efforts to minimise pain with excessive daily mindfulness could inadvertently increase the experience of suffering or lead to over-detachment. The challenges themselves are not new and have been identified in relation to the misunderstanding or misapplication of mindfulness meditation. For example, using meditation as an isolated coping mechanism, practicing meditation too intensively and for too long, simulating the act of meditation without actually meditating or mistaking meditation as an opportunity to analyse or evaluate one's thoughts or experiences (Frey, 2015). These challenges were also observed in the research literature. For example, Schroevers and Brandsma's (2010) study found that meditating participants were able to disengage from unpleasant emotions but didn't necessarily approach their negative thoughts and emotions with openness, curiosity and acceptance. And in Keane's (2013) study, participants identified that meditation practice often took them to places that they didn't want to go or were frightening, which resulted in experiences of heightened sensitivity and magnified emotions. This literature highlights how informal mindfulness practice might offer somewhat distinctive ways of overcoming these challenges compared to what can be done in mindfulness meditation. For instance, informal mindfulness can offer shorter opportunities within the familiarity of everyday life to practice mindfulness skills such as awareness, acceptance, detachment and non- judgement, which may be less intense or less 'frightening' outlets to explore aversive inner experiences or move through acceptance. Also having a context to practice informal mindfulness could again be helpful, for example, in terms of implementing other personal coping mechanisms that are appropriate in the activity, offering distinct parameters for practice (e.g. being mindful for 15 minutes whilst doing the dishes), inhibiting any simulation or posturing of meditation (e.g. sitting in the lotus position with eyes closed but not actually meditating) or reducing the likelihood of analysing or evaluating one's experiences as a result of full engagement in the activity.

The last finding demonstrated how personal experiences of daily informal mindfulness practice were found to positively affect professional experiences in terms of perceived ability to effectively deal with pain and suffering in clients without trying to "fix" it for them. Shapiro and Carlson (2009) point out that there is a natural tendency in the

helping professions to want to make things better or to fix things for others. At times, participants can also feel a certain responsibility to do so, which can result in the development of unrealistic goals and the participant losing sight of the importance of present moment encounters with the client. Thus the literature highlights the necessity for participants to be practiced in dealing with their own experiences of pain in order to be useful in dealing with the pain of their clients (Crane et al., 2010; Bruce, Manber, Shapiro & Constantino, 2010). Baker (2003) also mentioned that when participants are aware of their own experiences and know their limitations this allows them to extend even more sensitivity towards their clients.

And Hayes and Feldman (2004) pointed out that part of the responsibility of teaching mindfulness is being able to prepare clients for the experience of being able to sit with their painful experiences without relying on their existing coping strategies. This can sometimes bring about a disturbance or worsening of distress or what Buddhists have long acknowledged as a heightened period of neurosis (Chodron, 2001). This again implies the importance of participants having personal experience of doing this themselves so that they are better equipped to prepare clients to experience it themselves. Whilst there is substantial theory that underpins the significance of this finding, similar results have only been reported in studies of mindfulness meditation. For instance, mindfulness meditation practice has been found to be instrumental in developing emotional and psychological tolerance in practitioners towards painful or uncomfortable experiences (e.g. Schure, Christopher & Christopher, 2008; Christopher, Christopher, Dunnagan & Schure, 2006). The practice of meditation also reduced the likelihood of participants engaging in avoidant responses or becoming overwhelmed by distressing emotions in their clients and thus more able to work with these emotions constructively (e.g. Schroevers & Brandsma, 2010; Hoffman, Sawyer, Witt & Oh, 2010; Hayes & Feldmen, 2004). Bihari and Mullan (2012) also found that mindfulness meditation allowed meditators to deal with anger more constructively. Furthermore, one research study suggested that the ability to maintain a mindful attitude towards clients even in the face of strong emotions was an indicator of mindful competency at an advanced level (Crane et al., 2012). Therefore this is the first time this experience or effect has been reported as a qualitative outcome of having a long term, daily practice of informal mindfulness. This finding indicates that this type of mindfulness practice might also be capable of producing at least some of the quantitative findings of formal meditation and may potentially enhance competency in mindfulness practitioners.

4.1.4 Mindful therapy fosters use of self and other for therapeutic connection

One of the most interesting findings in this theme was the identification of 'mindful therapy' as constituting an informal mindfulness practice. Mindful therapy referred to the intentional, active and in-the-moment practice of being mindfully present with and for the client and bringing a kind and empathic attention to all inner experiences whilst engaging in the act of therapy. This was highlighted as being more involved and dynamic compared to the act of just mindfully listening to clients in therapy.

Mindful therapy was found to bring about the use of self and awareness of one's humanity and also allowed participants to rely on their personal wisdom and self-knowledge alongside their therapeutic and professional skills. This finding ties in well with the existing literature that proposes that mindfulness practice can prompt therapists to move away from seeing their roles as 'healers' or 'experts' and instead give themselves permission to be 'perfectly human' with others (Shapiro & Carlson, 2009). Gunaratana (2002) also mentioned that being mindful of one's impressions of oneself or of others weakens the ego attached to the ideal of the impression. It has also been stated that mindfulness has caused a shift away from the more traditional demarcation of participant and client roles in the third wave therapies. For instance, in ACT there are references to the participant and client being 'cut from the same cloth' (Flaxman, Blackledge & Bond, 2011) and in MBCT there are suggestions that mindfulness meditation allows participants to see that their client's suffering is not different to their own (Shapiro & Carlson, 2009; McCown, Reibel & Micozzi, 2010).

A related finding was that bringing one's self and one's sense of humanity to the therapy room could become a catalyst for developing meaningful, authentic and non-hierarchical therapeutic connections. Hick (2008) stated that when a participant and client are able to share their experiences of humanity it can be the basis for building a therapeutic relationship that is grounded in a deeper and more fundamental spiritual connection. Furthermore, the qualities of openness, curiosity, compassion and non-judgement, which were all referenced in the analysis, have been found to be conducive to overall improvements in the therapeutic relationship (Bruce, Manber, Shapiro & Constantino, 2010; Stauffer, 2008; Turner, 2009; Lambert & Ogles, 2004). In some studies on mindfulness meditation it has also been shown that therapists experience less hierarchy, are more comfortable bringing personal wisdom into therapy sessions and are more able to relate to themselves and to clients in an open and curious way (e.g. Keane, 2013; McCollum & Gehart, 2010; Bazzano, 2010; Nanda, 2005).

Therefore it could be surmised that this finding is somewhat supported by the existing literature and suggests that having a long term, daily practice of informal mindfulness might be comparable to meditation in terms of enhancing the therapeutic relationship and more specifically, bringing about important shifts in how therapists perceive and use themselves as tools in therapy.

Another key finding was that mindful therapy enlivened the embodiment of mindfulness qualities and the ability to teach through this embodiment. This is an important finding as there is a prolific amount of literature that highlights the fundamental importance of embodiment or embodied presence in the mindfulness participant in order to be able to teach through therapeutic presence rather than rely on theory, skills or activities alone (e.g. Geller & Greenberg, 2002; Hick, 2008; McCown, Reibel & Micozzi, 2010). Embodiment is also a significant marker of participants' competence as a mindfulness teacher (Crane et al., 2012). Epstein (2003) goes further in suggesting that the embodiment of mindfulness in therapists' behaviour could also be an ethical responsibility that the therapist has to the person they are teaching. Whilst teaching through embodiment was identified as a significant professional experience for participants, it has been stated that it could "spark possibility and potential to embody [mindfulness] in another" (Crane, 2009).
Embodiment of mindfulness has been found as a qualitative outcome in studies of mindfulness meditation (e.g. Cigollo & Brown, 2011; Bazzano, 2010; Nanda, 2005). Although this finding could suggest that the long term and daily practice of informal mindfulness was also capable of cultivating embodied presence in the participant, it is interesting to note that the experience of embodiment was discussed by the two participants who had the longest history of mindfulness meditation. So even though meditation wasn't currently their main form of practice, there is a suggestion that daily informal practice *on its own* might not be sufficient in fostering embodiment.

Aside from use of self, it was highlighted that engaging in mindful therapy stimulated greater efforts from participants to draw their client's life experiences and wisdom into the therapy process. Much of the existing literature highlights that a therapist's willingness to see their client as an expert of their own subjective experiences and their ability to provide opportunities for the client to increase their participation in therapy and become active 'self healers', could bring about considerable benefits to the client and to the therapeutic relationship (e.g. Crane and Elias, 2006; Gordon 2012). Grossman (2010) also identified how mindfulness has brought about a greater willingness for therapists to draw insight from subjective perceptions and personal experience in a

way that has previously been disparaged as a source of knowledge within behavioural psychology traditions. This finding has also been an outcome in studies of mindfulness meditation such as in Keane's (2013) study that demonstrated how engagement in mindfulness meditation practice allowed participant participants to recognise, appreciate and bring forth the 'Buddha nature' in their clients. The results from this study demonstrated similar results for those who had some meditation practice.

Two key challenges also arose from the practice of mindful therapy. The first challenge highlighted how mindful therapy could be a tiring and exhausting practice that felt qualitatively similar to meditation. This is not surprising considering that aspects of mindful therapy have been acknowledged in the literature to be quite challenging. For example, Shafir (2008) mentioned that practicing an active skill such as mindful listening requires the therapist to actually be fully present with the client (i.e. in mind and body) rather than just looking as though he or she is listening by nodding the head or maintaining eye contact. Shafir (2008) also acknowledged that sustaining the practice of mindful listening requires heightened attentional abilities as well as complete authenticity in the therapist. And Childs (2007) noted that when therapists hold their own thoughts in suspension in order to focus their attention entirely on their clients and what their clients are saying and doing, it can be experienced as very similar to meditation especially as therapists in this state tend to not say very much. Thus if mindful therapy provides participants with meditation-like experiences, it is possible that participants may be cultivating the qualities of meditation through this intense form of informal mindfulness practice. Furthermore, mindful therapy (as one example of "meditation-like" informal mindfulness practices) might constitute a "hybrid" form of informal and formal practice by combining the sensory awareness of informal mindfulness with the deeper levels of cognitive and emotional awareness of formal meditation and the more prolific application of acceptance and compassion towards one's experiences in everyday life activities. Another consideration is that if participants engage in this type of hybrid practice for relatively long periods during the working day, they might feel less compelled to meditate again in their personal time and consequently more inclined to engage in simpler or quicker informal practices.

The other challenge was in determining the extent to which mindfulness of self or other should guide the direction and content of therapy. This finding speaks to one of the main incongruities between humanistic and behavioural therapy that have been referenced in the literature, whereby the participants' desire to privilege the client's

experience is not ordinarily accommodated within a more protocol or manualized-based therapy approach (Grossman, 2010; McCown, Reibel & Micozzi, 2011). Stanley et al. (2006) also highlighted a similar dilemma in their study whereby higher levels of mindfulness in participants' led to less successful client outcomes in carrying out a manualized treatment. This suggests that some third wave therapists who practice mindfulness and deliver manualized treatments (e.g. DBT) may benefit from more explicit training in knowing how to accommodate clients' present moment experiences in the overall treatment structure.

4.1.5 Informal mindfulness can reconcile the stance of "being" in mindfulness with the culture and beliefs related to "doing" in the West

This theme revealed four key findings. The first finding, which has not been revealed in another study to date, was that daily informal mindfulness practice allowed for "being *whilst* doing" and therefore was a conducive and even enjoyable means to bring mindfulness into daily living. Informal mindfulness was also found to be conducive as it didn't require participants to necessarily step out of everyday life or to set time aside, whether it be for three minutes or thirty minutes, to meditate. In relation to the literature, informal mindfulness practice is seen to be adaptable to any event or situation and offers the opportunity to be mindful in any given moment (e.g. Siegal, 2010). Wolkin (2016) also stated that a deliberate informal practice of mindfulness can be a great way to help "bridge the gap" between formal meditation and daily life. And Amaro (2016) pointed out that informal mindfulness is able to disrupt behavioural habits that might go unnoticed and also may enhance enjoyment or interest in whatever activity that one is being mindful of. There are a few possible reasons that one may experience greater enjoyment or interest in the activity they are practicing mindfulness in, for example, it could be the result of greater sensory awareness of pleasurable or meaningful experiences, enhanced kindness or compassion towards one's performance in the activity or perhaps even greater detachment from the desired results of the activity. Within a therapy context, Halliwell (2010) pointed out that being and doing modes are actually quite compatible as both offer experiential and active processes for the therapist and client to engage in, even though the nature of these processes differ. Furthermore Crane, Kuyken, Williams, Hastings, Cooper & Fennell (2012) mentioned that competent mindful practitioners are able to use therapy and language skills to create an open space for curious and dynamic mindful exploration.

The second key finding was that having a personal informal mindfulness practice could be instrumental in preparing participants to address their clients' misconceptions, unrealistic expectations or difficulties in assimilating mindfulness into their life. Participants also expressed their willingness to take a more flexible teaching approach by integrating informal mindfulness practices for different purposes in therapy, such as an introduction to mindfulness, a way to sustain mindfulness practice during the day when one is unable to make time for meditation or as a gateway to meditation. Many of these purposes have been noted as valuable uses of informal mindfulness in therapy (Naumburg, 2016; Siegel, 2010). The difficulties or misconceptions that were identified also parallel the findings in the literature, such as placing too much value on "doing" or being busy, seeing mindfulness as a passive approach or mystical approach, and expecting the outcomes of mindfulness to occur immediately and to "cure" symptoms in a similar way to medication (e.g. McCown, Reibel & Micozzi, 2011; Harrington & Pickles, 2009; Hyland 2009; Hagen 1997). Addressing these issues could presumably be a difficult task for some therapists as the basic goals of mindfulness therapy are not necessarily the same as other forms of cognitive or behavioural therapy, i.e. mindfulness is about the cultivation of personal qualities such as insight, awareness, wisdom and compassion that may help to overcome suffering whereas therapy tends to focus on the elimination of presenting complaints (Grossman, 2010). In Keane's (2013) study, a couple of dilemmas were identified as a consequence of the "cultural dialectic taking place between eastern and western approaches to mental health" (p9). For example, some participants felt that mindfulness had been incorrectly packaged as a tool to fix people, although they felt that their meditation practice could be used as a teaching tool to address these dilemmas. Thus the current finding indicated that participants' who had an informal mindfulness practice were able to use their daily informal practice as a teaching tool in the same way as meditators.

The third main finding highlighted the experiences of being challenged by informal mindfulness practices due to the distractions of engaging in the activity itself or the competing sensory stimuli in the environment. This finding is validated in light of the literature that acknowledges the distraction that comes with practicing mindfulness alongside other life activities and also proposes that informal mindfulness as a standalone practice is generally not sufficient to overcome distraction in order to achieve fully focussed mindful awareness (Gotwals, 2016). Amaro (2016) also identified that informal practice can be more difficult than meditation, which tends to happen in physical and/or mental space that is still, quiet and more controlled. Thus bringing mindful attention to various tasks in less controlled environments can take

more effort (Amaro, 2016). And in Popper's (1963) work there are references made to the multi-faceted nature of here-and-now moments that usually consist of different internal events that compete for attention per se, for example, different thoughts, feelings, body sensations, beliefs, dreams, desires etc. Therefore, a person needs to implement a system of selective judgement to determine which aspect of their here-and-now moment to pay attention to. This suggests that in informal mindfulness, part of the challenge may rest in determining *which* inner experience to pay attention to.

Considering these points, it is possible that the existence of distractions during informal mindfulness practice might affect the person in different ways. For instance, distraction might hinder one's ability to develop high levels of mindful attention or alternatively, it might help to enhance mindful attention due to the extra effort required to overcome the distraction and refocus on present moment experiences. In the case that distraction enhances mindful attention, it could do so generally so that a person becomes more attentive to a broader range of sensory experiences or it could do so selectively so that a person becomes more skilled in discriminating between sensory experiences. To shed some light on how these possibilities might eventuate, it is interesting to reflect on how one participant who had a history of meditation, conceptualised both the activity (in informal mindfulness) and the breath (in meditation) as anchors to bring attention back to the present moment. In contrast, a non-meditating participant described having more difficulty in returning to present moment awareness following longer periods of distraction. The research on mindfulness meditation has also shown that the cyclical process of noticing when the mind has wondered and returning to the breath or other present moment experiences plays a significant role in the cultivation of selective attention and cognitive flexibility (e.g. Moore & Malinowski, 2009; Cigollo & Brown, 2011, Irving et al., 2012). Thus it is possible that the effects of meditation could considerably mediate how a person copes with distraction during informal mindfulness practice, even over the long term.

And the fourth finding highlighted a concern for how the popularity of informal mindfulness practice may further dilute mindfulness or detract from the value of mindfulness meditation and yet still be overshadowed by more dominant change-based protocols in many Western clinical settings. There have been several theorists and researchers in the field who have expressed concern for the dilution of mindfulness philosophy in the West (e.g. Brazier; 2013; Dimidjian & Linehan, 2003) and some participants in Keane's (2013) study also expressed this viewpoint, however the literature review did not uncover any direct reference to how the popularity of informal mindfulness could be a factor in diluting the value of meditation. Going forward though,

with further developments in the theory and evidence for informal mindfulness practices and with advances in personal technology and gadgets as reminders for informal practice, it is possible that both formal and informal mindfulness practices could be adapted to suit increasingly busier lifestyles in the West. It could also be the case that with greater integration of mindfulness in the West and better understanding of its underpinning Eastern philosophies, there may be individual or even cultural shifts in how excessive "busyness" is valued and how it could be seen as contributing to many mental health issues in the West.

However in regards to the dominance of change-based protocols, Lau and McMain (2005) observed that even though mindfulness practice has proliferated in the West, change-based technologies are still far more developed and more often employed than acceptance-based approaches in the West and likely based upon the mistaken belief that the most effective way of helping people is encouraging them to be active in doing something. At present, informal mindfulness practice seems to straddle both "being" and "doing" approaches, yet it is lacking in the evidence, theory and research impetus that characterises these approaches individually. Therefore the choice to engage in daily informal mindfulness as a main form of practice might bring up personal and professional conflicts for the therapist or may warrant further explanations or justifications in regards to its validity as a stand-alone practice, i.e. without any meditation or without it being delivered as part of a whole treatment package such as ACT or DBT.

4.1.6 Having both a personal and professional investment in mindfulness can be mutually reinforcing

In this final theme, there were two key findings that were reciprocally related. The first highlighted how the seamless integration of daily informal mindfulness into participants' personal and professional lives (i.e. "mindful living") was related to experiences of belief and fulfilment in teaching mindfulness to others. The references to mindful living in the literature have referred to the enduring effect of mindfulness practice in all areas of one's life, including how one relates to themselves, to others and the world in general (e.g. Wolkin, 2016; Amaro, 2016; McCown, Reibel & Micozzi, 2011; Siegel, 2010). Whilst the references commonly suggest that mindful living entails regular meditation that is supported by regular informal practices, the emphasis tends not to be on the practice itself but on how it is experienced as a way of life that "embodies … principles like gratitude, loving-kindness, and compassion" (Wolkin, 2016). Amaro (2016) makes a slight distinction by proposing that bringing attention and a reflective

attitude to the flow of mood and perception during daily activities could also be described as “mindfulness of everyday life.” Findings have also shown that bringing personal mindfulness skills into therapy work can be a fulfilling experience for therapists, even if they did not explicitly teach mindfulness to their clients or deliver mindfulness therapies (e.g. Cigolla & Brown, 2011; Keane, 2013). Aside from being a positive experience for the therapists, it is quite likely that conveying belief and fulfilment in teaching mindfulness would have positive repercussions on the client particularly as research has shown that outcomes of therapy may be moderated by the attitude of the teacher and what they bring to the therapeutic encounter (Blow, Sprenkle & Davis, 2007; Shafir, 2008). Crane (2009) also pointed out that therapists who personally enjoy teaching mindfulness provide “a sense of animation, honesty, aliveness, connection and presence in the room” (p45). Another perspective may be that the congruency between the model and therapist could allow the therapist to become a ‘personalized vehicle’ for the model to work in its intended way (Simon, 2006). In light of these references, this finding suggests that daily informal mindfulness over the long term may be sufficient in bringing about a sense of mindful living for some therapists as well as instilling belief, fulfilment and congruency in the teaching process. A further implication is that instead of taking a secondary or supportive role in the development of mindful living, daily informal mindfulness could potentially undergo a role reversal in terms of becoming the main form of practice, which is then supported by less regular meditation at least for some therapists.

The second key finding highlighted experiences of attenuation in participants’ self-efficacy or affective wellbeing if their mindfulness practice suffered or was perceived to be inconsistent in either or both areas of their life. In particular, it was implied that MBCT therapists or those who had strong ties to a Buddhist community were especially susceptible to experiencing guilt, ineffectiveness, dissonance or inauthenticity if they didn’t maintain sufficient meditation practice in their lives. This is not a surprising finding considering the professional expectations placed on MBCT therapists to meditate regularly and the difficulties that have been reported in maintaining a regular meditation practice in some studies (e.g. Keane, 2013; Cigollo & Brown, 2011; May and O’Donovan, 2007). However it is interesting to reflect on the significant role that meditation retreats played in these participants’ lives. A meditation retreat appeared to provide a meditating community or a *sangha*, which is considered to be one of the “three jewels” in Buddhism (Bodhi, 2010). Thus meditating on a retreat alongside others could hold more power and offer more support than meditating alone. It is also possible that for the participants who had a history of meditation, the intensity of these

retreats over longer periods of time may have offered a counter-balance to their current lack of regular meditation.

4.2 Implications for professional practice

The findings of this study suggest that the long term, daily practice of informal mindfulness carries a host of implications for third wave therapists who practice it in both their personal and professional lives.

Perhaps the most significant implication is the capacity for long term, daily informal mindfulness practice to cultivate many if not all the qualities of mindfulness, such as acceptance, compassion, openness, present moment awareness and curiosity, even if the person does not engage in regular meditation. Excuriex and Labbe (2011) pointed out that possessing the qualities of mindfulness not only improves the therapist's ability to teach mindfulness skills, but also equips them to provide effective therapy more generally. And Hemanth and Fisher (2015) also found that mindfulness training could be a way to develop the interpersonal skills of trainees. Thus a trainee or therapists' practice of daily informal mindfulness might also improve their broader therapeutic skills. This implication could be particularly appealing for counselling psychologists or trainees who wish to cultivate these qualities in the therapeutic work, regardless of whether they delivered third wave therapies or not. Also, as counselling psychologist trainees are normally expected to receive personal therapy in addition to clinical supervision throughout their traineeship, the practice of informal mindfulness might offer a flexible and adaptable addition to their current training requirements.

Another implication is that therapists who practice daily informal mindfulness might also be more inclined to apply their practice in therapy sessions in the form of "mindful therapy", which involves being actively mindful of one's inner experiences whilst delivering therapy e.g. mindful listening, mindful observing and mindful responding. Engaging in mindful therapy could allow therapists to be more *selectively* aware of their own and their clients' experiences in the room, be able to sit with uncomfortable or unpleasant feelings, be able to teach through embodiment or be more willing to create space for the clients' wisdom and knowledge to be an active part of the therapy process. Taking this approach could considerably affect how clients experience therapy, how they understand and conceptualise their experiences of pain and suffering and also how they come to see themselves as active agents for self-healing. It is also very likely that practicing mindful therapy or bringing a stance of mindfulness

to therapy could meaningfully improve and deepen the therapeutic relationships of these therapists. Again these possibilities are incredibly pertinent for counselling psychologists who tend to use the therapeutic relationship as a vehicle for therapeutic change. Should counselling psychologists learn how to be more mindful in therapy or engage in mindful therapy as an informal mindfulness practice, it could have drastic effects on their capabilities to attend to nuances in the therapeutic process and facilitate greater therapeutic presence.

The third implication is that the professional practice of informal mindfulness could instil the willingness and ability in therapists to take a flexible approach to teaching mindfulness to others, which could mean that clients have more choice and variety in how they learn mindfulness skills.

For the therapist, the benefits and enjoyment in practicing daily informal mindfulness implicates an avenue to self-care, a means to reduce the risks of stress, burnout and compassion-fatigue and a way to develop realistic expectations of one's own role as a mental health professional and increase longevity in the mental health field. These potential outcomes correspond with the findings for the positive effects of mindfulness meditation on therapists (e.g. Hemanth & Fisher, 2015; Boellinghaus, Jones & Hutton, 2012; Thomas & Otis, 2010; Shapiro, Brown & Biegel, 2007). For some therapists, the benefits and fulfilment could also reduce feelings of guilt or obligation to practice formal meditation regularly particularly if the therapist does not particularly enjoy meditating or struggles to find the motivation to do so. Another point is that the professional practice of mindfulness therapy and even practice-based research could be buoyed by any positive relationship that the therapist may form with meaningful activities or experiences in their personal lives. It could also become a way for therapists to develop a more integrated personal and professional identity and purpose in life. This possibility is reflected by Germer (2005) who stated, "mindfulness might become the construct that draws clinical theory, research and practice closer together and helps to integrate the private and professional lives of participants" (p11).

There were also some less positive implications. Firstly it was discernable that not having any meditation practice could possibly impede the development of mindful awareness and the cultivation of qualities such as acceptance and compassion. Also it is possible that perceiving one's mindfulness practice as a perfunctory activity for the purpose of gaining new skills or to fulfil a professional expectation rather than embracing mindfulness more holistically or non-dualistically could again potentially

hinder how effectively one is able to cultivate mindfulness skills and embody the qualities that are considered necessary for teaching. This may not necessarily be a significant concern for ACT or DBT therapists who deliver mindfully-informed therapies that do not have the same focus on meditation and also incorporate mindfulness into a package of clinical skills, however if these therapists choose to discuss their personal mindfulness practice with clients, it seems important that they offer an accurate account of their practice so as to avoid presenting a fragmented or incongruous representation of mindfulness to the client. Barker (2013) also considers transparency around personal mindfulness practice to be a professional and ethical responsibility of therapists who teach mindfulness.

The other negative implication could be the degree of pressure that some therapists might place on themselves to be mindful in therapy, which could pose risks for stress and burnout. And MBCT therapists who feel that their meditation practice is lacking may also be susceptible to stress as a result of experiencing personal and professional dissonance or feeling unable to be authentic about the nature of their practice. It is likely though that with regular and appropriate clinical supervision as well as on-going mindful awareness of these feelings of stress, this risk could be identified and managed well.

4.3 Strengths and limitations of the study

Kasket and Gil-Rodriguez (2011) emphasize the importance of providing “an honest and non-defensive account of the main strengths and limitations of the research process and the thesis itself” (p. 24) in any piece of counselling psychology research, which is the aim of this section.

To begin, I identify some of the key strengths of this study. The first strength would be that it has brought light to the relatively under-researched area of informal mindfulness practice, which has to date has not been the sole focus of any research study exploring the qualitative outcomes of mindfulness. This focus not only places informal mindfulness in a position of primary focus, which has so far been held by formal mindfulness meditation but also explores how informal mindfulness may be a comparatively viable means for therapists to experience the qualities and nature of mindfulness.

The second strength of this study was that it was able to include the experiences of an overlooked and perhaps even marginalised group of MBCT therapists who choose not to practice mindfulness meditation on a regular basis, even though it is considered to be an expectation of delivering the therapy. Thus the added value of this exploration was that it was able to explore what daily informal mindfulness offers to MBCT therapists who may not ordinarily be open to discussing non-meditation as a primary form of mindfulness practice, and also ACT and DBT therapists who are considered to rely more on informal techniques in their professional work but have not yet been the subject of any previous study.

And thirdly, this study presents an opening to incorporate the practice and study of mindfulness principles and in particular, informal mindfulness practices more overtly in the field of counselling psychology. The study also presented findings that are relevant for counselling psychologists in terms of working in accordance with the profession's underlying philosophy and values and potentially mediating some of the current dilemmas in the profession. Furthermore, this study might be a springboard for other counselling psychologist researchers to pursue research in this area.

Perhaps the main limitation was that it was not possible to know how much of what the participants said in the interview related to their daily informal mindfulness practice and not to their occasional or irregular meditation, for those participants who meditated. Many participants also used the term "mindfulness practice" generally rather than the specific term "informal mindfulness", which made it difficult to always know whether they were referring to their daily informal practice, their meditation or the overall experience of both practices in their life. It was also not possible to discern the extent to which other factors such as therapeutic skills and experience, spiritual affiliations or trait levels of mindfulness were implicated in the overall findings. Thus this study was not able to present the qualitative experiences of daily informal mindfulness as an autonomous and unaffected practice.

The second issue related to the nature of participants who chose to be involved in this study. It was quite obvious that all the participants had rather positive beliefs or experiences of informal mindfulness practice to reflect on even though there was much variability in the degree of positivity or belief shown. The study also attracted three MBCT therapists who were willing to discuss their daily informal mindfulness practice, even though it posed the risk of feeling judged or exposed. It is possible that these therapists decided to participate as they saw the interview as an unexpected

opportunity to authentically reflect on their experiences of informal mindfulness practice or perhaps they were spurred by a desire to contribute to a piece of research that was offering some recognition to informal mindfulness. Therefore, these therapists might have been more positive about their experiences in the interview or alternatively, less likely to point out the negative experiences even when asked. On the other hand, this study may have inadvertently excluded therapists who struggled with their informal practice or did not find it helpful in their personal lives and thus did not continue.

The third limitation pertains to the relatively small sample size for a thematic analysis. Although the study met the recommended minimum number of participants for a medium size TA project, a larger number of data items might have allowed me to capture more complexity and richness for contextualising the experiences of informal mindfulness practice.

The fourth limitation related to the use of TA itself whereby Braun and Clarke (2006) identify that the broader focus of TA across a data set prohibits researchers from maintaining a thread of consistency or contradiction within any one individual account and thus limits what can be revealed about individual accounts of a phenomena in a phenomenologically framed TA analysis. Thus I was unable to reflect on any interesting patterns or contradictions in informal mindfulness practice that emerged in any given data item.

4.4 Future directions for research

This study highlights a number of future directions that research could take in the field of informal mindfulness practice. One key direction that was implicated in the limitations of this study involves qualitative research into the experience of informal mindfulness as a stand-alone practice. Considering the difficulties that were experienced in recruiting participants for the present who had no experience of meditation, a future study could be designed around a short-term informal mindfulness program for participants who had no prior use of meditation.

Another significant area of research could lie in the exploration of a possible hybrid form of informal and formal mindfulness practice that was surmised on the basis of some participants' descriptions of their experiences, in particular those who previously had a formal meditation practice before embracing informal mindfulness as their main form of daily practice. This has rather exciting implications for the future of mindfulness

practice as it may offer an alternative practice that could be both beneficial and adaptable.
It would also be interesting to explore how factors such as trait mindfulness, contexts of mindfulness practice or spiritual applications of mindfulness could be implicated in the outcomes of informal mindfulness practice for therapists. For example, it would be valuable to determine what variables might mediate the relationship between context and the outcomes of informal mindfulness practice. Or whether trait mindfulness influenced how effective daily informal mindfulness practice was.

Another possible area for future research may explore whether there are actual quantitative or qualitative differences in how clients observe or experience therapists who practice formal or informal mindfulness or have no mindfulness practice at all, in terms of determining effectiveness or even embodiment of mindfulness qualities. This may help to understand how mindfulness practices can be best practiced by the therapist in the service of the client.

Many of the findings for informal practice also produced quite similar outcomes to mindfulness meditation. Therefore considering the research outlined in the Introduction that demonstrated how meditation produced changes in the brain structure, it would be interesting to conduct similar neurological studies of the brains of those who only practiced informal mindfulness to determine similarities and differences.

And lastly, it would be valuable for future counselling psychologist researchers to explore how mindfulness practices are perceived or experienced by counselling psychologists and whether the practice was able to facilitate a deeper engagement with the core values and humanistic approach of the profession.

4.5 Conclusion

Despite its limitations, this study highlights an array of unique and interesting findings for the long term, daily practice of informal mindfulness for third wave therapists. Overall this study represents a very small step into the field of research on informal mindfulness practices and clearly there is still much evidence needed in this area.

References

AGCAS Publications (2006). Occupational Profile. Counselling Psychologist [Pamphlet]. London: Lawrence, S.

Aiken, G.A. (2006). The potential effects of mindfulness meditation on the cultivation of empathy in psychotherapy: A qualitative enquiry. *Dissertation Abstracts International, Section B: Sciences and Engineering, 67*, 2212.

Alhojailan, M.I. (2012). Thematic analysis: A critical review of its process and evaluation. West East Journal of Social Sciences, 1(1).

Amaro, A. (2016). The Importance of Informal Meditation. Retrieved June 2, 2016, from:https://www.abhayagiri.org/reflections/the-importance-of-informal-meditation

Anderson, M.L. & Taylor, H.F. (2009). Sociology: The Essentials. Belmont, CA: Thomson Wadsworth.

Bach, P. & Hayes, S. C. (2002). The use of Acceptance and Commitment Therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 70(5)*, 1129-1139.

Baer, R.A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 10,* 125-143

Baker, E.K. (2003). *Caring for ourselves: A therapists' guide to personal and professional well-being.* Washington DC: American Psychological Association.

Barker, M. (2013). Mindful counselling and psychotherapy. London: Sage Publishing.

Barker, M. (2013) Special Issue: How mindful should psychotherapists and counsellors be about mindfulness? *European Journal of Psychotherapy & Counselling, 15(2).*
Barnes, S., Brown, K.W., Krusemark, E., Campbell, W.K., & Rogge, R.D. (2007). The role of mindfulness in romantic relationship satisfaction and responses to relationship distress. *Journal of Marital and Family Therapy, 33*, 482-500.

Batchelor, S. (1994). *The awakening of the West: The encounter of Buddhism and Western culture*. London: Aquarian Press/Berkeley: Parallax Press.

Batchelor, S. (1997). *Buddhism Without Beliefs: A Contemporary Guide to Awakening*. New York: Riverhead.

Bazzano, M. (2010). Mindfulness in context. Retrieved 6 June, 2011, from: http://www.therapytoday.net/TherapyToday

Berkovich-Ohana, A. & Glicksohn, J. (2016). Meditation, Absorption, Trascendent Experience and Affect: Tying it all together via the consciousness state space (CSS) model. *Mindfulness*, 1-10.

Bermingham, K. (2015). The mindfulness of drawing. Retrieved December 10, 2015, from: http://www.mindful.org/the-mindfulness-of-drawing/

Bien, T. (2006). Mindful Therapy. Wisdom Publications: Boston.

Bihari, J.L.N. and Mullan, E.G. Relating mindfully: A qualitative exploration of changes in relationships through mindfulness-based cognitive therapy. *Mindfulness.* Retrieved 20 January, 2014, from: DOI:10.1007/s12671-012-0146-x

Bishop, S.R., Lau, M., Shapiro, S.L., Carlson, L., & Anderson, N.D. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice, 11*, 230-241.

Blair, L. (2010). A critical review of the scientist-practitioner model for counselling psychology. Counselling Psychology Review, 25(4), 19-29.

Blow, A.J., Sprenkle, D.H. & Davis, S.D. (2007). Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. Journal of Marital and Family Therapy, 33(3), 298-317.

Bodhi, Bhikkhu (2000b). The Connected Discourses of the Buddha: A Translation of the Samyutta Nikaya. Boston: Wisdom Publications.

Bodhi, Bhikkhu (2010). *Sangha*. Retrieved 15 May, 2012, from: http://www.beyondthenet.net/sangha/sng_body.htm

Boellinghaus, I., Jones, F.W., & Hutton, J. (2012). The Role of Mindfulness and Loving-Kindness Meditation in Cultivating Self compassion and Other-Focussed Concern in Health Care Professionals. Mindfulness, 1-10. Retrieved 11 January 2014, from: http://dx.doi.org/10.1007/s12671-012-0158-6

Bohlmeijer, E. T., Fledderus, M., Rokx, T. A., & Pieterse, M. E. (2011). Efficacy of an early intervention based on acceptance and commitment therapy for adults with depressive symptomatology: Evaluation in a randomized controlled trial. *Behaviour Research and Therapy, 49*, 62-67.

Boyatzis, R.E. (1998). *Transforming Qualitative Information*. Cleveland: Sage Publishing.

Boyes, A. (2013). 6 Mindfulness exercises that each take less than 1 minute. Retrieved December 10, 2015, from: https://www.psychologytoday.com/blog/in-practice/201302/6-mindfulness-exercises-each-take-less-1-minute

BPS Division of Counselling Psychology (2005). Professional practice guidelines. Retrieved 5 February, 2014, from: https://www.google.com.au/?gws_rd=ssl#newwindow=1&q=division+of+counselling+psychology+professional+practice+guidelines

Brandon, G. S. F. (1972). *A Dictionary of Buddhism*. New York: Charles Scribner's Sons.

Braun, V. & Clarke, V (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3, 77 – 101.

Braun, V & Clarke, V. (2012) Thematic analysis. In H. Cooper, P.M. Camic, D.L. Long, A.T. Panter, D. Rindskopf and K.J. Sher (Eds). *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological and biological*. Washington, DC: American Psychological Association (57–71).

Braun, V. & Clarke, V (n.d). Thematic Analysis. Frequently Asked Questions. Retrieved 10 November, 2014, from: https://www.psych.auckland.ac.nz/en/about/our-research/research-groups/thematic-analysis/frequently-asked-questions-8.html

Clarke, V. and Braun, V. (2013) Successful qualitative research: A practical guide for beginners. London: Sage.

Brazier, D. (2013). Mindfulness reconsidered. *European Journal of psychotherapy and counselling, 15(2),* 2-7.

Brooks, J. (2012). *Everyday Mindfulness: Change Your Life by Living in the Present (Mindfulness for Beginners)*. Empowerment Nation.com

Brown, K.W., & Ryan, R.M. (2003). The benefits of being present: Mindfulness and its role in psychological wellbeing. *Journal of Personality and Social Psychology, 84*, 822-848.

Brown, K.W., & Ryan, R.M. (2004). Perils and Promise in Defining and Measuring Mindfulness: Observations from Experience. *Clinical Psychology: Science and Practice, 11(3)*, 242- 248.

Brown, K.W., Ryan, R.M., & Creswell, J.D. (2007). Mindfulness: Theoretical foundations and evidence for its salutary effects. *Psychological Inquiry, 18(4),* 211-237.

Brown, L.A., Gaudiano, B.A., & Miller, I.W. (2011). Investigating the Similiarities and Differences between Practitioners of Second- and Third- Wave Cognitive Behavioural Therapies. *Behavior Modification, 35(2),* 187- 200.

Bruce, N.G. (2006). *Mindfulness: Core psychotherapy process? The relationship between therapist mindfulness and therapist effectiveness* (Unpublished doctoral dissertation). PGSP-Stanford Consortium, Palo Alto, CA.

Bruce, N.G., Manber, R., Shapiro, S.L., & Constantino, M.J. (2010). Psychotherapist mindfulness and the psychotherapy process. *Psychotherapy Theory, Research, Practice and Training, 47(1)*, 83-97.

Carmody, J. (2009). Evolving conceptions of mindfulness in clinical settings. Journal of Cognitive Psychotherapy: *An International Quarterly, 23(3*), 270- 280.

Carmody, J. & Baer, R.A. (2008). Relationships between mindfulness practice and levels of mindfulness, medical and psychological symptoms and well-being in a mindfulness-based stress reduction program. *Journal of Behavioural Medicine, 31(1), 23-33.*

Carr, L. T. (1994). The strengths and weaknesses of quantitative and qualitative research: What method for nursing? *Journal of Advanced Nursing*, 20, 716–721.

Carson, J.W., Carson, K.M., Gil, K.M. & Baucom, D.H. (2004) Mindfulness-based relationship enhancement. *Behavior Therapy, 35 (3),* 471-494.

Chambers, R., Lo, B.C.Y., & Allen, N.B. (2008). The Impact of Intensive Mindfulness Training on Attentional Control, Cognitive Style and Affect. *Cognitive Therapy and Research, 32*, 303-322.

Childs, D. (2007). Mindfulness and the Psychology of Presence. Psychology and Psychotherapy: Theory, *Research and Practice, 80*, 367-376.

Chodron, P. (2001). *The places that scare you: A guide to fearlessness in difficult times*. Boston: Shambala Publications.

Cigollo, F. & Brown, D. (2011). A way of being: bringing mindfulness into individual therapy. Psychotherapy Research, 21(6), 709-721.

Cooper, M. and McLeod, J. (2010) *Pluralistic counselling and psychotherapy.* London: Sage.

C. Jagaro, D. (2011). *The struggle of effort and the effortlessness of mindful awareness*. Retrieved 10 April 2012, from: http://www.jagaro.net/2011/09/the-struggle-of-effort-and-the-effortlessness-of-mindful-awareness/

Clarke, V. & Braun, V. (2013). Teaching thematic analysis: Over- coming challenges and developing strategies for effective learning. The Psychologist, 26 (2),120-123.

Clarkin, J.F., Levy, K.N., Lenzenweger, M.F. & Kernberg, O.F. (2007). Evaluating three treatments for borderline personality disorder: a multiwave study. *American Journal of Psychiatry, 164(6)*, 922-928.

Cooper, M. (2009). Foreword. In T. Bond (Ed.), *Standards and Ethics in Counselling in Action*. London: Sage.

Copperstone, J.A. (2009). Doing Counselling Psychology the Heideggerian Way. Existential Analysis, 20(2), 329-340.

Corrigan, P. W. (2001). Getting ahead of the data: A threat to some behavior therapies. The *Behavior Therapist, 24(9),* 189-193.

Cortright, B. (1997). *Psychotherapy and spirit*. New York: SUNY Press.

Crane, C., Crane, R.S., Eames, C., Fennell, M.J.V., Silverton, S., Williams, M.G. & Barnhofer. (2014). The effects of amount of home meditation practice in Mindfulness Based Cognitive Therapy on hazard of relapse to depression in the Staying Well after Depression Trial. *Behavior Research and Therapy, 63*, 17-24.

Crane R.S. (2009). *Mindfulness-Based Cognitive Therapy - Distinctive Features.* London: Routledge.

Crane, R.S. & Elias, D. (2006). Being with what is. *Therapy Today, 17(10),* 1-4.

Crane, R.S., Kuyken, W., Williams, M.G., Hastings, R.P., Cooper, L. & Fennell, M.J.V. (2012). Competence in Teaching Mindfulness-Based Courses: Concepts, Development and Assessment. *Mindfulness, 3*, 76-84.

Creswell, J.W. (1994). *Research Design: Qualitative and Quantitative Approaches*. Thousand Oaks, CA: Sage Publications.

Dahl, J., Wilson, K. G., & Nilsson, A. (2004). Acceptance and Commitment Therapy and the treatment of persons at risk for long-term disability resulting from stress and pain symptoms: A preliminary randomized trial. *Behavior Therapy, 35*, 785-802.

Davidson, R.J. (2010). Empirical explorations of mindfulness: Conceptual and methodological conundrums. *Emotion, 10(1),* 1528- 1542.

Davis, D.M., & Hayes, J.A. (2011). What are the benefits of mindfulness? A Practice review of psychotherapy-related research. *Psychotherapy, 48(2),* 198-208.

Dimeff, L. A., & Linehan, M. M. (2008). Dialectical Behavior Therapy for Substance Abusers. *Addiction Science & Clinical Practice*, *4*(2), 39–47.

Dimidjian, S., & Linehan, M.M. (2003). Defining an Agenda for Future Research on the clinical application of mindfulness practice. *Clinical Psychology: Science and Practice, 10,* 166-171.

Dobson, K.S. & Khatri, N. (2000). Cognitive therapy: looking forward, looking back. *Journal of Clinical Psychology, 56*, 7. pp. 907-923.

Dozois, D. J. A. and Beck, A. T. (2011) Cognitive Therapy. In J.D. Herbert and E.M. Forman (Eds.). Acceptance and Mindfulness in Cognitive Behavior Therapy: Understanding and Applying the New Therapies. Hoboken, NJ: John Wiley & Sons.

Dunkley,C. & Loewenthal, D. (2013). Mindfulness: Current practices and criticisms. *European Journal of Psychotherapy & Counselling, 15(2).*

Epstein, R.M. (1999). Mindful practice. *Journal of the American Medical Association*, *282(9)*, 833-839.

Epstein, R.M. (2003). Mindful Practice in Action (1): Technical Competence, Evidence-Based Medicine, and Relationship-Centred Care. *Families, Systems & Health, 21(1*), 1-9.

Escuriex, B.F. & Labbe, E.E. (2011). Health care providers' mindfulness and treatment outcomes: A critical review of the research literature. *Mindfulness, 2*, 242-253.
Flaxman, P. E., Blackledge, J. T., & Bond, F. W. (2011). *Acceptance and commitment therapy: The CBT distinctive features series*. Hove, U.K: Routledge.

Fletcher, L., & Hayes, S. C. (2005). Relational Frame Theory, Acceptance and Commitment Therapy, and a functional analytic definition of mindfulness. *Journal of Rational-Emotive and Cognitive-Behavioral Therapy, 23(4),* 315-336.

Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D. & Geller, P. A. (2007). A randomized controlled effectiveness trial of Acceptance and Commitment Therapy and Cognitive Therapy for anxiety and depression. *Behavior Modification, 31(6),* 772-799.

Garland, E. (2015). My Research on Mindfulness in Everyday Life Covered by the Media. Retrieved June 2, 2016, from: https://drericgarland.com/2015/10/23/my-research-on-mindfulness-in-everyday-life-covered-by-the-media/

Garland, S.N., Carlson, L.E., Cook, S., Lansdell, L. & Speca, M. (2007). A non-randomized comparison of mindfulness-based stress reduction and healing arts programs for facilitating post-traumatic growth and spirituality in cancer outpatients. *Support Care Cancer, 15(8),* 949-961.

Gaudiano, B.A. (2008). Cognitive behavioural therapies: Achievements and challenges. *Evidence-based Mental Health, 11(1),* 5–7.

Geller, S. & Greenberg, L. (2002). Therapeutic Presence: Therapists' Experience of Presence in the Psychotherapy Encounter. *Person-Centered & Experiential Psychotherapies, 1(2)*, 71–86.

Germer, C.K. (2005a). Mindfulness: What is it? What does it matter? In Germer, C.K., Siegal, R.D. & Fulton, P.R. (Eds.). *Mindfulness and psychotherapy*. New York: The Guildford Press, 3-27.

Giddings, D. (2009). Counselling Psychology and the next 10 years: Some questions and answers. Counselling Psychology Review, 24, 1-10.

Gil-Rodriguez, E. & Hanley, T. (2011). Research methods in counselling psychology: What would Wilhelm Wundt think? Counselling Psychology Review, 26(4), 3-6.

Giorgi, A. (2009). *The Descriptive Phenomenological Method in Psychology.* Pittsburgh, PA: Duquesne University Press.

Gordon, R. (2012). Where oh where are the clients? The use of client factors in counselling psychology. *Counselling Psychology Review, 27(4),* 8-17.

Gotwals, J. (2016). How to integrate informal mindfulness practice into your daily life. Retrieved June 2, 2016, from: http://spiritualawakeningforgeeks.com/informal-mindfulness-practice/

Grepmair, L., Mitterlehner, F., Loew, T., Bachler, E., Rother, W., & Nickel, M. (2007). Promoting mindfulness in psychotherapists in training influences the treatment results of their patients: a randomized double-blind, controlled study. *Psychotherapy and Psychosomatic, 76,* 332-338.

Grossman, P. (2010). Mindfulness for psychologists: Paying Kind attention to the perceptible. Mindfulness, 1, 87-97.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits. A meta-analysis. *Journal of Psychosomatic Research, 57(1),* 35-43.

Guest, G., MacQueen, K.M. & Namey, E.E. (2012). Applied thematic analysis. New York: SAGE Publishing.

Gunaratana, B.H. (2002). *Mindfulness in Plain English*. Boston: Wisdom Publications.

Hagen, S. (1997). *Buddhism plain and simple*. Boston: Tuttle Publishing.

Halliwell, E. (2010). *Be Mindful report.* Retrieved 20 February 2011, from: www.livingmindfully.co.uk/downloads/Mindfulness_Report.pdf

Hamilton, N.A., Kitzman, H., & Guyotte, S. (2006). Enhancing Health and Emotion: Mindfulness as a Missing Link Between Cognitive Therapy and Positive Psychology. Journal of Cognitive Psychotherapy: *An International Quarterly, 20(2*) 123- 134.

Hanley, A.W., Warner, A.R., Dehili, V.M., Canto, A.I. & Garland, E.L. (2014). Washing Dishes to Wash the Dishes: Brief Instruction in an Informal Mindfulness Practice. *Mindfulness*, *6(5),* 1095-1103.

Harrington, N., & Pickles, C. (2009). Mindfulness and Cognitive Behavioural Therapy: Are they compatible concepts? *Journal of Cognitive Psychotherapy: An International Quarterly, 23(4),* 315- 322.

Harris, R. (2009). Mindfulness without meditation. *Healthcare Counselling and Psychotherapy Journal, 9(4),* 147- 159.

Hathaway, W., & Tan, E. (2009). Religiously Oriented Mindfulness-Based Cognitive Therapy. *Journal of Clinical Psychology: In Session, 65(2),* 158-171.

Hayes, A.M. & Feldman, G. (2004). Clarifying the construct of mindfulness in the context of emotion regulation and the process of change in therapy. *Clinical Psychology: Science and Practice, 11(3),* 255-262.

Hayes, S.C. (2004). Acceptance and Commitment Therapy, Relational Frame Theory and the Third Wave of Behavioural and Cognitive Therapies. *Behavior Therapy, 35*, 639-665.

Hayes, S. C. (2007). Hello darkness: Discovering our values by confronting our fears. *Psychotherapy Networker, 31 (5),* 46-52.

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational Frame Theory: A Post-Skinnerian account of human language and cognition.* New York: Plenum Press.

Hayes, S.C., Masuda, A., Bissett, R., Luoma, J. & Guerrero, F.L. (2004). DBP, FAP and ACT: How empirically oriented are the new behaviour therapy technologies? *Behaviour Therapy, 35,* 35–54.

Hayes, S. C. Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change.* New York: Guilford Press.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change* (2nd ed.). New York: The Guilford Press.

Hayes, S.C., Villatte, M., Levin, M., & Hildebrandt, M. (2011). Open, aware, and active: Contextual approaches as an emerging trend in the behavioral and cognitive therapies. *Annual Review of Clinical Psychology, 7,* 141-168.

Hayes, S. C., & Wilson, K. G. (2003). Mindfulness: Method and process. *Clinical Psychology: Science and Practice, 10*, 161-165.

Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology*, *12(4),* 335-344.

Hemanth, P. & Fisher, P. (2015). Mindfulness as a way of addressing the deficits in clinical psychology training programmes: A review. *Journal of Tropical Psychology, 5*, 10-21.

Hick, S.F. (2008). Cultivating therapeutic relationships: The role of mindfulness. In S.F. Hick & Bien, T. (Eds.). *Mindfulness and the therapeutic relationship*, (pp 3-18). New York: Guildford Press.

Hoffmann, S.G., & Asmundson, G.J. (2008). Acceptance and Mindfulness-based therapy: new wave or old hat? *Clinical Psychology Review, 28*, 1-16.

Hoffman, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78,* 169–183.

Hollon, S.D. (2001). Behavioral activation treatment for depression: A commentary. *Clinical Psychology: Science & Practice, 8*, 271-274.

Hyland, T. (2009). Mindfulness and the therapeutic function of education. *Journal of Philosophy of Education, 43(1)*, 119-131.

Ingram, L.C. (2005) *A Qualitative Evaluation of Mindfulness-Based Cognative Therapy for Oncology Outpatients* (unpublished MSc dissertation). Bath, UK: University of Bath.

Irving, J.A., Park-Saltzman, J., Fitzpatrick, M., Dobkin, P.L., Chen, A. & Hutchinson, T. (2012). Experiences of Health Care Professionals Enrolled in mindfulness-based medical practice: A Grounded Theory model. Mindfulness.

Jacobs, T.L., Shaver, P.R., Epel, E.S., Zanesco, A.P., Aichele, S.R., Bridwell, D.A., Rosenberg, E.L., King, B.G., Maclean, K.A., Sahdra, B.K., Kemeny, M.E., Ferrer, E., Wallace, B.A. & Saron, C.D. (2013). Self-reported mindfulness and cortisol during a Shamatha meditation retreat. *Health Psychology, 32(10)*, 1104-1109.

James, P. (2009). Further reflections on the future of Counselling Psychology. The Centrality and consistency of Counselling Psychology: Before during and after 2008. *Counselling Psychology Review, 24(2*,) 64-73.

Jennings, J.L. & Apsche, J.A. (2014). The evolution of a fundamentally mindfulness-based treatment methodology: From DBT and ACT to MDT and beyond. *International Journal of Behavioral Consultation and Therapy, 9(2),* 1-3.

Jha, A.P., Stanley, E.A., Kiyonaga, A., Wong, L. & Gelfand, L. (2010). Examining the Protective Effects of Mindfulness Training on Working Memory Capacity and Affective Experience*. Emotion, 10(1),* 54-64.

Joffe, H. (2011). Thematic Analysis in Qualitative Research Methods. In D. Harper & A. R. Thompson (Eds.), *Mental Health and Psychotherapy: A Guide for Students and Practitioners*. Chichester, UK: John Wiley & Sons, Ltd.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness.* New York: Dell.

Kabat-Zinn, J. (1994). *Wherever you go, there you are*: *Mindfulness Meditation in Everyday Life.* New York: Hyperion.

Kahl, K.G., Winter, L. & Schweiger, U. (2012). The third wave of cognitive behavioural therapies: what is new and what is effective? *Current opinions in psychiatry, 25(6)*, 522-528.

Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review, 27(2)*, 64- 73.

Kasket, E. & Gil-Rodriguez, E. (2011). The identity crisis in trainee counselling psychology research. *Counselling Psychology Review, 26(4)*, 20- 30.

Keane, A. (2013). The Influence of therapist mindfulness practice on psychotherapeutic work: A mixed-methods study. Mindfulness.

Kenny, M.A. & Williams, J.M.G. (2007) Treatment-resistant depressed patients show a good response to Mindfulness-Based Cognitive Therapy, *Behaviour Research and Therapy, 45(3*), 617-625.

Khong, B.S.L. (2009). Expanding the Understanding of Mindfulness: Seeing the Tree and the Forest. *The Humanistic Psychologist, 37*, 117-136.

Kingston, T., Dooley, B., Bates, A., Lawlor, E. & Malone, K. (2007) Mindfulness-Based Cognitive Therapy for residual depressive symptoms. *Psychology and Psychotherapy: Theory, Research and Practice, 80(2)*, 193-203

Kirschenbaum, H. & Henderson, V. (1990). *The Carl Rogers Reader*. London: Constable.

Koons, C., Robins, C.J., Tweed, J.L., Lynch, T.R., Gonzelez, A.M. & Morse, J.Q. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behaviour Therapy, 32*, 371-390.

Krippendorff, K. (2004). *Content Analysis: An Introduction to Its Methodology* (2nd ed.). Thousand Oaks, CA: Sage.

Kvale, S. (1996). *Interviews. An Introduction to Qualitative Research Interviewing*. London: Sage Publications.

Labbe, E.E. (2011). *Psychology moment by moment: A guide to enhancing your clinical practice with mindfulness and meditation*. London & Oakland: Harbinger Publications.

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139-193). New York: Wiley.

Larkin, M., Watts, S. & Clifton, E. (2006). Giving voice and making sense in Interpretative Phenomenological Analysis. *Qualitative Research in Psychology*, *3*, 102-120.

Larmar, S., Wiatrowski, S., & Lewis-Driver, S. (2014) Acceptance & Commitment Therapy: An Overview of Techniques and Applications. *Journal of Service Science and Management*, *7*, 216-221.

Lawler, S. (2002). Narrative in Social Research. In T, May (Ed.). Qualitative Research in Action (pp 242-258). London: SAGE Publications Ltd.

Lau, M. A., & McMain, S.F. (2005). Integrating Mindfulness Meditation With Cognitive and Behavioural Therapies: The Challenge of Combining Acceptance- and Change-Based Strategies. *Canadian Journal of Psychiatry, 50(13),* 863-869.

Lazar, S. W., Kerr, C. E., Wasserman, R. H., Gray, J. R., Greve, D. N., Treadway, M. T., & Fischl, B. (2005). Meditation experience is associated with increased cortical thickness. *Neuroreport: For Rapid Communication of Neuroscience Research, 16,* 1893–1897.

Lennie, C. & West, W. (2010). Dilemmas in counselling psychology research. *Counselling Psychology Quarterly, 23(1)*, 83-89.

Lester, S. (1999). An introduction to phenomenological research. Retrieved 5 May 2012, from: http://www.sld.demon.co.uk/resmethy.pdf

Linehan M.M. (1993a, 1993b). *Skills training manual for treating borderline personality disorder*. New York: Guildford Press.

Linehan, M.M. (2001). Mindful practice in behaviour therapy. In S. Dimidjian & L. Dimeff (Cochairs). The clinical application of mindfulness practice. Panel discussion conducted at the Association for the Advancement of Behavior Therapy 35th Annual Convention, Philadelphia.

Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D., & Heard, H.L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48(12),* 1060- 1064.

Linehan, M.M., Tutek, D.A., Heard, H.L., & Armstrong, H.E. (1994). Interpersonal outcomes of cognitive behavioural treatment for chronically suicidal borderline patients. *The American Journal of Psychiatry, 151(12),* 1771 -1776.

Lykins, E.L.B. & Baer, R.A. (2009). Psychological Functioning in a sample of long-term practitioners of mindfulness meditation. *Journal of Cognitive Psychotherapy: An International Quarterly, 23(3)*, 226-241.

Lynch, T.R., Morse, J.Q., Mendelson, T. & Robins, C.J. (2003). Dialectical behavior therapy for depressed older adults: a randomized pilot study. *American Journal of Geriatric Psychiatry, 11(1)*, 33-45.

Mardula, J. (2009). Mindfulness and acceptance based approaches. Counselling and *Psychotherapy Journal, 9(4),* 3-12.

Martin, J.R. (1997). Mindfulness: A proposed common factor. *Journal of Psychotherapy Integration, 7,* 291- 312.

Martin, J.R. (2002). The common factor of mindfulness- An expanding discourse: Comment on Horowitz. *Journal of Psychotherapy Integration, 12(2),* 139-142.

Ma, S.H. & Teasdale, J.D. (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology, 72*, 31–40.

May, S. & O'Donovan, A. (2007). The Advantages of the Mindful therapist. *Psychotherapy in Australia, 13(4)*, 46-53.

McAteer, D. (2010). Philosophical Pluralism: Navigating the sea of diversity in psychotherapeutic and counselling psychology practice. In M. Milton (Ed.). *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 5-20). London: Wiley-Blackwell.

McCollum, E.E., & Gehart, D.R. (2010). Using mindfulness meditation to teach beginning therapists therapeutic presence: A qualitative study. *Journal or Marital and Family Therapy, 36(3)*, 347-360.

McCown, D., Reibel, D., & Micozzi, M.S. (2011). *Teaching Mindfulness: A Practical Guide for Clinicians and Educators.* New York: Springer.

McMillian, R.L., Kaufman, S.B., & Singer, J.L. (2013). *Ode to positive constructive daydreaming. Frontiers in Psychology, 4 (626)*, 1-9.

Mills, A.J., Durepos, G., & Wiebe, E. (2010). Encyclopedia of Case Study Research, Volumes I and II. Thousand Oaks, CA: Sage Publishing.

Mollon, P. (2009). Our rich heritage- are we building upon it or destroying it? (or 'Why are counselling psychologists not angrier with clinical psychologists?'). *Counselling Psychology Review, 24(3&4)*, 130- 141.

Moore, A., & Malinowski, P. (2009). Meditation, mindfulness and cognitive flexibility. *Consciousness and Cognition, 18*, 176 –186.

Morgan, D.L. (2008). *The SAGE Encyclopedia of Qualitative Research Methods*. New York: SAGE Publications.

Namey, E.E., Guest, G., Thairu, L. & Johnson, L. (2008). Data reduction techniques for large qualitative data sets. In E. Namey, G. Guest, L. Thairu & L. Johnson Handbook for team-based qualitative research, 137-161.

Nanda, J. (2005). A phenomenological enquiry into the effect of meditation on therapeutic practice. *Counselling Psychology Review,* 17-25.

Nanda, J. (2009). Mindfulness. A Lived experience of Existential Phenomenological themes. *Existential Analysis, 20(1),* 147-162.

Naumburg, C. (2016). Informal Mindfulness Practice: Being Present for a Few Moments at a Time. Retrieved June 2, 2016, from: http://blogs.psychcentral.com/mindful-parenting/2012/10/informal-mindfulness-practice-being-present-for-a-few-moments-at-a-time/

Nightingale, D.J. & Cromby, J. (1999). Social constructionist psychology: A critical analysis of theory and practice. Buckingham: Open University Press.

Ortner, C. N. M., Kilner, S. J., & Zelazo, P. D. (2007). Mindfulness meditation and

reduced emotional interference on a cognitive task. *Motivation and Emotion, 31*, 271–283.

Öst, L. (2008). Efficacy of the third wave behavioural therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy, 46,* 296–321.

Pagnoni, G., & Cekic, M. (2007). Age effects on grey matter volume and attentional performance in Zen meditation. *Neurobiology of Aging, 28,* 1623–1627.

Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London & New York: Routledge.

Parker, I. (2005) *Qualitative psychology: Introducing radical research*. Buckingham: Open University Press.

Piet, J. & Hougaard, E. (2011). The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: a systematic review and meta-analysis. *Clinical Psychology Review, 31(6),* 1032-1040.

Popper, K. (1963), *Conjectures and Refutations*. London: Routledge.

Rachman, S (1997). The evolution of cognitive behaviour therapy. In Clark, D, Fairburn, CG & Gelder, M.G. (Eds.). *Science and practice of cognitive behaviour therapy* (pp. 1-26). Oxford: Oxford University Press.

Rizq, R. (2012). The perversion of care: Psychological therapies in a time of IAPT. Psychodynamic Practice: Individuals, Groups and Organisations. *Counselling Psychology Review, 18,* 7-14.
Roth, A., & Fonagy, P. (2005). What works for whom? A critical review of psychotherapy research (2nd ed.). New York: Guilford.

Ryan, G.W. & Bernard, H.R. (2000). Data management and analysis methods. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2nd Edition), 769-802.

Sandelowski. M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship, 34(3),* 213-220.

Sandelowski, M. & Barroso, J. (2003a). *Classifying the findings in qualitative studies. Qualitative Health Research, 13*, 905–923.

Sanders, K. (2010). Mindfulness and Psychotherapy*. Focus, 8*, 19-24.

Schroevers, M.J. & Brandsma, R. (2010). Is learning mindfulness associated with improved affect after mindfulness-based cognitive therapy? *British Journal of Psychology, 101*, 95-107.

Schure, M.B., Christopher, J. & Christopher, S. (2008). Mind-Body Medicine and the Art of Self-Care: Teaching Mindfulness to Counselling Students through Yoga, Meditation and Qigong. *Journal of Counselling and Development, 86*, 47-88.

Segal, Z.V., Williams, J.M.G., & Teasdale, J.D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse.* New York: Guildford Press.

Shafir, R. (2008). Mindful listening for better outcomes. In S.F. Hick & T. Bien (Eds). *Mindfulness and the therapeutic relationship*. New York: The Guildford Press.

Shapiro, S.L., Astin, J.A., Bishop, S.R. & Cordova, M. (2005). Mindfulness-based Stress Reduction for Health care Professionals: Results from a randomized trial. *International Journal of Stress Management, 12(2)*, 164-176.

Shapiro, S.L., Brown, K.W., & Biegel, G.M. (2007). Teaching Self-care to Caregivers: Effects of Mindfulness-based Stress reduction on the Mental Health of Therapists in Training. *Training and Education in Professional Psychology, 1(2)*, 105-115.
Shapiro, S.L. & Carlson, L.E. (2009). *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions.* Washington, DC: American Psychological Association.

Shapiro, S.L., & Izett, C.D. (2008). Meditation: A universal tool for cultivating empathy. In S.F. Hick & Bien, T. (Eds.). *Mindfulness and the therapeutic relationship* (pp 161-175). New York: Guildford Press.

Sharf, R.H. (1995). Buddhist modernism and the rhetoric of meditative experience. *Numen, 42*, 228-283.

Siegal, R.D. (2010). *The Mindfulness Solution: Everyday practices for everyday problems.* New York: The Guildford Press.

Simon, G. M. (2006). The heart of the matter: A proposal for placing the self of the therapist at the centre of family therapy research and training. *Family Process, 45*, 331–344.

Smith, J. (1995) Semi-structured interviewing and qualitative analysis. In J.Smith, R.Harré & L.Van Langenhove, (Eds). *Rethinking Methods in Psychology*. London: Sage Publications.

Smith, J.A. & Eatough, V. (2006) Interpretative phenomenological analysis. In Breakwell, G.M, Hammond, S., Fife-Schaw, C., & Smith, J.A. (Eds.) *Research Methods in Psychology* (3rd ed.). London: Sage.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Research, Practice*. London: Sage Publications.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), Qualitative Psychology: A Practical Guide to Methods. London: Sage Publishing.

Stanley, S., Reitzel, L.R., Wingate, L.R., Cukrowicz, K.C., Lima, E.N., & Joiner (Jr.), T.E. (2006). Mindfulness: A Primrose path for therapists using manualized treatments? *Journal of Cognitive Psychotherapy: An International Quarterly, 20(3),* 327-335.
Stauffer, M. (2008). *Mindfulness in counseling and psychotherapy: A literature review and quantitative investigation of mindfulness competencies* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Stone, M. (2006). The Two Darts: Meeting pain with mindfulness practice. *Revision, 29(2)*, 2-10.

Strosahl, K., Hayes, S. C., Wilson, K. G., & Gifford, E. V. (2004). An ACT primer: Core therapy processes, intervention strategies, and therapist competencies. In S. C. Hayes & K. Strosahl (Eds.), *A practical guide to Acceptance and Commitment Therapy* (pp. 31-58). New York: Springer.

Surawy, C., Roberts, J. & Silver, S. (2005). The effect of mindfulness training on mood and measures of fatigue, activity and quality of life in patients with chronic fatigue syndrome on a hospital waiting list: A series of exploratory studies. *Behavioral and Cognitive Psychotherapy, 33,* 103-109.

Swales, M.A., & Heard, H.L. (2009). *Dialectical Behaviour Therapy: Distinctive features*. East Sussex: Routledge.

Swanson, R. A. (2013). *Theory Building in Applied Disciplines*. San Francisco, CA: Berrett-Koehler Publishers.

Teasdale, J.D. (1999). Metacognition, Mindfulness and the Modification of Mood Disorders. *Clinical Psychology and Psychotherapy, 6*, 146-155.

Telch, C.F., Agras, W.S., & Linehan, M.M. (2001). Group dialectical behaviour therapy for binge eating disorder: a preliminary uncontrolled trial. *Behaviour Therapy, 31*, 569–582.

Thich Nhat Hanh (1990). *Present Moment Wonderful Moment*. California: Parallex Press.

Thich Nhat Hanh (1999*). The Miracle of Mindfulness: An Introduction to the Practice of Mindfulness.* Boston MA: Beacon Press.

Turner, K. (2009). Mindfulness: The present moment in clinical social work. *Clinical Social Work Journal, 37(2),* 95-103.

Vaismoradim, M., Turunen, H. & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study.
Nursing Health Science, 15(3), 398-405.

Van Aalderen, Breukers, Reuzel & Speckens (2012). The Role of the Teacher in Mindfulness-Based Approaches: A Qualitative Study. *Mindfulness, 5(2),* 1-9.

Vinca, M. A., & Hayes, J. A. (2007). *Therapist mindfulness as predictive of empathy, presence and session depth.* Presentation at the annual meeting of the Society for Psychotherapy Research, Madison, WI.

Walsh, R. (1985). Things are not as they seemed. In J. Welwood (Ed.). *Awakening the heart. East West approaches to psychotherapy and the healing relationship*. Boston & London: Shambhala.

Wegela, K.K. (2010). Practicing mindfulness without meditating. Retrieved October 5, 2015, from: https://www.psychologytoday.com/blog/the-courage-be-present/201002/practicing-mindfulness-without-meditating

Weiss, A. (2004). Beginning mindfulness. Retrieved October 5, 2015, from: http://beginningmindfulness.com/excerpts.html

Williams, E.N. (2008). A psychotherapy researcher's perspective on therapist self-awareness and self-focused attention after a decade of research. *Psychotherapy Research,18,* 139—146.

Willig, C. (2008). *Introducing Qualitative Research in Psychology (2nd ed)*. Maidenhead: Open University Press.

Wolf, C. & Serpa, J.G. (2015). *A clinician's guide to teaching mindfulness*. Oakland, CA: New Harbinger.

Wolkin, J. (2016). How To Achieve Mindful Living? Just Mind The Gap! Retrieved June 2, 2016, from: http://aboutmeditation.com/mindful-living-mind-gap/

Woolfe, R., Dryden, W. & Strawbridge, S. (2003). Handbook of Counselling Psychology (2nd ed.). London: SAGE Publications.
Woolfe, R. & Strawbridge, S. (2010). Counselling Psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.). Handbook of Counselling Psychology (3rd ed., pp. 3-22). London: Sage Publications.

Woolston, C. (2016). Multi-tasking and stress. Retrieved June 2, 2016, from: https://consumer.healthday.com/encyclopedia/emotional-health-17/emotional-disorder-news-228/multitasking-and-stress-646052.html

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215-228.

Zettle, R. D. & Hayes, S. C. (1986). Dysfunctional control by client verbal behavior: The context of reason giving. *The Analysis of Verbal Behavior, 4*, 30- 38.

Zettle, R. D., & Rains, J. C. (1989). Group cognitive and contextual therapies in treatment of depression. *Journal of Clinical Psychology, 45,* 438-445

Appendix A- Examples of mindfulness exercises

Example 1: Guided mindfulness meditation (extract)

This guided sitting meditation will help you learn to simply be and to look within yourself with mindfulness and equanimity. Allow yourself to switch from the usual mode of doing to a mode of non-doing; of simply being. As you allow your body to become still, bring your attention to the fact that you are breathing. And become aware of the movement of your breath as it comes into your body and as it leaves your body. Not manipulating the breath in any way or trying to change it. Simply being aware of it and of the feelings associated with breathing and observing the breath deep down in your belly. Feeling the abdomen as it expands gently on the in-breath, and as it falls back towards your spine on the outbreath. Being totally here in each moment with each breath. Not trying to do anything, not trying to get any place, simply being with your breath.

You will find that from time to time your mind will wander off into thoughts, fantasies, anticipations of the future or the past, worrying, memories, whatever. When you notice that your attention is no longer here and no longer with your breathing, and without judging yourself, bring your attention back to your breathing and ride the waves of your breathing, fully conscious of the duration of each breath from moment to moment. Every time you find your mind wandering off the breath, gently bring it back to the present, back to the moment-to-moment observing of the flow of your breathing. Using your breath to help you tune into a state of relaxed awareness and stillness.

Source: http://mindfulnesshamilton.ca/meditation-scripts

Exercise 2: Informal mindfulness

During the day see if you can find different ways to increase your awareness of your sense of touch. For example, you can bring a conscious noticing to the warmth of a cup of coffee or tea, pausing briefly to hold your awareness there for a second. At work you can feel your fingers touching the computer keyboard, or bring your awareness back into the present moment while driving by noticing your hands on the steering wheel of the car at a red light. When you wash your hands really notice the touch of the water, and the softness of the soap. If you are having a drink of water feel the touch of the glass, the coldness or warmth of the contents. Finally, when eating, use your senses to notice the colours of the food, their aroma, the taste of the different elements, staying with the sensations of the food rather than thoughts about it.

Source: https://mindfulbalance.org/mindfulness-in-daily-life/

Appendix B- Research flyer

Mindfulness and the Third Wave

Are YOU a *Psychologist or Psychotherapist* who *currently* engages in an *informal mindfulness* practice and delivers at least one *of* the following therapies as your main approach?

- Mindfulness Based Cognitive Therapy
- Dialectical Behavioural Therapy
- Acceptance and Commitment Therapy

If so, I would greatly appreciate your consideration to participate in my qualitative research study. This would involve a *60-minute interview* to explore your personal and professional experiences of *informal* mindfulness practice.

Financial recompense of £50 will be offered for time!

If you are interested in being a participant or know someone who would be, please contact me using the contact details provided below.

Sincerely,

Salena Bhanji – Lead Researcher (Research Supervisor: Dr Jay Watts)

Trainee Counselling Psychologist
Doctorate in Counselling Psychology
City University, London UK

E: XXXXX
M: XXXX

Appendix C: Pre-Interview Letter

CITY UNIVERSITY LONDON

Dear: [Title] [Surname]

Date:

Re: **<u>Confirmation of Participation in Research Interview</u>**

Date:

Time:

Location:

Thank you for agreeing to be a participant in my qualitative research study in which I am seeking to examine the personal and professional experiences of having a long term and daily informal mindfulness practice for third wave therapists.

Participation will take approximately an hour and a half and will include:

a) A brief on the research study, signing of consent form, completion of monitoring form and payment for time (15 mins)

b) A semi structured interview (60 mins)

c) A debrief on the interview process, an opportunity to provide feedback and/or ask questions and recommendations for further support (15 mins)

I have prepared a short list of some questions I may ask or areas I may explore, however I would like to emphasize that my primary interest is to allow the interview to be guided by your reflections and understanding of the subject matter ***as you experience and describe it***, even if it steers the interview in unexpected directions.

I look forward to meeting you soon and have included my mobile number in case you need to contact me. If you no longer wish to participate in the study or are unable to do so for any reason, please do contact me in the earliest instance so I can update my research records accordingly. Your decision will be treated with utmost respect and not be questioned further.

Kind regards,

Salena Bhanji

Lead Researcher

+44 (0) XXXX XXX XXX

Appendix D: Research Brief

CITY UNIVERSITY LONDON

Purpose of the study:
I am conducting this study for completion of a Doctorate in Counselling Psychology at City University London. My research has been granted ethical approval by City University and is being supervised by Dr Jay Watts, a Clinical Psychologist and Psychotherapist. She can be contacted via email (XXXX) or on her office number at City University (XXXX).

Aim of the research:
To explore the research question: '*What are the personal and professional experiences of having an informal mindfulness practice for third wave therapists?'* Please let me know if there have been any recent events that may raise aversive emotions for you when responding to this research question? Would you still like to participate in the study?

Participants Involvement and Ethical Considerations:
Participation will take approximately 1.5 hours and will include a brief, a semi-structured interview and debrief. You will be paid £50 for your time and have the right to withdraw your participation at any point during the interview without penalty and up until the point that analysis commences (approximately 2 weeks after the interview). You will be asked to sign a form confirming 'informed consent' before the interview and a short monitoring form after the interview. You have the option of declining to answer items on the monitoring form.

I do have a brief interview schedule that I will refer to from time to time throughout the interview, however my primary interest is to allow the interview to be guided by your reflections and understanding of the subject matter ***as you experience and describe it***, even if it steers the interview into a different direction. I may also ask for clarification or examples from you to ensure that I have understood the nature and context of your experiences to the best of my ability. I would just like to remind you that I will be taping the interview so please try to avoid covering your mouth whilst you are talking just so that I can get as clear a recording as possible. Also I would like to ask that your mobile phones are switched off or on silent so that our interview is not interrupted.

Anonymity:
Interviews will be recorded electronically and saved as a .wav file using a unique participant number (e.g. PP1.wav). The anonymized .wav files will be stored on a password protected USB drive and given to a professional typist to be transcribed. All interview material and any notes that I make during the interview will be protected in the same way except for the consent form, which requires a name and signature. The storage of research material will either be on a secure and password protected laptop or in a locked filing cabinet in a private location. They will be seen either by the researcher or research supervisor. Once analysis of the interview transcriptions are completed, the documents containing your personalised information will be destroyed. Interview transcripts may be published whole or in parts in the final dissertation, which you can access publicly from the ETHOS database. Other reports may be produced from the interview material to be submitted for publications. **ANY QUESTIONS?**

Appendix E: Consent Form

CITY UNIVERSITY LONDON

I, _____ agree to take part in this research study on *'The practice of informal mindfulness for third wave therapists'* and be interviewed by Salena Bhanji, the lead researcher, on:

Date: _____

Time: _____

The researcher has provided a research brief outlining the purpose of the study, what participation involvement entails, ethical considerations made and the measures taken to ensure anonymity.

I understand and accept that:

- I have the right to withdraw my participation at any point during the interview without penalty and up until the point that analysis commences (approximately 2 weeks after the interview).
- My identity will be protected on all electronic and written interview material through the researcher's use of a unique participant number, except for on the consent form that will be kept in a separate location. Interview material will be accessed only by the researcher and her research supervisor
- I understand that interview transcripts *may* be published whole or in parts in the final dissertation, which can be accessed publicly. Also other reports *may* be produced from the interview material to be submitted for publications.

Name of Interviewee: _____

Signature of Interviewee: _____

Date of Interview: _____

Name of Researcher: _____

Signature of Researcher: _____

Date of Interview: _____

Appendix F: Participant monitoring form

CITY UNIVERSITY LONDON

Dear Participant,

Please take a few moments to complete this questionnaire for monitoring purposes.

Instructions: Circle the most appropriate response or DECLINE

1. *AGE:*

20-30 31-35 36-40 41-45 46-50 50+

2. *ETHNICITY*

Please state your ethnicity (e.g. White British, Black British, Asian, Other) _____

3. *SPIRITUAL or RELIGIOUS AFFILIATION*

Please state if you have any spiritual or religious affiliation with mindfulness _____

4. *THERAPY AND QUALIFICATION*

Please state your professional qualification/s _____

Please state length of post qualification experience (yrs) _____

Please specify which third wave therapy you mainly practice _____

Please state how long you've been practicing this therapy (yrs) _____

Please indicate in what setting you practice this therapy _____

Please indicate what other therapies you practice _____

5. *MINDFULNESS PRACTICE*

Please state how long you have had a mindfulness practice in your life (yrs) _____

Please state how long you have regularly practiced informal mindfulness, as main (yrs) _____

Please state all *informal* mindfulness practices and regularity (e.g. how many times per day, week etc.? How long would each practice last?):

_____

_____

Please state all *formal* mindfulness practices and regularity (as above): _____

_____

Please state all professional formal and/or informal mindfulness practices and regularity of each: _____

Thank you for your time.

Appendix G: Semi-structured interview schedule

CITY UNIVERSITY LONDON

1) Could you reflect on how your informal mindfulness practice started in your life?

2) What does it feel like to have a daily informal mindfulness practice?

3) How, and in what ways does your daily *informal* mindfulness practice affect you personally (i.e. in your life outside of work)?

4) How, and in what ways does your daily *informal* mindfulness practice affect you professionally (i.e. as a therapist and in other areas of your work life)?

5) Could you reflect on your experience of daily *informal* mindfulness practice now compared to when you first started? (Probe: For example, could you reflect on any changes that have occurred over time or if relevant, any difficulties that might have been part of your journey?)

Appendix H: Research debrief

CITY UNIVERSITY LONDON

Thank you for your time. We've come to the end of the interview and I will now turn off the recording before we progress with the debriefing.

- To begin, I would just like to ask how you're feeling at the moment?
- Do you have any after-thoughts about anything that has been discussed?
- Is there anything else that you consider to be important or relevant about your experiences that I didn't ask you about in the interview?

Over the next couple of weeks, all the interviews will be transcribed and analysed in order to generate themes that illustrate the key personal and professional experiences of having a long-term and regular informal mindfulness practice.

I chose to focus on this particular area of research as the bulk of evidence in the field has concentrated almost exclusively on the therapeutic outcomes of formal mindfulness meditation. Consequently, there has been very little evidence generated for the outcomes of informal mindfulness practice despite its growing popularity and extensive usage particularly by third wave therapists.

Before ending our meeting, I would like to ask whether any aspect of this interview process has produced any aversive experiences for you?

- **Discuss with participant**
- **Offer "Sources for further support" leaflet**

If you wish, I would be open to receive your feedback in regards to how you felt this interview and the lead up to the interview was conducted. You are welcome to provide this feedback now, or to send your feedback to me via email. This is entirely optional.

Thank you for your time.

Appendix I- Thematic table with data extracts

Themes	Data extracts
"Wow! This is really life changing!": Daily informal mindfulness practice enhances wellbeing in an unexpected and life changing way	Andrew: "It gave me er, a feeling of, 'hey, there's something in this! I'm on the track of something here, this isn't just some, you know, it's not some slightly wacky Eastern spiritual thing you know, but wow! This is really life changing! There's something shifting in, in my consciousness, and I can feel it in everything I do…. now I am here, existing, living… fully!" (p3) Claire: "It erm, it sort of offered me something different, it was a somewhat different skill, and when it became a significant part of my life, it took me by surprise (pause) …It just feels like this is something that is very, very nourishing for me, in a different way to sitting in meditation (pauses)… It erm, just feels very special (pause)" (p2) Phil: "I started to connect to so many more emotions throughout the day… I didn't even know I could feel so many feelings just making a cup of tea!" (p1) Sharon: "life is… starting over" Neena: "I only need to switch off my phone, or the TV or erm, close the laptop and just find a way of focusing completely on what I'm doing at the time, it doesn't matter what it is, the cooking, shopping, erm, having a conversation with my partner…giving myself this time just gives me that feeling of 'ahhh' [release of breath]… It just really affects how the rest of my hour or even how the rest of my day will go…" (p3) Liz: "I'm less full of all the rubbish that's going on in my head, or at least I respond to it, um, without getting too much into all the arguments in my head … Also, I think probably I'm far less stressed as I'm able to deal with what comes up as it does instead of letting it all build and build to, you know that pressure point where you feel like, ah, I'm about to explode… it all just gets dealt with in a different sort of way that is more helpful" (p2)

	Mark: "[mindfulness] helps keep my engine going… it's a kind of useful, useful oil in the engine" (p5) Jeff: "Rather than being swept along by a tide of events or emotions, I feel a little bit like, I'm back in the driving seat, I can slow things and I can choose to focus on what is going on right now… on what I'm doing right now… And this helps me to direct my life more effectively" (p3) Steven: "…as beneficial and uh, as much as I enjoy the practice [of informal mindfulness], I know I wouldn't be able to go too long without meditation… it's my foundation really, even though it's not often, it, erm, you know, my daily practice wouldn't work in the same way without it" (p1)
"Just brushing my teeth can bring wonder and enchantment to my life": Informal mindfulness heightens sensory awareness and gratitude for taken-for-granted experiences	Neena: "It's about bringing full awareness to the simple things in life, such as brushing my teeth and tasting the mint in my mouth and feeling the foam inside my cheeks and the cool water on my face… it's delightful how just brushing my teeth can bring wonder and enchantment to my life (short laugh)!" (p4) Claire: "My mother had this fridge magnet that said something like 'thank God for these dirty dishes as they uh (pause)… I can't remember exactly, something like, the dirty dishes meant that we had enough food to eat or we that we didn't go hungry, or something similar to that… On those days when I'm tired and have to wash a sink full of dishes (short laugh), being mindful of what those dishes mean in my life (pause), it helps to becomes less of a chore" (p4) Jeff: "…It's like having the world on slow motion and all my senses are amplified, which feels unreal!" (p3) Sharon: "…Sometimes when I look at my face in the mirror, I feel sad as I, I look at my wrinkles, and, touch my face, and see this and this … Then I can look at these same things that uh, make me sad, and I show them love and kindness, and my face changes! I have wrinkles, yes, but I have a body, and a heartbeat…. I can not be sad when I am being mindful of my heart beat" (p2) Steven: "Actually some of the, erm, (pause) the less relaxed states, actually are more valuable, in terms of being present with them, and accepting the feelings that they bring up, it feels like more progress" (p7) Phil: "…it was like hairs pricking the back of my neck… I knew that something had happened at school that

	day... she was happy and smiling but it was just a fleeting look she gave me that I could have so easily missed if I wasn't being mindful in that moment…" (p8) Liz: "…sometimes it's about listening to my gut reaction and following it really… I don't always know if I'm on the right track, but I can get a sense of it in my body" (p5) Rosanna: "…so when I'm in Sainsburys, I erm, I sometimes feel bombarded at times by all the colours, sounds, smells…it, erm, can be quite stressful" (p9)
"Any life activity that generates suffering is an opportunity to overcome suffering": Informal mindfulness offers multiple, in vivo contexts for overcoming suffering and dealing with pain more effectively	Claire: "I could let go of all the judgment and all the erm, regret and guilt, there was always so much guilt! But by bringing this gentle and compassionate attitude to whatever I'm doing…the judgement and the guilt extinguishes … over time, I have found that any activity that generates suffering is an opportunity to overcome suffering and um (pause), that has been incredibly freeing"(p2) Andrew: "I can have my sadness… but that sadness can almost feel (pause) uh, comforting (pause)…? When I can appreciate that I'm human and I've lost something valuable and then look around me and see that everything is impermanent and that's the natural order of things, it changes the pain a little bit... It uh, makes it a bit easier to swallow" (p11) Sharon: "One of the choices is to accept that this is how it's always going to be… it is more liberating than trying to err, deny what's not there (pause). In the past I just deny what I didn't want to face, and it stopped me from moving on and being happy… my denial added baggage in my marriage" (p12) Rosanna: "…mindfulness has helped me to realise that I cannot be responsible for what they do or say, I can only be responsible for myself, and my actions, and my feelings… it is my need for control that controls me and makes me suffer, this is on me…." (p7) Phil: "I think there is something about this approach that, that, stops the prolongation of suffering, you know (pause) ruminating over, why me, kind of questions and stuff like that…I think in the past, the why me attitude, really interfered in my life and took away a lot of pleasure… I think now, practicing mindfulness everyday, I'm much more able to not judge [the pain] or wish for it not to be there…however in certain

	situations I find that detaching doesn't, you know, lead to acceptance immediately, I still need time to process stuff… yes, time is still the ultimate healer…" (p8) Steven: "…[acceptance] almost feels like an onion… I'm pretty accepting of my experiences, but actually there are whole other layers, of not really, you know? So, (pause) yeah, it's like each time you are mindful of anything in your life, it's like you are peeling back those different layers, it's like saying, I don't have to be *fully* accepting of my experiences in this moment' (p11) Jeff: "I learnt pretty quickly that you can't trick mindfulness into working! (laugh)" (p12) Mark: "…it became quite obsessive, and frustrating as my performance was, ironically, getting worse!" (p10) Claire: "…thankfully, I don't experience it as intensely anymore, but I have to admit that I don't have the same experience when I'm living mindfully… watching the news can be hard and it poses um, a *big* risk for over-detachment, for me, because of how I am as a person, but I've learnt how to uh (pause). I really try to be mindful of how I'm feeling whilst watching the news, and try to remain grounded in the moment so that the suffering doesn't overwhelm me …" (p14) Neena: "I don't need to band- aid their problems to make them or make me feel better… if I can be with [their pain] without trying to change it or remove it, then I can hopefully show them that it is ok for their pain to exist…." (p11) Jeff: "My children have taught me how to be a better therapist!" (p8) Liz: "I can create a space in the session to step away from the anger and, to find more fertile ground, um (pause) but actually to want to do that rather than doing it begrudgingly" (p12)

"*Mindful therapy allows for therapist and client to be both human and expert":* Mindful therapy fosters use of self and other for therapeutic connection	Claire: "… it's like mindful therapy allows the therapist and client to be both human and expert, which is rather fortunate for both parties!" (p6) Phil: "…What my patients hear from me is you know, we're all in the same boat, you're not different from me, erm… You suffer at times, I suffer at times, life can be difficult, it's difficult being human… there's no rigid boundary between us… and this develops their trust in me… I can't come in here and be anything I'm not, sort of thing…" (p14-15) Andrew: "… I take the approach of normalising rather than pathologising human suffering in my patients… I've never been entirely fond of providing diagnoses... " (p9) Jeff: "… And the funny thing is that we are all the same, our triumphs, our struggles, our uh (pause), our insecurities!... I've always found it funny how talking about our mental health issues [as therapists] can still be so uh, taboo (laughs)!" (p10) Liz: "…If [I'm] there with them and connecting to what they are experiencing in that moment and not trying to be a super-hero, it erm, it feels more meaningful, it's (pause), it feels like a more real, relationship" (p8) Phil: "I'm not having to sell it, 'cos it's sort of selling itself through me!" (p7) Neena: "…So I have much more insight into [my clients'] abilities, in their strengths and their um, their resources (pause)… and I probably spend more time talking about that than I would have done in the past… I ask 'what do you bring to the table already and how can we enhance, nourish and nurture those things within you?'" (p12) Mark: "I've sometimes thanked [my clients] for sharing their truths and their wisdom…I think it's important to let them know that I have taken something away with me" (p10) Phil: "… so when you bring that degree of concentration to each session, and you have a full day of clients, you know, that is quite intense and uh, quite tiring and timeless… I feel like I've meditated without

	meditating…" (p13)
"It's like a bridge between being and doing": Informal mindfulness can reconcile the stance of "being" in mindfulness with the culture and beliefs related to "doing" in the West	Claire: "…Because I'm being mindful in whatever I'm doing, (pause)… I er don't feel pressure um (pause), to ah, slot it in somewhere… I can be mindful at work, I can be a mindful mum, I can be a mindful wife and daughter and psychologist…" (p4) Neena: "I really embraced that idea of sowing seeds as a metaphor … so I can be in my garden, planting and watering and pruning… but I'm not prodding at the seeds all the time to see where they've got to, I'm just letting them grow…. I'm just putting in the work and the time when I can, and what will be, will be… I think I've lost track a little, but what I'm er, (slight laugh) what I'm trying to say is that I can be sowing seeds in my head or in my garden, my attitude to either will be the same (pause), however I much prefer being in my garden! (laugh)… " (p14) Sharon: "We live in a society, that, sees uh, virtue, [is that right?] (laugh) in the *art* of busyness. You know, cramming lives with more and more… there's not the same value for meditation, I mean, of course there is for some, but other people find it more difficult to sit and, uh (pause) just sit… informal mindfulness can help these people, it's like a bridge between both worlds, uh, between being and doing… a stepping stone that opens the door to meditation" (p8) Liz: "I found that when I was open about my own practice, it was so helpful (pause). Some of them were surprised that I practiced and so it felt really important that I didn't try to glorify it or, or uh, I didn't want to give them the idea that it was a panacea that could *cure* everything, kinda thing…" (p11) Phil: "On one hand I'm (deep breath; pause) wondering around not really knowing what I'm doing, and er, on the other hand I'm sort of professing competence at this, that and the other, erm (pause) and then again, they're all, they're all parts of me and where I am in my journey" (p13) Andrew: "… there are so many processes to pay attention to…in what is said, what is seen, what is felt…and so many ways we can respond to these processes… we reflect, we ask, we challenge (pause), we

	theorise… therapists are verbal creatures and we receive ample training in learning how to 'do' therapy but not enough of uh, actually sitting with one's own response to these processes or allowing the patient to sit with what they're feeling…"(p10) Steven: "My mind still succumbs to the same degree of wandering as it does in meditation, but instead of coming back to the breath I, um, it's about returning to my awareness of whatever I'm doing… there's an excitement in following where my mind wanders and then an excitement in coming back to my life…" (p3) Mark: "…when I say I practice mindfulness, everyone assumes I meditate… they don't really get informal practice but when they hear about it, they think its pretty doable…" (p7) Neena: "The concept of *being* with patients is not necessarily a shared narrative erm, and there is still a really strong pull towards doing or changing in the culture we work in… And erm, I think it's really hard sometimes to stay true to the practice of being when there is so often the temptation to jump on change-oriented interventions in an effort to be seen as *doing something!* (release of breath)" (p15)
"If I hadn't had one or the other, both would be weaker": Having both a personal and professional investment in mindfulness can be mutually reinforcing	Phil: "If I hadn't had one or the other, both would be weaker. It's more like they're mutually reinforcing" (p15) Claire: "…mindful living is my reality in a way, and through me, it has become my family's reality" (p5) Sharon: "I can see myself teaching mindfulness for the rest of my life!" (p6) Jeff: "I've always had an interest in Buddhism and Buddhist psychology… and I used to, well, I tried to attend meditation retreats regularly before I got married, then I stopped going regularly for many, many years… but bringing mindfulness into my daily life feels like those weekends… it's inevitable in a way, that I got into this field…" (p2) Mark: "I don't think I would have ever started mindfulness if I hadn't become a DBT therapist" (p1) Liz: "…my aim is to be mindful of at least one thing I do every couple of hours… I guess there is always the odd day that, uh, my practice is (cough) kinda, not as much on track as I would like, and I find that, or it feels

	like my [clients] get the rubbish side of me on those days" (p11) Steven: "…it still feels like I'm meditating, even when I'm not… it actually feels like life is my anchor, like life has become one big meditation" (p3) Phil: "It's a bit like coming out of the closet, in a way (laugh)…" (p5) Sharon: "So many of my colleagues don't practice like I do; I breathe mindfulness 24 hours a day! My colleagues don't appreciate the spiritual aspects… what they get taught on training courses is only a drop in the ocean!" (p9)

Appendix J: Prevalence of themes in data items and across the data set

Themes	Sharon ACT	Claire MBCT	Mark DBT	Rosanna DBT	Liz DBT	Andrew ACT	Phil ACT	Neena MBCT	Steven MBCT	Jeff ACT	*How many across data set?*
"Wow! This is really life changing!": Daily informal mindfulness practice enhances wellbeing in an unexpected and life changing way	X	X	X	X	X	X	X	X	X	X	10
"Just brushing my teeth can bring wonder and enchantment to my life": Informal mindfulness heightens sensory awareness and gratitude for taken-for-granted experiences	X	X	X	X	X	X	X	X	X	X	10
"Any life activity that generates suffering is an opportunity to overcome suffering": Informal mindfulness offers multiple, in vivo contexts for overcoming suffering and dealing with pain more effectively	X	X	X	X	X	X	X	X	X	X	10
"*Mindful therapy allows for therapist and client to be both human and expert":* Mindful therapy fosters use of self and other for therapeutic connection	X	X	X	X	X	X	X	X	X	X	10
"It's like a bridge between being and doing": Informal mindfulness can reconcile the stance of "being" in mindfulness with the culture and beliefs related to "doing" in the West	X	X	X	X	X	X	X	X	X	X	10
"If I hadn't had one or the other, both would be weaker": Having both a personal and professional investment in mindfulness can be mutually reinforcing	X	X	X	X	X	X	X	X	X	X	10

Appendix K: Braun and Clarke's (2006) 15-point checklist for conducting good TA

1 Transcription: The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'
2 Coding: Each data item has been given equal attention in the coding process
3 Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive
4 All relevant extracts for all each theme have been collated
5 Themes have been checked against each other and back to the original data set
6 Themes are internally coherent, consistent, and distinctive
7 Analysis: Data have been analysed – interpreted, made sense of - rather than just paraphrased or described
8 Analysis and data match each other – the extracts illustrate the analytic claims
9 Analysis tells a convincing and well- organized story about the data and topic
10 A good balance between analytic narrative and illustrative extracts is provided
11 Overall: Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly
12 Written report: The assumptions about, and specific approach to, thematic analysis are clearly explicated
13 There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent
14 The language and concepts used in the report are consistent with the epistemological position of the analysis
15 The researcher is positioned as active in the research process; themes do not just 'emerge'

Appendix L: Ethical release form from City University

Ethics Release Form for Psychology Research Projects

All trainees planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Trainees are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ☐ MPhil ☐ MSc ☐ PhD ☐ DPsych **X** N/a ☐

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

A qualitative exploration of the challenges that 'Third Wave' therapists face in applying Mindfulness and Acceptance both professionally and personally"

2. Name of student researcher (please include contact address and telephone number)

Salena Bhanji
M:07989 940 838
E: salena.bhanji.1@city.ac.uk
H: 78 Lindsay Drive, Kenton Middlesex HA3 0TL

3. Name of research supervisor

Dr Don Rawson

4. Is a research proposal appended to this ethics release form? **Yes X** **No**

5. Does the research involve the use of human subjects/participants? **Yes X** **No**

If yes,

a. Approximately how many are planned to be involved? **10**

b. How will you recruit them? **Posters, advertisements (Appendix A)**

c. What are your recruitment criteria? **Therapists who have been trained and have at least 2-years post qualification experience in a third wave therapy of focus.**

(Please append your recruitment material/advertisement/flyer)

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent? **Yes** **No X**

e. If yes, will signed parental/carer consent be obtained? **Yes** **No**

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Participants will be required to complete a brief screening form (Appendix B), participate in a 50 minute interview and complete a short questionnaire (Appendix F). In total, the time commitment should not exceed 90 minutes.

7. Is there any risk of physical or psychological harm to the subjects/participants?
Yes **No X**

If yes,
a. Please detail the possible harm? ----------

b. How can this be justified? ----------

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?
Yes X **No**

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers) **(Appendix C)**

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?
Yes **No X**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?
Yes X **No**

(Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers) **(Appendix D)**

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Recorded interviews and hard copy transcripts on interviews

12. What provision will there be for the safe-keeping of these records?

Electronic records will be kept on password-protected computers and hard copy material will be kept in locked filing cabinets

13. What will happen to the records at the end of the project?

Record will be destroyed at the end of the study

14. How will you protect the anonymity of the subjects/participants?

Participants will be given a unique number that will be used on any hard copy material. Names will not be mentioned during the interview or will be cropped out from the recording using WavePad software.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be given a debriefing sheet and also a list of support options

(*Please append any de-brief information sheets or resource lists detailing possible support options)* **(Appendix E) (Support options list pending)**

If you have circled an item in bold print, please provide further explanation here:

_____

_____

_____

_____

_____

_____

Signature of student researcher ---------- Date ----------

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

☑ Ethical approval granted
☐ Refer to the Department of Psychology Research Committee

☐ Refer to the University Senate Research Committee

_____

Signature ---------- Date 25/2/10

Section C: To be completed by the 2nd Department of Psychology staff member
(Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)

☑ I agree with the decision of the research supervisor as indicated above

Signature ---------- Date 26/6/10

SECTION C:

Professional Practice

Combined Case Study and Process Report

From Change to Acceptance: A trainee's first case of using Acceptance and Commitment Therapy (ACT) to treat depression

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1. Introduction

1.1 Implicit rationale for the choice of the case

This case was based upon the first client with whom I implemented techniques from Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999). The client had previously accessed a number of cognitive behavioural therapy (CBT) sessions through the clinic, however she reported that she didn't find certain aspects of CBT very helpful such as the use of thought records or worry diaries so instead she was "looking for something else" that felt more relevant or meaningful for her. Thus I decided to use ACT in our therapeutic work as it had some evidence as a suitable treatment approach for depression (e.g. Hayes, Wilson, Gifford, Follette & Strosahl, 1996; Zettle, 2004; Forman, Herbert, Moitra, et al., 2007; Bohlmeijer, Fledderus, Rokx, et al., 2011) and also the client expressed keen interest in an acceptance and values based approach. Thus studying this case represented an opportunity to reflect on some of my earlier skills in using ACT and also how I could deepen my understanding of this therapeutic approach and develop my skills further.

1.2 Summary of theoretical orientation

ACT has been conceptualised as a 'third wave therapy' by Hayes (2004), which indicates it belongs to the cognitive and behavioural therapy tradition. Hayes, Strosahl and Wilson (1999) highlight that the focus of third wave therapies is on changing the *relationship* one has to their thoughts or inner experiences i.e. by approaching these experiences with a stance of acceptance, kindness and detachment, rather than employing direct change methods to psychological events or evaluating their validity as is done in CBT. There is also a focus on the function of psychological experiences within specific contexts and thus third wave therapies are commonly referred to as contextual behavioural therapies (Hayes, Villatte, Levin & Hildebrandt, 2011).

ACT as a distinct third wave therapy is underpinned by Relational Frame Theory (RFT), which holds that everyday human language can construct realistic negative experiences and therefore produces the drive and capacity for experiential avoidance (Hayes, Barnes-Holmes & Roche, 2001). Flaxman, Blackledge and Bond (2011) note that experiential avoidance can impede a person's capacity to develop psychological flexibility and thus hinder their ability to live in accordance with their values.

As such, psychological flexibility lies at the heart of the ACT process-oriented model known as the ACT *hexaflex and is* composed of six core therapeutic processes (Hayes, 2004). These processes, which are applied fluidly rather than procedurally, include, 'contact with the present moment', 'acceptance', 'defusion', 'self as context', 'values' and 'committed action'. These processes and some of the common ACT techniques used to facilitate them are outlined as follows:

Contact with the present moment: In ACT is it thought that failures to be aware of present moment processes arise when clients engage in mental activities such as worry, rumination, mental inflexibility or excessive distractibility, which result in many psychological difficulties. Thus part of the role of an ACT therapist is to assess and teach clients how to bring focussed and flexible attention to their present moment using techniques such as formal and/or informal mindfulness exercises or moment by moment observing of internal experiences (Wilson, Bordieri, Flynn, Lucas & Slater, 2011).

Acceptance: Hayes, Strosahl and Wilson (1999) identified that acceptance processes are the reciprocation of experiential avoidance processes such that any difficult inner experience that may have previously elicited a particular unhelpful behaviour or avoidance of a situation, needs to be identified before the ACT therapist can help the client to open up and eventually accept these difficult experiences. ACT techniques used to develop acceptance processes include exposure strategies tied to valued life directions, the use of metaphors and acceptance-oriented meditations.

Defusion: Defusion processes in ACT are informed largely by the RFT framework of ACT that identify how an individual is "cognitively fused" to verbal rules or language that are affecting their behaviour and restricting their ability or willingness to pursue their life values (Hayes, Barnes-Holmes & Roche, 2001). Interventions used by ACT therapists to work with cognitive fusion include exploring the function rather than the accuracy of the verbal rules and by clients learning how to lessen the control of these rules over their behaviour. For example, a client may be encouraged to repeat a distressing thought very rapidly to undermine the meaning of its content or they may imagine that their unhelpful thoughts are leaves on a stream in order to experience their thoughts as transient events rather than reality (Luoma, Hayes & Walser, 2007).

Self as context: This process explores the flexibility of perspective-taking for clients in different situations and also how verbal rules about oneself or one's roles in life i.e. 'self

as content' can govern the client's behaviour. Thus an ACT therapist works with the client to try and create a more fluid and movable perspective of oneself that can transcend any given verbal rule that the client has. The observer exercise developed by Hayes, Strosahl and Wilson (1999) requires the client to close their eyes and visualise their thoughts, emotions, bodily states etc. at various points in their life history and to reflect on how these may be affected by their perspectives at the time. Luoma, Hayes and Walser (2007) point out that other techniques used to see self as context rather than content are very similar to defusion techniques whereby instead of focusing on defusing from verbal rules about the world, the focus is on defusing from verbal rules about the self.

Values: Within ACT, values are seen to have four qualities i.e. they are freely chosen, they are verbally constructed, they involve ongoing, evolving patterns of activity and they are focused on the present moment rewards that arise from engaging in the valued activity itself (Hayes, 2007; Wilson & DuFrene, 2009). ACT therapists assess whether their clients are able to develop patterns of valued activity in their lives and whether they can identify obstructions to engaging in these activities. To do this ACT therapists can use certain interventions that can bring mindfulness awareness to one's values and then construct what determines an active valued activity for the client. If a client is struggling to discover their values an exercise such as 'The Sweet Spot' (Wilson & DuFrene, 2009) can be used whereby the therapist engages the client in a mindfulness exercise that allows the client to experience moment by moment the visual, auditory, tactile and emotional rewards of a particular moment, which can help identify what the client values.

Committed action: From an ACT perspective, committed action processes involve specific engagement in a valued life domain and a return to this committed activity even if one drifts from it (Hayes, Strosahl & Wilson, 1999). Sometimes difficulties can arise in determining committed actions when value conflicts arise and levels of action in different domains change. For example a client may highly value being a parent but also value superior performance in their job and financial security, which can cause imbalances in the levels of committed actions in either domain. Thus an ACT therapist can use behavioural techniques or experiential present moment exercises that can affirm life values, which may also involve defusion or acceptance exercises (Wilson & Sandoz, 2008).

Hayes and colleagues (2012) state that in order for these processes to take place, the ACT therapist and client need to first work towards *creative hopelessness* whereby unworkable control or change agendas that have not worked in the past are revealed and let go in order to make room for new behavioural strategies. Luoma, Hayes and Walser (2007) indicate that this process may take longer for clients with extensive histories of experiential avoidance.

Although the theoretical orientation of this case study focuses on ACT, it stems from the same behavioural tradition as CBT and thus it is useful at this point to explore some of the main overlaps and differences in the core techniques that either therapy uses to treat depression. In CBT, cognitive restructuring is used to appraise thoughts more rationally and logically so that depressive thoughts emanating from dysfunctional cognitive patterns can be progressively modified (Herbert & Forman, 2011). This technique of cognitive distancing used in cognitive restructuring is similar to the process of cognitive defusion in ACT, however the difference is that defusion is tied more with verbal rules that can elicit certain negative experiences rather than directly to dysfunctional cognitive patterns. Also in ACT the focus is on using defusion to help clients detach from or de-literalise their depressive thoughts, rather than trying to undermine their rationality or directly modify them (Hayes, Strosahl & Wilson, 2012). Similarly behavioural activation in CBT is traditionally used to moderate depression by encouraging depressed individuals to engage in positively reinforcing activities and noting improvements in their mood before and after the activity in order to reduce the depressive symptoms. Whereas in ACT, engagement in activities is for the purpose of being open and flexible towards any negative emotion, thought or memory etc. that inhibits movement in a valued life direction rather than trying to eliminate the unwanted experience (Flaxman, Blackledge & Bond, 2011).

Whilst ACT is a relatively new approach to treating depression compared to CBT, it has been found to be a relatively effective approach according to some reviews (e.g. Öst, 2008). Zettle and Hayes (1986) conducted the first empirical study that showed ACT to be comparably efficacious as cognitive therapy (CT) in the treatment of depression. Subsequently a study carried out by Zettle and Rains (1989) demonstrated again that ACT was as significantly effective as CT in treating groups of depressed participants but operated using different processes to CT i.e. ACT does not target whether dysfunctional beliefs about depression are true or false whereas CT does. Other studies have shown that ACT has produced comparable results to CBT for depression (Forman et al., 2007) and there is also evidence that ACT treatment was effective in a

group based intervention for people who were unemployed and on sick leave from depression (Folke & Parling, 2004; Folke, Parling & Melin, 2012), as an early intervention for adults with mild to moderate depression (Bohlmeijer et al., 2011) and as a self-help program to reduce depressive symptoms (Fledderus, Bohlmeijer, Pieterse & Schreurs, 2012).

1.3 Personal and biographical details of client

1.3.1 Personal details as presented in session

Rose[2] was a 56-year-old, white British female who lived alone in a North London flat that she rented. Rose worked part time as a community development manager, which she enjoyed but didn't feel as though her manager and colleagues respected her experience and qualifications. She had aspirations to return to work as a philosophy lecturer or in another academic capacity that she previously held but resigned after taking the educational institution to court for bullying and harassment.

Rose identified herself as heterosexual and had not had a relationship for a number of years. She described herself as an "independent woman" who was capable of living a full life without a male partner but admitted that there was a part of her that would appreciate the companionship of a male partner at the stage of life she was at. Despite this desire, Rose revealed that she was sceptical about whether she would ever meet a partner and insisted that she would rather be alone forever than compromise any of her ideals. On a couple of occasions, Rose had mentioned that she had been "promiscuous" yet remained emotionally aloof in many of her romantic encounters. However she also stated that she is able to maintain relatively normal relationships with males whom she considered as "just friends".

In regards to physical presentation Rose alternated between being animated and open to being quite aloof and austere in her expressions and demeanour. This was demonstrated in both her verbal and body language. Rose also presented herself in professional attire as she normally attended sessions before starting work. She expressed enjoying artistic, cultural and/or spiritual activities such as reading, writing, art, music, rhythmic dance, yoga, meditation and travel in order to release stress and get in contact with her emotions.

[2] A pseudonym has been used to protect the client's identity

1.3.2 Biographical details and early childhood experiences

Rose was born in a city in the West Midlands region of the UK and was the seventh child in what she described as a poor, working class family who had not attended formal tertiary education. Rose described her mother as quite stern and always preoccupied with household chores and stated that her father was a labourer who worked long hours and drank heavily and would occasionally become verbally and/or physically abusive towards her mother and elder siblings. Rose recalls being her father's favourite child and stated that her siblings were envious of her relationship with their father and often teased or bullied her as a result. Despite the poverty and sibling rivalry, Rose recalls enjoying parts of her childhood especially when her father was in a good mood, which meant the rest of the family was happy.

The onset of Rose's first episode of depression occurred when she was 20 and in her final year at university. At the time she said that she felt trapped in a difficult relationship with her then boyfriend, who tended to be passive aggressive towards her and often tried to belittle her. At the same time Rose also feared returning home when university ended. This led her to taking an overdose of aspirin and was found unconscious by her boyfriend and taken to hospital. Rose said that she didn't necessarily want to die but felt so desperate that she wanted to escape for a little while. Rose completed a PhD in her 30's and later travelled around the Far East doing anthropological research. In this time she described falling in love with a much younger man of Asian ethnicity who moved back with her to England. When his visa was about to end, Rose decided to marry him so that he could stay in the country but a few years after they married, their physical relationship ceased and Rose later found out that he was having a relationship with another man. Rose filed for divorce and recalls feeling very bitter and angry about her partner's deceit and ashamed of herself for not recognising his sexual preferences earlier. Rose has not had any other serious and/or long-term relationships since.

1.4 Setting and Referral

The setting for our sessions was a High Intensity IAPT[3] service within a GP surgery in North East London, which offered up to twelve, free sessions of cognitive behavioural therapy (CBT) to patients who present with predominantly symptoms of depression and/or anxiety to their primary care providers. Within the surgery, my therapy sessions

[3] Improving Access to Psychological Therapies

with Rose took place in a comfortable and spacious room that ensured the client's privacy and minimal disruptions.

Rose's GP provided a brief referral through the IAPT referral route and indicated that Rose had a diagnosis of clinical depression/ major depressive disorder (MDD) as per the DSM-5 classification (American Psychiatric Association, 2013). The GP indicated that Rose had been experiencing interpersonal difficulties at work for awhile however over the past week she had started to experience severe symptoms of depression including not being able to eat or sleep, having difficulty leaving the house and having thoughts of suicide with no intention to act. She was taking antidepressants and was open to seeing a therapist but was reluctant to do further CBT as she hadn't found it helpful in the past.

1.5 Initial assessment

The initial assessment was 60 minutes in which I firstly introduced myself, informed her of my role as a trainee counselling psychologist and explained the confidentiality policy and the nature of the IAPT service in terms of its duration and structure.

I then tried to build some therapeutic rapport by discussing her referral and offering Rose the opportunity to comment on the details in the referral form. Following this a more thorough assessment was conducted that explored her current life situation and some relevant biographical and historical details in relation to her diagnosis and current episode of depression. We proceeded to discuss her previous experience of CBT and explore the reasons why she hadn't found it helpful. Rose was initially concerned that CBT would be her only option, however I spoke about how CBT could be delivered in various ways depending on the therapist and that the treatment approach was more than just "thought diaries" as she had assumed. I assured her that we could talk about the type of approach that she thought would best suit her.
Towards the end of the assessment, I completed a suicide risk assessment that confirmed occasional thoughts of wanting to end her life but no current suicidal intent or plans. Rose's score on the Beck Depression Inventory (BDI-II) and the Patient Health Questionnaire (PHQ) indicated severe depression. Rose's scores on the Beck Anxiety Inventory (BAI) and Generalised Anxiety Disorder (GAD) questionnaire indicated moderate anxiety.

I checked in to find out how she had found the session and whether she wanted to book another session with me. She said she was satisfied so far and we booked an appointment for the following week.

1.6 Presenting problems

The main presenting problems were that Rose was feeling deeply unsatisfied with her current employment situation and her roles and responsibilities in her workplace. She expressed that her manager was “incompetent” and that she felt “undermined” by both her manager and her colleagues. The stress of this situation had spiralled over the past few months and led to a recent altercation with her manager and an informal warning being issued. Rose stated that she was frustrated by the situation and also felt “powerless” to voice her needs in the workplace and to her manager in case it led to another altercation and potentially losing her job, which she needed to pay her rent. Rose also perceived her colleagues distancing themselves from her leading to increased feelings of isolation and loneliness in her workplace. Rose identified that her current situation was indicative of what happened in her previous workplace whereby she had experienced prolonged exposure to managerial bullying that resulted in a court action in her favour. Despite the favourable outcome, she felt too uncomfortable to remain in the same workplace and decided to resign despite really enjoying the role. The culmination of these work experiences for Rose resulted in feelings of low self worth, hopelessness and exhaustion which affected her mood significantly. She found herself waking up at night and not being able to get back to sleep so she was quite tired and forgetful during the day. Rose also reported losing her appetite and thus feeling too tired to go out or engage in her usual leisure activities.

In terms of receiving support, Rose expressed that she no longer felt she had anyone to talk to about her problems as she was still grieving over her parents’ death a couple of years earlier especially her mother’s death as she was the person whom Rose felt closest to. Rose also discussed struggling with feelings of guilt that she left her mother’s bedside on the night she died because didn’t want to be in the family house for Christmas. She also mentioned that a close friend of hers had died suddenly in a car accident a year earlier and she felt rather “misunderstood” and estranged from her siblings and her other friends.

1.7 *Initial case formulation*

As this was the first ACT case formulation I had attempted, I used to use a simple version called, 'A quick guide to ACT case conceptualization' offered by Harris (2009). According to this version, I was able to formulate Rose's presenting problems in relation to how her cognitive fusion, experiential avoidance and unworkable actions were getting in the way of her taking committed actions towards her life values. This is outlined as follows:

In relation to Rose's main presenting problem regarding her situation at work, Rose seemed fused to the idea that her manager was inferior to her as she perceived her own experience and qualifications to be more extensive than those of her managers'. Rose was also fused to thinking that she was repetitively victimised in various workplaces by managers and/or colleagues who were threatened by her intelligence and capabilities and thus she felt powerless to change the situation. As a result, Rose avoided situations at work where she felt she may achieve success (e.g. doing presentations or special projects) as she thought that it would alienate herself further from her colleagues and lead to further bullying. She also avoided social situations at work whereby she could spend time with her colleagues in an informal manner in order to build more friendly professional relationships as she was afraid her attempts to be friendly would be rejected or ridiculed by her colleagues. Rose also avoided expressing valid frustrations to her manager as she felt she would be ignored or that her manager was not capable enough of appropriately addressing her concerns. And even though Rose was unsatisfied in her current position due to it not being challenging enough and not in her desired field of work, she avoided applying for any academic positions as she was fearful that other universities may have heard about the court case at her previous university and would be reluctant to employ her despite her experience. Rose felt that she would prefer the feeling of failure that arose from doing a job that she was over-qualified for rather than failing as a result of receiving rejection letters from university jobs that she really wanted.

Her fusion resulted in a number of unworkable actions including alternating modes of passive and aggressive verbal communication that undermined her ability to communicate her needs or ideas constructively and thus deterred her from getting her needs and goals met. Another related unworkable action was in Rose's behavioural tendencies to deliberately undermine her manager (e.g. correcting her manager in front of others or challenging her manager's feedback). This created an additional tension in

her workplace that didn't directly address her issues but potentially caused others to see her as uncooperative or defensive.
In terms of existing psychological flexibility, Rose was able to see that there had been a pattern in how she related to colleagues in her workplace however she often felt confused in trying to understand why certain patterns arose or why she was "disliked" by her colleagues. Rose was also willing to explore these patterns and open to understanding the aspects of herself or her behaviour that may be contributing factors. The values that Rose wished to work towards in this area of her life were to find meaning and satisfaction in her work, to be able to learn from her managers and have the opportunity to be up-skilled, to be recognised for the skills and knowledge she brings to her work and to her colleagues and to be able to have some degree of financial security in her employment.

Rose's other presenting problem pertained to her resistance to engaging in personal and/or social support from family, friends or a partner particularly when experiencing difficulties at work or trying to manage her symptoms of depression. In this respect Rose demonstrated cognitive fusion to the idea that she can only rely on herself in life and that anyone else whom she relies on will just let her down, deceive her or disappear (e.g. leave her or pass away). She also was fused to the idea that she only attracted men who wanted to take advantage of her, exploit her or have a sexual relationship and that in order to exist in this kind of relationship, she would have to compromise her values or lose her independence in some way. Rose also repeated the idea that she had somehow "missed the boat" in terms of finding a loving male partner or that she was too different from her siblings for them to understand what she was going through. She believed that if her friends and family really cared about her, especially the ones who were aware of her depression and the recent losses in her life, they would make more of an effort to reach out to her so that it wouldn't feel so effortful for her. As a result, Rose engaged in extensive experiential avoidance including not allowing herself the opportunity to reflect on her past relationships, isolating herself from her social groups (e.g. not answering phone calls or emails, not attending meetings), avoiding family gatherings or celebrations, and switching off emotionally from hearing her family and/or friends convey their own pain or difficulties in trying to reach out to her. Rose also avoided exploring any situation in which she felt vulnerable or subject to rejection or pity from others. In regards to unworkable actions, Rose described instances in which she was deliberately "sexually provocative" with men whom she met at bars in order to feel as though she was in control of any sexual intimacy arising from the interaction. This led to a self-confirming bias that "men are

only after one thing" and made her even more reluctant to engage with men whom she could have a relationship with. It also elicited feelings of shame that fed back into her cycle of avoiding social contact with others. Rose also tended to ruminate over the negative aspects of her relationships with others and engaged in a myriad of distraction and/or dissociative behaviours (e.g. watching television for several continuous hours without eating, not getting out of bed or having a shower, staring into space). Rose also tended to intellectualise her feelings or emotional/ sensory experiences and struggled to identify or validate her emotions or what she was feeling in her body. Rose did demonstrate some psychological flexibility in terms of recognising that she was purposely avoiding contact with people in her life because she was afraid of being let down and that she knew that her behaviours were not helping her. Rose also expressed that her behaviours were incongruent with her values but that she didn't know how to change her patterns. Her values in this domain were that she wanted to have meaningful and loving connections with her family and friends and wanted others to know that she cared for them and could be relied upon. Rose also valued authenticity, honesty and mutual respect in relationships and also having a sense of self worth and self esteem.

1.8 Therapeutic contract and aims for therapy

The therapeutic contract was for the provision of 12 sessions of ACT therapy on a weekly basis, with a review in the 6th and 12th session. Although CBT was meant to be the prescribed treatment approach by the service, the use of ACT was deemed as appropriate by my supervisor who was satisfied by the client's interest in the therapy and considered ACT to be a variation of CBT.

Our overall aims for therapy were to reduce the severity of Rose's symptoms of depression as well as improve her general day to day functioning at work and also in her personal and social life.

2. The Development of Therapy

2.1 The therapeutic plan and main techniques used

The therapeutic plan was to provide Rose with some initial psychoeducation on the ACT model and its applications for treating depression. This psychoeducation would also highlight some of the similarities and differences between ACT and CBT to

highlight how ACT may satisfy her presenting needs for therapy. The plan also entailed using techniques from the ACT hexaflex to directly address the factors precipitating and maintaining her depression according to her initial formulation.
This would include doing cognitive and experiential work in sessions and as homework and encourage Rose to partake in committed actions in line with her values between sessions.

The main techniques included the following:

Mindfulness techniques- Rose was taught the principles of mindfulness and short mindfulness exercises were practiced in every session to help her get in contact with the present moment and learn how to observe and detach from her feelings and thoughts.

Acceptance- The concept was discussed and psychoeducation was provided to address some of Rose's unhelpful beliefs about acceptance e.g. that acceptance was not the same as resignation or "giving up". Acceptance of present moment experiences was also practiced in session in terms of sitting with uncomfortable feelings and observing with detachment the thoughts that elicited strong aversive emotions such as anger and defensiveness.

Cognitive defusion- This concept was explained and Rose was encouraged to think of the many ways in which she was fused to the literal meaning of her cognitions. Techniques such as continuously repeating certain key words or phrases, "taking the mind for a walk" and "thinking the opposite" (Luoma, Hayes & Walser, 2007) were used to highlight how her use of language was creating part of her reality.

Self as context- I used a number of metaphors to help Rose begin to distinguish her sense of self that was separate from her thoughts and beliefs. For example, the metaphor of getting back onto a horse after falling off was applied whereby Rose was encouraged to get back onto the metaphorical horse every time one of her thoughts took her for a ride to an unhelpful place. We also explored the idea of forgiveness and what it would feel like to leave her psychological material in the past without carrying the "baggage" into her future as recommended by Strosahl, Hayes, Wilson and Gifford (2004).

Values exercises- One technique we used to work with Rose's values was the Lifeline exercise (Dahl, Plumb, Stewart & Lundgren, 2009) in which we examined the common emotional and behavioural detours that Rose made from her valued life directions and did some exploration around why she thought those detours occurred.
Another technique used was the Bulls-eye dart board worksheet (Luoma, Hayes & Walser, 2007) in which clients identify their values in different areas of their life and then indicate on the worksheet how consistently they are living by their values with the bull-eye representing complete consistency in living by their values.

Committed action- Committed action plans were worked out each week by referring back to the values exercises and completing a goal setting worksheet (Strosahl, Hayes, Wilson & Gifford, 2004). We identified different actions Rose could take and these would get reviewed in each weekly session.

2.2 Key content issues

The key content issues pertained to her work and to her relationships with others in both a professional and personal capacity. In regards to her work and professional relationships, the content issues focussed on her feelings of frustration and anger towards both her current and former managers and her sense of feeling like a victim in both these situations. Rose identified on a number of occasions that she felt trapped in her work situation and that she was experiencing significant value conflicts between wanting a successful and satisfying job that she had in her previous academic position but also wanting financial stability and personal freedom as what was offered in her current role. Rose recognised that these inner experiences were difficult to detach from and were exacerbating her depression.
In discussing her personal relationships, we talked at length about her fear of vulnerability and how this was impeding her from making choices that would help her live in accordance with her values, for example, by developing loving relationships with others and having a sense of interpersonal comfort with others. Other content issues pertained to Rose's acknowledgement of her impulsive and self-sabotaging behaviours that arose when she felt she was not in control of a situation. Rose also discussed how she doesn't believe she can change these behavioural patterns, which caused her to feel hopeless and led to further depression.

2.3 Patterns in the therapeutic process

A number of patterns arose as part of our therapeutic process that were recognised and addressed to varying degrees. Firstly, I observed that Rose completed her homework assignments after each session and often wanted to spend a significant proportion of the session discussing the assignments in detail and receiving feedback on how well they were done, rather than engaging in the more experiential or mindful aspects of the session. Rose also repetitively attempted to intellectualise the nature of the work and would avoid or side- track directions to pay attention to what she was feeling or physically experiencing at the time. Examples of this included patterns of successively asking questions, over-explaining the reasons for her behaviours or requesting for the theory to be explained and re-explained to her. In a related way, when Rose did experience some emotion, she at times would shutdown or become unresponsive for lengths of time in the session. During earlier sessions I would spend more time trying to provide the feedback and respond to her questions about the theory or otherwise, but after this happened a number of times I started to feel stuck in her pattern of intellectualisation and to a degree frustrated by my own inability to address what was going on and engage her in the experiential exercises.

Secondly, I noticed a pattern of passive-aggressive behaviour that Rose would demonstrate at times when I tried to correct her assumptions or gently lead her back towards the topic we were discussing, for example, ending a sentence abruptly or taking on a slightly harder tone of voice. At times it seemed as though Rose was trying to seek my approval by zealously confirming that my tentative suggestions or questions were “100% true” for her and that I was the first therapist to understand her completely. I also observed Rose mirroring my body language or the way I was sitting. At other times, Rose would sometimes react with a degree of defensiveness or superiority and make specific reference to our age difference if I didn’t immediately reinforce her response with verbal or behavioural agreement e.g. if I wasn’t nodding.
As a result I often felt under pressure to offer positive reinforcement to ensure she felt comfortable enough to share her thoughts and to prevent her from retreating from the session. When I offered my tentative observation of this behaviour to her, Rose stated that she didn’t realise she was doing it but later acknowledged that she sometimes does do this with other people in an attempt to gain approval in situations when she does not feel in control.

2.4 Difficulties in the work and how I made use of supervision

Many of the difficulties I experienced with Rose were in regards to the process issues as outlined in the previous section. My supervisor helped me to explore the ways in which my own experiential avoidance and cognitive fusion was hindering my therapeutic processes. For example, I recognised how I was fused to thoughts such as "I am not an experienced ACT therapist and I'm not going to be able to help" and "I hope I don't prove to be another disappointing therapist". Also as ACT was still new for me, I was anxious that she would ask me theoretical questions that I wouldn't be able to answer and that my inadequate answers would leave her feeling disheartened or unwilling to continue therapy with me or with anyone else. I also recognised that I was a little fearful about what the consequences would be if she came in contact with very intense emotions in the session and I could not contain them. My supervisor also encouraged me to explore the source of my frustrations when Rose tried to side-track or take control of the situations, which allowed me to recognise a parallel process between Rose and I whereby we were both trying to control situations that were causing us feelings of anxiety and vulnerability. These explorations with my supervisor helped me to recognise and accept my own inner experiences so that I could be more flexible in responding to what was arising in the moment with Rose and also invite her to be present of these processes also as recommended by Gehart and McCollum (2008). I also felt that this enhanced my ability to role model what it meant to sit with difficult emotions and be able to approach these experiences with a stance of compassion and curiosity. And a further benefit was being able to practice a skill highlighted by Wilson and DuFrene's (2009), which was to reflect on therapeutic processes occurring in the room and relate these patterns back to the ACT model so that Rose could receive immediate feedback on how her present moment behaviours were examples or demonstrations of cognitive fusion, experiential avoidance or unworkable actions.

2.5 Changes in the formulation and the therapeutic plan

As our sessions progressed, Rose's ACT formulation using the hexaflex revealed a growing degree of psychological flexibility particularly in regards to her willingness to address the ideas she was fused to. As a result the therapeutic plan shifted from establishing creative hopelessness and identifying her valued life directions to actively engaging in committed actions and practicing mindfulness and detachment.

2.6 Lead-in to the session and rationale for transcript

The transcript was taken between the 29th – 39th minute from our fourth session together. In our previous ACT sessions we had reviewed psycho-education material on mindfulness and acceptance in ACT, evaluated the consequences of Rose's experiential avoidance, identified her core values and completed the lifeline exercise as explained above. Prior to the transcript, we discussed Rose's homework exercise, which was to identify some of the conflicts in her values and I introduced the "leaves on a stream" exercise to facilitate observation of her thoughts.

I chose to present this transcript as it demonstrates some of my skills in using techniques from the ACT hexaflex and also contains a few key moments that reflect significant therapeutic shifts and my attempts to address process issues.

3. Transcript and Commentary

CP1: You're right, the 'leaves on the stream' is quite a pleasant visualisation exercise to do. You can get quite creative with it and imagine all sorts of things such as birds chirping, a beautiful green willow tree or even background music! This is a common visualisation in ACT but there are also others that you can play around with, but we can always explore them later. I'm just wondering, aside from enjoying the imagery, what was your experience like of observing your thoughts and watching them wash away down the stream?

Comment 1: I wanted to validate Rose's experience of the visualisation as being pleasant and engage her in the scope for creativity in the exercise as she had previously identified that she valued creativity, music and colour in her life. At the same time, I also wanted to draw her attention back to the therapeutic purpose of the exercise, which according to Dahl, Plumb, Stewart and Lundgren (2009) was to facilitate detachment from thoughts and observe their transient nature as the leav es wash away in the stream and are replaced by new leaves. Rose's response indicated that she had struggled with the observing and detachment aspect, which I attributed to her intricate fusion with the thoughts and also potentially her unwillingness to detach from them. I also recognised in hindsight that I could have spent a bit more time explaining the nature of the activity and provided more explicit instructions, for example, guiding her to focus on her breath and recognise the bodily sensations associated with the emotion arising. Also to acknowledge that it is normal for the mind

to wander during the exercise and also for there to be some resistance to detaching from the thoughts and watching them drift by, but to try and bring her attention back to seeing her thoughts as the moving leaves. I suspect that even though she would have still found the activity difficult, it might have helped her to understand and be more accepting of the difficulty she was experiencing.

CL1: Ah, I found it fairly difficult to let the thoughts go and just watch them, I'm not sure if they were actually my thoughts on the leaves (pause)… I was just seeing the stream and the water and I think I was getting caught up in that. I'll keep trying though, (pause) but ah, yeah, it was a bit difficult.

CP2: Rose, this is obviously your introduction to a new technique and a new way of relating to your thoughts, (CL: Hmm), so its not surprising that you found it difficult, but I'm glad to hear that you're not giving up on it just yet! This type of activity just takes time and practice especially as you are doing something that is kind of the opposite of what you, you know, your mind is used to doing. And to be honest, we started out with a rather challenging situation! I know anger is ah, quite difficult for you… I think even just allowing anger to be present without trying to rationalize or, uh minimise it… that's a good start!

Comment 2: I wanted to show that I was mindfully listening and empathic towards Rose's difficultly in doing the exercise and offer some context as to why this difficulty may have existed, which Shafir (2008) identified as an important therapeutic approach to dealing with clients' difficulties. I also wanted to validate Rose's efforts in trying to approach detachment rather than defending against it entirely through rationalization or minimisation. This was also intended to highlight that her efforts could demonstrate committed action towards letting go of her anger and that Rose wouldn't be deterred from the activity just because she couldn't perfect it the first time. Whilst Rose nodded agreement, I realised that she had pulled back slightly from our engagement and I wondered whether I had been slightly too overzealous in trying to justify her difficulty. Perhaps it might been helpful to ask her at the end whether I had made the correct assumptions about why the activity was challenging for her, which would have given her the opportunity to clarify my assumptions or to offer her own alternative explanation.

CL2: Hmm, yeah (nodding)

CP3: According to ACT, it can be difficult to detach from your thoughts if you are fused to them. This means that you are quite attached to them or they have some special meaning or significance in your life or in your past that you find difficult to uh (pause) let go of or think about in a different way. So essentially, the leaves on a stream is one activity that can help to uh, get some distance I suppose between you as a person and your thoughts so that you can let them go rather than letting them control you.

Comment 3: My intention here was to explain how the leaves on the stream mindfulness exercise related directly to cognitive fusion, one of the key theoretical underpinnings of ACT so that Rose could understand its relevance. I was also aware that Rose tended to get stuck in her thoughts and struggled to engage willingly with the experiential aspect of the activity unless she first understood the concept clearly. Rose seemed to latch onto the word "control", which we had previously identified as a theme or issue in her life, but after a brief pause, her laugh indicated that she was able to recognise that she was slipping into her usual pattern of intellectualising which was partly the aim of the technique.

CL3: Yeah, I mean, I know I've got a bit of a problem with controlling and it's just started me thinking about that and why I do it and what it would mean to detach instead and how controlling is different to detaching… (pause) I'm still intellectualising it a little bit here aren't I…? (laughs)

CP4: (laughs too) I'm glad you noticed that. I mean, it's understandable that you would be asking yourself this at this time and they are valid questions, but uh (pause)… I just wanted to maybe uh, find out what it felt like to notice uh or observe your questions in that moment and then to realise that you were intellectualising the process? And how did it feel to not be able to immediately have the answer or be able to understand what was going on in your head? What feelings or thoughts did it bring up?

Comment 4: My laugh was to share the experience of her insight in that moment and it also felt important to verbally acknowledge her recognition of her own avoidance. I also wanted to validate her thoughts however I didn't want to detour into theory at a point where I had the opportunity to use the process arising in the room to demonstrate an experiential observation technique i.e. noticing what was present in her mind and in her body. Flaxman, Blackledge and Bond (2011) stated that facilitating present moment

experience can be useful in identifying the types of inner experiences that lead to experiential avoidance. Whilst Rose was able to recognise one key emotion that she was in contact with in the moment, I did feel that I might have overwhelmed her with my successive questions or at least made it difficult to focus on just one aspect of her experience at a time. As she struggled most with her feelings it would have been better if I had asked her a simple question such as, "What were you feeling or what was happening in your body when you were intellectualising, right before you noticed it was happening?"

CL4: (Pause) Doubt. Uh, doubt whether it will have an effect for me. It didn't uh feel nice, it just felt like doing this will become just another thing that I will try to control or uh I will find a way of negating it.

CP5: Hmm, I see.

Comment 5: Rose responded with a tone of seriousness and it appeared as though she was trying to be present with her feeling of doubt in the moment, which I was observing but didn't want to interrupt. I was also experiencing my own realisation of how pervasively her need to control or avoid feelings of doubt or uncertainty were not just in Rose's life but in our therapy sessions. Rose seemed to automatically become self- critical upon recognising her experiential avoidance, which Zettle (2004) acknowledged was a common process in using ACT with depression and needs to be addressed in therapy. One way I could have done this would have been to ask, "What are you trying to avoid by controlling or negating these techniques?"

CL5: Which you know, sounds like me!

CP6: Hmm. I'm wondering in what way does it "sound" like you? I mean, in terms of your process of uh, intellectualising or controlling…. In what way does it serve you in your life?

Comment 6: I realised I was aiming to do two things here; firstly I was trying to identify how fused Rose was to the language she used to describe herself or her behaviours as described by Hayes, Strosahl and Wilson (2012). And secondly I changed direction to find out the extent to which Rose used this experiential avoidance tactic in her life and what she thought the results were. As this was a double-barrelled question, it was not surprising that Rose only responded to my second query however it also seemed as

though this question elicited the realisation that she experiences a strong need to be in control. It appeared that this was the first time that Rose recognised this quality in herself and understood why it manifested in her behaviour although there also seemed to be a wryness in her response, which suggested a feeling of criticalness towards herself. Whilst this was an important realisation, I felt I undermined my own efforts to explore her fusion further through asking more than one question and in hindsight would have tried to ask both of these questions separately.

CL6: (Pause) Well it helps to feel like I'm in (pause) control! (shared laughter). Well that's exactly it! I like to be in control! The irony of it! (more laughter). The intellectualising helps me to feel like I am in control (pause), or needing to feel in control!

CP7: That sounds like that was a significant realisation! (pause). So it must be difficult then to approach any kind of activity that may take away your feeling of control? (CL: Hmm). I imagine that when you experience a threat to your ability to control a situation, you may try to do something to avoid the cause of the threat or maybe even avoid the situation itself? (pause; waiting for client's reaction). I'm wondering if we could just see what would happen if we allowed these experiences to be present, without judgement or reaction, in the room right now (pause)? Can I ask you to just be present with your feelings (pause), with any doubt that comes up for you or any urge to control what you are feeling or doing in the moment?

Comment 7: This seemed to be a perfect opportunity to address Rose's experiential avoidance of difficult emotions and also to present another opportunity to approach these feelings mindfully and with a stance of acceptance in the present moment, which is a significantly powerful ACT tool (Hayes, Strosahl & Kelly, 2012).
I was also quite aware there had been a shift in the therapeutic process and Rose was beginning to open up further and show signs of wanting to connect even though it still felt as though she was struggling to know how. It also seemed crucially important that I wasn't being seen to dismiss her question, rather that we were putting it on hold so that pay attention to what was going on in the room as recommended by Wilson and DuFrene (2009). Even though Rose responded to my observation with zealous recognition, she again became distracted by her thoughts and didn't end up engaging in the way I had intended. Knowing that this was her pattern, a preferable direction would have been to indicate more explicit guidance within a short time frame, such as,

"Can I ask that in the next 30 seconds, can you try to notice what is happening in your body and where your mind is taking you when you think about not being in control? You may feel the urge to avoid these thoughts, but notice this too…" With this on-going guided mindfulness intervention it might have helped her to stay present in that moment.

CL7: Yeah, well I think I need to, I need to. I can't always have it my way. In a way I'm trying to- in a sense I'm trying to take that over (points at activity sheet) and say "well that's that, but what about this? How can you know that exactly? What can I gain by this?" That's, it's so, I do that all the while, and then I take away the value and don't go with it, and I'd like to go with it, I'd like to, you know, I'd really like to begin to think that I can become a bit more detached, a lot more detached. And, then automatically I go to try to find a way of doing something different. Do you see what I mean…?

CP8: Yes, I do. I mean, you're kind of doing it now! (client nods; shared laugh) It's wonderful though that you are recognising it! Honestly that can be the hardest part, but you seem quite open to recognising openly and non-defensively!

Comment 8: Whilst Rose did become distracted by her thoughts I wanted to reinforce Rose for her willingness to reflect openly on the processes taking place. I also wanted to demonstrate a stance of compassion and kindness towards her struggles, which Wilson and Sandoz (2008) note is an important aspect of the ACT approach, particularly as she tended to become self critical every time she reflected on her 'dysfunctional' patterns of thinking or behaving. Rose initially did seem to respond positively by acknowledging her progress in our sessions but then seemed to focus on exploring how pervasive these unhelpful patterns had been in her life.

CL8: Yeah, I've learnt a lot about myself in these sessions and I'm more aware of that now... about my behaviours and (pause). I mean it's, it's frightening me how much I control things, how much I try to control things, including myself. And I do wonder how much that rubs off on relationships, you know....

CP9: Hmmmm.

Comment 9: On one hand I felt eager to re-engage Rose in the experiential activity of being present with her feelings in the moment and on the other hand it appeared that

Rose was having some meaningful epiphany into understanding how her behaviour affected her past and present relationships. On this basis, it felt more therapeutic to not immediately step in but instead just listen and observe where her thoughts took her, which would be supported by the literature (e.g. Shafir, 2008; Wilson & DuFrene, 2009).

CL9: (Pause) Because somebody might, you know, in all good will that day, will say, oh look this is what we're having for dinner, or how about this or how about that, and I'll just say, 'oh what did she mean by that or where are our boundaries?' and I've just take it over and changed it, and you know, how annoying is that, how annoying must I be sometimes, to do stuff like that!

CP10: (Pause) You sound quite frustrated with yourself (pause). It can be hard when confronted by certain aspects of yourself in therapy that you might not have realised before. It just feels really important I guess to be kind to yourself in this process and give yourself a break for being human (pause). Um, the idea of self compassion can be a foreign one at first, but it is so important in this process (pause). Um, I just wanted to know whether we could get back to my earlier question, um, in regards to being present with doubt or uh not feeling that you are in control? What does that *feel* like?

Comment 10: Upon hearing Rose's epiphany lead her again to a place of anger and self-criticism, I wanted to acknowledge very explicitly the idea of self compassion and kindness we had only briefly discussed before. I had the sense that Rose might struggle with the idea of being self-compassionate so I tried to point out the reasons why it was needed and tried to model a stance of acceptance towards her struggles. I was also keen not to lose the immediacy of Rose's insight into the dysfunctional aspect of her control and the feeling of frustration that it brought up for her in order to work towards creative hopelessness, which is used in ACT to help a client realise the unworkable reality of their experiences and create space for new actions to be developed (Dewane, 2008).

CL10: Panic.

CP11: Panic. Hmm.

Comment 11: I repeated her word almost to reinforce that she had uttered it especially as it appeared as though the recognition of her panic had taken her by surprise. Following this, her next statement was possibly the most powerful moment in the session and seemed to drastically affect her as she had lowered her tone and looked down. It felt as though her reflection of her vulnerability had arisen from a willingness to experience vulnerability in the room, which can be a crucial therapeutic process in ACT to approach experiential avoidance (Hayes, Wilson, Gifford, Follette & Strosahl, 1996).

CL11: If I am not in control, I'm, I'm uh (pause) vulnerable, and that makes me panic (in a low tone)

CP12: That feels like quite a powerful realisation for you (long pause). Vulnerability can be such a frightening experience (pause). It takes courage to be able to admit that (pause). And in many ways, it makes sense that you try to control as many things in your life as you can so that you can protect yourself from feelings of vulnerability (pause). However it also seems to be holding you back from living your life, fully.

Comment 12: In line with the ACT approach to psychotherapy outlined by Wilson and DuFrene (2009) it felt critically important that my response to Rose in this moment was validating and compassionate, particularly as she had let her guard down and allowed herself to be vulnerable with me. In doing this, I tried to validate the reason/s why her controlling behaviour had developed and how she thought it was serving her, yet also reference how it was becoming unworkable and keeping her from living in accordance with her values. I also sensed that this dialogue could be drawn upon in another ACT based exercise to identify her values and possible committed actions.

CL12: Yes (client looks down)

CP13: (long pause) I guess in these sessions with you, I would like to find a way that we could start to change this pattern so that you could learn how to not feel so frustrated or panicked or depressed in situations that feel out of your control. I guess also, I would like to revisit your lifeline so we can explore how your life values may be able to start influencing your actions, um, instead of your need to control.

Comment 13: With my pause I wanted to give Rose some space to explore the gravity of what had just arisen in the room, however I also wanted to keep Rose focussed on the purpose of our therapy goals. I also wanted to relate how her admission about vulnerability could help to make sense of our previous activity in which we explored behavioural detours on her values lifeline, but Rose was unable to see herself as a vulnerable person at that earlier point. My use of 'we' in this statement was to imply to Rose that she was not alone in this process and that I was willing to be present and participatory in whatever came up in the room. Wilson and Sandoz (2008) highlight the primacy of the therapeutic relationship in ACT and point out that it can be cultivated when therapist and client appear to be standing on "shared ground" (p.95). Rose indicated a certain willingness to engage with this suggestion and her response also suggested that she was reaching a point of creative hopelessness and looking for new ways to deal with her vulnerability.
Rather than criticalness, Rose's tone revealed a degree of hope for things being different and even a willingness to give up current unworkable behaviours.

CL13: (Pause) Yeah, I would like that. I want things to be different, I can't go on like this…

CP14: How does it feel to reach this point, I mean, to realise that your control, is not working for you?

Comment 14: This question was intended to help Rose face the current situation openly but without judgement and also to reach creative hopelessness in recognising that Rose's high need for control was preventing her from living in line her values (Hayes, 2007). Rose was quite emotional at this point but her reply suggested that the insight she experienced was positive even though it was painful to acknowledge. Instead of an openly reflective question, it might have been helpful to use a more explicit ACT intervention to illustrate our journey of reaching creative hopelessness, such as the 'paradox of control' or 'driving with the rear view mirror' techniques whereby clients learn through metaphor how their control is problematic in their lives (*Hayes, Wilson, Gifford, Follette & Strosahl, 1996).*

CL14: (Pauses; sighs; covers her face while talking) It is good, it is good (puts hands down), it hurts, but it is good (CP: Hmm). You know, I'm only just beginning to really realise how much I've been in this control freak mode (pause)...

CP15: I'm really glad to hear that you are open to working with me in this way. Look, I feel it's important to have realistic expectations. It's not going to change overnight and you may always have somewhat of a tendency to control your environment, many people do and that can be ok. But hopefully in our sessions we can work through it so that your reaction is not quite so panicky or distraught, and we can also identify what actions you can take so that you're living more in line with your values.

Comment 15: My purpose here was to acknowledge Rose's willingness quite explicitly and also create a non-threatening starting point for moving forward. Part of this was to ensure Rose that it was the behaviours we were going to be working on rather than changing her as a person and the other part was to reinforce our goal of reducing her mood symptoms by using values based principles in our sessions. I also implicitly wanted to convey the idea that this process of behaviour change would likely take more time and effort and would need to be worked on an on-going basis. Rose again turned to her thoughts as she recognised how her automatic thought process was going to be difficult to change especially as she was already trying to control the process of letting go of her control. In retrospect, my attempts to reduce her anxiety by being open and transparent about the process not being an easy one seemed to have the opposite effect by directing her focus to how difficult it would be and setting up an expectation that she should "be ahead of the game". Instead, I would have perhaps not reflected on what the process may look like in the future and just focussed on what was going on in the moment, which may have helped Rose to keep her attention focussed on the present moment as well.

CL15: Yeah, that'll be good. It's funny though (short laugh) when you mention realistic expectations, my mind automatically jumped to trying to control this (pointing at the worksheet)… It's like I already want to be ahead of the game and be in control of it! I think for me, it's going to be a very difficult thing to do, as it's so automatic… And then I get stuck in the loop of wanting, um, to be more, to be better… Do you know what I mean?

CP16: Hmm. Yeah, yeah I get it, I do. I mean, it is going to take effort, and I think your meds will help… but, that's why a lot of these mindfulness and acceptance based therapies refer to the importance of just being with what is and I guess also taking that stance of kindness or self-compassion. Even taking this stance requires some effort as it's not something we're used to in the Western way of

thinking so that's double effort! (shared laughter followed by pause) But uh, I guess it's worth it but you probably need to recognise yourself whether you think it's worth it or whether you would like to continue as you have been doing?

Comment 16: I felt that constant reinforcement of taking a stance of kindness and self compassion was needed, particularly in changing a way of thinking that was both personally and culturally prescribed (Herbert & Forman, 2011). I hoped that if I highlighted it often enough as well as embodied this stance in my own behaviours, which Strosahl and colleagues (2004) identified is a key therapeutic competency in ACT, Rose would be able to adopt this attitude more readily and consciously. Rose was honest in her response and admitted that whilst she wasn't without doubts, she was willing to put in the effort and try something different.

CL16: I want to be honest, I still have my doubts but I uh know that I don't want things to remain as they are… I really can't handle much more of this, I feel like I'm losing my mind and it's just uh, not a great place to be.

4. Conclusion and Review

4.1 Evaluation of the work

I felt that the work covered in the transcript highlighted quite significant and progressive therapeutic movements in respect to familiarising Rose with the ACT model and key experiential techniques. In particular, we used mindfulness practice as a technique for experiencing her unwanted emotions and defusing from her thoughts, we moved towards creative hopelessness and a more experiential understanding of how her control strategies were problematic and we discussed the importance of self-compassion in moving towards her valued life directions. Two significant moments occurred when Rose became acutely aware of the extent of her control strategies and her underlying motivation to avoid any experience of vulnerability.
Overall, this piece of work was an important catalyst to the development of our therapeutic relationship and Rose's willingness to engage more openly in therapy.

4.2 Changes in the therapeutic process

Over time there were a number of significant shifts in our therapeutic process that occurred for Rose and within the therapeutic relationship. Rose had begun to show

considerably more openness and emotional vulnerability in sessions by acknowledging painful experiences and reflecting on the meaning of these experiences for her. She also demonstrated a greater willingness to be authentic and rather than accepting all of my reflections, she became an active agent by offering her own interpretations without my prompting. As Rose seemed to develop more trust in our relationship and in my non-judgemental approach, her passive-aggressive behaviour (e.g. using one-word responses or deliberately side-tracking from the activity at hand) towards me diminished as she began to communicate her needs with greater confidence and could disagree in an assertive rather than aggressive manner. Other shifts included Rose regularly pausing after my questions to think about her responses rather than responding automatically and showing a growing interest in the experiential rather than just the theoretical aspects of ACT.

4.3 The therapeutic ending

The remaining sessions focussed on developing and evaluating Rose's committed actions and using behavioural techniques to increase Rose's exposure to situations in which she feared vulnerability, for example by speaking to her manager and colleagues at work. We also engaged in regular mindfulness exercises in every session, which helped Rose to recognise her emotions and defuse from many of her unhelpful thoughts. The review sessions (i.e. in the 6th and 12th sessions) revealed that Rose's scores on the BDI-II and PHQ reduced from severe to only very mild depression and she described a subjective improvement in her quality of life.

In the final session, Rose expressed that the work we had completed together had been very difficult but had helped her to make some significant changes in her life. I informed Rose that she would be discharged back to the care of her GP and that her GP would receive a discharge letter summarising the outcomes of our work.
Flaxman, Blackledge and Bond (2011) note that skill development can be helpful in continuing committed actions and overcoming experiential avoidance.
On this basis, we discussed and made a list of some personal and social skills that Rose could practice herself or by attending skills-based courses e.g. assertiveness and communication skills, dealing with anger and conflict in the workplace etc. Rose was recommended an ACT based CD resource to continue practicing ACT and mindfulness skills and encouraged to revisit her GP should she experience a reoccurrence of her depressive symptoms.

4.4 What I learnt about the ACT model

This piece was work was critical in developing my understanding of the theory underlying the ACT model as well as the various therapeutic applications of ACT-based techniques inherent in the hexaflex. In particular, this case study taught me how to effectively explain ACT principles such as living in accordance to your values, committing to value-laden actions and acceptance of present moment experiences. Similarly, working with Rose highlighted the value of developing a thorough ACT conceptualisation in order to determine which ACT techniques would be most appropriate for her presenting problems as well as appealing for her as a person.

4.5 Learning from the case about yourself as a therapist

This case was instrumental in consolidating my affinity for ACT as a therapeutic approach for depression, particularly in its integration of practical mindfulness techniques and the value it places on acceptance rather than direct change interventions. The process of doing ACT therapy with Rose and evaluating the work that was completed in this case also highlighted that my preference as a therapist is to, wherever possible provide my clients with an approach that is best suited to them and adheres to their individual needs rather than delivering a therapy based *solely* on its evidence base.

Another key learning point is that as a therapist I derive the most satisfaction and greatest sense of attunement when I am able to be fully authentic with my clients and espouse the characteristics of the approach I am intending to teach, for example, by being able to sit with my own discomfort or showing compassion towards my own mistakes. With Rose I learnt how to demonstrate many ACT skills and qualities such as acceptance, compassion, surrendering control and mindful presence by overcoming my own anxieties, which I think helped Rose to better understand what it would look like to cultivate acceptance and compassion towards herself.

Lastly, this case taught me the value of observing and reflecting on process issues in the room and how to integrate process reflections into whatever treatment approach I am using in order to create powerful therapeutic shifts. Doing this with Rose had significant effects on Rose's understanding of her own inner experiences as they were occurring and indicated to her that I was attuned to patterns in her thoughts and behaviours and aware of what was happening in the moment. I felt this approach

contributed to deepening our therapeutic relationship and appeared to be as satisfying for Rose as it was for me as I could bring myself wholly to my role as therapist. It also created an avenue to address issues as they arose in context with an air of honesty and transparency and evoked a therapeutic quality of equality rather than hierarchy between us.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Bohlmeijer, E. T., Fledderus, M., Rokx, T. A., & Pieterse, M. E. (2011). Efficacy of an early intervention based on acceptance and commitment therapy for adults with depressive symptomatology: Evaluation in a randomized controlled trial. *Behaviour Research and Therapy, 49*, 62-67.

Dahl, J.C., Plumb, J.C., Stewart, I. & Lundgren,T. (2009). The Art and Science of Valuing in Psychotherapy. Oakland, CA: New Harbinger.

Dewane, C. (2008). The ABCs of ACT- Acceptance and Commitment Therapy. Social Work Today, 8(5), p 34.

Flaxman, P.E., Blackledge, J.T. & Bond, F. (2011). Acceptance and Commitment Therapy- Distinctive Features. London: Routledge.

Fledderus, M. Bohlmeijer, E.T. Pieterse, M.E. & Schreurs, K.M. (2012). Acceptance and Commitment Therapy as guided self-help for psychological distress and positive mental health: a randomised controlled trial. Psychological Medicine, 42(3), 485-495.

Folke, F. & Parling, T. (2004). Acceptance and commitment therapy in group format for individuals who are unemployed and on sick leave suffering from depression: A randomised control trial. Unpublished Paper. Upsala, Sweden: Upsala University.

Folke, F., Parling, T., Melin, L. (2012). Acceptance and commitment therapy for depression: A preliminary randomized clinical trial for unemployed on long-term sick leave. *Cognitive and Behavioral Practice,19,* 583–594.

Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D. & Geller, P. A. (2007). A randomized controlled effectiveness trial of Acceptance and Commitment Therapy and Cognitive Therapy for anxiety and depression. *Behavior Modification, 31(6),* 772-799.

Gehart, D, & McCollum, E. E. (2008). Inviting therapeutic presence: A mindfulness based approach. In S.F. Hick & T. Bien (Eds.). Mindfulness and the therapeutic relationship, (pp. 176-194). New York: Guilford Publications.

Harris, R. (2009). A quick guide to ACT case conceptualisation. Retrieved 5 July, 2011, from: http://www.thehappinesstrap.com/upimages/A_QUICK_GUIDE_TO_ACT_CASE_CONCEPTUALIZATION.pdf

Hayes, S.C. (2004). Acceptance and Commitment Therapy, Relational Frame Theory, and the Third Wave of Behavioural and Cognitive Therapies. *Behavior Therapy, 35*, 639-665.

Hayes, S. C. (2007). Hello darkness: Discovering our values by confronting our fears. *Psychotherapy Networker, 31 (5),* 46-52.

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational Frame Theory: A Post-Skinnerian account of human language and cognition.* New York: Plenum Press.

Hayes, S.C., Strosahl, K.D. & Wilson, K.G. (1999). Acceptance and Commitment Therapy: An experiential approach to behaviour change. New York: Guildford Press.

Hayes, S.C., Strosahl, K.D., and Wilson, K.G. (2012). *Acceptance and Commitment Therapy: The Process and Practice of Mindful Change* (2 ed.). New York: Guilford Press. p. 240

Hayes, S.C., Villatte, M., Levin, M., & Hildebrandt, M. (2011). Open, aware, and active: Contextual approaches as an emerging trend in the behavioral and cognitive therapies. *Annual Review of Clinical Psychology, 7,* 141-168.

Hayes, S. C., Wilson, K. W., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64*(6), 1152-1168.

Herbert, J.D. & Forman, E.M. (2011). Acceptance and Commitment Therapy. In J.D. Herbert and E.M. Forman (Eds.). Acceptance and Mindfulness in Cognitive Behavior

Therapy: Understanding and Applying the New Therapies. Hoboken, NJ: John Wiley & Sons.

Luoma, J.B., Hayes, S.C. & Walser, R.D. (2007). Learning ACT: An Acceptance and Commitment Therapy Skills-Training Manual for Therapists. Oakland, CA: New Harbinger.

Öst, L. (2008). Efficacy of the third wave behavioural therapies: A systematic review and meta-analysis. *Behaviour Research and Therapy, 46,* 296–321.

Shafir, R. (2008). Mindful listening for better outcomes. In S.F. Hick & T. Bien (Eds). *Mindfulness and the therapeutic relationship*. New York: The Guildford Press.

Strosahl, K., Hayes, S. C., Wilson, K. G., & Gifford, E. V. (2004). An ACT primer: Core therapy processes, intervention strategies, and therapist competencies. In S. C. Hayes & K. Strosahl (Eds.), *A practical guide to Acceptance and Commitment Therapy* (pp. 31-58). New York: Springer.

Wilson, K. G., Bordieri, M. J., Flynn, M. K., Lucas, N., & Slater, R. (2010). Understanding acceptance and commitment therapy in context: A history of similarities and differences. In J. Herbert & E. Forman (Eds.). *Acceptance and Mindfulness in Cognitive Behavior Therapy* (pp. 233-263). Hoboken, NJ: Wiley.

Wilson, K.G. & DuFrene,T. (2009). *Mindfulness for Two: An Acceptance and Commitment Therapy Approach to Mindfulness in Psychotherapy.* Oakland, CA: New Harbinger.

Wilson, K.G. & Sandoz, E.K. (2008). Mindfulness, values, and the therapeutic relationship in Acceptance and Commitment Therapy. In S. F. Hick & T. Bein (Eds.), *Mindfulness and the therapeutic relationship*. New York: Guilford Press.

Zettle, R. D. (1990). Rule-governed behavior: A radical behavioral answer to the cognitive challenge. *The Psychological Record, 40*, 41-49.

Zettle, R.D. (2004). ACT with Affective Disorder. In S. Hayes & Strosahl, K.D. (Eds), *A practical guide to Acceptance and Commitment Therapy* (pp. 77-102). New York: Springer.

Zettle, R. D. & Hayes, S. C. (1986). Dysfunctional control by client verbal behavior: The context of reason giving. *The Analysis of Verbal Behavior, 4*, 30- 38.

Zettle, R.D. & Rains, J.C. (1989). Group cognitive and contextual therapies in treatment and depression. *Journal of Clinical Psychology, 45*(3), 436-445.

SECTION D:

Critical Literature Review

Should more third wave therapies be included as IAPT interventions to treat depression?

A review of the theory and evidence with implications for counselling psychology

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Introduction

The focus of this article is to conduct a review of the evidence for three third wave therapies including Dialectical Behavioural Therapy (DBT), Metacognitive Therapy (MCT) and Acceptance and Commitment Therapy (ACT) with a view to considering whether or not they might be suitable for inclusion in IAPT services as treatments for depression.

Depression is one of the most ubiquitous presentations of mental health across health services in the UK and has been found to be highly susceptibility to relapse and recurrence (NHS Centre for Reviews and Dissemination, 2002). At present, any known or suspected presentations of depression are assessed, monitored, treated and managed according to the National Institute for Health and Clinical Excellence (NICE) mental health guidelines for recognising and managing depression in adults (NICE, 2009). These NICE guidelines for managing depression largely promote different forms of cognitive behavioural therapy (CBT) to treat depression based on the extensive evidence base that demonstrates the efficacy of CBT compared to many other forms of therapy and/or medication for treating and preventing relapse of depression (e.g. Butler et al., 2006; Hollon et al., 2005; Gloaguen et al., 1998; Evans et al., 1992; Shea et al., 1992). NICE guidelines also form the basis of the Improving Access to Psychological Therapies (IAPT) agenda, which is funded by the UK National Health Service (NHS). The development of IAPT was influenced significantly by the Layard (2005) report on happiness that documented how the detrimental effects of depression and other psychological problems were having an impact on society and the economy. Thus one of the key aims of IAPT was to make it easier and more affordable for people to access appropriate mental health treatment and to increase the promptness and likelihood of those with depression or other mental health problems to return to work after periods of short or long term absence (www.iapt.nhs.uk, 2015).

The NICE guidelines for depression currently outline the provision of services within IAPT according to a stepped care model. Following assessment and psychoeducation, individuals with persevering subclinical symptoms of depression or present with mild to moderate depression will generally be offered low intensity psychosocial interventions. They may include individual guided self-help based on the principles of cognitive behavioural therapy (CBT), web-based cognitive behavioural therapy programs, group based CBT or structured physical activity group programs (NICE, 2009).
For individuals who have mild to moderate depression or if their depression becomes

severe and more complex, NICE recommends the provision of high intensity psychological interventions. These include individual CBT sessions, interpersonal therapy (IPT), behavioural activation, behavioural couples therapy, short-term psychodynamic psychotherapy, which may all be provided alongside antidepressant medication (NICE, 2009).

A recent review of the first year outcomes of IAPT indicated fairly substantial rates of recovery and improvement with these results hinging on compliance with NICE treatment guidelines and the IAPT clinical model (Gyani, Shafran, Layard & Clark, 2013). Whilst these reported outcomes are positive and based upon worthwhile objectives, the IAPT clinical model has been subject to a number of criticisms due to its it's heavy reliance on CBT approaches. McPherson, Evans and Richardson (2009) questioned whether IAPT has a sound evidence base for producing change in quality of life and functioning as it was intended to do rather than merely relying on CBT to deliver improvements in symptom change alone. Other mental health practitioners have raised disconcerted voices regarding the status of CBT as a national panacea (e.g. Rogers 2009; see also debate between Professor Andrew Samuels and Dr David Veale, 2007). There have also been concerns about whether the evidence base of CBT is robust enough to support such widespread dissemination, particularly as many of the components of CBT have been increasingly challenged. For example, some studies have failed to demonstrate that the processes of CBT actually operate in accordance with the model (Burns & Spangler, 2001) and in other studies the specific cognitive components of CBT have failed to outperform basic behavioural strategies (e.g. Jacobson et al., 1996; Gortner et al., 1998). Several anomalies have also been identified in CBT studies including improvements in symptoms that do not logically follow from the implementation of cognitive techniques and inconsistencies in how assumed cognitive mediators (e.g. thoughts, assumptions) function in accordance with the cognitive model (e.g. Dobson & Khatri, 2000; Ilardi & Craighead, 1994).
Aside from these empirical studies, the underpinning theory and approach of CBT has also been contested. For example, some theorists question whether it is necessary to actively change the content of thoughts as CBT suggests (e.g. Longmore & Worell, 2007). Gaudiano (2008) highlighted that CBT also comes across as an overly mechanistic approach that fails to address the issues of the whole person or adequately take into consideration the social or environmental issues that may be contributing to mental health presentations. It has also been stated that CBT as it is normally practiced may not be suited to people from non-Western cultures (Naeema et al., 2009) nor for people who are less psychologically minded (Whitfield & Davidson, 2007).

Third wave therapies are a growing branch of cognitive and behavioural therapies that include aspects of mindfulness and acceptance based theory into their treatment approach, which has largely emanated from Buddhist philosophy and practice (Baer, 2003). Kabat-Zinn (1994) helped to define mindfulness in the West as 'paying attention in a particular way: on purpose, in the present moment, and non- judgmentally'. The practices of mindfulness have tended to focus largely on meditation to stimulate mindful awareness and mindful qualities such as acceptance, compassion and loving-kindness towards one's aversive and unwanted inner experiences.

The practice and theory of mindfulness has been present for many decades in various schools of psychotherapy including person-centred therapy, gestalt therapy and psychodynamic psychotherapy amongst others, however came to be more prominently featured in what is now referred to as the third wave therapies in the 1990s (McCown, Reibel & Micozzi, 2011). The term 'third wave' therapies was first coined by Steven Hayes, a leading third wave theorist and researcher, who used the term to distinguish between the era of pure behavioural therapies that he refers to as the first wave, the addition of Beck's cognitive therapy in the second wave that developed into cognitive behavioural therapy (CBT) and the integration of mindfulness based interventions into the third wave (Hayes, 2004). Hayes (2004) noted that one of the key differences between second wave and the third wave CBT is the shift from directly changing the content of one's thoughts to the focus on changing how one relates to, observes or processes their thoughts.

The therapeutic approaches that fall under the umbrella of third wave therapies includes Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1994), Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams & Teasdale, 2002), Metacognitive Therapy (MCT; Wells, 1995), Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999), Dialectical Behaviour Therapy (DBT; Linehan, 1993), Functional Analytic Therapy (FAP; Kohlenberg & Tsai, 1991), Compassion Focussed Therapy (Gilbert, 2009), Behavioural Activation (Jacobson, Martell & Dimidjian, 2001). and Cognitive Behavioural Analysis System of Psychotherapy (CBASP; McCullough, 2000) amongst a growing group of others.

As with CBT, the expansion of third wave therapies has also been subject to debate and challenge as to be expected with the progression or shift in any existing paradigm. For example many researchers have questioned whether third wave therapies differ significantly enough from the techniques used in CBT, whether they add incremental value or whether they represent simply an enriched form of CBT (Hoffman & Asmundson, 2008; Leahy, 2008; Herbert & Forman, 2011). Other researchers state

that third wave therapies are indeed different from the second wave as they use therapeutic techniques to enhance the overall quality of a person's life and increase a person's engagement in meaningful activity rather than just challenging and changing unhelpful thoughts and behaviours (Micallef-Trigona, 2014). Dunkley and Loewenthal (2013) also propose that whilst third wave therapies use many of the same techniques as CBT, they add a more human and compassionate quality to what CBT has to offer.

Although IAPT services have broadened to include other treatment approaches since it was initially implemented, the Halliwell (2010) *Be Mindful* report notes the considerable absence of many third wave therapies from the IAPT agenda despite their expanding evidence base and theoretical viability for treating depression amongst other mental health disorders. At present the NICE guidelines include two third wave therapies as high intensity interventions including BA for the treatment of mild, moderate and severe depression and MBCT to treat relapse from depression. BA is underpinned by learning theory and contextual functionalism and is a development of activity scheduling, which is a component of cognitive therapy (Martell et al., 2001). The difference however between BA and scheduling pleasant or satisfying events in cognitive therapy is that it focuses less on the cognitive causes of depression and more on identifying valued directions in life and influencing the variables that might get in the way of engaging with these values in a similar way to ACT (Hayes et al., 1999). Dimidjian et al. (2006) conducted a key RCT study that compared BA with standard CBT, an antidepressant and a placebo. It was found that BA was as effective as the antidepressant and more efficacious than CBT.

MBCT was developed from MBSR and integrates mindfulness meditation with cognitive therapy to treat recurring bouts of depression and chronic unhappiness. It is an 8-week course that participants need to attend and also engage in regular mindfulness meditation as 'homework' (www.mbct.com, 2015). The initial clinical trials conducted by Teasdale et al. (2000) and Ma and Teasdale (2004) were the foundations for the strong evidence supporting group-based MBCT to reduce relapse for people who had experienced three or more depressive episodes. Unfortunately though the infrastructure and resources needed to establish MBCT groups is limited and as a result MBCT is not available in many areas of the UK (Crane & Kuyken, 2012; Halliwell, 2010).

To conduct the literature search, the online City University Library catalogue was used to access several psychology related databases including PsycArticles, PsycINFO, PsycTHERAPY and PubMed. Using a combination of various search terms (e.g. 'third

wave', 'third wave therapies', 'depression' and the names and acronyms of individual third wave therapies), the search revealed that DBT, MCT and ACT offered the most promising outcomes for the treatment of depression and thus form the focus of the literature review to follow.

The research into these therapies and evaluation of this field is progressing rapidly as indicated by the numerous reviews that currently exist (e.g. Hayes, 2004; Ost, 2008; Ruiz, 2012; Kahl, Winter & Schweiger, 2012; Hunot, Moore, Caldwell, Furukawa, Davies, Jones, Honyashiki, Chen, Lewis & Churchill, 2013; Normann, van Emmerik and Morina, 2014; Ost, 2014). What sets the current review apart from the existing ones is that it focuses on the evidence base for how various third wave therapies have performed in the treatment of depression rather than focusing on the evidence base of individual therapies. The Cochrane report (Hunot et al., 2013) was also compiled to determine the efficacy of third wave therapies for depression but focused only on the outcomes of randomized controlled trials (RCTs). The current review includes a range of quantitative and qualitative studies that have produced outcomes for depression.

Critical review of the third wave therapies in the treatment of depression

Dialectical Behavioural Therapy (DBT)

Theoretical background

Dialectical Behavior Therapy (DBT) is widely regarded as a third wave group-based, cognitive behavioral therapy that was originally developed by Marsha Linehan to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD) and it is now recognized as the gold standard psychological treatment for this disorder (Friedel, 2012). The term "dialectical" means a synthesis or integration of opposites as Linehan aimed to synthesize change-based strategies from CBT with acceptance-based strategies from the eastern and contemplative traditions, most specifically from Zen Buddhism that emphasises radical acceptance of the moment. On this basis, Linehan herself doesn't consider DBT to be a third wave therapy but rather a therapy that evolved in its own right based on Zen principles (Swales & Heard, 2009). Linehan and Dimeff (2001) point out that another distinguishing factor of DBT is the particular importance that is placed on the relationship between client and therapist and how this relationship is actively used to elicit motivation to change and full engagement in the treatment.

DBT therapy involves therapists teaching clients acceptance and change-based skills to help them change their behaviours and reach their goals. There are four skills modules that incorporate mindfulness and distress tolerance as acceptance-oriented skills and emotion regulation and interpersonal effectiveness as change-oriented skills. The mindfulness skills teach clients how to be fully aware and present in the moment. The distress tolerance skills are designed to help clients tolerate pain rather than actively trying to change it in difficult situations. Interpersonal effectiveness skills show clients how to ask for what they want and what they need and also to be able to decline requests from others whilst upholding self-respect and without harming relationships or self. Lastly emotional regulation skills teach clients how to manage and change emotions and/or emotional reactions (Linehan & Dimeff, 2001).
DBT therapists offer the therapy using four components including skills training group, individual treatment sessions, in-the-moment telephone coaching and being part of a consultation team. Generally the groups run for 24 weeks however the frequency and nature of the four components can vary according to the population and setting that the DBT treatment approach is being applied.

Critical review of the literature

Lynch, Morse, Mendelson and Robins (2003) carried out the first randomized pilot study of DBT that focused primarily on its application for depression in the older adult population. Matta (2013) pointed out that depression in later life can be a serious issue as it can also contribute to physical health problems in older adults The participants were 34 largely chronically depressed adults above the age of 60 who were randomly assigned to two treatment groups. Both groups received 28 weeks of anti-depressant medication and clinical management however the second group also participated in a DBT skills training program and received scheduled telephone coaching sessions. The post-treatment outcomes showed that only the group who received the DBT skills training demonstrated significant reductions on their mean self-rated scores, however both groups demonstrated significant and almost equal decreases on their depression scores as rated by the research interviewers. It was also found on the interviewer ratings of depression that a significantly greater proportion of the participants who participated in the DBT program were in remission at post-treatment compared to the participants who only received medication and clinical management i.e. 71% for the DBT group compared to 47% in the medication only group. Furthermore, there was an even greater significant difference in the remission rates at the six-month followup i.e. 75% of the DBT group were in remission compared with only 31% of the medication

only group. Overall the researchers found that only the patients who received the DBT skills training program as well as medication demonstrated significant improvements from pre to post treatment in their adaptive coping skills. Some of the limitations of this study was firstly that it relied on a relatively small sample size thus there was limited generalizability of these results to the population at large. Also, the study used two treatment groups without a control group as such, which may limit the degree to which the outcomes can be attributed to the effect of DBT skills training alone particularly as the medication only group also reported significant reductions in their post-treatment interviewer-rated outcome scores of depression.

Looking now at a different population, a study carried out by Katz, Cox, Gunasekara and Miller (2004) conducted a feasibility study that compared DBT as an intervention to treatment as usual (TAU) for suicidal adolescents. The participants included 62 adolescent patients who were admitted to one of two psychiatric impatient facilities on the basis of current and previous incidences of suicide attempts or suicidal ideation severe enough to warrant admission to inpatient treatment, as determined by a psychiatrist (Fiorello & Long, 2012). One inpatient facility provided participants with an intensive DBT program that comprised of DBT skills training groups teaching the four core skills modules. Patients in this group also received individual psychotherapy twice a week and a milieu of DBT trained mental health nurses to support skills generalization. The treatment team engaged in regular consultation meetings and their adherence to the treatment protocol was evaluated by a DBT consultant. The patients in the other inpatient unit were provided with treatment as usual (TAU), which included a daily psychodynamic psychotherapy group, weekly sessions of individual psychodynamic psychotherapy and were supported by a psychodynamically-oriented milieu of staff. Participants were assigned to one of the two inpatient units based on availability of beds at the time of admission, however researchers determined that there were no significant differences in the demographic variables of patients assigned to one facility compared to the other. Participants in both of the inpatient facilities were assessed at pre and/or post treatment on measures of depressive symptoms, suicidal ideation, hopelessness, parasuicidal behavior, hospitalizations and emergency room visits. The outcomes showed that both groups demonstrated significant symptom improvement on measures of depression, hopelessness and suicidal ideation. However there was an absolute difference in the effect sizes between the DBT and TAU groups with the DBT group showing better improvement than TAU on self-reported depression, suicidal ideation and hopelessness.

One of the main limitations of this study was that the focus of the treatment was on suicidal behaviours rather than depression therefore a thorough examination of how DBT affected different facets of depression symptomology could not be attained from a study such as this. Also the results showed that DBT did not provide significantly superior outcomes for this population, however they were as effective as a psychodynamic-oriented TAU intervention rather than a CBT based program that may be considered more relevant to the IAPT agenda. Lastly as with the first study, the participants represented a specific high suicide risk population, which limits the generalizability of these findings to other IAPT patients who do not fall into this population category.

Using a similar population as the previous study, Goldstein, Axelson, Birmaher and Brent (2007) conducted a 1-year open trial in which they used an adapted version of DBT with adolescents who were diagnosed with bipolar disorder, which is a disorder characterized by alternating states of mania and depression and sometimes referred to as manic depression (Goodwin, 2012). The study comprised of 10 patients with an age range between 14-18 years old who received treatment in an outpatient pediatric bipolar specialty clinic. The adapted DBT intervention was designed as an adjunct to medical management and consisted of two modalities included family skills training and individual therapy, with sessions of each modality alternating over 6 months and an 12 additional sessions tapering in frequency over the remainder of the year. An independent evaluator assessed symptom severity and participants' functioning on a 3-monthly basis and the participants' satisfaction with the intervention was measured at post-treatment.
The results showed that patients exhibited significant reductions in bipolar symptomology from pre- to post- treatment on measures of suicidality, nonsuicidal self-injurious behavior, emotional dysregulation, and depressive symptoms. It was also found that the feasibility and acceptance of the treatment was high with 9 of the 10 patients completing the treatment program with a 90% attendance rate and all patients indicating high levels of treatment satisfaction. These outcomes seem promising for the viability of this adapted version of DBT, however the study was limited by the relatively small sample size. Also as with the previous study, the population group was adolescents who are currently offered services through the Children and Adolescent Mental Health Services (CAMHS) rather than through the mainstream IAPT agenda and thus these outcomes may be less relevant in influencing the NICE

guidelines for treating depression in adults but may be instrumental in influencing the Children and Young People's IAPT project launched in 2011 (www.england.nhs.uk/mentalhealth/cyp/iapt/).

Another study by Harley, Sprich, Safren, Jacobo and Fava (2008) used an adaptation of a DBT skills training group program for treatment-resistant depression, which can be difficult to overcome and lead to significant functional and social impairment. The participants were 24 adult outpatients who had not achieved remission despite taking adequate and stable antidepressant medication treatment for major depressive disorder symptoms. Participants were randomly assigned to the DBT skills group therapy or a wait-list control condition. The skills group consisted of 16 weekly group sessions that delivered the four DBT modules including mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. The clinicians who were blind to each participants' study condition, compared the outcomes of depressive symptoms for the waitlist participants (n=9) with the skills group participants (n=10) who completed the study using a clinician-rated Hamilton rating scale for depression as well as a self-report measure using the Beck Depression Inventory.

The results showed that the participants in the DBT skills group demonstrated significantly greater improvements in their overall depressive symptoms compared to participants in the waitlist control condition and both measures of depression (i.e. Hamilton and Beck) producing large effect sizes. The results also revealed that increases in emotional processing were correlated with decreases in depression symptoms in the DBT-based skills group but were conversely associated with increases in depression in the waitlist condition.

Feldman, Harley, Kerrigan, Jacobo & Fava (2009) noted that the results from this study may offer preliminary evidence that DBT-based skills training may be useful in developing emotional processing skills that alleviate rather than exacerbate depression symptoms for people with major depressive disorder.

One of the limitations of this study is that the study started with a small sample size and an even smaller number of participants completed the study, which limits the power of these results. Also the reasons for drop out were not clearly outlined therefore there could have been difficulties in participating in the skills program that were undocumented. Lastly, there were no follow up measures conducted by the researchers, which limits what can be known about the longer term effects of this program.

The most recent study that my search revealed was a pilot RCT that used DBT skills in a psychoeducational group for adult patients with bipolar

disorder, which is a relatively unexplored area (van Dijk, Jeffrey & Katz, 2013). The study used 26 adults who were diagnosed with either bipolar I disorder (i.e. more episodes of depression and one or more manic episodes) or bipolar II disorder (i.e. episodes of both hypomania and depression but no manic episodes) as defined by the DSM-5. These participants were randomly assigned to either a waitlist control group or the DBT skills treatment group, which involved 12 weekly, 90-minute sessions that taught DBT and mindfulness skills as well as psychoeducation on bipolar disorder. All participants completed the Beck Depression Inventory, the mindfulness-based self-efficacy scale and an affective control scale at pre- and post- treatment. The results showed that participants in the DBT skills group demonstrated a reduction in their depressive symptoms compared to waitlist participants. Also DBT participants experienced significant improvements in their mindful awareness and more control over their emotional states as indicated on the scales used. Results also revealed that the DBT group had fewer emergency room visits and mental health related admissions than participants in the waitlist group following the intervention. As with many of the previous studies, the small sample size of the RCT limited the power to detect between group differences and there was no follow up review of how well participants in the DBT group maintained improvements after the 12 week program. This study's main strength in regards to the current review is that it is based on an adult population with bipolar depression, which would be relevant for IAPT.

In summary, the DBT studies showed that DBT was superior to medication in treating depression in older adults and adapted versions of DBT programs were found to significantly reduce depressive symptoms for adolescents and adults with bipolar depressive disorder. DBT and a psychodynamic based intervention both showed improvements in depression for suicidal adolescents however DBT showed greater improvements. Lastly, an adapted DBT program was found to produce greater improvements in treatment-resistant depression than a waitlist control for adults. The limitations for many of these DBT studies were small sample sizes, absence of a control group, not having follow up outcome data and not comparing the effectiveness of DBT with CBT. Also many of the outcomes were also based on adolescent rather than adult samples and thus have limited generalizability to IAPT.

Metacognitive Therapy (MCT)

Theoretical background

Metacognitive therapy (MCT) is interested in the beliefs that modify the ways in which thoughts are experienced and regulated and was founded upon a theoretical framework entitled the self-regulatory executive function model (S-REF; Wells & Matthews, 1994). According to this model, the activation of a pattern of thinking and self-regulation called the Cognitive Attentional Syndrome (CAS) is linked with the presence of maladaptive 'self-regulating' metacognitive beliefs that lead to the development of emotional disorders (Wells & Purdon, 1999). Two types of metacognitive beliefs are implicated; (1) positive beliefs about the need to engage in worry, rumination and threat monitoring; and (2) negative beliefs about the uncontrollability and danger of these thoughts (Papageorgiou & Wells, 2000).

Caselli (2012) notes that Wells doesn't necessarily consider MCT to fall under the umbrella of third wave therapies seeing it instead as an extension to CBT, however one of the main differences between MCT and CBT is that CBT tends to focus on the content of rumination whereas MCT focuses on the content of the metacognitive belief that underlies worry and rumination processes. MCT also offers many therapeutic convergences with the third wave therapies such as detached mindfulness (Wells & Matthews, 1996; Wells 2005) and situational attentional refocusing (Wells & Papageorgiou, 1998) to challenge the positive and negative metacognitive beliefs. Detached mindfulness refers to a specific state whereby the client is encouraged to become metacognitively mindful of their negative thoughts and then stop or disconnect from any ruminative response to this thought in order to experience the self as separate from the thought or just an observer of it (Wells, 2005). Situational attentional refocusing is used largely for anxiety whereby the patient is taught how to shift their attention from an internal interpretation of threat to an external point of reference, for example, a tapping sound (Wells & Papageorgiou, 1998). Other metacognitive techniques used in this therapy approach include versions of cognitive restructuring, behavioural distraction, thought replacement, attentional training or passive acceptance of the thought (Wells & Purdon, 1999).

Critical review of the literature

Wells, Fisher, Myers, Wheatly et al. (2009) conducted the first case study series using a full MCT package for severe and recurrent depression. Theirs was a multiple-baseline study whereby four participants with a primary diagnosis of recurrent major depressive disorder were randomly assigned to four baseline conditions that offered between 4- 8 sessions of MCT. Participants' positive and negative beliefs about rumination and metacognitions were assessed and their levels of rumination, depression and anxiety were measured on a weekly basis. The results revealed that all participants showed large and clinically significant improvements in depressive symptoms in addition to rapid and substantial reductions in the extent of their rumination. Also, both positive and negative metacognitive beliefs decreased substantially during treatment and the unhelpful attentional style of focussing excessively on thoughts also decreased. The study controlled for the confounding effects of maturation, exposure to the clinical setting and repeated testing, utilised several outcome measures and incorporated two follow-up periods. The researchers concluded that this showed that MCT might be an effective brief treatment for depression however the outcomes were limited by a number of factors including the very small sample size, the absence of control conditions, the absence of any formal assessment of clinicians' adherence to the treatment manual. Furthermore the clinicians were not blind to the condition of each participant, such that clinician expectations might have impacted on how they completed the various measures.

A study conducted by Nordahl (2009) aimed to assess the effectiveness of brief MCT compared to CBT in a sample of 28 patients who had previously failed to respond to antidepressant medication. The study was conducted in an heterogeneous outpatient setting whereby 13 participants were randomly allocated to treatment as usual (TAU), which consisted of CBT sessions and 15 participants assigned to the MCT group. The results revealed that there were improvements in depression for participants in both conditions and the only area in which MCT outperformed TAU was on measures of anxiety and worry. This study suggests that MCT can be as effective as CBT in the brief treatment of depression, however the sample size was relatively small and there were no follow up reviews conducted.

A later study conducted by Wells, Fisher, Myers, Wheatly and colleagues (2012) was an open trial that explored how MCT could be used in treatment –resistant depression. Patients (n=10) with treatment-resistant depression received 8 sessions of MCT targeting attentional control, rumination, worry and metacognitive beliefs. A baseline period was followed by weekly sessions and follow up reviews were carried out at 6 and 12 months following treatment. The results showed that there were large and significant improvements across all symptom measures (i.e. Hamilton rating scale and BDI) at post treatment and also at both follow up points. Also 80% of the participants met the criteria of being recovered at post treatment and 70% at follow up as indicated on the BDI. Highlights of the study showed that a mean number of 6.5 sessions of MCT treatment was associated with significant improvements in depression. Whilst low sample size remained a limitation of this study, the results showed promising results for MCT being a brief and effective treatment for treatment-resistant depression.

Similar to the previous study, Jordan, Carter, McIntosh and colleagues (2014) conducted a pilot RCT that looked specifically at MCT versus CBT for depression in an outpatient setting. They used 48 participants who were randomly assigned to 12 weeks of either MCT or CBT treatment with their depressive symptoms being measured by independent clinicians in week 4 and week 12 of the intervention. The outcomes of this study were that both MCT and CBT were efficacious in producing significant reductions in depressive symptoms with both interventions producing moderate to large effect sizes and no difference being found between the therapies in overall outcomes. Once again this study was limited by a small sample size and thus lacking in power and also participants in the MCT group had greater comorbidity than in the CBT group, which may have affected the results for this group.

The most recent baseline controlled RCT was carried out by Papageorgiou and Wells (2015) to explore how effective group-based MCT could be for patients who were severely resistant to both antidepressants and CBT for depression. This study employed 10 participants who were monitored during a no-treatment baseline period and then participated in 2 hour weekly sessions over 12 weeks. All participants completed the group based MCT program indicating the acceptability of the intervention and received 2 booster sessions following treatment and were followed up post treatment at the 6-month mark. The results at post treatment showed that all participants experienced significant improvements on their measures of depression, anxiety, rumination and metacognitive beliefs about rumination (i.e. both positive and

negative) and these improvements were also found at 6 months follow-up. Further analysis of the results revealed that 70% of the participants were deemed to be recovered and a further 20% significantly improved at post-treatment and follow up and also that there were reductions in the number of comorbid diagnoses indicated following treatment. Some of the limitations were that the study relied on a small sample size, independent clinician ratings were not used as part of the assessment of measurement procedure and also that participants were still on anti-depressant medications during their time in the group MCT program, which may have contributed to the observed outcomes.

In summary, two MCT studies showed that MCT was an effective brief treatment that produced significant improvements in depressive symptoms in adults with severe and recurrent depression and treatment resistant depression. MCT was also found to be as effective as CBT in reducing depressive symptoms in two other studies with adults in outpatient settings. Lastly, adults who were resistant to medication and CBT participated in a group based MCT program and showed significant improvements on measures of depression. The limitations of these studies were similar to those for DBT including small sample sizes, not having a control condition, some studies lacking follow up reviews and one study's results confounded by concurrent medication. Despite these limitations, all the MCT studies were conducted with adult samples and a few of them directly compared MCT with CBT, which enhances their relevance for inclusion in IAPT.

Acceptance and Commitment Therapy (ACT)

Theoretical background

Acceptance and Commitment Therapy (ACT) is another of the third wave therapies with some research that has clinical implications for the treatment of depression. As noted in Hayes (2004), ACT was developed from a philosophy called functional contextualism that focuses on influencing psychological events by acting effectively within a specific context, and has its conceptual roots in Skinner's work on verbal and rule-governed behaviour that came to be known as radical behaviourism. Functional contextualism underpins a theory of language and cognition that ACT is based upon, which is referred to as Relational Frame Theory (RFT; Hayes et al., 2001). RFT puts forward the notion that relational frames are constructed associations that are formed

between words and events when a person engages in verbal and cognitive processes (Hayes, 2004). It suggests that the clinical goals of ACT in respect to depression, are to erode the control that the literal verbal content of the depressive thought (e.g. 'I am hopeless') can have on behaviour (e.g. lying in bed all day) and instead create an alternative context whereby the initial thought can give rise to behaviour that falls in alignment with the depressed person's life values (Hayes, 2004). ACT implements many techniques similar to traditional cognitive therapy, however it does not seek to correct these unrealistic or irrational thoughts through cognitive restructuring. Instead ACT uses mindfulness and acceptance based tools to teach the depressed person to embrace a non-judgemental approach to their depressogenic thoughts. ACT therapists aim to use various techniques from the ACT 'hexaflex' model that highlights six core processes, which help clients to distance from and observe their thoughts (Fletcher & Hayes, 2005). *Acceptance* is the first process that aims to demonstrate the futility of avoidance or control strategies and to create opportunities for action; *Defusion* is the second process that helps to distance the thinker from their inner experiences; *Contact with the present moment* is the third process that aims to bring clients' awareness back to their present moment experiences; *Self as conte*xt is the fourth process that attempts to 'defuse' clients from the ideas that they hear most frequently about themselves; *Values* is the fifth process that helps to clarify the aspects of life that hold most meaning to clients; and *Committed action* is the sixth process that attempts to establish a pattern of behaviour that helps clients to align their behaviours with their life values (Hayes, 2004).

Critical review of the literature

Two early studies used comprehensive distancing (CD) as an earlier version of ACT with CD and ACT sharing the common goal of weakening dysfunctional control (Zettle, 2005). As these In the first RCT, Zettle and Hayes (1986) conducted a small study (N=18) in which depressed women were randomly assigned to a twelve-week course of either CD or Beck's (1979) cognitive therapy for depression with treatment delivered in an individual format for both groups. Results revealed that CD produced significantly greater reductions in depression when compared to CT at the stage of post-treatment and at two-month follow-up. Aside from the small sample size and the short follow up period, Hunot, Moore, Caldwell et al. (2013) noted that this particular study was limited by the fact that the

researchers did not report their randomisation methods nor did they use rating scales to measure treatment fidelity, which could pose an unclear risk of bias.

A subsequent RCT carried out by Zettle and Rains (1989) with depressed women (N=31) compared treatments across three groups including one CD and two CT groups, with and without cognitive distancing. Results showed significant yet equivalent reductions in depression for all three-treatment conditions at post-treatment and at two-month follow-up, which was thought to have resulted from the administration of CD in a group context. However significant reductions in the believability of depression- related thoughts were only found for the CT groups suggesting that CD and CT functioned through different therapeutic processes, i.e. CD worked through behavioural rather than cognitive processes. The methodological flaws included a small sample size, a short follow-up period, the lack of a systematic diagnostic procedure for depression and also a high drop out rate of 16% with no reasons provided for drop out (Hunot et al., 2013; Hayes et al., 2006). Furthermore, Hunot et al. (2013) noted that both this study and the previous one was supervised by Steven Haye, the developer of ACT, which could have also posed a risk of bias.

A study conducted by Folke and Parling (2004) applied a brief ACT treatment protocol in a group format with 24 individuals who were unemployed and on sick leave suffering from depression. Participants (n=13) were randomized to either the ACT group treatment or treatment as usual (TAU; n=11), which consisted of general interventions provided by the Regional Social Insurance Office and the Public Employment Service. Participants in the ACT group received one individual and five group sessions in addition to receiving the public interventions. Participants in the ACT group showed significantly lower levels of depression and reported higher scores on quality of life, general health and perceived functioning compared to participants who received public service interventions as measured on self-report scales. The main limitations were the small sample size and also that there was no follow up conducted on these participants and therefore the researchers weren't able to determine how long these outcomes were maintained following treatment. One particular in regards to the current review is that the context is quite similar to that of IAPT and thus demonstrates that group based ACT could be a brief and cost-effective treatment to help depressed patients return to work.

Forman et al. (2007) conducted a randomised controlled effectiveness trial comparing the relative effectiveness of CBT and ACT in the treatment of 101 heterogeneous patients presenting with moderate to severe anxiety or depression in an outpatient clinic. Participants were randomized to either the CBT or ACT treatment conditions. After 10 weeks of treatment, the results showed that there were significant reductions in depression, anxiety and functioning difficulties and increases in quality of life and life satisfaction for all of the participants. There were no significant differences by treatment for any of the outcomes that were assessed, demonstrating that the rate and degree of patient improvement over time appeared equal across both CBT and ACT. The results however were consistent with the researcher's predictions in that participants in the CBT group were better able to identify and describe changes in their inner experiences whereas acting with awareness and acceptance was more strongly seen in the ACT group, supporting their premise that ACT and CBT operate using different processes. Whilst the study relied on 23 trainee therapists to deliver the treatments and rate the measures, the research design incorporated checks on adherence to the therapy and controlled for therapist allegiance. Limitations included the modest sample size and the rate of attrition was high and also there were no design controls for the overlap of therapeutic techniques across the two approaches. Overall the findings showed that ACT was as effective as CBT for heterogeneous patients, which is particularly relevant for IAPT.

A RCT carried out by Bohlmeijer et al. (2011) investigated the efficacy of ACT as an early intervention for adults (with a mean age of 49) who had mild to moderate depressive symptoms. Participants were randomly assigned to either the ACT treatment intervention (n=49) or to a wait list control group (n=44). All participants completed various self-report measures to determine depression, anxiety, fatigue and acceptance at pre-treatment, post-treatment and at 3-month follow- up.
Participants in the ACT group experienced significant reductions in depressive symptoms at post-treatment and at 3-months follow up and the results showed that improvements in acceptance during the intervention mediated the effects of ACT on depression at the 3-month follow-up review. Also significant reductions in anxiety and fatigue were observed. One of the limitations was that there might have been a gender and cultural bias as the majority of the participants were female

and of Dutch origin, nevertheless the study offers some support to ACT being a an early intervention treatment for depression.

Hayes, Boyd and Sewell (2011) conducted a small RCT comparing ACT to CBT for 38 depressed adolescents between the ages of 13- 17 in an outpatient setting. The researchers randomly assigned the participants to ACT or TAU, which consisted of manualised CBT based therapy and all participants completed self-report measures at pre and post treatment as well as 3 month follow up. In the ACT condition, the post treatment data could only be collected for 79% of the sample and the follow up data was based on only 32% of the sample. Researchers noted that the rates of attrition were higher in the TAU group. The results showed that self reported depression symptoms significantly improved in ACT but not in TAU and that participants in ACT but not TAU continued to show improvements at follow up. Both groups improved during treatment on the Strengths and Difficulties Questionnaire (SDQ). This was the first study to show superior results for ACT compared to CBT however the study was limited by a small sample size, reliance on self-report measures and a very high attrition rate over a short follow up period. The other issues were that the clinicians providing both treatments were not randomly allocated to conditions and there was no evaluation of treatment adherence or competence to ensure that interventions were delivered to protocol.

Another study that looked at the efficacy of ACT for unemployed individuals on long term sick leave for depression was carried out by Folke, Parling and Melin (2012). They randomised unemployed individuals to either TAU (n=16), which consisted of the same general interventions as what was provided in Folke and Parling (2004) or TAU with ACT (n=18). The ACT treatment included an individual session and five group sessions. It was found that the ACT participants showed significantly greater improvement in self-reported depression, general mental health and quality of life from pre-treatment to the 18-month follow-up period compared to the participants who only received TAU. The researchers noted however that there was no significant difference between the conditions in regards to the sick leave and employment status at post-treatment or follow-up. This study extended the findings of Folke and Parling (2004) as they were able to show that ACT was able to maintain improvements in depression after a relatively long follow-up period (i.e. 18 months), however the researchers did not evaluate how much contact the ACT

participants had with TAU interventions or other simultaneous treatments, so there could be some ambiguity about the extent to which therapy-unspecific factors could have influenced the positive outcomes for ACT participants.

The most recent study by Fledderus, Bohlmeijer, Pieterse and Schreurs (2012) looked at the effectiveness of an early intervention using an ACT-based self help program to reduce depressive symptoms. They randomised participants from the general population with mild to moderate depression to one of three conditions. The participants (n=125) in the first treatment condition participated in the ACT group program with extensive email support; the participants (n=125) in the second treatment condition also participated in the ACT group program but with minimal email support. The third condition was the waitlist control group (n=126). Participants in all conditions were required to complete self-report measures at pre- and post- treatment to assess depression, anxiety, fatigue, experiential avoidance, positive mental health and mindfulness. The participants in the two treatment conditions were also asked to complete these measures at 3-months follow-up. The outcomes found that participants in the treatment conditions reported significant reductions in depression, anxiety, fatigue and experiential avoidance and also experienced improvements in their mental health and levels of mindfulness compared to participants in the waiting list group at post-treatment and were maintained at 3-month follow-up. There were no significant differences on the outcome measures between the treatment groups and thus the researchers concluded that an ACT-based self help intervention with even minimal email support could be effective in treating mild to moderate depression. These outcomes may have more influence for IAPT if they were compared to a similar CBT-based program particularly if comparative sample sizes were used as well as a longer follow up period.

In summary, the ACT studies demonstrated more extensive comparisons between ACT and CBT, with two of the initial studies showing that an earlier version of ACT produced greater reductions in depression symptoms compared to cognitive therapy at post treatment and follow up. Also when the earlier form of ACT was combined with CT, it produced greater reductions in depression than CT alone and also indicated that ACT and CT worked through different processes. An ACT group showed significantly superior results for treating depression in adolescents compared to a group receiving CBT, which also had a higher attrition rate and less improvement at follow up. However

ACT was found to be comparable to CBT in reducing depression symptoms for adults in an outpatient setting. Other advantageous studies showed that ACT in a group format showed greater reductions in depression compared to TAU for adults who were on sick leave with depression and was able to maintain improvements in depression over a long follow up period, which is highly relevant to IAPT settings. Also relevant to IAPT were the findings that ACT was found to be effective as an early intervention for mild to moderate depression symptoms and also effective as a self-help intervention with minimal email support from the therapist. Some of the main limitations that were identified in a few of these studies also identified modest sample sizes, the lack of randomisation procedures, having either short or no follow up periods and also having high attrition rates over short time frames.

Summary of main outcomes and suggestions for future research

The main outcomes of this review showed that these third wave therapies contributed some promising outcomes as treatments for depression, including severe and recurrent depression, treatment- and medication- resistant depression and bipolar depressive disorder. The outcomes were found in inpatient and outpatient settings and for various populations including adults, older adults and suicidal adolescents. The structure of the treatments also included individual, group or self help therapy. These outcomes however were subject to a number of limitations including, small sample sizes, absence of control groups, lack of randomization procedures, high attrition rates over short time frames, presence of confounding variables, lack of follow up outcome data, limited comparisons with CBT and limited generalizability to IAPT.

Further research for all these therapies would hope to address many of the limitations of these studies by ensuring that randomisation procedures were implemented preferably in double-blind conditions, that there were large sample sizes with reasons for attrition recorded, ensuring that there are clear treatment guidelines and monitoring of treatment adherence and also included control conditions and long follow up periods. When considering the viability of including these third wave therapies in the IAPT agenda future research should be aiming to offer direct comparisons of DBT, MCT and ACT with CBT and be based upon adult participants who were on sick leave or long term unemployed due to their depressive symptoms as per IAPT criteria. It could also be beneficial if each of these therapies were adapted to the session structure

and schedule of low and high intensity CBT interventions, whether in group or individual formats. For example, if implementing an individual therapy protocol it could be structured to be carried out for 6- 10 sessions for mild to moderate depression or up to 20 sessions for severe depression, which parallels the current schedule of individual CBT sessions within low and high intensity IAPT settings. This would allow researchers to directly compare specific mediating factors, therapeutic processes and treatment efficacy across the third wave therapies and CBT.

What are the implications for counselling psychologists working in IAPT?

IAPT based services represent a significant area of employment for a range of therapists including trainee and chartered counselling psychologists. At present, counselling psychologists who wish to work as low and/or high intensity therapists in IAPT settings are expected to adhere to evidence-based practices that have been developed from randomised controlled trials and employ psychometric tools in every session with their client (Moller, 2011). IAPT therapists are also expected to complete specific training that is predominantly CBT based in accordance with the NICE guidelines. Mollon (2009) makes the point that the NICE guidelines that prioritise protocol-driven psychotherapies such as CBT are based upon a medical model that conceptualises therapies as drugs that can "cure" mental illness. On this basis a vast amount of research evidence on psychotherapies that are not easily amenable to measurable outcomes or manualised approaches are ignored by NICE and thus discourages therapists and clients alike to engage in broader psychological thinking (Mollon, 2009).

In theory and practice, the current state of IAPT service provision proves to be a contentious issue for many counselling psychologists for a few reasons. To begin, it means that the humanistic underpinnings and values of the profession, which guide counselling psychologists to privilege the unique presentations of each client, does not mesh well with the therapeutic models used within the NHS. Instead it fosters a "one size fits all" framework that does not support phenomenological approaches to therapy that counselling psychologists tend to gravitate towards (Moller, 2011). Furthermore, the almost exclusive use of CBT and emphasis on following protocols in

sessions means that counselling psychologists are inhibited from adopting a pluralistic or integrative therapeutic approach. Blair (2010) notes that pluralism is a backbone of counselling psychology practice as it allows for individually tailored therapeutic delivery based on client presentations rather than blanket delivery of evidence base treatments. Without scope to work in this way, a rigid and limited model of therapy would likely dishearten many counselling psychologists in the long term and also potentially undermine the importance that the profession places on the therapeutic relationship. James (2009) stated that in any type of humanistic working, the therapeutic relationship is considered to be the main instrument for evoking therapeutic change. Thus therapeutic change in itself may be negatively impacted by the absence of any genuine relationship between therapist and client. Even though the guidelines and operation of IAPT appears to diverge from the underpinning values of the profession, Giddings (2009) points out that with greater job insecurity, privatisation and limited funding of services, counselling psychologists like other therapists may need to secure their positions and status within expanding government services like IAPT, which would expect adherence to the norm.

At this point, it is interesting to consider how the inclusion of third wave therapies such as DBT, MCT or ACT into the IAPT agenda would address some of the issues mentioned above. One such consideration may be the overlap in the philosophies of these therapies with the inherent values of the counselling psychology profession. For example, the focus of DBT, MCT and ACT redirect effort from trying to change immediate symptoms to attempting to be mindful and accepting of present moment experiences or changing one's *relationship* to their thoughts rather than trying to change the thoughts themselves. This approach parallels to that of counselling psychologists who are not concerned with fixing immediate symptoms but exploring how they are experienced and understood by the individual in a more holistic framework (Giddings, 2009). Counselling psychology and third wave therapies also appear to share a focus on 'being' rather than 'doing' with clients (AGCAS Publications, 2006), with *doing* more closely associated with the CBT approach. One way that counselling psychologists can demonstrate being in the room is by observing process in therapeutic engagement and reflecting this to the client so that it becomes a source of introspection and insight for both parties. Thus the integration of mindfulness therapies in IAPT would seemingly

foster opportunities for counselling psychologists to be present and introspective with their client in IAPT sessions. The integration of these third wave therapies into IAPT may also contribute to diminishing some of the tensions in how counselling psychologists define their professional identity, as identified by Moller (2011). For instance, having third wave therapies available in IAPT even if they appear in more structured or manualised formats may mean that counselling psychologists have a greater repertoire of therapies to select from according to the needs and presentations of the client. Also, it may mean that there is more compatibility between their humanistic focus of counselling psychologists and the mindful and acceptance focus of third wave therapies.

Another benefit of introducing these therapies to IAPT for counselling psychologists pertains to their scope of working with mental health problems and developmental issues across all domains of an individual's lifespan rather than just in clinical spheres (NHS, 2009). Thus the accessibility of third wave therapies in IAPT may be useful for counselling psychologists to help clients generalise skills for coping with depression to other areas in their life on the basis that mindfulness has been reported to cultivate greater insight, enhanced problem-solving capabilities, improved attention, reductions in selfishness, greater self acceptance and greater quality of life (Halliwell, 2010). From a broader perspective, introducing mindfulness more expansively through IAPT in the form of third wave therapies may reduce the likelihood of the client repeatedly accessing IAPT services. It may even begin to overcome Rizq's (2012) criticisms of the NHS by addressing the complexities of clients' suffering, vulnerability and psychological distress in a more real and relevant way. Both of these eventualities would be presumably satisfying for counselling psychologists who prefer to work holistically and to address underlying and contextual issues where appropriate to support an individuals' long-term or developmental well-being (Giddings, 2009).

The question now appears to be how to increase the likelihood of these third wave therapies being included as low and high intensity IAPT interventions? It's inevitable that further research demonstrating the efficacy of these treatment models for depression is required for this to occur and may prove to be a fruitful area of research for current and future counselling psychologists.

Conclusion

Whilst the current evidence base for DBT, MCT and ACT offers some promise that these therapies or versions of these therapies may be efficacious in the treatment of clinical depression, there are still too many gaps that impede a strong argument being made for their current inclusion as IAPT interventions.

Further research is needed to demonstrate the efficacy of these treatments compared to CBT in RCTs that use large samples of adult patients and employ adequate follow up measures. Counselling psychologists in particular may be advantaged by positive outcomes of this research and the future inclusion of third wave therapies in the IAPT agenda.

References

AGCAS Publications (2006). Occupational Profile. Counselling Psychologist [Pamphlet]. London: Lawrence, S.

Baer, R.A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. Clinical Psychology: Science and Practice, 10(2), 125–139.

Baer, R.A., Smith, G.T. & Allen, K.B. (2004). Assessment of mindfulness by self-report: The Kentucky Inventory of Mindfulness Skills. Assessment, 11(3), 191–206.

Beck, A.T Rush, A.J Shaw, B.F. & Emery, G. (1979). Cognitive therapy of depression. New York: Guilford Press.

Bohlmeijer, E.T Fledderus, M., Rokx, T.A. & Pieterse, M.E. (2011). Efficacy of an early intervention based on acceptance and commitment therapy for adults with depressive symptomology: Evaluation in a randomised controlled trial. Behavioural Research Therapy, 49(1), 62–67.

Burns, D.D. & Spangler, D.L. (2001). Do changes in dysfunctional attitudes mediate changes in depression and anxiety in cognitive behaviour therapy? Behaviour Therapy, 32, 337–369.

Butler, A.C., Chapman, J.E., Foreman, E.M. & Beck, A.T. (2006). The empirical status of cognitive behavioural therapy: A review of meta-analyses. Clinical Psychology Review, 26, 17–31.

Caselli, G. (2012). Metacognitive Therapy (MCT): An interview with Professor Adrian Wells. Retrieved 2 Nov 2015, from: http://www.stateofmind.it/2012/05/adrian-wells-metacognitive-therapy/

Corcoran, K.M. & Segal, Z.V. (2008). Metacognition in depressive and anxiety disorders: Current directions. International Journal of Cognitive Therapy, 1(1), 33–44.

Corrigan, P.W. (2001). Getting ahead of the data: A threat to some behaviour therapies. The Behaviour Therapist, 24, 189–193.

Cullen, C. (2008). Acceptance and Commitment Therapy (ACT): A third wave behaviour therapy. Behavioural and Cognitive Psychotherapy, 36, 667–673.

Department of Health (2008). Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit. Retrieved 10 June 2009, from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084065

Dobson, K.S. & Khatri, N. (2000). Cognitive therapy: Looking backward, looking forward. Journal of Clinical Psychology, 56(7), 907–923.

Evans, M.D., Hollon, S.D., DeRubeis, R.J., Piasecki, J., Grove, W.M., Garvey, M.J. & Tuason, V.B. (1992). Differential relapse following cognitive therapy and pharmacotherapy for depression. Archives of General Psychiatry, 49, 802–808.

Feldman, G., Harley, R., Kerrigan, M., Jacobo, M. & Fava, M. (2009). Change in emotional processing during a dialectical behavior therapy-based skills group for major depressive disorder. Behavior Research and Therapy, 47(4), 316-321.

Fiorillo, J. & Long, J. (2012). Dialectical behavior therapy skills groups in schools: A review of the empirical findings. From Science to Practice. Retrieved on November 26, 2015, from: http://www.apadivisions.org/division-16/publications/newsletters/science/2012/07/empirical-findings.aspx

Fledderus, M. Bohlmeijer, E.T. Pieterse, M.E. & Schreurs, K.M. (2012). Acceptance and Commitment Therapy as guided self-help for psychological distress and positive mental health: a randomised controlled trial. Psychological Medicine, 42(3), 485-495.

Folke, F. & Parling, T. (2004). Acceptance and commitment therapy in group format for individuals who are unemployed and on sick leave suffering from depression: A randomised control trial. Unpublished Paper. Upsala, Sweden: Upsala University.

Forman, E.M., Herbert, J.D., Moitra, E., Yeomans, P.D. & Geller, P.A. (2007). A randomised controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. Behaviour Modification, 31(6), 772–799.

Gaudiano, B.A. (2008). Cognitive behavioural therapies: Achievements and challenges. Evidence-based Mental Health, 11(1), 5–7.

Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment, 15,* 199–208.

Gloaguen, V., Cortraux, J., Cucherat, M. & Black- burn, I. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. Journal of Affective Disorders, 49, 59–72.

Goldstein, T.R., Axelson, D.A., Birmaher, B. & Brent, D.A. (2007). Dialectical behavior therapy for adolescents with bipolar disorder: a 1-year open trial. Journal of the American Academy of Child and Adolescent Psychiatry, 46(7), 820- 830.

Goodwin, G.M. (2012). Bipolar disorder. Medicine, 40(11), pp 596–598.

Gortner, E.T., Gollan, J.K., Jacobson, N.S. & Dobson, K.S. (1998). Cognitive behavioural treatment for depression: Relapse revention. Journal of Consulting and Clinical Psychology, 66(2), 377–384.

Halliwell, E. (2010). Be Mindful report. Retrieved February 20, 2011, from: www.livingmindfully.co.uk/downloads/Mindfulness_Report.pdf

Harley, R., Sprich, S., Safren, S., Jacobo, M. & Fava, M. (2008). Adaptation of Dialectical Behavior Therapy Skills Training Group for Treatment-Resistant Depression. Journal of Nervous and Mental Disease, 196(2), 136-143.

Hayes, S.C., Masuda, A., Bissett, R., Luoma, J. & Guerrero, F.L. (2004). DBP, FAP and ACT: How empirically oriented are the new behaviour therapy technologies? Behaviour Therapy, 35, 35–54.

Hayes, S.C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioural and cognitive therapies. Behaviour Therapy, 35, 639–665.

Hayes, S.C., Luoma, J.B., Bond, F.W., Masuda, A. & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. Behaviour Research and Therapy, 44, 1–25.

Hofman, S.G. & Asmundson, G.J.G. (2008). Acceptance and mindfulness-based therapy: New wave or old hat? Clinical Psychology Review, 28, 1–16.

Hollon, S.D., Shelton, R.C. & Davis, D.D. (1993). Cognitive therapy for depression: Conceptual issues and clinical efficacy. Journal of Consulting and Clinical Psychology, 61(2), 270–275.

Hollon, S.D., DeRubeis, R.L., Shelton, R.C., Amsterdam, J.D., Salomon, R.M., O'Readon, J.P., Lovett, M.L., Young, P.R., Haman, K.L., Freeman, B.B. & Gallop, R. (2005). Prevention of relapse following cognitive therapy vs. medications in moderate to severe depression. Archives of General Psychiatry, 62, 417–422.

Ilardi, S.S & Craighead, W.E. (1994). The role of non- specific factors in cognitive behaviour therapy for depression. Clinical Psychology: Science and Practice, 1, 138–156.

Jacobson, N.S., Dobson, K.T., Traux, P.T., Addis, M.E., Koerner, K., Gollan, J.K. et al. (1996). A component analysis of cognitive behavioural treatment for depression. Journal of Consulting and Clinical Psychology, 64(2), 295–304.

Jacobson, N.S., Martell, C.R. & Dimidjian, S. (2001). Behavioral Activation Treatment for Depression: Returning to Contextual Roots. *Clinical Psychology: Science and Practice, 8,* 255–270.

Kabat-Zinn, J. (1994). Full catastrophe living: The programme of the Stress Reduction Clinic at the University of Massachusetts Medical Centre. New York: Dell.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present and future. Clinical Psychology: Science and Practice, 10(2), 144–156.

Katz, L., Cox, B.J., Gunasekara, S. & Miller, A.L. (2004). Feasibility of Dialectical Behavior Therapy for Suicidal Adolescent Inpatients. Journal of the American Academy of Child and Adolescent Psychiatry, 43(3), 276-282.

Layard, R. (2005). Happiness: Lessons from a new science. London: Allen Lane.

Longmore, R.J. & Worrell, M. (2007). Do we need to challenge thoughts in cognitive behaviour therapy? Clinical Psychology Review, 27, 173–187.

Lynch, T.R., Morse, J.Q., Mendelson, T. & Robins, C.J. (2003). Dialectical behavior therapy for depressed older adults. A randomized pilot study. *American Journal of Geriatric Psychiatry, 11(1),* 33-45.

Ma, H.S. & Teasdale, J.D. (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. Journal of Consulting and Clinical Psychology, 72(1), 31–40.

Matta, C. (2013). Dialectical Behavior Therapy for Depression in Older Adults. *Psych Central*. Retrieved on February 15, 2016, from http://psychcentral.com/lib/dialectical-behavior-therapy-for-depression-in-older-adults/

McCullough, J.P. (2000). Treatment for Chronic Depression: Cognitive Behavioural Analysis System of Psychotherapy (CBASP). New York: Guilford Press

McPherson, S., Evans, C. & Richardson, P. (2009). The NICE depression guidelines and the recovery model: Is there an evidence base for IAPT? Journal of Mental Health, 18(5), 405–414.

Moulds, M.L., Yap, C.S.L., Kerr, E., Williams, A.D. & Kandris, E. (2010). Metacognitive beliefs increase vulnerability to rumination. Applied Cognitive Psychology, 24(3), 351–364.

Naeema, F., Gobbi, M., Ayub, M. & Kingdon, D. (2009). University students' views about compatibility of cognitive behaviour therapy with their personal, social and religious values (a study from Pakistan). Mental Health, Religion & Culture, 12(8), 847–855.

NHS Centre for Reviews and Dissemination (2002). Improving the recognition and management of depression in primary care. Effective Health Care, 7(5), 1–5.

NHS (2009). Counselling psychology within the NHS. Retrieved 10 June 2009, from: www.nhscareers.nhs.uk.

NHS (2009). Depression. The treatment and management of depression in adults. Retrieved 20 February 2011, from: www.nice.org.uk/nicemedia/live/12329/45888/45888.pdf

NHS (2010). Curriculum and Commissioning Outline. IAPT approved high Intensity therapies (additional to CBT). Retrieved 20 March 2011, from: www.iapt.nhs.uk/silo/files/commissioning-and- curriculum-outline-guide.pdf

Nordahl, H.M. (2009). Effectiveness of brief metacognitive therapy versus cognitive behavioural therapy in a general outpatient setting. International Journal of Cognitive Therapy, 2(2), 152–159.

Öst, L. (2008). Efficacy of the third wave behavioural therapies: A systematic review and meta-analysis. Behaviour Research and Therapy, 46, 296–321.

Papageorgiou, C. & Wells, A. (2000). Treatment of recurrent major depression with attention training. Cognitive and Behavioural Practice, 7, 407–413.

Papageorgiou, C. & Wells, A. (2001a). Metacognitive beliefs about rumination in recurrent major depression. Cognitive and Behavioural Practice, 8, 160–164.

Papageorgiou, C. & Wells, A. (2001b). Positive beliefs about depressive rumination: Development and preliminary validation of a self-report scale. Behaviour Therapy, 32, 13–26.

Papageorgiou, C. & Wells, A. (2015). Group Metacognitive Therapy for Severe Antidepressant and CBT Resistant Depression: A Baseline-Controlled Trial. Cognitive Therapy and Research, 39, 14-22.

Rogers, E. (2009). The need for re-appraising psychological therapies in the light of IAPT. The Journal of Mental Health Training, Education and Practice, 4(1), 19–26.

Samuels, A. & Veale, D. (2007). Improving access to psychological therapies: For and against. Andrew Samuels-David Veale Correspondence: October- December 2007. Psychodynamic Practice, 15(1) 41–56.

Scherer-Dickson, N. (2004). Current developments of metacognitive concepts and their clinical implications: Mindfulness-based cognitive therapy for depression. Counselling Psychology Quarterly, 17(2), 223–234.

Segal, Z.V., Williams, J.M.G. & Teasdale, J. (2002).Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. New York: Guilford Press.

Shea, M.G., Elkin, I., Imber, S.D., Sotsky, S.M., Watkins, J.T., Collins, J.F., Pilkonis, P.A., Beckham, E., Glass, D.R., Dolan, R.T. & Parloff, M.B. (1992). Course of depressive symptoms over follow–up: Findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Programme. Archives of General Psychiatry, 49, 782–787.

Singh, N., Lancioni, G.E., Wahler, R.G., Winton, A.S.W. & Singh, J. (2008). Mindfulness approaches in cognitive behaviour therapy. Behavioural and Cognitive Psychotherapy, 36, 659–666.

Sperry, L. (2001). Spirituality in clinical practice. Hove: Brunner-Routledge.

Teasdale, J.D., Segal, Z.V., Williams, J.M.G., Ridgeway, V.A., Soulsby, J.M. & Lau, M.A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. Journal of Consulting and Clinical Psychology, 68, 615–623.

Van Dijk, S., Jeffrey, J. & Katz, M.R. (2013). A randomized, controlled, pilot study of dialectical behavior therapy skills in a psychoeducational group for individuals with bipolar disorder. Journal of Affective Disorders, 145(3), 386-393.

Watkins, E. & Baracaia, S. (2001). Why do people ruminate in dysphoric moods? Personality and Individual Differences, 30, 723–734.

Wells, A. (1995). Metacognition and worry: A cognitive model of generalised anxiety disorder. Behavioural and Cognitive Psychotherapy, 23, 301–320.

Wells, A. (2000). Emotional disorders and metacognition: Innovative cognitive therapy. Chichester: Wiley.

Wells, A. (2008). Metacognitive therapy: Cognition applied to regulating cognition. Behavioural and Cognitive Psychotherapy, 36, 651–658.

Wells, A. (2009). A prospective test of the clinical metacognitive model of rumination and depression. International Journal of Cognitive Therapy, 2(2), 123–131.

Wells, A., Fisher, P., Myers, S., Wheatley, J., Patel, T. & Brewin, C.R. (2009). Metacognitive therapy in recurrent and persistent depression: A multiple- baseline study of a new treatment. Cognitive Therapy and Research, 33, 291–300.

Wells, A. & Matthews, G. (1996). Modelling cognition in emotional disorder: The S-REF model. Behaviour Research and Therapy, 34, 881–888.
Wells, A. & Papageorgiou, C. (1998). Social phobia: Effects of external attention on anxiety, negative beliefs and perspective taking. Behaviour Therapy, 29, 357–370.

Wells, A. & Purdon, C. (1999). Metacognition and cognitive behaviour therapy: A special issue. Clinical Psychology and Psychotherapy, 6, 71–72.

Whitfield, G. & Davidson, A. (2007). Cognitive behavioural therapy explained. Oxford: Radcliffe Publishing.

Zettle, R.D. (2005). The evolution of a contextual approach to therapy: from comprehensive distancing to ACT. The International Journal of Behavioural Consultation and Therapy, 1(2), 77–89.

Zettle, R.D. & Hayes, S.C. (1986). Dysfunctional control by client verbal behaviour: The context of reason giving. Analysis of Verbal Behaviour, 4, 30–38.

Zettle, R.D. & Rains, J.C. (1989). Group cognitive and contextual therapies in treatment and depression. Journal of Clinical Psychology, 45(3), 436–445