# Acceptance and Commitment Therapy for Depression and Anxiety: An Interpretative Phenomenological Analysis of Clients' Experiences in a Group Context

A thesis submitted in partial fulfilment of the Doctorate in

Counselling Psychology at London Metropolitan University

*by*

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2017

# Declaration

I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated.

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# Acknowledgements

I would firstly like to thank my research supervisor, Dr Angela Loulopoulou, for her support throughout my journey completing this thesis. Thank you for the knowledge you imparted and helping to relieve anxiety along the way! I am appreciative of my cohort/good friends for the support we have shared and for making the journey enjoyable. I am deeply thankful to Professor Gary Kupshik and Dr Greg Wood for seeing potential in me, continuing to have faith in me and providing me with great opportunities. Sadly, I could not say this to them in person, but I must say a very special thank you to my dearest Bappou and Yiayia for working so hard over the years to provide for their family, despite hardships. I found this inspiring and it instilled a hardworking nature and determination in me. Without this, along with my parents' generosity and kindness, I would not have had the opportunity to complete my Doctorate. Thank you also to my Dad for taking the time to proof read my thesis. Finally, a big thank you goes to the participants who kindly took part in this study. This thesis could obviously not have been completed without you.

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**Abstract**

*Rationale:* There is accumulating evidence supporting the effectiveness of Acceptance and Commitment Therapy (ACT) in a group context for individuals with depression and/or anxiety. However, there is limited qualitative research in this area. *Aim:* This thesis aimed to address this gap by exploring individuals' experiences of an ACT group for depression and/or anxiety. This may provide an insight into how individuals understand ACT processes and the mechanisms for therapeutic change within ACT. *Method:* Semi-structured interviews were conducted with six participants. Transcripts were analysed using Interpretative Phenomenological Analysis. *Findings:* Three master superordinate themes emerged; Group Dynamics; The Journey of Therapy; Usefulness of Therapy. A description of these superordinate themes and the seven related subordinate themes are discussed. The findings highlighted the benefits and challenges of ACT tools and concepts as well as the group context. Recommendations for clinical practice and future research are outlined.

# Introduction

Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is described as one of the 'third-wave' of behavioural therapies and has been receiving a lot of attention in clinical, academic and research fields in recent years. ACT is a transdiagnostic approach. Rather than focusing on diagnostic classifications, it posits that there are common processes that underlie various psychological difficulties which become the target of therapy. ACT proposes that *cognitive fusion* and *experiential avoidance*, which lead to *psychological inflexibility*, are key in the aetiology and maintenance of various psychological difficulties (Hayes, 2004; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). *Cognitive fusion* is described as the tendency to become entangled with the literal content of thoughts and using this to predominantly guide our actions (Hayes et al., 1999). *Experiential avoidance* refers to being unwilling to experience unpleasant internal events, such as thoughts, feelings, memories and physical sensations (Hayes et al., 1996). In addition, it involves attempting to avoid or alter the form of these unpleasant internal events, even though this can consequently lead to more distress (Hayes, 2004). *Psychological inflexibility* is characterised as being excessively entangled in *cognitive fusion* and *experiential avoidance*, which can lead to inflexible behaviour that is not in accordance with an individual's values.

The processes of *cognitive fusion* and *experiential avoidance* are targeted in ACT to create greater *psychological flexibility*. This entails altering the relationship one has with one's thoughts, unlike other behavioural approaches which suggest that treatment should target thought content (Hayes et al., 1999). ACT aims to help individuals be aware of private experiences in the present moment and respond to these without avoidance or struggling. Furthermore ACT entails taking committed action towards valued directions to contribute to a rich and fulfilling life (Hayes,

Luoma, Bond, Masuda, & Lillis, 2006). As can be seen, the primary aims of ACT involve valued-based living rather than symptom reduction. This differs from many other mainstream therapies where the primary focus is often symptom reduction.

It is suggested that transdiagnostic approaches are able to overcome some of the limitations of diagnostic-specific therapies (Egan, Nathan, & Norton, 2009). For example, as transdiagnostic approaches have one set of principles to target key constructs across multiple disorders, this overcomes the difficulty of deciding which diagnosis to target first for individuals with co-morbidities. As various disorders within one individual can be targeted, it is assumed that treatment effectiveness would improve (McManus, Shafran, & Cooper, 2010). ACT is showing promising results for a range of psychological difficulties.

This thesis is focused on ACT in a group setting for individuals with struggles that would be explained, within a medical model, as coming under the umbrella of depression and anxiety disorders.

**Reflexive Statement**

The subjectivity of researchers is intimately involved in the research process, particularly with regards to qualitative as opposed to quantitative research (Morrow, 2005). In addition, sometimes researchers may already have or may develop a close relationship with the research they conduct (Tufford & Newman, 2010). This can influence several stages of the research process, which can threaten its validity (Morrow, 2005). To manage this, researchers engage in a process named bracketing (Husserl, 1931). This process involves the researcher being reflexive throughout the research process by being aware of their biases,

assumptions, values and reactions. Researchers then make these explicit and outline the strategies they carried out to maintain fairness (Yeh & Inman, 2007). My reflexive statement now follows.

I decided to focus the study on ACT as it is an approach that interests me and I enjoy incorporating into my clinical work. There are several reasons for this. I initially became interested in ACT as I felt that it overcame some limitations of cognitive behavioural therapy (CBT), which I experienced in my clinical practice. Although I value and draw upon CBT in my clinical practice, I feel that it is not always appropriate for individuals, such as, those whose thoughts are a realistic perception resulting from difficult life experiences. CBT focuses on challenging 'unhelpful thoughts' which leads to the problem being located within the client (Johnstone, 2000; Smail, 2001). In contrast to this, the content of thoughts is not given importance in ACT. Instead, ACT suggests that 'unhelpful thoughts' are part of a normal human experience and it is beneficial to change our relationship with these (Hayes et al., 1999). I consider this to be a more compassionate approach.

I feel that ACT has had a positive influence on me personally, which has also attracted me to this approach. In my own family, we tend to shy away from discussing emotional difficulties. Learning about ACT highlighted to me that this perhaps has led me to over-rely upon avoidant coping strategies when faced with emotional difficulties. For example, when I feel stressed following an interpersonal difficulty, I tend to keep myself busy, exercising and arranging social activities. ACT teaches that avoidant strategies can be maladaptive in the long term and can exacerbate difficulties. I have found mindfulness particularly helpful in overcoming this, which is a key tool utilised in ACT. Mindfulness helps

me to slow down and appreciate the here and now. Due to my personal positive experience of ACT, I am keen to incorporate this approach into my work with clients in the hope that they find it equally beneficial. In addition, I wish to raise the profile of ACT so that other clinicians consider using the approach.

During an early research supervision session, a co-trainee queried why I had chosen to focus on a group as opposed to an individual context. I found this interesting as I had not even considered the latter. This led me to further consider why I had chosen this area of study. I have experience of applying ACT in both individual and group settings for clients experiencing chronic pain as well as depression and/or anxiety. However, I have only co-facilitated one ACT group for clients with depression and/or anxiety, therefore my experience with regards to this is more limited. My experience has been that some clients with chronic pain seem to find the approach beneficial. However, many of the clients in the ACT group for depression and/or anxiety that I co-facilitated appeared to find it more challenging to incorporate the concepts of ACT into their lives. My own hypothesis is that those with depression and/or anxiety may struggle to be clear on what aspects of their difficulties they would benefit from learning to accept. This is in comparison to those with chronic pain where it is seemingly clearer. Therefore, I was keen to gain an understanding of how these clients experience ACT and explore if, according to my perception, they did struggle with it. Furthermore, I personally dislike the experience of struggling, therefore, I wish to help others who struggle. In addition, when clients are unsatisfied by limited progress within therapy this perhaps threatens my confidence as a practitioner and my need to please others is challenged. I was motivated, therefore, to conduct a study in this area to gain a better understanding of clients' potential struggles with the therapy to help elucidate ways to improve it. I also chose to focus my thesis on

this area as I had a desire to gain new knowledge that would inform not only my own but my other colleagues' practice when delivering ACT groups for clients with depression and/or anxiety.

I have highlighted my positivity towards ACT. However, I also have some reservations. I find the experiential nature of the delivery of ACT quite difficult and have less experience of delivering this approach, as opposed to CBT, which is more structured and thus I find easier to deliver. Another reservation I have of ACT is that I value exploring clients' developmental context of their difficulties, however, ACT places more emphasis on the here and now. In addition, I have found that it is not uncommon for some to struggle to understand some of the ACT tools and concepts. My hypothesis is that this may be partly due to ACT's abstract nature and the unfamiliar terms that are used. This has recently led me to adjust my delivery of ACT by placing less emphasis on more abstract concepts and simplifying the language that is used. I wonder whether my perception that clients with depression and/or anxiety found the ACT group difficult was partly due to projection of these reservations I have of ACT. This further motivated me to study this area to gain some clarification. Do individuals struggle with an ACT group for depression and/or anxiety or is this my own projection?

Whilst conducting this research I was aware that I needed to try not to let my beliefs lead me to assume that participants would find the ACT group difficult and be hypervigilant to this. My own experience of ACT and beliefs of the approach, along with my prior knowledge of research into ACT groups, had the potential to have a greater influence during the interviews and analyses. I noticed that I found it interesting when things arose, during both the interviews and analyses, that were in keeping with my own beliefs and findings from previous studies. When this

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occurred during the interviews I thought more carefully about the questions that I asked. Whilst analysing, I made a more concerted effort to try to ensure that the themes that arose were indeed a reflection of participants' accounts. I did this by regularly re-reading the transcripts. For each theme I identified I tried to ensure that there was sufficient evidence from the transcripts to support them. I also verified the themes with my research supervisor as well as two participants.

I noticed that whilst searching for studies for the critical literature review (CLR) I was drawn to those investigating ACT and CBT, particularly those that compared the two. This may have been due to my increased familiarity of these approaches, but also possibly because I was interested in whether one showed superiority over the other.

These reflections suggest that my personal investment in the study influenced my chosen area of study and literature search at an early stage. These reflections helped me to try to establish a more balanced view and broaden my searches. As I feel both positive about ACT and have reservations, I believe that this helped me to adopt a more balanced stance. Throughout the progress of this study I continued to note my reflections in a reflective journal to further facilitate bracketing (Kasket, 2013; Morrow, 2005).

## Relevance to Counselling Psychology

Many of the philosophies that underpin ACT seem to correspond with those of counselling psychology (CoP). This suggests the potential relevance of this study to the field of CoP. Firstly, as Murdock, Duan, and Nilsson (2012) highlight, both ACT and CoP emphasise the importance of clients' strengths and the influence of wider environmental and contextual factors upon distress. This can lead to a more

compassionate and empowering approach. Secondly, ACT recommends that therapists train experientially by applying all of the exercises to their own lives (Hayes, Pistorello, & Levin, 2012). Therapists themselves are on their own journey with inevitable challenges. This leads to the notion that therapists are not experts, a feature shared with CoP. Thirdly, ACT and CoP both focus on 'being' with clients as opposed to 'doing' with clients (Bhanji, 2011). This further reduces the inherent power imbalance between therapist and client. Fourthly, Hayes et al. (2012) highlight that ACT is not concerned with diagnoses as the model is broadly applicable to all psychological difficulties and is more concerned with the universal processes that underlie these. The use of diagnoses also does not fit comfortably within CoP (Milton, Craven, & Coyle, 2010). Fifthly, ACT emphasises the importance of the therapeutic relationship. Pierson and Hayes (2007) even suggest that the ACT model can help to explain why the therapeutic relationship is important and how to enhance it. The theoretical models in CoP also consider the therapeutic alliance to be of central importance. Lastly, key processes of ACT involve helping clients to develop acceptance and encourage them to work towards their valued directions to lead a more fulfilling life. The idea of acceptance has long been emphasised in humanistic and existential approaches (Greenberg, 1994), in which the work of counselling psychologists is grounded. Values work seems to mirror Maslow's (1943) concepts of personal growth and self-actualisation, which are central to the humanistic approach.

ACT can be applied to various areas of work that counselling psychologists undertake (Hayes et al., 2012). The purpose of this study in exploring individuals' experience of ACT will hopefully be informative to therapists who choose to draw upon ACT. This study may also raise the profile of ACT in this field.

# CHAPTER 1

# CRITICAL LITERATURE REVIEW

## 1.1 The Features and Impact of Depression and Anxiety

The Diagnostic and Statistical Manual of Mental Disorders proposes that major depressive disorder is characterised by depressed mood, loss of interest and a range of cognitive, emotional, physical and behavioural symptoms (5th ed.; *DSM-5*; American Psychiatric Association, 2013). The DSM-5 specifies twelve different anxiety disorders. They all have different symptoms but all are associated with excessive irrational fear and dread as well as heightened physiological arousal and behavioural avoidance.

According to the findings from the Office for National Statistics (2013), nearly one-fifth of adults in the United Kingdom experience depression or anxiety. They are associated with a high impact upon the quality of life for both individuals and their relatives (Hoffman, Dukes, & Wittchen, 2008), significant levels of service utility (Katon et al., 1990; Wittchen, 2002) and costs (Greenberg et al., 1999; Timonen & Liukkonen, 2008) as well as increased mortality rates (Cougle, Keough, Riccardi, & Sachs-Ericsson, 2009; O'Leary & Lee, 1996). Moreover, relapse is common (Mintz, Mintz, Arruda, & Hwang, 1992; Yonkers, Dyck, Warshaw, & Keller, 2000). In this CLR the focus is on exploring the empirical support for group psychological interventions for depression, generalised anxiety disorder (GAD), social anxiety disorder (SAD) and panic disorder with or without agoraphobia (from here onwards the term PD is used for panic disorder both with and without agoraphobia). The dilemma that counselling psychologists face when using diagnostic categories is now discussed along with the reasons for focusing on these diagnostic categories.

## 1.2 Counselling Psychology and Diagnostic Categories

A dilemma for the CoP profession concerns the use of diagnostic categories. Larsson, Brooks, and Loewenthal (2012) provide a thorough discussion of this issue. CoP is embedded in humanistic principles whereby an individual's subjective experience and capacity for self-actualisation are valued. However, in contrast to this, many settings that counselling psychologists work within, such as the Community Mental Health Team (CMHT) which deliver the ACT groups under investigation in this research study, are dominated by the medical model. For example, individuals' are often labelled with a diagnosis, thus pathologising their distress. Also, the National Institute for Health and Care Excellence (NICE) guidelines recommend for psychological services, such as CMHTs, to be organised around a stepped-care model, which is based on diagnoses and their severity.

To further fuel this dilemma, counselling psychologists are trained to be scientist-practitioners, which entail the best available evidence being used to guide clinicians' choice of intervention. Psychological research has been influenced by medical research where the research methodology that is considered to be of the highest quality is randomised controlled trials, which often focus on specific diagnostic categories. Thus engaging in the scientist-practitioner role and evidence-based practice implies accepting the medical model (Albee, 2000). A central debate within the CoP profession concerns the degree to which counselling psychologists hold onto their humanistic principles as well as whether they embody diagnostic categories, and if they do, to what extent. Golsworthy (2004) argues that counselling psychologists should reflect upon the strengths and limitations of using diagnostic categories and the impact that they have upon

clients and therapy. Golsworthy also asserts that counselling psychologists should challenge reductionistic approaches to psychological difficulties.

The dilemma outlined above led me to have difficulties deciding how to present the following literature review, which explores the empirical support for group psychological therapies for psychological difficulties. I am a trainee counselling psychologist and my own standpoint (which is detailed in the Epistemology and Ontology Reflexivity section) is in line with Golsworthy's (2004) highlighted above, whereby I am wary of the reductionistic potential of diagnostic categories and value the importance of critically appraising the use of these. However, the decision was made to review group psychological therapies in relation to several diagnostic categories; depression, GAD, SAD and PD. The main reason for this was that, as mentioned above, the majority of psychological research studies focus on particular diagnoses. It also seemed a clearer way to present the literature review. In addition, this study recruited participants from ACT groups delivered by a CMHT where diagnostic terms are a common discourse and they are loosely used as inclusion criteria for the ACT groups. Other conditions are not considered in this CLR due to limited space and because the aims of the research are to explore the experiences of individuals attending an ACT group where depression, GAD, SAD and PD are the most frequent presentations.

### 1.3 Rationale for Focusing on Group Therapy

I chose to focus this study on group therapy as opposed to individual therapy for several reasons. I have already provided some reasons based on my personal motivation and experiences in the Reflexive Statement section. In addition to these reasons, there seems to be little existing literature on ACT in a group context. Group therapy has been shown to be cost-effective (McRoberts,

Burlingame, & Hoag, 1998) and more clients can be seen within a shorter space of time. This has made it increasingly popular due to the current climate of cost cutting and increasing demand upon psychological services. Furthermore, research suggests that group therapy is effective (e.g. Huntley, Araya, & Salisbury, 2012). The potential benefits of group therapy have long been recognised in the psychodynamic field. A central tenet of psychodynamic group therapy is that the therapy group becomes a 'social microcosm', where the relationships between group members reflect their relationships outside of therapy. The therapist searches for transferences and resistances, which become available for interpretation. It is proposed that the group setting enhances the possibilities of exposing a variety of relationships, which broadens the context in which such intrapsychic problems can be examined (Rutan, Stone, & Shay, 2014). Yalom (1970) was highly influential in the field of psychodynamic group psychotherapy and proposed that there are various factors associated with client outcome. Many of these factors are suggested to be exclusive to, or more prominent in, group therapy, as opposed to individual therapy, including interpersonal learning, family re-enactment, group cohesiveness and universality. However, there are potential shortcomings of group therapy. For example, they may be monopolised by one member of the group and clients can feel disheartened when they compare their progress to others (Lockwood, Page, & Conroy-Hiller, 2004). Further investigation of group therapy is thus warranted to explore clients' experiences and satisfaction of this modality. Due to the importance of delivering evidence-based practice the recommendations within the NICE guidelines with regards to group therapy for depression, GAD, SAD and PD are now presented.

## 1.4 NICE Guidelines

The NICE guidelines recommend cognitive behavioural group therapy (CBGT) for depression, GAD and PD, under certain conditions and within the stepped care model (NICE, 2009; 2011). For example, CBGT is recommended for clients with persistent subthreshold depressive symptoms or mild to moderate depression who decline individual psychosocial interventions. Mindfulness-based cognitive therapy (MBCT) delivered in a group format is also recommended to prevent depressive relapse. NICE guidelines advocate CBGT for GAD and PD, which is described as psychoeducational or supportive. Group therapy is not recommended for SAD as evidence suggests it is less effective than individual therapy (NICE, 2013). Despite this, there seems to be potential for this form of therapy for this client group as the group context allows for social exposure (Whitfield, 2010).

## 1.5 Limitations of Diagnostic-Specific Psychological Therapies

There is a vast amount of research investigating the effectiveness of diagnostic-specific treatment in group settings. This is in line with recommended guidelines which have developed from the widely held assumption that different diagnoses are qualitatively distinct. However, many clients do not have a clear diagnosis. Also, some argue that there are strong similarities between different diagnoses, such as depression and anxiety disorders (Barlow, 2004). It is suggested that depression and anxiety disorders share the same maintenance processes (Harvey, Watkins, Mansell, & Shafran, 2004), which is reflected in the high rates of comorbidity (Brown, Campbell, Lehman, Grisham, & Mancill, 2001; Kessler, Chiu, Demler, Merikangas, & Walters, 2005). However, individuals with comorbidities are often excluded from research studies to increase internal validity. This compromises the external validity (Rothwell, 2005). There is currently little guidance based on the best available evidence to inform treatment

decisions for individuals with comorbidities who may be considered as more complex (Clark, 2009). This leads to clinicians facing the challenge of determining the primary disorder to be addressed first. Additionally, many clients who receive such evidence-based psychological therapies either do not respond to therapy or experience residual symptomatology and remain substantially impaired following treatment (Orsillo, Roemer, Block-Lerner, LeJeune, & Herbert, 2005). The above highlights some of the reasons that have led to the increasing interest in transdiagnostic approaches, which are now discussed.

## 1.6 Transdiagnostic Approaches

Transdiagnostic approaches have been described as moving away from diagnostic-specific treatment approaches and instead focusing on using a single set of treatment principles and applying them to common maintaining processes across mental health difficulties (Watson et al., 2010). As such, they are considered to be a viable and clinically effective way of treating clients with complexities that are often seen in secondary care services (Clark, 2009). This is the setting on which I have focused this thesis. Egan, Wade, and Shafran (2012) suggest that transdiagnostic approaches are appealing due to their practicality and cost-effectiveness. They argue that having one set of principles to target key constructs across multiple disorders minimises training demands, is easier to deliver and more efficient than delivering several single diagnostic-specific interventions. Transdiagnostic groups can be populated more quickly resulting in treatment being initiated sooner (Norton & Barrera, 2012). This is particularly important given the increasing demand upon psychological services.

As transdiagnostic approaches are able to target various disorders within one individual it is assumed that treatment effectiveness would improve (McManus et

al., 2010). Several transdiagnostic therapies have been developed for use in a group context for heterogeneous anxiety disorders as well as mixed anxiety and depression samples. Evidence supporting their effectiveness is gradually accumulating and is now briefly discussed.

### 1.6.1 Empirical Support for Transdiagnostic Approaches in a Group Context

CBGT has been adapted into a transdiagnostic approach, which targets cognitive behavioural processes across disorders (Harvey et al., 2004). CBGT has shown promising results for heterogeneous anxiety disorders in several uncontrolled studies (Erickson, 2003; Garcia, 2004; Norton, 2008) and also randomised controlled studies where it has been compared to a waiting list (WL) group (Erickson, Janeck, & Tallman, 2007; Norton & Hope, 2005; Schmidt, Buckner, Pusser, Woolaway-Bickel, & Preston, 2012). Two studies (Norton, 2012a; Norton & Barrera, 2012) found CBGT to be equally efficacious in the treatment of heterogeneous anxiety disorders compared to applied relaxation and a diagnostic specific CBT, respectively. Moreover, one open trial found that CBGT for a mixed depression and anxiety group also showed promise (McEvoy & Nathan, 2007). The constraints of the length of this CLR prevent a more detailed review of the empirical support for transdiagnostic CBGT for emotional and anxiety disorders. For interested readers, see Norton and Philipp (2008), Norton (2012b) and McEvoy et al. (2009) for detailed reviews.

Other popular approaches which are based on transdiagnostic principles are mindfulness-based cognitive therapy (MBCT; e.g. Segal, Williams, & Teasdale, 2002) and mindfulness-based stress reduction (MBSR; e.g. Kabat-Zinn, 1982). These approaches are often delivered in group formats. Evidence for these

approaches also shows promising results for depression and anxiety. A study by Vøllestad, Sivertsen, and Nielsen (2011) compared MBSR to a WL group for individuals with heterogeneous anxiety disorders. Those in the MBSR group showed significant improvements on all measures compared to the WL group. Another study, by Kim et al. (2009) compared the effectiveness of MBCT versus an anxiety education group for individuals with PD or GAD. Those in the MBCT group showed significantly more gains with regards to the depression and anxiety measures. Two uncontrolled studies (Finucane & Mercer, 2006; Ree & Craigie, 2007) explored the outcomes of MBCT for a heterogeneous sample of depression and/or anxiety. Both studies showed that the MBCT was associated with significant reductions in depression and anxiety. An uncontrolled study by Green and Bieling (2012) explored the effectiveness of MBSR for individuals with depression and/or anxiety. This group showed significant improvements to depression and mindfulness skills. Last but not least, Arch et al. (2013) directly compared two transdiagnostic approaches, MBSR to CBGT for heterogeneous anxiety disorders ($N = 105$) and found comparable results. Both groups were effective in reducing the severity of the principal disorder. CBGT was superior in reducing anxious arousal, whereas MBSR was more effective in reducing worry and comorbid disorders. This study involved a representative sample. However, perhaps due to the complexity of individuals seen, the attrition rate was notably high with around only half completing treatment.

Overall, research supports the conclusion that CBGT, MBCT and MBSR in group settings are potentially helpful for heterogeneous anxiety and depression client groups. However, transdiagnostic approaches have faced several criticisms. Firstly, they have not always led to improvements (e.g. Toneatto & Nguyen, 2007). McManus et al. (2010) propose that more randomised controlled studies

are needed, particularly those that compare transdiagnostic approaches to each other, have direct comparisons with diagnostic-specific treatments and have larger sample sizes. Despite these criticisms, transdiagnostic approaches are increasingly being employed by clinicians due to their benefits outlined above.

Apart from CBGT, MBCT and MBSR, another increasingly popular transdiagnostic approach is ACT, which is the approach this thesis is focused on. A brief summary of this approach along with its empirical support in group settings for depression and anxiety follows.

## 1.7 Acceptance and Commitment Therapy

ACT is a so called 'third-wave approach' of behaviour therapy. Before describing ACT in more detail its philosophical and theoretical underpinnings are firstly outlined.

### 1.7.1 Philosophical and Theoretical Underpinning of ACT

ACT is grounded in functional contextualism (FC; Hayes, 1993; Hayes et al., 1999) which acts as the philosophical basis for relational frame theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001) both of which are now briefly described.

**1.7.1.1 Functional Contextualism.** FC views psychological events as on-going interactions of the whole person in and with situationally and historically defined contexts (Hayes et al., 2006). The goal of FC is the prediction and influence of events with precision, scope and depth (Hayes, 1993). It assumes that behaviours have a function and purpose which are dependent upon context and not regulated by thoughts, memories and feelings (Hayes et al., 1999). Another feature of FC is that 'truth' is defined only by what works to accomplish specified

goals. According to this philosophy, thoughts, memories, feelings and behaviours themselves are not believed to be pathological but are seen as being more or less useful in working towards a valuable life. It is possible to go beyond trying to modify thoughts or feelings to influence overt behaviour, to changing the context that causally links these psychological domains (Hayes et al., 2006).

**1.7.1.2 Relational Frame Theory.** The ACT model is theoretically underpinned by RFT which aims to provide a modern behavioural account of human language and cognition (Hayes et al., 2001). A central tenet of RFT is that human behaviour is largely governed through mutual networks called relational frames. Humans have the ability to arbitrarily relate any object in the environment, thought, memory, feeling, behaviour or physical sensation to any other of these in almost any possible way. Through relational framing humans are able to plan for the future, learn from the past, maintain knowledge and evaluate (Hayes et al., 1999). Relational frames are believed to have the potential to contribute to psychological distress (Tull, Gratz, Salters, & Roemer, 2004). RFT proposes that once a relational frame has been learnt, this guides future behaviour and can be difficult to break (Hayes, 2004). The clinical implication of this is that it is unfruitful to target and change thought content. A more helpful approach would be to alter the relationship one has with one's experiences.

### 1.7.2 ACT model of Psychological Suffering

According to Hayes (2004), prolonged *cognitive fusion* and *experiential avoidance* lead to *psychological inflexibility.* These processes are believed to underlie the aetiology and maintenance of different psychological difficulties (Hayes et al., 1996). These three concepts are now described.

**1.7.2.1 Cognitive Fusion.** Cognitive fusion refers to the excessive and inappropriate tendency to act according to the literal content of thoughts rather than as the on-going process of thinking (Hayes et al., 1999; Hayes et al., 2006). During this process, an individual becomes more guided by verbal rules and relations as opposed to being guided by other aspects of the environment in the present moment (Hayes et al., 2006). This is particularly problematic when this contributes to behaviours that lead an individual away from their chosen life values.

**1.7.2.2 Experiential Avoidance.** Experiential avoidance involves an individual being unwilling to experience unpleasant private events (thoughts, memories, feelings, physical sensations), and attempting to alter the form or frequency of these. Avoidance can take different forms. It may involve distraction, suppression or avoiding situations. In the short term this can relieve unpleasant feelings but over time this can be negatively reinforcing, increasing the likelihood of experiential avoidance strategies being employed when facing similar situations in the future (Chapman, Gratz, & Brown, 2006). However, avoidance has been shown to have a paradoxical effect in that it increases the frequency, severity, salience and accessibility of these private events which can contribute to psychological distress (Cioffi & Holloway, 1993; Wegner, 1994). It can also lead to behaviour that is inconsistent with an individual's values.

**1.7.2.3 Psychological Inflexibility.** ACT considers that being excessively tangled in cognitive fusion and experiential avoidance contributes to psychological inflexibility, or rigidity. Other fundamental characteristics of psychological inflexibility include being preoccupied with the past and future whilst losing contact with the present moment, attachment to the conceptualised

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self whereby an individual acts in line with rigid stories about themselves which may no longer apply and, finally, not taking steps towards one's values (see Figure 1 for ACT model of psychological rigidity).

Dominance of conceptualised past and feared future
(i.e., assess propensity for continuous worry, rumination and planning)

Experiential Avoidance
(i.e., assess for avoidance of internal content such as emotions or thoughts; the individual might be strongly invested in acquiring avoidance strategies.

Absent or confused values
(i.e., assess for avoidance of meaningful life activities and overreliance on what others or society promotes as important).

Cognitive fusion
(i.e., assess the strength of attachment to internalised beliefs; there might be difficulty recognising thoughts as the product of the mind).

Psychological Rigidity

Inactivity, avoidance and impulsivity.
(i.e., actions are only pursued under certain acceptable conditions, procrastination might be evident, committed action is not seen as a free choice).

Attachment to the conceptualised self.
(i.e., individuals see themselves as no more than the sum of verbal descriptions and memories; there is an inability to contact self as a perspective).

*Figure 1.* ACT model of psychological rigidity (retrieved from https://contemporarypsychology.org)

### 1.7.3 ACT Model of Psychological Flexibility

ACT aims to target psychological inflexibility and, instead, increase psychological flexibility. Psychological flexibility is defined as the ability to be aware of private experiences in the present moment and responding to these without avoidance or struggling. Furthermore it entails taking committed action towards valued directions to contribute to a rich and fulfilling life (Hayes et al., 2006). This is achieved through six targeted processes which form the 'Hexaflex Model'; acceptance, present moment awareness, values, committed action, self as

context and defusion (see Figure 2 for ACT model of psychological flexibility).
These six processes are now briefly outlined.
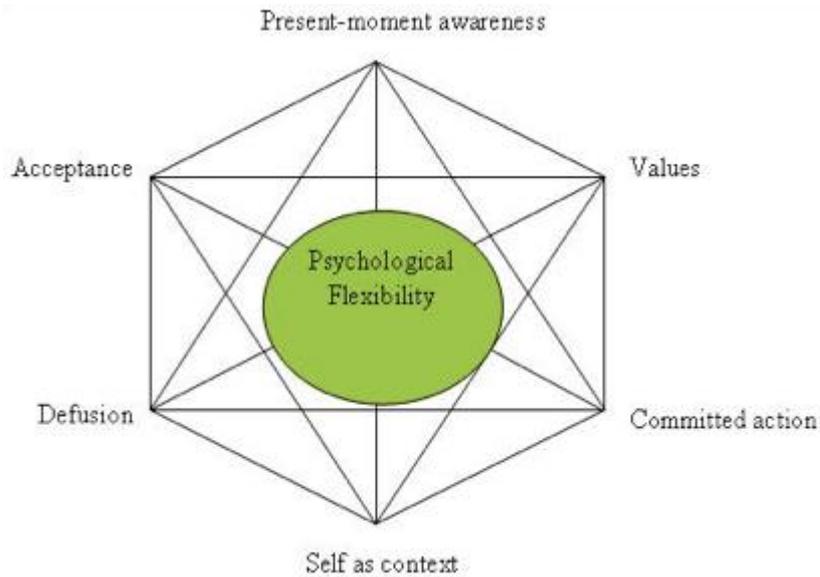


*Figure 2.* ACT model of psychological flexibility (retrieved from https://contemporarypsychology.org)


**1.7.3.1 Acceptance.** Acceptance is framed as the alternative to avoidance. It involves actively embracing private events, seeing them as natural human responses, even though they may be unpleasant (Blackledge & Hayes, 2001). By reducing the struggle to try to avoid these private events, individuals can more effectively use their energy to take workable actions in line with the life they value.


**1.7.3.2 Present Moment Awareness.** Contacting the present moment involves experiencing internal and external events as they are occurring, without attachment to judgment (Twohig & Hayes, 2008). By being more mindful of the present moment, individuals are better able to consider whether actions will be consistent with their values.

**1.7.3.3 Values.** Values are areas of importance in different life domains, such as, leisure, family relationships and health. In ACT, clients are encouraged to use their values to guide their actions. Values can never be obtained unlike goals, but rather they are on-going and continuous.

**1.7.3.4 Committed Action.** Committed action involves engaging in behaviours that lead individuals towards their values whilst being willing to experience any discomfort that may arise.

**1.7.3.5 Self As Context.** Self as context refers to the observing self which is the part of us that is always noticing thoughts, feelings and behaviour. By observing, one is able to be aware of one's experiences whilst not becoming attached to them, thus fostering acceptance and defusion.

**1.7.3.6 Defusion.** Defusion aims to undermine cognitive fusion by changing the way one interacts with thoughts by creating contexts in which their unhelpful functions are diminished (Hayes et al., 2006). Individuals are taught not to take thoughts literally but instead to see them as they are, just thoughts (Cullen, 2008).

### 1.7.4 ACT Groups

The evidence base supporting the ACT model and its delivery in a group setting is rapidly growing (e.g. Zettle, Rains, & Hayes, 2011). A summary of the benefits of ACT being delivered in a group context is now presented. A literature review of the empirical support for ACT groups for depression, GAD and SAD, respectively, is then explored. This is followed by a detailed discussion of studies investigating the effectiveness and satisfaction of ACT groups for depression and

anxiety treated within the same group. Finally, qualitative research investigating ACT in group settings is considered, followed by a summary of this CLR and the research question.

**1.7.4.1 Benefits of ACT in a Group Format.** It is argued that ACT is highly suited to being delivered in a group format and can actually increase its effectiveness (Walser & Pistorello, 2004). Boone and Canicci (2013) state that the group can provide social support and encouragement for individuals to take challenging moves towards valued directions, which is an important component of ACT. The concepts of ACT can be counter-intuitive in that it is human nature to want to avoid unpleasant experiences rather than accept them. Furthermore, ACT can be difficult to understand due to the unfamiliarity of its concepts (Bach & Moran, 2008). Walser and Pistorello (2004) suggest that hearing group members' interpretations and experiences of the ACT concepts can enhance other members' understanding and motivate them to persevere. They also suggest that ACT groups can be a good opportunity to practice being willing to face and share emotional experiences along with relating to others in helpful ways whilst being in a supportive climate.

**1.7.4.2 Empirical Support for ACT Groups for Depression.** ACT is showing promise when delivered in a group format for depression. Folke, Parling, and Melin (2012) randomly allocated participants experiencing depression who were unemployed and had been on long-term sick leave to an ACT group (one individual session and five group sessions) versus treatment as usual. With regards to severity of depression, general health and quality of life those in the ACT group showed significantly greater improvements from pre-treatment to the eighteen month follow-up. However, the reductions in levels of depression were

modest. This may have been due to treatment being relatively short and persistent depression being associated with long-term unemployment. There were no differences between the groups in relation to sick leave and employment status. It should be noted that the amount of contact in the control group as well as concomitant treatment in the ACT group were not explored. Therefore, it is unclear as to the degree to which the results were influenced by other factors unrelated to the ACT treatment. Furthermore, the study did not assess adherence to ACT principles. However fidelity to the ACT model was monitored in regular supervision.

Several studies have compared ACT in a group context to other psychological therapies for the treatment of depression. An early study by Zettle and Rains (1989) found similar improvements in depression when comparing an ACT group with a cognitive therapy (CT) group. It should be noted that this study was based on a small sample ($N = 31$) of female volunteers who responded to media advertisement. It is unclear whether the results from these findings can be generalised to males and those who are not inclined to volunteer who may have different characteristics to those that do volunteer. In a re-analysis of this data by Zettle et al. (2011), ACT was shown to produce greater reductions of self-reported depression at follow up. A more recent study has been conducted by Tamannaeifar, Gharraee, Birashk, and Habibi (2014) which compared the effectiveness of an ACT group versus a CT group for participants with depression. They found that both groups led to significant reductions in depression and, similar to Zettle and Rains' (1989) findings, at post treatment there were no significant differences in improvement between the groups. Limitations of this study were that it was, again, small and based on a female sample.

Two further randomised controlled studies focused on college samples (Pellowe, 2007; Zhao, Zhou, Liu, & Ran, 2013). In one study, Pellowe (2007) compared a brief ACT group to a supportive therapy group for students experiencing dysphoria. Both groups showed improvements from pre to post treatment and ACT was superior only with regard to psychological flexibility. A strength of this study was that good attempts were made to ensure treatment fidelity. In another study, Zhao et al. (2013) compared an ACT group with CBGT for Chinese students with severe depression. The results showed that those in the ACT group showed reductions in depression and rumination whereas the CBGT only showed reductions in depression. As these two studies were based on student samples it is uncertain whether the results would generalise to the wider population who may be of a different age group and education level to these student samples. Moreover, both studies lacked a waiting list control group. As a result it cannot be ascertained whether the improvements made in the groups were due to the unique aspects of the treatments or whether changes represented a regression to the mean over time.

**1.7.4.3 Empirical Support for ACT Groups for GAD.** A highly rigorous study by Sachs (2005) randomly allocated individuals diagnosed with GAD to an ACT group, which incorporated elements of imaginal exposure and emotion-focused therapy, or a WL group. One third of those in the ACT group no longer met GAD-diagnosis criteria post treatment. Although those in the ACT group achieved significantly better clinician rated anxiety severity improvements, there were no significant differences between the groups with regards to client-rated anxiety severity. Swain, Hancock, Hainsworth, and Bowman (2013) highlight that a strength of this study was that the training of the research assessors was well specified. Furthermore, assessors were blind to the conditions and good attempts

were made to check that this was the case. However, a weakness of this study was that its small sample sizes limited the degree to which the results can be generalised to the wider population. A study by Avdagic, Morrissey, and Boschen (2014) randomly allocated participants diagnosed with GAD to either an ACT or CBT group. Both groups showed significant improvements which were maintained at a three month follow up period. No significant differences were found between the two groups. However, more participants in the ACT group achieved reliable change (78.9%) compared to those in the CBT group (47.4%) at the end of treatment in relation to worrying. Although, at the time of the follow up, both groups show equivalent reliable change rates (60%). Strengths of this study were that it included both male and female participants and did not exclude those with co-morbid difficulties, such as depression. This increased the degree to which the sample was representative of the wider population. However, participants were volunteers who had responded to an advertisement and a large proportion were employed. It is questionable the degree to which the results can be generalised to those who would not be inclined to volunteer and who are unemployed.

**1.7.4.4 Empirical Support for ACT Groups for SAD.** Two uncontrolled studies (Kocovski, Fleming, & Rector, 2009; Ossman, Wilson, Storaasli, & McNeill, 2006) assessed the effectiveness of a group therapy largely based on ACT for participants with SAD. Ossman et al. (2006) found significant improvements in levels of social anxiety and experiential avoidance at post treatment and follow up. There were also significant improvements to pursuing valued relationships at follow up. This was a relatively small trial with a high attrition rate (12 out of 22 participants completed treatment). It also lacked a control group. Therefore the degree to which time contributed to the reduction in

symptoms is unknown. Kocovski et al. (2009) found similarly high attrition rates in their slightly larger trial (29 out of 42 participants completed treatment). In their study, at post treatment, participants showed significant improvements in social anxiety, depression, rumination, mindfulness and acceptance. Both studies were relatively small in size which reduced their power in detecting potentially significant results. Despite this, a systematic review by Swain et al. (2013) reported that Kocovski et al.'s (2009) study made good attempts to ensure their sample was representative of clients seeking help for SAD. In addition, Swain et al. highlight that the above two studies found large effect sizes for anxiety improvement. However, due to these being uncontrolled studies it cannot be ascertained whether the improvements were due to the ACT group or other factors.

Two small randomised controlled trials explored the effectiveness of an ACT group compared to CBGT and a WL group for students experiencing public speaking anxiety, a form of social anxiety (Block, 2002; Block & Wulfert, 2000). There were similar improvements in various measures for both active treatment groups whereas participants in the ACT group showed greater improvements to behavioural avoidance. Perhaps the full benefits gained from group processes were limited due to the small number of participants in each active group. Furthermore, session frequency and duration were relatively short and it would be interesting to explore whether any additional benefits would be gained from increasing these. Due to the small sample sizes and student samples used in these studies the generalisability of the results to the wider population is questionable. The particularly small sample size in Block and Wulfert's (2000) study ($N = 11$) precluded the use of statistical analysis. Instead, there was sole reliance on self-report data, which is more susceptible to social desirability.

England et al. (2012) compared an ACT group to a habituation-focused exposure group for participants ($N$ = 45) who were mostly students with public speaking anxiety. Those in the ACT group were more likely to be in remission at the six week follow up. Participants in both groups demonstrated significant and equivalent improvements to confidence and social skills. The study was limited due its small sample size resulting in low power to detect potentially significant results. Two further limitations were with regards to the lack of assessment of therapist allegiance and adherence. Therefore their influence on the findings cannot be ruled out.

A somewhat larger study ($N$ = 137) by Kocovski, Fleming, Hawley, Huta, and Antony (2013) randomly allocated participants with SAD to either a group largely based on ACT, CBGT and a WL group. Both active treatment groups were significantly more effective than the control group, but not significantly different from each other on most measures. The sample in this study was more representative of the wider population than the above studies based on student samples. However, a limitation was that the therapists in the study had developed the ACT group, therefore, may have inadvertently been more enthusiastic about this approach and been more competent in its delivery compared to CBGT. Another limitation was that most of the data relied upon self-report which is more likely to be influenced by experimenter demands. The findings, therefore, should be interpreted with caution.

### 1.7.4.5 Summary of Empirical Support for ACT Groups for Depression, GAD, SAD and PD.

Overall, there appears to be a paucity of studies exploring the effectiveness of ACT in a group setting for depression, GAD and SAD. Those that do exist show promising results. ACT groups for individuals

with depression are associated with significant improvements and seem to be as effective as other empirically supported approaches. ACT groups for individuals with GAD and SAD seem to result in a large proportion achieving remission. At the time of writing, there seemed to be no studies exploring the effectiveness of ACT in a group format in the area of PD.

This review of the ACT research highlights the need for larger and more methodologically sound randomised controlled studies which investigate ACT groups for depression, GAD, SAD and PD. Longer follow up periods are required as well as an assessment of therapist allegiance, with more representative samples. In addition, this review shows that there was variability with regards to the ACT interventions that were investigated. For example, there was variability in terms of the length of the ACT interventions and the degree to which the interventions were strictly based upon ACT, particularly as some interventions incorporated elements from other therapy approaches. This makes it difficult to develop a sound evidence base for ACT to inform clinical decision making (Swain et al., 2013). To further increase the quality of RCTs investigating ACT, it could be argued that studies should standardise the ACT intervention employed and for there to be high therapist adherence to this. A caveat to this is that therapists delivering ACT are encouraged to work flexibly and experientially. Standardising the ACT intervention compromises this and, therefore, is likely to reduce its effectiveness.

Another reason why ACT does not lend itself well to RCTs is that, traditionally, therapies are considered to be efficacious in RCTs if they lead to symptom reduction associated with the primary DSM-defined diagnosis (Forman & Herbert, 2009). However, symptom reduction is not the primary aim of ACT.

Rather the aim of ACT is to help individuals become more willing to experience such symptoms to enable them to live life more in line with their values. Symptom reduction may occur in the longer term and be a beneficial by-product. On the contrary, an increase in symptoms may be considered indicative of good progress as it may be the result of increased willingness to take steps towards challenging situations in order to live a more values-consistent and fulfilling life. As the primary aims of ACT differ from other mainstream therapy approaches, such as CBT, comparing them becomes less meaningful. The ACT studies in this literature review have symptom reduction as one of their main measures of improvement. Gaudiano (2011) argues that not including measures of ACT-specific therapeutic change in research studies may fail to capture the full benefits of ACT. Moreover, it has been recommended that researchers use reliable and valid measures of ACT processes and outcomes. These should be the primary measures of improvement (Gaudiano, 2011; Pellowe, 2007). However, more research is needed to understand the most important mechanisms underlying therapeutic change in ACT (Swain et al., 2013).

**1.7.4.6 Effectiveness of ACT groups for Depression and/or Anxiety.** At the time of writing this CLR there seemed to be four studies which examined the effectiveness of ACT groups for individuals with depression and/or anxiety (Boone & Manning, 2012; Cox, 2012; Pinto et al., 2015; Shankar, 2014). All four studies also investigated participants' satisfaction of the intervention. These studies are now briefly outlined.

Pinto et al. (2015) explored the effectiveness of a 10 week ACT group for a transdiagnostic sample which took place in a private psychiatric hospital on an outpatient basis. The group was offered to individuals with various diagnoses,

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however, the main presenting diagnoses were depression, followed by anxiety. Various significant improvements were found to ACT processes as well as depression and anxiety. However, there was no significant improvement in mindfulness and the clinical significance results were less promising. For example, less than 50% of participants showed reliable improvement, 40% showed no change and a small percentage deteriorated. The authors reported a high attrition rate at follow up resulting in them being unable to make inferences regarding whether the improvements had been maintained. High levels of satisfaction were reported and the majority said that they would recommend the therapy.

Boone and Manning (2012) investigated the effectiveness of a 10 week ACT group for 20 students who self-reported depression and/or anxiety difficulties at a college in the USA. Two groups were run with 10 students attending each group. Two students did not attend the follow up and their reasons for this were unknown. Clinically and statistically significant results were found for depression, anxiety, quality of life and psychological flexibility, which were maintained at the time of the three month follow up with large effect sizes. A satisfaction survey indicated that students were largely highly satisfied with the treatment, all saying that they would recommend it. Overall this study demonstrated that the ACT was effective for this sample of students and they were largely satisfied with the intervention. However, it was not without its shortcomings. For example, the primary therapist had an allegiance to ACT which may have increased therapist demand effects.

Shankar (2014) conducted a small-scale research project similar to the above study. Shankar explored the effectiveness of a 10 session ACT group for

individuals with severe and enduring depression and/or anxiety in a secondary care setting. Shankar found no statistical difference in levels of symptoms, distress levels or psychological flexibility between pre and post measures. Reliable clinical change was also assessed. When a confidence level of 68% was used, 27% and 23% of participants showed reliable clinical improvement on levels of depression and anxiety respectively. It was also found that 38% of participants showed reliable clinical improvement to levels of acceptance. However, 23% of participants experienced a negative change with regards to their acceptance levels. When the confidence level increased to 95% very few participants showed positive reliable clinical change on the various measures. A thematic analysis of the written subjective feedback received at the end of therapy was conducted. The aspect of the group context that participants found most helpful was learning from others and sharing experiences. The least helpful aspect of being in the group was 'difficulties sharing/being in the group'. It appeared that participants differed on what elements of the ACT group they found the most and least helpful. However, a greater proportion found mindfulness the most helpful aspect of therapy. Overall, the ACT group intervention showed weak effectiveness for this sample. The qualitative data showed participants had mixed experiences. It was suggested that, due to the sample being considered 'difficult to treat', a longer, more intensive therapy may be warranted.

Cox (2012) investigated the effectiveness of two ACT groups for individuals who mostly experienced depression and/or anxiety and a small number also experienced other mental health difficulties (e.g. obsessive compulsive disorder (OCD)). Similar to Shankar's (2014) research project, this study was also conducted in a secondary care setting. Eight out of nine participants completed the first ACT group, which was 12 sessions in length. Two out of five completed the

second ACT group, which was 16 sessions in length. In the first group, participants improved statistically on measures for anxiety, depression and stress. 63% of participants showed a clinical significant improvement on stress. However, there were not statistically significant improvements to psychological flexibility. As the second group was too small, statistical significance could not be tested. However it was found that the two participants both clinically improved with regards to anxiety, depression, stress and psychological flexibility. Participants had mixed feelings about their overall experience of the group. Themes that emerged were; the negative impact of being around others, finding the group helpful and interesting, the importance of self-reflection, and wanting but being unable to make self-disclosures. All but one noticed improvements after completing the group. Aspects participants found particularly helpful were the group dynamics, cognitive defusion and mindfulness. Six out of the nine participants did not find anything unhelpful. However, some considered hearing others' comments unhelpful. One noted that disclosing experiences was difficult. Cox concluded that the ACT groups were clinically effective and most participants' symptoms statistically improved. It was felt that the qualitative feedback from participants corroborated these findings.

The above four studies share similar limitations. As they were uncontrolled studies and participants were not prevented from accessing other treatment, it cannot be ascertained whether the improvements were attributed to components of the ACT group, other treatments received, a combination of these or non-specific factors. Another limitation was that the sample sizes were small. It is unclear whether the findings can be generalised to the wider population who seek psychological treatment.

The studies considered so far in this CLR are all quantitative studies, which reflect the literature on ACT being dominated by such studies. This lack of attention given to qualitative research reflects the existence of a valid evidence hierarchy where quantitative studies are located at the top and are more highly regarded, compared to less highly regarded qualitative studies (Akobeng, 2005). However, qualitative studies are able to provide important information that is less amenable by quantitative studies. For example, qualitative studies are able to explore individuals' experience of therapy as well as *why* therapy is effective or ineffective (Curry, Nembhard, & Bradley, 2009). Although the studies by Boone and Manning (2012), Cox (2012), Pinto et al. (2015) and Shankar (2014) incorporated qualitative elements to their studies, they were not in-depth explorations of individuals' experiences. Below, the status of qualitative studies on ACT groups is elaborated upon.

**1.7.4.7 Qualitative Studies Exploring ACT Groups.** There appears to be only a handful of in-depth qualitative studies exploring various populations' experiences of an ACT group. The populations for which there have been in-depth qualitative studies in this area are; chronic pain (Harrison, 2012; Mathias, Parry-Jones, & Huws, 2014), psychosis (Bacon, Farhall, & Fossey, 2014; Bloy, 2013), borderline personality disorder (Cosham, 2013) and family caregivers of individuals with an acquired brain injury (Williams, Vaughan, Huws, & Hastings, 2014). A brief outline of these studies will now be presented.

Harrison (2012) explored the experiences of an eight week ACT pain management group for those with chronic pain in an NHS secondary care setting. Twelve participants were interviewed and thematic analysis was employed which led to the production of three global themes. The first global theme concerned

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participants' prior expectations regarding the ACT group, including both hopefulness and hopelessness. Within this theme, receiving validation was shown to be important in fostering hope. The second global theme identified entailed participants oscillating between finding certain ACT strategies helpful and struggling with specific aspects of the intervention. Participants seemed to find it helpful to live more in the present moment, to reduce their fight with their pain and to move towards their values despite their pain. It appeared that some found the concept of acceptance easier to comprehend and practice than others. One factor which seemed to make acceptance difficult was associating acceptance with 'giving up'. The last global theme identified was positives and negatives of the group setting. Positives included mutual support experienced and feeling understood by other members. Lastly, the negatives of the group setting were the disruption of some members and difficulties hearing the struggles of others. A limitation of this study was that participants were recruited via purposive sampling in collaboration with one of the therapists who had a strong allegiance to ACT. It is possible that clients who had a more positive experience of the ACT group were more likely to be recruited and therefore provide a more positive account of the therapy.

Mathias et al. (2014) explored individuals' experiences of an acceptance-based pain management group programme. Six participants were interviewed and the interviews were analysed using IPA. Five themes emerged, the first of which was 'I'm not alone, others understand my pain'. This theme detailed that having their difficulties heard and validated and listening to others' experiences was highly valuable and helped participants feel that they were not alone. The second theme; 'Freedom from pain taking over' indicated that participants had learnt to accept that they could experience pain alongside living their lives, which was key in

overcoming the debilitating impact of pain. The third theme was 'A new self – one with pain'. This detailed participants' viewing themselves as changed as a result of attending the therapy, for example their confidence improved. The fourth theme identified was 'Parts of the programme that participants felt facilitated change'. These included gaining greater control over pain through relaxed breathing and meditation. The final theme identified was 'Exercise is possible' which involved participants discussing being able to exercise again. A limitation of this study was that social desirability may have been increased due to the researcher being allied to one of the therapists.

Bacon et al. (2014) explored the experience of an ACT group for individuals with psychosis. Nine participants were interviewed. Thematic analysis was employed and four themes were identified. The first theme was 'Usefulness of therapy'. Feeling listened to was found to be beneficial by several participants. Several ACT concepts were also found to beneficial. For example, the majority found mindfulness helpful as it provided a distraction and it was relaxing. Some found identifying values helpful as it gave them direction. Many found defusion helpful in managing paranoia and reducing the associated distress. Two participants found the concept of acceptance beneficial in allowing them to let go of their struggles. The second theme was 'Changes attributed to ACTp'. This involved participants not being dictated by their symptoms, changing their view of their voices, reducing the impact of the voices and making positive behavioural changes. The third theme was 'Understanding of therapy'. Within this theme it was noted that some found it difficult to understand and connect to the ACT concepts and tools whereas others demonstrated a good understanding. The last theme was 'Non-specific therapy factors' where participants' observed the good qualities of the therapist, which was deemed helpful. The authors suggested that the results be

interpreted with caution due to the acknowledgement that the ACT processes that participants found helpful may have been influenced by the amount of time devoted to such processes during therapy as well as the therapist's own judgements.

Bloy (2013) interviewed nine participants and employed a grounded theory analysis to investigate mechanisms of change in an ACT group for psychosis. Three main processes of change were identified as awareness, relating differently (to self and internal experiences) and reconnecting with life. These processes led to reductions in distress and behavioural change. Another process, namely leaning on others, created a context for change. This was a small-scale study which may have limited the methodological quality of this study.

Cosham (2013) adopted a phenomenological design to explore how six participants with borderline personality disorder, who had attended an ACT group, experienced acceptance of intense emotions. Post therapy it seemed that participants felt that their emotions were less important and influential. Fear around emotions appeared to reduce. Participants seemed to be responding to emotions more flexibly. For example, they thought carefully about if and how they wished to respond to emotions. The findings also revealed that developing a different relationship with emotions seemed to lead to various improvements for participants, such as improved independence and confidence as well as improvements with regards to social, occupational and interpersonal functioning. A strength of this study was that the researcher remained blind to the treatment protocol and quantitative outcomes. Therefore, the interviews and their subsequent analysis were conducted without this knowledge which otherwise may have led to biases. A limitation of this study, which was shared with Harrison's

(2012) study detailed above, was that the interviews were conducted shortly after therapy completion. Therefore, no conclusions can be drawn as to whether changes were maintained over time.

Williams et al. (2014) explored the experiences of an ACT group for five acquired brain injury family caregivers using IPA. Five key themes were identified. The first of which was 'Increasing personal awareness' regarding unpleasant emotional and physical experiences, which, for some, was difficult at times. The second theme was 'The dialectics of emotional acceptance vs emotional avoidance'. This theme captured how participants' had engendered greater acceptance and what acceptance meant for them. Two participants spoke about their tendency to employ avoidant coping strategies. The third theme was 'Integration of ACT principles'. Within this theme some found that embracing the ACT principles was relatively easy as it reinforced their pre-existing perspectives on coping. One participant integrated the ACT principles into their religious beliefs, which was easier to do for some ACT concepts than others. Two participants found that implementing ACT principles elicited difficult emotions which led them to revert back to previous ways of coping. The fourth theme was 'peer support'. This involved participants finding the group context helpful as it allowed for mutual support and they were able to share things. The last theme identified was 'Moving forward after the group'. This theme involved important changes participants had learnt and begun to make which would help them 'move forward' in the future, such as going out more and considering their own needs more. The validity of the findings in this study would have been strengthened had the identified themes been checked by participants.

To my knowledge, there has not been an in-depth qualitative study focusing on ACT in a group context for individuals with depression and/or anxiety.

**1.8 Summary of the CLR and Proposed Research Question**

This review highlights the potential benefits of transdiagnostic approaches which have numerous advantages compared to diagnostic-specific interventions. ACT is one transdiagnostic approach which has been given a lot of attention in the literature. Evidence supporting the delivery of ACT in group formats for depression, GAD and SAD is gradually accumulating. Much of this evidence is based on RCTs. However, this research methodology is not well suited to investigating ACT and it appears that the mechanisms underlying therapeutic change need to be better understood. There is a notable lack of qualitative studies in the literature, which can provide important information to clinicians (Paulson, Everall, & Stuart, 2011). Considering the lack of qualitative studies and their potential usefulness, along with the demonstrated effectiveness of ACT in a group setting, the present study aims to address this gap by conducting a qualitative study to investigate individuals' experiences of attending an ACT group for depression and/or anxiety. This study intends to provide individuals with an opportunity to have their voices heard and their experiences taken into account. It is hoped that this study may help elucidate knowledge on whether individuals struggle or not with aspects of ACT in a group setting for those with depression and/or anxiety as well as whether ACT in a group modality is acceptable to individuals. As highlighted earlier, symptom reduction is not the primary aim of ACT, but rather improvement is reflected in an increased willingness to experience unpleasant internal sensations and taking steps towards valued directions. Exploring individuals' experiences of ACT groups may uncover whether the primary aims of ACT are consistent with any improvements made by

individuals who have undergone the therapy. Additionally this study aims to discover factors which influence understanding and ability to embrace ACT tools and concepts. The study also aims to explore the mechanisms of change from individuals' perspectives. This potentially valuable information may suggest to therapists which processes to focus therapy on. This can possibly lead to improvements to therapy, which can increase therapy effectiveness, satisfaction, adherence (Britten & Fisher, 1993; Pope, van Royen, & Baker, 2002) and cost-effectiveness (Bosmans et al., 2008). It may also lead to tailoring of therapy to better suit clients' needs, which is at the heart of the pluralistic characteristics of CoP philosophy and practice (Ashley, 2010).

# CHAPTER 2

# METHODOLOGY

The literature review in the previous chapter highlighted gaps in the literature which has led me to wish to explore individuals' experiences of attending an ACT group for individuals' with depression and/or anxiety. The Methodology section which follows outlines the rationale for the use of a qualitative approach to investigate this. A discussion on how my epistemological position has evolved and how this has influenced my chosen area of study and adopted methodology follows. The parallels between CoP and qualitative approaches are briefly presented. This is followed by the rationale for why Interpretative Phenomenological Analysis (IPA) was chosen and the design of the study is then detailed. This begins with information regarding the route from referral to the ACT group and a description of the ACT group. This chapter ends with a description of the recruitment process and a discussion of ethical considerations.

## 2.1 Rationale for Using a Qualitative Approach

A qualitative methodology was chosen for various reasons. Psychological research has been dominated by the positivist paradigm leading to a high prevalence of quantitative studies (Ponterotto, 2005). There has been a gradual increase in interest in qualitative approaches, which hold several advantages over quantitative approaches in the field of social science. One of these advantages is that qualitative methodologies allow for a complex and in-depth exploration of individuals' thoughts, feelings and experiences. Moreover, the subjective meanings attributed to experiences can be elucidated, which is in line with the research aims. Access to these is less amenable by quantitative methods, which are more focused on objective data, seek precise measurement and analysis of

target concepts (Willig, 2008). In-depth analysis of individuals' experiences mirrors the relational and individually-focused therapy that counselling psychologists engage in (McLeod, 2001). In section 2.3 the parallels between qualitative methods and CoP is discussed in more detail. Furthermore, the flexibility of qualitative approaches may lead to an enrichment of our understanding and generate new insights into individuals' experiences of an ACT group for depression and/or anxiety. This is particularly important given the paucity of research in this area and qualitative methods are deemed effective when there is little previous research on the topic under study (Morrow, 2007). Finally, Finlay (2006) suggests that a researcher should adopt a research approach which closely relates to their own epistemological position. In line with this, I chose a qualitative approach due to my own epistemological perspective, which is now outlined.

## 2.2 Epistemology and Ontology Reflexivity

Epistemology and ontology reflexivity refers to the researcher engaging in a reflective process whereby they explore their assumptions of what we can know (epistemology) and their understanding of the world (ontology). Epistemological reflexivity encourages researchers to reflect upon the influence of this upon their research, such as their chosen methodology (Willig, 2001). I will now describe how I arrived at my current epistemological position.

Throughout my academic studies and early work experience there seemed to be a greater emphasis on quantitative approaches. My academic studies seemed to be dominated by a positivist stance with its focus on experimentation and statistics. Following my degree I worked at a private mental health hospital and the Improving Access to Psychological Therapies (IAPT) service. I felt that both of

these places of work were reductionistic and largely based upon the medical model whereby there was an emphasis on diagnostic labels and treatment was guided by this. Furthermore, there was a focus on treating symptoms as opposed to exploring wider influences upon individuals and understanding the meaning behind the symptoms. It was during my work at the private hospital and IAPT that I began to become explicitly aware of and question my epistemological position.

My subsequent clinical experience helped me to further evolve my epistemological position. I have been supervised by, and worked alongside, several psychologists who value the wider context when working therapeutically. I have also worked with diverse communities, which highlighted the importance of wider factors in influencing the development of clients' difficulties, how they perceive and cope with their difficulties. This encouraged me to attend to these factors in my clinical practice, which I found to be both useful and empowering for clients. It also led me to be drawn to approaches which give value to these influences, such as ACT (Hayes, 2004), and reject the reductionist position. These experiences led to my epistemological position becoming more in line with critical realist ideas, which I felt more comfortable with. Critical realism posits that there are fundamental truths in the world, however, these are experienced and perceived differently by individuals (Eatough & Smith, 2008). This is because the way individuals construct these truths is dependent upon social processes, prior beliefs and expectations (Finlay, 2006).

My personal experiences have also led me to favour the critical realist position, to pursue a career in CoP and have influenced how I practice. As I became older I noticed that I feel anxious about expressing my opinion and I find it difficult speaking at length about myself, which I link to my upbringing. I had a very

happy childhood and feel very privileged. However, emotions were rarely discussed in my family and, at times, I struggled to voice my opinion. This led me to value listening to the subjective experiences of individuals, to allow their emotions to be heard and validated as well as for this to be done in a caring and non-judgemental environment. Correspondingly, critical realism suggests that perception of reality is subjective (Bunge, 1993) and critical realism is encapsulated well by qualitative approaches which allow for individuals' to express themselves and to be heard.

As can be seen, my epistemological position has gradually moved away from a more positivist position whereby I favoured, and was more familiar with, quantitative approaches. My position has moved closer to an interpretative position and I have come to value the critical realist approach and qualitative approaches. I discovered that qualitative approaches can provide an effective alternative to explore phenomena to quantitative approaches.

## 2.3 Counselling Psychology and Qualitative Approaches

Many people working in the CoP field, such as myself, are drawn to qualitative approaches due to their compatibility (Ponterotto, Kuriakose, & Granovskaya, 2008). Both emphasise that knowledge is socially constructed. A strength of qualitative research is that it is more clinically valid as it mirrors therapy (Hill, 2005). Both qualitative research and therapy can involve an in-depth exploration of individuals' subjective experiences. Counselling psychologists value empowering individuals and qualitative research allows participants to have their voices heard, which can be an empowering experience (Rafalin, 2010).

## 2.4 Rationale for Using Interpretative Phenomenological Analysis

IPA is a qualitative approach developed by Smith (1996) and was chosen for this research study. There were several reasons why IPA was deemed to be the most suitable. Firstly, IPA gives value to the unique, subjective experience of individuals (Smith, Flowers, & Larkin, 2009), which is in line with the research aims. Although large generalisations cannot be made, in-depth analyses at the individual level can possibly take us closer to making more general claims about the experience of others in a particular context, albeit cautiously (Smith & Osborn, 2003). In addition, Willig (2001) recommends that researchers employ methodologies that are consistent with their epistemological position. As mentioned above, I align myself with the critical realism position. IPA endorses critical realism assumptions that sociocultural and historical processes are believed to influence how individuals experience and make sense of their lives (Eatough & Smith, 2008). Both critical realism and IPA are focused on gaining a rich understanding of individuals' unique subjective experiences (Smith et al., 2009). Finally, IPA considers the role that the researcher's beliefs and interpretations play in the research process. Overall, it was important that my chosen methodology could help me answer my research question as well as be faithful to my epistemological position.

## 2.5 Description of Interpretative Phenomenological Analysis

The aim of IPA is to explore and understand in detail an individual's experience, the meaning of that experience and how they make sense of that experience (Smith & Eatough, 2007). Participants are viewed as experts of their own experiences. It has theoretical roots in phenomenology, hermeneutics and idiography (Smith, 2011). IPA is phenomenological as it is interested in an individual's perception as opposed to producing an objective truth of their

experiences (Smith & Osborn, 2003). A 'double hermeneutics' is involved as the researcher adopts an active role in a dual interpretation process whereby 'The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world' (Smith & Osborn, 2003, p. 51). IPA is also idiographic in its approach. As opposed to traditional nomothetic approaches, which focus on the population level and generalisability of findings, an idiographic approach is concerned with a detailed analysis of experiences in a particular context (Smith et al., 2009).

**2.6 Why Not Use a Different Qualitative Method?**

Alternative methodologies were considered and were not deemed as suitable as IPA. Discourse Analysis (DA) did not seem appropriate as it mainly focuses on the psychological aspects of discourse and the role of discourse in the construction of understanding reality as well as group dynamics. This was not in line with the research aims. IPA also places importance on the role of discourses and how this shapes an individual's reality. However it also focuses on other aspects which I was interested in, such as, the influence of culture and historical context. Also DA often uses focus groups and explores dynamics. However, I was not particularly interested in the dynamics between participants. In addition, if I were to have used DA, the focus groups would have consisted of participants who may have been members of the same ACT group. This may have raised ethical issues, biases and influenced the group dynamics.

Grounded Theory (GT; Glaser & Strauss, 1967) aims to produce a theoretical explanation for phenomena and testing this theory (Starks & Brown Trinidad, 2007). Whilst this may have been interesting, I was more drawn to using IPA as I

wished to adopt a more ideological approach to elucidate and make sense of individuals' experiences, including their feelings of the ACT group.

Narrative Analysis (NA) was initially considered as it shares features with IPA since both require small sample sizes and emphasise meaning-making. However, narratives are only one way of meaning-making leading NA to be somewhat restricted. On the other hand IPA may be considered more flexible as it explores different ways of meaning-making in addition to narratives (Smith et al., 2009).

## 2.7 Design

### 2.7.1 Context

To provide some context, I will now outline participants' route from referral to the CMHT to subsequent attendance of the ACT group. Following this a brief outline of the ACT group from which I recruited participants is provided. Finally, the procedure for data collection and recruitment is described.

**2.7.1.1 Route from Referral to the CMHT to the ACT Group.** Please refer to Appendix A for a flow chart of participants' route from referral to the CMHT to the ACT group. Clients are referred to the CMHT if they have severe and enduring mental health difficulties and it is believed that they may benefit from receiving support that the service provides. All clients who are offered individual or group psychological therapy are initially invited to a 'Psychological Awareness Group'. This is a rolling psychoeducational group that consists of 4 weekly sessions, each lasting two hours. The topics covered during this group are; what to expect from therapy, outline of CBT, goal setting, grounding techniques, distraction and self-care.

There are various factors that are considered to help decide whether clients are likely to benefit from the ACT group and are invited;

- If clients have a diagnosis of depression and/or anxiety (by the time clients are referred to the psychology service within the CMHT they often have already received a diagnosis. The diagnosis is tentatively used to guide the decision. Psychologists who work within this CMHT loosely use diagnostic labels and adhere to the view that the ACT group is a transdiagnostic therapy).
- If it is felt that they would be able to tolerate and make good therapeutic use of therapy in a group context.
- If they have previously received CBT and found it of limited benefit.
- If it is felt it may be more helpful for clients to learn to distance themselves from the content of cognitions as opposed to an analytical exploration of the content of thoughts.

**2.7.1.2 Outline of the ACT Group.** Details about the ACT group from which participants were recruited are now provided. The ACT group was based upon a protocol developed by Boone (2010). This protocol was very similar to the protocol used in his pilot study that was outlined in section 1.7.4.6. The 10 session protocol incorporates didactic elements, mindfulness exercises, experiential exercises, group discussion/process, and homework. The rough framework for each session is as follows:

- Opening mindfulness exercise.
- Review of homework from the previous week.

- Didactic portion with group discussion.

- Experiential exercise with group discussion.

- Further group discussion.

- Assigning homework for next time.


The sessions are designed to address one of the six aspects of the 'Hexaflex

Model' (see Figures 1 and 2). The order of the topics covered is as follows:


- Session 1: "Control is the problem" and contact with the present moment.

- Session 2: Defusion.

- Session 3: Acceptance/willingness.

- Session 4: Values.

- Session 5: Observing self.

- Session 6: Committed action.

- Sessions 7-10: All processes, with a focus on building greater patterns of
  committed action in the service of values.


Therapists are encouraged to be flexible, to work experientially and to explore

interpersonal processes by drawing upon ACT concepts. Between 13 and 15

clients are usually invited to the ACT groups.


### 2.7.2 Procedure for Data Collection/Recruitment

A fairly homogeneous sample was recruited through purposive sampling. An

administrator, who worked for the NHS psychological service which delivered the

ACT groups from which I recruited, identified potential participants who met the

inclusion criteria (see Appendix B for the inclusion and exclusion criteria). The

administrator then sent these potential participants an information sheet (see

Appendix C) and an opt-in form (see Appendix D). Once the opt-in form was received by the administrator, their names and contact details were given to the researcher who then contacted the potential participants. The researcher discussed the research with them and provided them with the opportunity to ask questions. The researcher then sent the potential participants the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001; see Appendix E) and Generalised Anxiety Disorder-7 (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006; see Appendix F). Once they were completed and returned, those that were eligible (i.e. scores met the inclusion criteria), were invited for an interview. Before the interview commenced, participants were asked to sign a consent form (see Appendix G). Please see Diagram 1 for a flow chart showing the procedure to recruit the six participants.
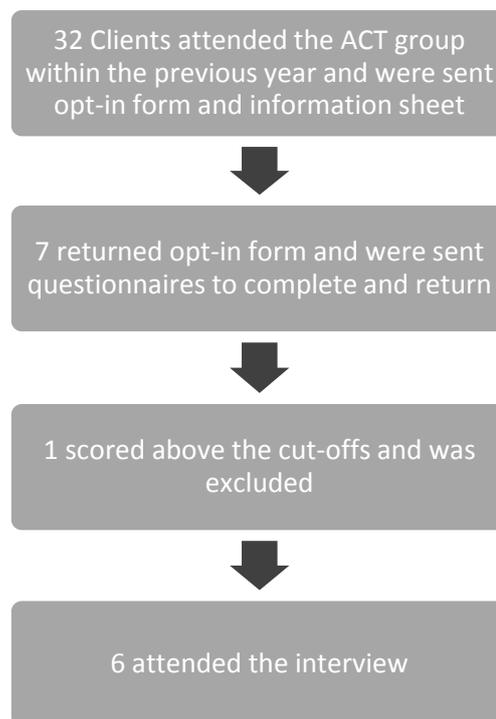


*Diagram 1*. Flow chart of the procedure to recruit participants.

### 2.7.3 Participants

Following Smith and Osborn's (2008) recommendations, a small sample size of six participants were recruited. As IPA was employed and focused on individuals' idiographic accounts, a small sample size was appropriate. Participants had all attended the ACT groups, which were being run within a CMHT, where the majority of clients experienced depression and/or anxiety. See Table 1 for the demographics of participants.

| Participant[1] | Gender | Age range | Presenting difficulties[2] | Ethnicity |
|---|---|---|---|---|
| 1. Richard | M | 46-50 | Mixed anxiety and depression | White British |
| 2. Paul | M | 46-50 | Depression with psychotic symptoms | White British |
| 3. Penny | F | 51-55 | Depression | White British |
| 4. Alison | F | 41-45 | Depression | White British |
| 5. Robert | M | 31-35 | Depression | White British |
| 6. Suzanne | F | 36-40 | Depression | White British |

*Table 1.* Demographic information and presenting difficulties of the six participants.

[1]*Pseudonyms have been used to preserve anonymity*

[2]*It should be noted that these presenting difficulties are based upon the psychiatric diagnosis participants received. Despite some only receiving a primary psychiatric diagnosis of depression, their interviews suggested that several, if not all, participants struggled with both depression and anxiety.*

### 2.7.4 Interview

The chosen method of data collection for this study was semi-structured interviews. Most IPA studies employ semi-structured interviews as their method of data collection (Smith & Osborn, 2003). The interview questions that were developed (see Appendix H) aimed to guide the participant to tell their story in their own words but not dictate the course of the discussions. By not asking too many questions it was hoped that this would allow the researcher to get close to their story and not be overly influenced by such questions. Semi-structured interviews are particularly useful in obtaining a detailed and rich picture of participants' experiences (Smith, 1995). This is consistent with the phenomenological approach which focuses on trying to understand participants' perceptions.

### 2.7.5 Analysis

Transcribing the interviews and analysing each transcript was undertaken soon after each interview so that the interview remained fresh in the researcher's mind. The interview transcripts were analysed following IPA principles and the procedure outlined by Willig (2008) was used as guidance. The first stage of the analysis involved closely reading and re-reading the transcripts several times to be immersed in the data. Preliminary thoughts and observations were noted in the left-hand margin of the transcript. The second stage required the researcher to identify themes that emerged from these notes and were recorded in the right-hand margin (see Appendix I for a section of one transcript with accompanying notes). These themes were developed from the experiences that participants reported that seemed salient, were relatively rich in detail, were frequently reported and were in line with the research question relating to their experience of the ACT group. The third stage involved attempting to produce a structure for the analysis by looking

for connections between the themes. Themes that shared similar meaning were then clustered together. This process was repeated for each transcript. The fourth stage involved the production of summary tables of the identified superordinate and subordinate themes for each transcript (see Appendix J). These were then compared, integrated and refined to produce a master table of themes.

Throughout the analytical process reflective notes were made on my own views and assumptions which facilitated bracketing. It was important for me to re-read the transcripts several times whilst being aware of my reflections and their possible influence. I also regularly checked the emerging themes against the data to ensure they accurately reflected participants' accounts and I verified the themes with my research supervisor. Additionally, I contacted two participants and asked them whether the themes that were developed for each of them accurately reflected their experience. They both felt that the themes did indeed corroborate their experience. I would have like to have verified the accuracy of the themes with more participants but unfortunately was not able to do so due to time limitations.

### 2.7.6 Ethical Considerations

Prior to recruitment ethical approval was obtained from London Metropolitan University (see Appendix K), NHS ethics committee (see Appendix L) and also the NHS trust's Research Governance who provided the service from which participants were recruited.

**2.7.6.1 Informed Consent.** Participants were given sufficient information about the details of the study and ethical issues in the information sheet and also verbally. They were given the opportunity to ask questions.

**2.7.6.2 Confidentiality.** The researcher outlined confidentiality and its limits verbally to participants and confidentiality was also detailed in the information sheet. Personal identifying information was removed from the transcripts and participants were given pseudonyms to preserve anonymity.

**2.7.6.3 Affiliation to the Study.** With regards to my involvement with the psychology service within the CMHT from which I recruited participants, I had previously helped to facilitate one ACT group. I ensured that I did not recruit participants from this group to avoid participants feeling uncomfortable about revealing information. Over a year after I had chosen my area of focus for my thesis, I was offered paid work within this particular psychology team. I had already interviewed three participants at this time. I discussed the ethical implications of this with my research supervisor. To avoid deception, when I contacted the remaining potential participants by telephone, I verbally informed them that I worked within the psychology team. I was cognisant that this may increase the potential for some participants to feel coerced into participation in the study and into giving desirable responses. This may have biased the results as participants may have felt pressure to give a more positive account of their experience of the ACT group. To minimise this, I informed them that I was not involved in the ACT groups and provided reassurance that I would not communicate with the psychologists within the service about their decision to take part. They were also informed that their decision to take part or not would not affect their care.

**2.7.6.4 Potential Distress.** Research suggests that participants can find reflecting upon their experiences therapeutic (Birch & Miller, 2000). However, there was the potential for participants to become mildly distressed during the

interviews, particularly, as they were recruited from the clinical population. To minimise this likelihood participants were given sufficient information regarding the purpose and nature of the study. They were also informed that they could withdraw at any time.

To offset the likelihood of high distress levels, those who scored 12 and above on the PHQ-9 and 13 and above on the GAD-7 were excluded. To further minimise potential distress, at the end of the interviews participants were debriefed. A distress protocol (see Appendix M) would have been followed if a participant showed evidence of becoming distressed.

**2.7.6.5 Data Protection.** Data was saved on an NHS computer and was password protected. Written notes were kept in locked storage and would be destroyed, along with the interview transcripts and audio-recordings, as soon as the thesis had been completed. If participants had withdrawn their consent all of their data collected would have been immediately destroyed.

# CHAPTER 3

# RESULTS

Interpretative phenomenological analysis of the six transcripts led to the identification of three master superordinate themes and seven subordinate themes, which are presented in Table 2 below.

| Superordinate themes | Subordinate themes | Quotes |
|---|---|---|
| Group Dynamics | Fear of Being "Judged" | *"Are you going to make a fool out of yourself? Or are people going to look at you and think…he's weird." (Robert; 379-381)* |
| | Group Size Preference | *"Maybe it would have felt less threatening in a smaller group." (Penny; 438-439)* |
| | The Imbalance of Putting Your "Two Pence Worth In" | *"I got annoyed with people…I'm giving up my time here and other people are trying to give up their time to help…what's the point in giving up an hour and a half of your day once a week if you're not going to listen and not even going to try?" (Suzanne; 443-446; 449-452)* |
| The Journey of Therapy | Perceptions Prior to Therapy | *"I went in there thinking oh I'm going to be cured one hundred percent." (Suzanne; 34-35)* |
| | The Challenge of Letting Go of the Cure and Accepting Acceptance | *"You can have very high expectations that, things can be different…and that can be an issue when you maybe don't get to that point. It's kind of managing the maybe disappointment." (Robert; 313-317)* |
| Usefulness of Therapy | From Being "Alone" to the Empowerment of Being in "The Same Boat" | *"I just think well it's only me that's rubbish and useless and can't get out of bed…To actually hear other people find it as difficult…That was quite…empowering I guess because I thought…it's not just me." (Penny; 278-284)* |
| | Learning Acquired and Improvements Made | *"I can do a lot more, I'm thinking about getting a job now…I'm not worried anymore that people go, well she's <age> years old, why hasn't she got a job?...it's just helped boost me a little bit. I feel more worth." (Suzanne; 139-141; 157-158)* |

*Table 2.* Master superordinate themes and subordinate themes

I will now explore these master superordinate and subordinate themes in detail. This is supported by verbatim extracts from the interviews. In presenting the verbatim extracts utterances, such as, "umm", and repeated words have been omitted to aid readability. Pauses of more than a few seconds are represented by three dots in square brackets. If it is unclear what participants are referring to, words have been added and these have been put in square brackets.

## 3.1 Group Dynamics

In discussing their experience of the therapy, participants spoke about their experiences of different aspects of the group context.

### 3.1.1 Fear of Being "Judged".

The majority of participants discussed feeling anxious about the group setting and some disclosed feeling anxious about this before the therapy had commenced. This seemed largely due to a fear of being judged. Of the three participants who disclosed feeling anxious about the group setting before the therapy commenced, two seemed to attribute this to a fear of talking in front of others:

> *"I had visions of getting in there and there was loads of people that are going to be listening to ya" (Richard; 47-49)*

> *"Before I went I found it quite worrying that I was going to a group…I found that difficult…'Cause I'm not very good at expressing myself in front of other people"(Paul; 3-4; 8-9; 11-12)*

Perhaps Richard's concern of there being lots of people listening and Paul's concern of not being good at expressing himself were due to them both worrying about what others thought of them and a fear of being judged. This can be inferred

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from their interviews as they both seemed to express these worries and fears, which are outlined further below.

It seemed that participants' fear of being judged was heightened in the earlier stages of therapy. For example, Paul reported, in a joking manner, that in the first session:

> *"You kind of just sit there and nod but, try and look intelligent, unsuccessfully." (Paul; 298-299)*

In the above extract, perhaps due to a fear of being judged in the group setting, Paul tried to present a better version of himself by trying to *"look intelligent"*. However he seemed to express self-doubt of being able to do this. Robert also disclosed feeling particularly anxious in the first session during an ice-breaker exercise:

> *"As they went round all the people…and they…like say a favourite biscuit…it kind of just felt really uncomfortable 'cause…what biscuit do I say?..Thoughts going through your head…are you going to make a fool out of yourself? Or are people going to look at you and think…he's weird." (Robert; 365-371; 377-381)*

In Robert's extract above it seemed that his high anxiety in this situation was due to worrying about how others perceived him. It seemed that Penny also feared being judged by other group members:

*"[I] would always have to kind of build myself up to kind of go ok I have to expose myself again now. 'Cause I'd actually much prefer everyone to think that I'm this wonderful confident person who can do everything rather than actually for people to see that I'm not like that at all really."* (Penny; 331-335)

It seemed that the source of Penny's fear of judgement was due to what others would think of her when she shared *"intimate"* information with others regarding her depression and anxiety. She reported that usually she put on a confident façade and dropping this during the therapy required effort, perhaps because of the intensity of her concerns about what others would think of her. It may be possible that her concerns about disclosing were also due to a fear of being exposed and vulnerable.

Whereas Penny seemed to drop her confident façade during the group therapy sessions, conversely, Richard seemed to put on a façade:

*"Sometimes when I'm feeling down I get...bigger...to try and compensate for that...You start feeling like a child you try and compensate by being louder...and you say 'that's not me'."* (Richard; 338-339; 352-353; 355-356)

*"But when you're louder you kind of worried about wh-"* (Researcher; 358-359)

*"What people are thinking yeh so it...Kinda backfires."* (Richard; 360; 362).

Richard seemed to put on a façade, by being louder, to help him cope in the group setting. Perhaps, in a similar way to Paul who tried to *"look intelligent"*, Richard

was also trying to present himself in a more socially favourable way to the group by being louder. The question I asked above was perhaps too leading. However, I asked this as I got the impression that this was what he was trying to convey to me and I wanted to check that my impression was correct. Richard seemed to agree with me, that being louder had the opposite desired effect in that it increased his fear of being judged, which seemed to add to his difficulties of being in a group setting.

As evidenced in Richard's extracts above, outside of the therapy, when he felt depressed he over-compensated by becoming louder. This same issue entered into the therapy room, culminating in him fearing being judged. This also appeared to be the case for two other participants, Penny and Robert, whereby outside difficulties entered the therapy room and contributed to their fear of judgement:

> *"I have…probably social anxiety so, I'm a bit concerned, so like sometimes I've said things in a group and I have gone back home and think maybe I shouldn't have said it or it could be taken…in a way that I didn't mean. So I kind of did kind of make me think a little bit about what I would say". (Robert; 51-57)*

> *"A lot of my anxiety is around how other people perceive me so…when I am really badly depress[ed]…I just assume everybody's looking at me and saying oh well wonder whatever because and all that kind of stuff so in a group like that I kind of felt very similar, I kind of thought people would kind of yeh judge me. (Penny; 45-47; 49-52)*

It seemed that Robert's anxieties centred around upsetting others, which may also be linked to a fear of being negatively judged. It seemed that he not only felt anxious during the group but this anxiety also extended upon returning home

where he ruminated about this. His fear of judgement appeared to affect him during the group:

> *"I was a bit anxious about maybe saying things…bringing up maybe positive things to [others]…I wasn't sure how it would be judged, so I kind of didn't really…I didn't know the people well enough to maybe do that." (Robert; 41-46)*

The extract above suggests that Robert's fear of judgement led him to hold back saying things or to think carefully about what he said in the group, even if he was providing positive feedback to other group members. Not knowing other members of the group very well seemed to increase his anxiety.

Despite most of the participants disclosing that they had a fear of being judged, they persevered and completed the group. Some reported that this fear reduced over time and the experience of talking in the group became easier. Some did not specify why this fear reduced, whereas others provided insight into the reason(s) why:

> *"You knew that everyone wasn't judging you. So if I get into a situation…and if I got the feeling that someone was a bit like ahh 'ere she goes again...I'd be like, I don't care I'm gonna talk, I'm going to tell you how I'm feeling at the moment whether you want to hear it or not…'cause in the group everyone wanted to know, so it made me more...stand up for myself?" (Suzanne; 235-242)*

It seemed that Suzanne's fear of being judged dissipated, which appeared to result from her direct experience of the therapy. She learnt that those in the group were not judging her and also that they were interested in what she had to say. This

seemed to lead to the reduction of similar fears in her social interactions outside of therapy, which gave her confidence and helped her to express herself more.

Both Robert and Suzanne noted that the seats being arranged in a circle/semi-circle was helpful:

> *"I think because you could see everyone…you could see no one was judging anything." (Suzanne; 350; 353-354)*

In the extract above, Suzanne suggested that the seating arrangement helped reduce her fear that others were judging her. Seeing other group members' faces perhaps further helped provide her with evidence that her fears that others were judging her were not necessarily valid thus weakening them.

A fear of judgement seemed to account for much of the participants' anxieties in the group setting, however, it was not the only factor that contributed to anxieties. For Alison, who did not disclose any fear of judgement, her anxieties seemed to be partly due to the room feeling crowded. This related to issues with the size of the group, which the next subordinate theme, to be discussed, expands upon.

### 3.1.2 Group Size Preference

All of the participants commented on the size of the group. Some felt a smaller group was preferable, whereas others felt a larger group was preferable. One participant, Richard, believed that there were benefits and drawbacks in having small and large group sizes. It appeared that the strongest opinion came from those participants' favouring a smaller group. One participant who favoured a

smaller group was Alison. In the following extract she described her difficulties of a larger group in the earlier stages of therapy:

*"You were sitting like that <curls body up> 'cause there was a seat right up against you either side…my experience of anxiety is - it is difficult to sit in a room with a load of people you don't know." (Alison; 45-47; 50-52)*

In the above extract, Alison described feeling uncomfortable in the early stages of therapy as there were a lot of people and there was not enough space in the room. This scenario was something that she was *"sensitive to"* outside of the therapy, which contributed to her difficulty with this in the therapy. Alison found that as therapy progressed, her concerns reduced as the number of participants decreased:

*"When the group thinned out a bit and there were less seats, and it felt less packed, it felt better." (Alison; 38-39)*

Penny also favoured a smaller group, but did not expand upon the reason in much detail, apart from:

*"Maybe it would have felt less threatening in a smaller group." (Penny; 438-439)*

Penny may have been referring to herself in the above extract. In her interview she noted that she did well to share things about herself with the group, despite having some anxieties around this. Perhaps she felt she would have been less nervous about doing this if she had been in a smaller group. However, she may have been referring to other people where she felt that if there were fewer people in the

group, other group members would have been more comfortable and would have spoken more.

Others felt that a larger group would have been more beneficial:

> *"I think it would have been better if more people were there…Obviously the more people that are there, the more experiences you have, the more people…giving their views, the better in a way." (Robert; 203-204; 208-210)*

The above extract suggests that Robert would have preferred a larger group for there to be more variety of perspectives and experiences to learn from.

Richard expressed his view that there were benefits and challenges of both a smaller and larger group. He described feeling anxious about the size of the group before the therapy commenced:

> *"Before you go you don't know how big the group is going to be it's just a group. I had visions of getting in there and there was loads of people that are going to be listening to ya and when I got in there it was alright, there was only sort of eight or nine of us in the circles…Sort of quite pleasant." (Richard; 46-51)*

As the above extract suggests, before the group commenced, Richard was concerned about a large group size. Perhaps this related to a fear of being judged as discussed in the previous subordinate theme. However, he discovered that it was not as bad as he thought it might be. In the extracts below he noted the benefits of being in a larger group, which may help to elucidate why he found the group easier than he anticipated:

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*"You can speak and it's just sort of part of the group." (Richard; 571)*

*"For the quieter people in the group, if there's a lot [of people in the group] they don't mind saying something 'cause then the next person gonna say somin'". (Richard; 590-592)*

Whereas in a smaller group:

*"You're not anonymous." (Richard; 570)*

It seemed Richard felt more comfortable in a larger group to an extent as there were more people willing to talk and he could hide somewhat. There were fewer silences and he felt less pressure to speak. However, similar to Alison, he seemed to become more comfortable about speaking over the course of the sessions when the group became smaller:

*"It was easier to talk…then you can only be judged by three instead of nine." (Richard; 126-127)*

However, Richard noted a further disadvantage of a smaller group:

*"You don't get that...sort of different perspectives." (Richard; 558-559)*

This echoes Robert's opinion; that a disadvantage of a smaller group size was that it leads to there being fewer perspectives.

### 3.1.3 The Imbalance of Putting Your "Two Pence Worth In".

Several of the participants commented on other group members not opening up very much during the therapy sessions. There seemed to be a mixture of opinions with regards to this. Some participants felt indifferent, others felt somewhat frustrated and one participant appeared to feel particularly sorry for another group member who struggled to talk in the group. Paul provided his opinion on this matter in the extract below:

> *"One person especially said nothing but...you know people are different and they do deal with things differently." (Paul; 62-64)*

He seemed to feel indifferent about other group members not contributing as much during the therapy. He did not expand upon this, perhaps further suggesting that this was not a significant issue for him. Penny offered her perspective on others not opening up:

> *"If you're in a group of people...everybody puts their two pence worth in...but when there's people in the group that...never say anything...there were...maybe three of us, that seemed to do all of the giving of ourselves and there were other people, I'm not saying...they weren't active in the group and they may well have taken a lot from it...but it wasn't a group participation." (Penny; 108-118)*

In the above extract Penny gave the impression that she found the imbalance of people opening up difficult. She spoke in greater length about this issue, perhaps suggesting that this was more pertinent for her. She seemed to want everybody to contribute, given that it was a group setting. It appeared that Penny felt that it was unfair that not everyone contributed and I sensed that it elicited a sense of frustration that the onus was more on her and a limited number of others in the

group to almost 'do the work'. As previously discussed, Penny found the experience of sharing *"intimate"* information difficult. As it was difficult for her to share information about herself in the group, this perhaps intensified her frustrations towards others for not doing the same. In addition, her frustrations that others did not share as much may have been further increased as others knew *"intimate"* details about her whilst she knew little about them. This may have left her feeling vulnerable. In the above extract Penny used the term "*everybody puts their two pence worth in"*, in other words, everybody shares their thoughts and opinions. She may be suggesting that it is helpful for everybody to provide their thoughts and opinions thus providing more perspectives. In line with this, she later went onto say that she found it beneficial hearing that others faced similar difficulties as it helped to normalise her difficulties. Perhaps these also added to her frustrations.

Suzanne seemed to share a similar view to Penny:

> *"I got annoyed with people, but I think that's my anger again, because I'm like, I'm giving up my time here and other people are trying to give up their time to help [..] open up a bit, listen...what's the point in giving up an hour and a half of your day once a week if you're not going to listen and not even going to try?" (Suzanne; 443-446; 449-452)*

Suzanne seemed somewhat frustrated by some members of the group not participating. She used the term *"open up a bit"* in the above extract. This may refer to both opening up to the possibility of therapy being helpful but also opening up in the sense of sharing things in the group, or perhaps both. There were other parallels between Suzanne and Penny's accounts. In Suzanne's extract above she acknowledged that her difficulties with others not talking and the

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emotions that this elicited were linked to her wider issues with anger. Penny also made a link between her difficulties with others not participating and wider issues. Penny described that the non-active participation by some group members contributed to silences, which she found uncomfortable:

> *"Maybe it's my upbringing when someone asks me a question I have to answer…The silence would just almost kind of weigh down on me because it's like, someone surely answer, it can't be me all the time." (Penny; 130-134)*

She linked her need to fill silences, and perhaps feeling the need to take responsibility for this, to her upbringing. As Penny's extract above suggests, the pressure to speak and fill silences seemed to be a burden for her. Suzanne, however, did not appear to experience this pressure:

> *"You just sat there and you were quite chilled…if you didn't want to talk you didn't talk. And if you did that day you did." (Suzanne; 212-215)*

Perhaps the reason why Penny felt this pressure and Suzanne did not was because managing silences was a wider issue for Penny, but not for Suzanne.

Richard seemed to be more sympathetic towards others not participating, which was indicated when he discussed the difficulty for one individual to speak due to feeling nervous:

> *"She was very nervous about talking and I don't even think she should have been in the group…It's like [the therapists] were torturing her." (Richard; 573-576)*

It seemed that Richard found this difficult to observe and was very sympathetic towards an individual who experienced this.

It appeared that the reason participants gave for why others did not contribute varied and affected how they felt about this. For example, as seen above, because Richard attributed non-participation to an individual feeling highly anxious, he felt some sympathy for them. Conversely, Alison attributed this to individuals not being willing to try. This elicited a more intense emotion, even anger around this.

**3.2 The Journey of Therapy.**

This superordinate theme details participants' journey through the therapy, from their early perceptions prior to therapy through to the challenging process that participants experienced of moving their focus away from wanting a cure and towards acceptance. This is followed by a discussion on how many participants came to acknowledge the importance of acceptance and some were able to apply it.

**3.2.1 Perceptions Prior to Therapy**

All of the participants spoke about their perceptions prior to the commencement of therapy. There were varying degrees of expectation in regards to the therapy. Some expressed worries about the therapy. The majority of the worries that participants described seemed to relate to the group setting:

> *"At the beginning when it was first discussed that it was going to be a group setting I was quite nervous about that, because I have had one-to-one…previously…so I'm quite comfortable on a one to one setting…but when it's more than one person that's when I start to feel less comfortable."(Robert; 100-103; 105-107)*

As Robert's extracts above suggest, he seemed somewhat daunted by the group setting, particularly as this would be a new experience, whereas he was more familiar and comfortable with individual therapy. It seemed that participants' anxieties, before the commencement of the therapy, were also due to uncertainty around what to expect:

*"Didn't know how much of my personal experience of what led me to the group I would have to…go into and divulge…I had no idea what to expect." (Penny; 53-56)*

In the extract above, it seemed that Penny was uncertain as to what to expect with regards to how much to share, which led her to feel anxious. In her interview she described having difficulties divulging, and perhaps she also had trepidations about this before the group. As previously discussed, underlying Penny's difficulties of divulging seemed to be a fear of being judged. The fear of being judged was also a fear shared by Richard and Paul before the commencement of the group.

A few participants appeared to have low, if not negative, expectations of the therapy before it started. Richard seemed to express the strongest negative perception as evidenced in the following extract:

*"I didn't really expect that it would help me much...I thought it was going to be…sort of...hippie psychology…If you think it's alright it's alright...Sort of like oh if you think positive it will be positive. Bullshit innit?" (Richard; 438-446)*

As the therapy progressed it appeared that Richard learnt that the therapy exceeded his low prior expectations. This was illustrated by his next statement:

> *"It wasn't...as bad as I thought it was a lot...umm...it did make sense once I got there."* (Richard; 452-453)

Alison also seemed to have a negative perception of the therapy:

> *"You do sort of think mmm...is it the NHS way of dealing with a few people on the waiting list?"* (Alison; 288-289)

She did not state when she had this perception, although it may be assumed it was prior to the group and her conviction in this increased in the early stages when she experienced the room to be *"packed"*. This may have led her to believe that the group was offered to her merely to reduce the waiting list, rather than because it would be beneficial and of value. I sensed that her initial negative attitude was not as strong as Richard's because when speaking about this she seemed somewhat hesitant and her tone was lighter than Richard's. She also went straight on to say that she recognised that maybe she was being initially overly critical. She understood resources were limited and the group did eventually help her. However, in the interview she expressed ambivalence about whether individual therapy would have been more beneficial. This may indicate that she continued to hold some conviction in her prior perceptions that the group was offered to her simply as a means to reduce the waiting list rather than because it would be the most beneficial form of treatment for her.

Suzanne also spoke about her beliefs before the group commenced:

> *"It wasn't that freakiness I thought it would be, I thought I'd walk in there and sort of have to stand up, hello I'm Suzanne and I'm a depression freak"* (Suzanne; 209-212)

> *"You know you got AA meetings and all that sort of thing in your head, and it's like oooh God, you know, I gotta tell everyone what I'm doing and why I'm here." (Suzanne; 391-384)*

It seemed that Suzanne believed that the upcoming group therapy would be similar to AA meetings and this had negative connotations for her. This seemed to be a daunting prospect for her as she thought that she would be required to speak about herself and her difficulties. In addition, her use of the word *"freakiness"* implied that she expected to feel strange and uncomfortable. Telling others that she was *"a depression freak"* may suggest that she felt that her difficulties with depression made her weird in some way. Perhaps this is linked to her fearing that others would judge her and think she was weird if she were to disclose her difficulties.

Despite Richard's, Alison's and Suzanne's negative prior perceptions, they all attended the group therapy and completed treatment. I wonder what factor(s) encouraged them to attend and complete therapy given their expressed trepidations. Later in Richard's interview, he elucidates his purpose for attending the group despite his negative prior perceptions:

> *"I just wanted the next step to gettin' counselling." (Richard; 393-394)*

In line with this, when asked what he had hoped to gain from therapy he said:

> *"Well someone to sit down and go through it all this shit in my head from childhood and I know no one's going to be able to help to fix it but I just...I don't know." (Richard; 523-525)*

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It appeared that Richard saw the group therapy as a stepping stone to receiving individual therapy to explore early childhood experiences to help him address specific difficulties. This was somewhat mirrored by Alison, when she questioned whether individual therapy would have been of more value. I wonder if being eager to receive individual therapy cast a shadow over Richard's experience of the group therapy, especially as his overall opinion of the group seemed more negative. Perhaps it led him to focus on the end goal of completing the group therapy enabling him to then receive individual therapy. This may have prevented him from being open to the possibility that he may gain benefits from the group therapy, contributing to him finding the therapy of limited use. In comparison, I did not get the sense that Alison and Suzanne's negative prior perceptions significantly cast a shadow over their experience of the therapy. This is because overall they spoke about more positive aspects in greater detail and noted more benefits than Richard.

Other potential explanations for why those who had negative prior perceptions continued to engage and complete therapy may have been because their negative prior perceptions were not very strong. Or perhaps the participants also held hopeful beliefs that the therapy could be helpful. This seemed to be the case for Suzanne. Although on the one hand she was initially pessimistic about the group therapy, somewhat contradictory, she also held high expectations:

> *"I went in there thinking oh I'm going to be cured one hundred percent."*
> *(Suzanne; 34-35)*

Robert also seemed to have high expectations, which seemed to parallel Suzanne's:

> *"Initially I had hoped umm <pause and sigh> it would change things…it was going to kind of maybe, be a eureka moment...and that it was this new theory that's…going to change the way people with anxiety think and how they can act." (Robert; 262-266)*

It seemed that both Suzanne and Robert held high hopes that the therapy would be a magic cure and finally change things for them. Robert perceived the therapy to be based upon a new theory and this seemed to contribute to his high expectations. Perhaps he thought that this could mean that there had been advances in theory, which had been incorporated into this therapy that could significantly change things for him.

Penny shared her expectation prior to therapy:

> *"I thought the reason for coming to these groups was going to help me change" (Penny; 85-87)*

Although Penny did not give the impression that she had high expectations to the same extent as Suzanne and Robert, it seemed that Penny's expectations were relatively optimistic as she hoped for change and to be rid of her anxiety and depression.

These three participants appeared to have high hopes of becoming symptom free, prior to the start of the group. I cannot help but wonder whether many of the others also had similar high hopes beforehand. This is because, as described in the

discussion of the following subordinate theme, all participants seemed to struggle with the idea of letting go of a cure and instead accepting their difficulties. This seemed to be evident particularly in the early stages of therapy, suggesting that they might have come to the therapy with the hope of a cure.

### 3.2.2 The Challenge of Letting Go of the Cure and Accepting Acceptance

In the ACT group participants are guided to let go of the struggle of trying to control their difficulties and to, instead, accept them. Participants did not seem to find this easy. Penny outlined why she found this difficult:

> *"I don't want to accept this [anxiety and depression] I don't like being like this I want to change it." (Penny; 84-85)*

As the extract above suggests, one reason why this seemed difficult for Penny was because her difficulties, including anxiety and depression, were unpleasant. Therefore she wished to change and be rid of these. Another difficulty of letting go of the change agenda seemed to be that the message to change had been instilled in participants from the world around them, for example from the media and other people:

> *"The way the world is and the media is it's basically about change everything about…changing who you are, how you look…It's never…accept who you are…that gets drowned out really. So I guess that that, the change thought gets implanted in you, especially if you have anxiety 'cause you think you're different from other people so you, so you feel you should be more like other people, and you feel that, to do that you should be changing." (Robert; 282-284; 287-293)*

It seemed that, due to the messages Robert received around him, he had come to believe that needing to change aspects of himself was a fact, which had not previously been questioned. On the other hand, the concept of acceptance was rarely heard. He perceived himself as different from others, which seemed to lead him to focus on changing to be more like others.

When participants discovered that their expectation of a cure would not be met and, instead it was suggested that they learn to accept their difficulties, a sense of disappointment was evoked to varying degrees:

> *"You can have very high expectations that, things can be different...and that can be an issue when you maybe don't get to that point. It's kind of managing the maybe disappointment." (Robert; 313-317)*

Some also expressed discontent because the therapy did not address, or cure, certain difficulties. For example, Richard expressed his opinion, and almost anger, on the concept of acceptance:

> *"I don't think acceptance and commitment helps depression...You've gotta accept it if you're depressed [...] I've accepted that already ain't I depressed is you feel shit all the time." (Richard; 464-465; 467-469)*

Richard seemed to feel angry that the ACT group had not helped his depression and at the suggestion that he would benefit from accepting his difficulties. Suzanne also expressed annoyance that her main issue (of anger) was not addressed:

*"I would have liked to have come away with thinking, right I've dealt with that side of me now, which I still haven't so I still got to have therapy for that, so in a way it's a pain because you're like uh I'm still there."* *(Suzanne; 42-45)*

Suzanne seemed somewhat annoyed that she would require further therapy to work on her difficulties around anger. Perhaps the disappointment was higher for some participants because they had particularly high hopes for change to their difficulties. This may have been because their difficulties were more severe and debilitating. Paul also expressed frustration that his difficulties with paranoia were not addressed. Despite Paul and Suzanne's discontent that their specific issues were not addressed, they both expressed an understanding of the reasons why. As can be seen, Suzanne attributed this to the group consisting of people with a variety of difficulties and there were time limitations:

*"I understand you can't [deal with the past in therapy] 'cause it's such a variety of people… you can't, you can't do everything in one go can you? In such a short time."* *(Suzanne; 40-41; 46-47)*

Paul shared the same understanding. For both Suzanne and Paul, the fact that their specific difficulties were not addressed did not seem to cast a shadow on their overall satisfaction with the group. This could be deduced from them showing an understanding of why their specific difficulties were not addressed and they spoke about various aspects of the ACT group that they found helpful.

The difficulties of letting go of the cure and accepting their problems, outlined above, seemed to contribute to it taking time for the concepts that were introduced, including acceptance, to *"click"*:

> *"The first seven weeks I probably sat there thinking, this is a waste of time…I'm not dealing with my issues and then after that it all started to click into place." (Suzanne; 75-78)*

As can be seen, for Suzanne, letting go of the cure and accepting her difficulties did not occur straight away, it happened in the seventh session. Her use of the word *"click"* may suggest that, when the shift of moving away from focusing on the cure to acceptance occurred, it happened quickly. However, her extract below contradicts this and suggests that this process occurred more slowly over time:

> *"I just changed with it…it wasn't a moment I could go, oh yeh, I accepted it. Just, I think through everyone talking you just sort of, no almost go with the group. And it worked. Ah I wouldn't say there was anything, any key words or anything you just accepted it." (Suzanne; 324-329)*

When discussing letting go of the cure and instead, accepting his difficulties, Robert also reported that accepting the concept of acceptance did not happen straight away:

> *"It took me a little while to kind of, again, accept that that was the case." (Robert; 280-281)*

Alison stated that she was able to embrace the concept of acceptance and she reported that the group was:

> *"Easy to understand." (Alison; 466)*

It seemed that, although Alison reported that she found it disappointing that the therapy was not about finding a cure, she found the concept of acceptance *"easy"*

to both understand and apply. This seemed to be in stark contrast to others' experience of the concept of acceptance:

> *"I still don't like accepting it but I know I have to…by the end of it I have learnt to accept…and I suppose it's even hard voicing it even now to accept that I will always suffer from anxiety and I will always suffer with depression, but there isn't a quick fix." (Penny; 77-78; 88-91)*

> *"Accepting the problem I've got..or…the issues my thought processes not going to change that's quite difficult. I'm still kind of struggling with that…but, I'm a bit more clear." (Robert; 332-336)*

In Penny and Robert's extracts above, they both seemed to acknowledge the importance of acceptance, however, this remained challenging. Penny suggested that she had been able to be more accepting. Richard seemed to have mixed views about the importance of acceptance. As highlighted earlier, he seemed to be angry about the concept of acceptance. However, he said the following:

> *"I know I got [to] accept it 'cause…I can't change what's happened but I just can't accept it." (Richard; 234-235)*

The above extract suggests that despite finding the concept challenging he acknowledged the importance of acceptance. However, it seemed that he was not able to apply acceptance. I wonder whether he found this particularly difficult as he was referring to trying to accept traumatic childhood experiences. This issue is elaborated upon in the Discussion section.

Overall, it seemed that many, if not all, of the participants came to understand the importance of acceptance. The subordinate theme 'Learning Acquired and

Improvements Made' details the degree to which participants found the concept of acceptance helpful and were able to apply this.

## 3.3 Usefulness of Therapy.

This superordinate theme details aspects of the ACT group that participants found beneficial. Participants spoke about the useful elements of the group context as well as the usefulness of the ACT tools and concepts.

### 3.3.1 From Being "Alone" to the Empowerment of Being in "The Same Boat"

All of the participants spoke about the benefits of being around others who were in the *"same boat"*. It seemed that one of the main reasons for why this was useful was that it helped to normalise their difficulties:[3]

> *"I think sometimes in a group, when you're with people in the same boat as you, it really does sort of help…it doesn't make you feel so weird <laugh>." (Alison; 305-307; 309)*

> *"I wasn't the only one…you do tend to put yourself in a bubble, where you're the only one in the whole world that's got these problems." (Suzanne; 167-170)*

As the above extracts suggests, Alison and Suzanne tended to think of themselves as *"weird"* and put themselves in a *"bubble",* almost as though they were different and separate from others in the world. Penny expressed her experience of

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[3] It should be noted that in addition to hearing that others shared similar experiences, it is likely that there were additional factors which helped participants to normalise their difficulties. For example, in correspondence to the ACT approach, the therapists facilitated discussions about the notion of learning that unpleasant thoughts and feelings were normal as was the experience of suffering.

being in the *"same boat"* as others during the group:

> *"I just think well it's only me that's rubbish and useless and can't get out of bed…To actually hear other people find it as difficult…That was quite…empowering I guess because I thought…it's not just me." (Penny; 278-284)*

It appeared that viewing herself as different contributed to Penny being self-critical. However, she seemed to be suggesting that learning that others in the group experienced similar difficulties led her to let go of her self-critical thoughts, which perhaps helped her to become more compassionate towards herself. Her use of the word *"empowering"* indicates that this was a significantly helpful aspect of the therapy for her. Being in the *"same boat"* also helped Robert become more compassionate towards himself and he gave an insight into this process:

> *"It was nice when someone said they were struggling in the week that I was to realise that other people were having those similar issues. And then maybe being able to step back a little bit and see…how you would react to them as opposed, when you think about it yourself it's a bit different, you're more harsh on yourself than you would be to another person…You…empathise a bit more when someone else, when you're…going through it yourself…you're in a bubble…You don't have that opportunity to maybe be more level-headed." (Robert; 9-19; 24-25; 28-30; 32-33)*

Similarly to Suzanne, Robert also used the word *"bubble"* and he used this word to describe his experience when facing struggles. He noted that when facing struggles he tended to be harsh towards himself, whereas he found it easier to be more compassionate towards others. Also, it was easier to think about how he would approach and consider in a *"more level-headed"* way others' difficulties as it allowed him to distance himself from the struggle. Therefore, when others

described struggles they experienced in the group that were similar to his own, he considered what advice he would give to them and then tried to apply this same, more compassionate and balanced advice to himself. The group seemed to be a different experience for him allowing him to talk about his own difficulties and explore these in greater detail, whereas, perhaps, he was usually alone in dealing with his difficulties. The strongest evidence that he felt alone with his difficulties came from him saying that he would recommend a follow up session to help:

*"Feel that maybe you're not alone." (Robert; 605)*

Perhaps his sense of being alone was exacerbated by his belief that he was *"different"* from others. As discussed in the subordinate theme 'The Challenge of Letting Go of the Cure and Accepting Acceptance', feeling *"different"* seemed to contribute to participants striving to change and become more like others. Being in *"the same boat"* seemed to help participants learn that they were not radically *"different"* from the rest of the world. If feeling *"different"* led participants to strive to change, one may assume that, if they were to feel similar to others, striving to change may reduce and perhaps lead them to be more open to the idea of acceptance. There were indicators that this was indeed participants' experience. For example in the extract below Alison described how the therapy helped her to manage her anxiety:

*"It sort of made me realise that other people felt the same…you're just a bit more sort of open to it, you know, not open to it but I mean as soon as you feel anything you shut down sort of thing and hide." (Alison; 237-241)*

Although she corrected herself by saying *"not open to it"*, I wonder whether she did actually mean to say the therapy helped her to be more open to anxiety. This is because, in her interview, she described how she learnt to *"expose"* herself to unpleasant emotions in the service of helping her to work towards her goals. This is the essence of acceptance.

Participants reported other benefits of being amongst others' who shared similar difficulties. For example, some reported that it was nice to be with others who understood what they themselves were going through. This appeared particularly *"refreshing"*, as Paul puts it, as this was not something that participants tended to experience outside of therapy. Paul described his reasons for finding this *"refreshing"*:

> *"A problem shared is a problem halved…And I think half the problem is if somebody understands what you are saying…it takes the burden off you a little bit…and it makes you feel as though you've unloaded your problems on somebody, not as though I want to give somebody my problems but it would be nice if they could…help" (Paul; 156-157; 159-162; 164-167)*

In the above extract Paul seemed to find the process of unloading his difficulties with those who shared similar difficulties cathartic. He also seemed to be suggesting that, in comparison to receiving advice from people who did not share similar difficulties, the advice from people who did share similar difficulties was more valuable. It also helped him to problem solve, as presumably others had first-hand experience of dealing with similar problems. Suzanne also reported that sharing tips with others facing similar difficulties was helpful:

*"You just give each other tips on how to deal with it…if you're on your own, like I was for so many years with it…you get to the point where…you're at your wits end, you don't know what you're doing."* *(Suzanne; 403-407)*

She seemed to give the impression that she struggled to manage her difficulties on her own. Perhaps, similarly to Robert, she felt alone with her struggles. It seemed that struggling with issues on her own and not knowing what to do left her exasperated. However, the support she both offered and received during the ACT group may have helped her to not feel so alone and exasperated.

### 3.3.2 Learning Acquired and Improvements Made.

In the discussion of the previous subordinate theme, it was outlined that being amongst others who were in the *"same boat"* was beneficial. Participants also spoke about other benefits of the ACT group with regards to the tools and concepts that were learnt. Some participants seemed to take something helpful away from the group processes and apply this to their difficulties outside of therapy. Some detailed the positive changes that they had made in everyday life as a result of the therapy. This shall be the focus of the discussions of this subordinate theme.

Several participants highlighted that the breathing and mindfulness exercises were helpful. One of the benefits of mindfulness, that participants described, was that it helped them to bring their attention to the present moment rather than dwell on thoughts of the past and future:

> *"[Mindfulness is] very clever. Trying to stay in the moment. Not to preconceive, not to…endanger your thoughts with the future or the past…for someone who's got a mental health problem….I think it makes you carry on living in the moment." (Paul; 239-244)*

Alison also highlighted the importance of mindfulness:

> *"I think with depression and anxiety you can live in your head a bit so it takes you out of your head a little bit into the room so...it was helpful from that point of view to sort of move you on."(Alison; 124-127)*

In the extract above Alison described that part of the difficulty with depression and anxiety was that you can *"live in your head"*. She suggested that mindfulness can help to take yourself out of this and bring your attention to the world around you, which can help you to *"move on"* or get on with life. Penny also stated that she found mindfulness helpful in managing anxiety and she described how it helped:

> *"[Mindfulness] helps with the [anxiety] because I'm not focusing on it I'm focusing on my legs or my feet or where I'm going." (Penny; 158-159)*

> *"Mindfulness exercises yeh, just to try to shut out some of the destructive thoughts that go through my head." (Penny; 244-245)*

It seemed that Penny used mindfulness to move her attention away from unpleasant thoughts and emotions. She appeared to use it as a form of distraction. It seemed that Robert also viewed mindfulness as a form of distraction:

> *"Be mindful of aspects of life as a way of maybe distracting for a little period of time, especially if it's a really negative thought. But still accepting that they're there." (Robert; 296-299)*

However, perhaps more in line with how the proponents of ACT suggest mindfulness should be used, Robert did not seem to see its purpose as a way to fully get away from or get rid of negative thoughts. As his last sentence in the above extract suggests; one has to still accept *"that they're there"*. Although Robert described the purpose of mindfulness, he did not explicitly state that he practiced it or found it useful.

Although Richard said that mindfulness helped his anxiety, he also outlined its limitations:

> *"When the depression's full on...it's hard to do mindfulness when you're really depressed." (Richard; 31-32)*

As Richard suggests, it was difficult for him to practice mindfulness when his depression was severe. As previously discussed, he was disappointed that therapy had not helped him to manage his depression, which he acknowledged was *"deeper rooted"*. He felt that he needed individual therapy to explore his difficult early experiences. This perhaps contributed to him being of the opinion that mindfulness was not able to meet his need and was not sufficient in helping him manage his depression.

Several participants outlined the progress that they had made outside of therapy due to what they had learnt. An improvement most frequently mentioned was engaging in more activities:

*"[The group is] helping me manage it a bit better, sort of feeling a bit more exposed out in the open...when sort of managing your anxiety and stuff... I saw a friend last night and normally what I would do if I had a migraine I'd sort of text and say I can't, you know, so I took the tablets and just sort of paced myself and I still saw my friend in the evening."(Alison; 157-159; 165-168)*

In the above extract Alison reported that she would normally have cancelled plans. However, she described that she became better at making plans and sticking to them despite experiencing unpleasant sensations, such as anxiety and migraines. It seemed that her fear of these unpleasant sensations reduced and she became more willing to *"expose"* herself to them. Suzanne also described that she was facing more situations, such as using public transport, that she would normally avoid due to anxiety:

*"I was sort of going to London, I had like that negative passenger on the bus going ohh you're going to have a panic attack blah blah blah and I was the driver going pfff no I'm not, I'm going to go and enjoy myself thank you very much, and just sort of shut up and get on with it." (Suzanne; 128-133)*

In the extract above Suzanne outlined that she also did not allow unpleasant sensations to put her off doing these things. She seemed to find the 'passengers on the bus' metaphor helpful. This metaphor encapsulates the main messages taught in ACT, of allowing unpleasant sensations to be there and not letting them interfere with you moving towards things that are important to you. On the surface, the above extract seems to indicate that Suzanne had been able to apply the concepts of ACT into her life. However, there were indicators that she addressed her thoughts in a way which is more in line with cognitive

restructuring, a CBT based approach. She seemed to argue with her unpleasant thought, that she is *"going to have a panic attack"*, and said *"shut up"*, in an attempt to get rid of it. This somewhat mirrors the way in which Penny used mindfulness; to *"shut out destructive thoughts"*.

Suzanne further detailed the improvements she had made:

> *"I can do a lot more, I'm thinking about getting a job now…I'm not worried anymore that people go, well she's <age> years old, why hasn't she got a job?...I'm just now I want a job…you'll either take me or you won't and so it's not putting me off anymore. So I'm more positive about myself there… it's just helped boost me a little bit. I feel more worth."* *(Suzanne; 139-144; 157-158)*

The above extract suggests that the therapy had helped Suzanne to improve her self-esteem and this helped her face situations she had previously been avoiding. She demonstrated her determination and not being so concerned about others' judgements. It was not entirely clear what had helped to improve her self-esteem. As discussed earlier, in the 'Fear of Being "Judged"' subordinate theme, during the therapy she had learnt that others in the group were not judging her. It seemed that she had learnt to apply this to her social interactions outside of therapy. Perhaps this had contributed to her improved self-esteem, which motivated her to do more and not be deterred by thoughts that others would judge her.

It seemed that the therapy had also helped Penny make improvements to her activity levels:

*"I go into [...] self-destruct mode so I'm useless, I'm fat, I'm thick, I'm stupid, I'm a rubbish mother, the guilt, all of that stuff so when I then look at the goals, how is all of that stuff actually helping me achieve some of the goals that I wrote down that I wanted to do at the beginning I can learn that it's actually taking me away from my goals and not taking me to them. So there are lots of stuff that I use."(Penny; 187-193)*

In the above extract Penny also outlined how she had gained a great deal from the group, including questioning whether her self-critical thoughts were helping or deterring her from working towards her goals that she identified at the beginning of therapy. Penny further outlined aspects of the therapy that she found beneficial:

*"I like tick lists to be able to tick off a bold move yeh I've achieved that yeh that's quite good. And then to go back and share, although we didn't, we would just say, you know, did you achieve any bold moves, were you able to write your own bold moves down. Did you, could you see that taking you towards your goals and stuff. So that was quite good." (Penny; 313-318)*

Penny described gaining a sense of achievement from making *"bold moves"* in line with her values. It seemed that having the opportunity to feedback to others about her progress towards goals helped to motivate her. As can be seen above, some participants, including Suzanne and Penny, seemed to have identified and worked towards values, goals and bold moves. On the other hand, Richard and Robert did not mention these and Paul appeared to struggle in this area:

*"I was so wrapped up…with my own problems, paranoia, that values and things like that aren't something that really entered my mind…Just getting through today is a value for me…so…I didn't get it." (Paul; 221-222; 226-228)*

As mentioned above, the group seemed to motivate Penny to work towards her goals. Robert also seemed to believe that the therapy was motivational when he commented on other members of the group hoping for a follow up session:

> *"With the group obviously you…have that motivation when you're there but, when you're not there then it slowly slips but if you had that thought that…I've got to go, I can go back and…see everyone…see the course leaders again. It can keep that motivation up a bit and you feel that maybe you're not alone, at the end of it." (Robert; 599-606)*

Whereas Penny seemed to be suggesting that the group was motivating in terms of committing to taking steps towards goals, Robert seemed to be suggesting that the group was motivating in a more general sense. It could be argued that he was suggesting that the group was particularly motivating in helping individuals to continue to practice what they learn, otherwise things *"slowly slip[s]"*. Although Robert said that this was what others suggested, I wonder whether he shared these same beliefs. This may be concluded from his use of the personal pronoun "I" and at the beginning of his interview he expressed disappointment about the group coming to end. In the last sentence of his extract above, it appeared that Robert found the group supportive and countered his sense of being alone.

Overall, some participants seemed to take more away from the therapy than others. This may be inferred by some participants reporting that they found more tools and concepts helpful and spoke at greater length about this compared to others. There was also variation in regards to the extent of the improvements made.

As previously discussed, many, if not all of the participants acknowledged the importance of acceptance. Participants' description of the tools and concepts based upon ACT that they found useful, how they applied these and what improvements they made as a result, helped to elucidate the degree to which they found the concept of acceptance helpful and were able to apply this concept. Penny, Alison and Suzanne seemed to have applied the concept of acceptance well as they all outlined how they did not allow unpleasant sensations get in the way of what they wanted to do, which is at the crux of acceptance. In terms of the tools and concepts that Richard and Paul took away, Richard was able to apply mindfulness to his anxiety and Paul found mindfulness and defusion helpful. These tools are believed to facilitate acceptance (Hayes, Levin, Yadavaia, & Vilardaga, 2007). However, they did not say that this had helped them to work towards their goals and values more, unlike Penny, Alison and Suzanne. Robert demonstrated an excellent understanding of the concepts of ACT. For example he said the following:

> *"The thoughts you have are not necessarily the issue, it's…the way you process the thoughts…bad things happen so you can't really exclude them all the time…this course was more, you are who you are, accept that but challenge your thoughts." (Robert; 274-277; 294-295)*

> *"I'm a bit more clear…that there's [no] point using the energy to…change…more focused now on..accepting reasonable change." (Robert; 335-339)*

Although he said he was *"clear"* about the concept of acceptance and explained such concepts well at an intellectual level, I wonder to what degree he was able to apply them. As discussed in section 3.2.2, he said that he was still *"struggling"* with letting go of striving for a cure and, instead, accepting the concept of

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acceptance. In addition, he did not explicitly state that he had been able to apply the tools and concepts to help him build upon his acceptance or how this had led to improvements. Another interesting point was that although he mentioned that accepting thoughts was taught, he also seemed to suggest that the therapy taught to *"challenge your thoughts"*. This is more in accordance with cognitive restructuring which, as mentioned earlier, is a tool derived from CBT as opposed to ACT. This issue is expanded upon in the Discussion section.

# CHAPTER 4

# DISCUSSION

The aim of this study was to explore participants' experiences of the ACT group for depression and anxiety that they attended. Six participants in total were interviewed. Through the use of IPA, three master superordinate themes and seven subordinate themes emerged. These themes are explored in relation to existing theory, research and practice. Recommendations for clinical implications are intertwined throughout this chapter. Future research recommendations are outlined followed by the study's strengths and limitations. Finally a concluding statement is presented.

## 4.1 Group Dynamics

### 4.1.2 Fear of Being "Judged"

The majority of participants expressed a fear of being judged in the group, which led to anxieties about disclosing. Some said that they experienced these fears before the commencement of the group as well as during the group. A fear of being judged has been identified as a common fear shared by people in group therapy (Corey & Corey, 2005). From an evolutionary perspective, a fear of being judged is believed to be associated with an innate drive to be accepted by others and avoid rejection, which is adaptive for survival (Marks & Nesse, 1994). Therefore, in social situations, such as group therapy, people can be sensitive to being judged and are compelled to act in ways to ensure that they are accepted, approved and respected (Yalom & Leszcz, 2005). In line with this, it seemed that participants' fear of being judged led them to act in ways, which they may have perceived as being more socially desirable. For example, Paul reported that he tried to *"look intelligent"* and Robert held back saying things to avoid upsetting

other members of the group. They may have felt that these behaviours protected them from being rejected.

Several participants were aware that their fear of being judged and their protective behaviours within the group were linked to fears and behaviours in their everyday lives. Yalom and Leszcz (2005) described that this often occurs in group therapy as it becomes a 'social microcosm', whereby people relate to each other in group therapy as they do with others outside of therapy. It is believed that group therapy can provide a fruitful environment for interpersonal learning, whereby problems in the outside world can be played out, identified, tested and addressed (Yalom & Vinogradov, 1993). This is considered to be the most essential mechanism for change (Yalom & Leszcz, 2005). This seemed to occur for Suzanne who learnt during therapy that her fears about others judging her negatively were not accurate. This led to a reduction in this fear in her everyday life, which helped her to speak her mind more in social interactions.

Robert and Suzanne both commented on the benefit of sitting in a circle, or semi-circle. Suzanne reported that this helped her see that others were not judging her. Having circular seating where every member of the group can see each other is often recommended to symbolise that everyone in the group is equal and it prevents remarks only being directed at the therapist (Barnes, Ernst, & Hyde, 1999; Vinogradov & Yalom, 1989). This study suggests that there is also benefit in having circular seating as it reduces group members' fears of being judged by others in the group.

### 4.1.2 Group Size Preference

All of the participants commented on the size of the group. Both the benefits and drawbacks of a smaller and larger group were raised. Overall, it seemed that there was a stronger preference for a smaller group and participants offered various reasons for this. Alison preferred a smaller group size. In the earlier stages of therapy she felt that a larger group size led to the room being *"packed"*, which she struggled with. It also seemed that it contributed to her feeling that the group was offered as a way to see more people in a shorter space of time, rather than it being a valuable option in its own right. Having an adequate size room is considered to be important and requires careful attention (Barnes et al., 1999; Vinogradov & Yalom, 1989).

Other reasons for preferring a smaller group size that participants gave were that it seemed that larger group sizes heightened fears of being judged, leading them to feel less comfortable speaking. In correspondence with this, Castore (1962) found that the number of verbal interrelationships dropped when there were more than eight members in a group. Large group sizes are also problematic as members can become hidden (Barnes et al., 1999) and it can have a negative impact upon group cohesion (Burlingame, McLendon, & Alonso, 2011). For this reason Vinogradov and Yalom (1989) suggest for there to be no more than ten in a group. Although being hidden may be less therapeutic for individuals, Richard seemed to find this situation favourable as it reduced the pressure upon him to speak.

Several participants favoured a smaller group size. Richard, however, struggled with this as it seemed that he felt more pressure to speak. Geller, Norcross, and Orlinsky (2005) recommend for group sizes not to be too small for this reason, to avoid members of the group feeling overly compelled to speak. In addition, some

participants noted that having a group with too few members led to fewer perspectives and experiences, which was considered disadvantageous.

As can be seen, there are a number of factors to take into account when considering the number of people to invite to group therapy. The pros and cons of smaller and larger group sizes, that this study highlights, as well as the size of the room should be considered. There are other factors that often need to be taken into account. For example, a challenge services commonly face is striking a balance between having an optimal group size that is likely to achieve the highest therapeutic effect, with possibly a need to increase the group size beyond this to take into account attrition as well as being able to see more people more quickly, thereby reducing wait times for therapy (Freeman, Pretzer, Fleming, & Simon, 2004).

### 4.1.3 The Imbalance of Putting Your "Two Pence Worth In"

Several participants commented on other members in the group not opening up and sharing their thoughts. Some found this somewhat frustrating and felt that every group member should contribute, rather than just a few 'do the work'. In the Results chapter it was discussed that some may have found this particularly difficult because revealing so much of themselves and knowing little of the silent members' problems led them to feel vulnerable. In addition, Penny noted that members not participating led to more silences, which she struggled with. Boone and Manning (2012) found a similar finding, that some participants attending an ACT group for people with depression and/or anxiety found silences uncomfortable and difficult. In correspondence to the above, Fehr (2003) is of the opinion that group members remaining silent can have a negative impact upon the group cohesiveness and dynamics. In line with the findings of this study, Fehr

suggests that it is unfair for some members to disclose intimate details of their lives while others look on. This can lead to those who contribute becoming angry towards the silent member(s).

Penny and Suzanne linked their struggles with the lack of participation of others with wider problems. Therefore it may be therapeutically beneficial to have a discussion around individuals' experience of other group members remaining silent. Eddins (2014) suggests that exploring such group processes is just as important to do in ACT groups as it is in traditional group therapy. Eddins proposes that it can be helpful to incorporate interpersonal group processes into discussions around acceptance, mindfulness and values.

The above has focused on the impact of a lack of participation upon other members of the group, as this was raised by some of the participants in the interviews. I also wonder about the impact of this on the quieter members themselves. Disclosure of personal material is believed to be extremely important for individuals in group therapy (Farber, 2006; Yalom & Leszcz, 2005) and has been associated with greater therapeutic outcomes (Yalom, Houts, Zimerberg, & Rand, 1967). It is believed that this is due to the potential usefulness of the cathartic effect and interpersonal learning from disclosing (Yalom & Leszcz, 2005).

As there are potential therapeutic benefits of self-disclosing, for both the wider group and the silent individual, it may be helpful to understand the reasons for lack of participation and to consider how to possibly address this. Fehr (2003) highlights possible reasons for lack of self-disclosure in group therapy; having previous aversive experiences, lack of self-esteem and worrying their

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contributions will not be as valuable as other group members. This study found that a fear of judgement can prevent members of a group from divulging. Spitz and Spitz (1998) recommend that if members of a psychotherapy group are silent, this should not be challenged in the early stages of therapy, however, as the group progresses this should be explored. On the other hand, Corey and Corey (2005) recommend that barriers to members remaining silent to be openly identified and explored in the early stages of therapy.

Walser and Pistorello (2004) suggest a way to address peoples' reservations about group settings. They propose that it can be beneficial to offer people, particularly those who are likely to feel overwhelmed by divulging personal information, individual sessions prior to group therapy. Prior guidance can be provided on how best to engage in group processes. Although some claim that offering individual therapy prior to group therapy is more effective due to higher therapy dosage (e.g. Sperry, Brill, Howards, & Grissom, 1996), there are no studies which support this notion (Walser & Pistorello, 2004). If it was deemed potentially useful, the increased pressure upon resources may need to be considered.

Conversely, in an ACT context, Walser and Pistorello (2004) propose that it may not always be necessary or beneficial to challenge members if they remain silent. They suggest that members of a group therapy can learn intrapersonally as well as interpersonally and challenging their silence may impede them experiencing 'here and now' sensations. In addition, ACT posits to be an empowering approach whereby individuals are allowed choice (Hayes, Strosahl, & Wilson, 2011), such as being free to choose whether or not to participate.

It seems that clinical judgement should be used when facilitating ACT groups, whereby the pros and cons of members remaining silent for both themselves and the group are considered to inform whether or not to address lack of disclosure.

## 4.2 The Journey of Therapy

### 4.2.1 Perceptions Prior to Therapy

All participants spoke about perceptions that they had prior to the therapy. Some disclosed feeling worried about the group setting and underlying this may have been a fear of being judged. Worries before the therapy also seemed to be attributed to not knowing what to expect. This study also found that some participants held negative perceptions of the group prior to its commencement. For example, Richard thought that it would be a *"hippie psychology"*. In Harrison's (2012) study, exploring an ACT group for chronic pain, a degree of scepticism regarding the therapy was also evident. This seemed to be a consequence of several previous failed attempts to alleviate pain. Offering sessions prior to therapy, in an individual format or in the form of a group 'taster session', can perhaps provide a useful space to explore concerns about the group and provide information about the group. Butler et al. (2016) report that their experience is that 'taster sessions' used in this way increased people's interest in subsequently attending an ACT group for psychosis. Therefore, it may seem logical that clients attending an ACT group for depression and/or anxiety may find this similarly helpful and it may improve attendance. In addition, or alternatively, perhaps more information about what the ACT group involves can be provided in a leaflet that is given to clients who are invited to attend.

Richard expressed arguably the strongest prior negative perceptions of the group. His negativity seemed to be centred around his hope for individual therapy to

explore early difficult experiences rather than receiving group therapy. This appeared to play a role in casting a shadow over his experience of the group. This highlights the importance of carefully clarifying during assessments what clients wish to gain from therapy. If clients wish to explore their past, perhaps individual therapy may be more valuable for these individuals. However, there were others in the group who expressed a desire to have individual therapy, yet seemed to make significant gains in the group. ACT promotes the idea of choice (Hayes et al., 2011), so in line with this, individuals should be offered the choice of different therapy options. However, resources need to be taken into consideration.

Some participants seemed to have high expectations prior to the commencement of the group. They seemed to have hoped for significant improvement to their conditions or even a cure. This finding was mirrored in Harrison's (2012) study, which also found that prior to therapy participants were hoping for a cure. These high expectations probably reflect the emphasis in Western culture of the importance of control, involving taking active steps to change, or get rid of problems (Hall, Hong, Zane, & Meyer, 2011). The next section discusses participants' experience of these high expectations not being met.

### 4.2.2 The Challenge of Letting Go of the Cure and Accepting Acceptance

It is recommended in the early stages of ACT to introduce the notion that attempts to avoid and control difficulties are futile and contributes to suffering (Hayes et al., 1999). Individuals are encouraged to let go of the control agenda and an alternative option is suggested, that of acceptance (Hayes, Luoma, & Walser, 2007). As was found in this study, individuals can often struggle with this as this is not the reason they came to therapy (Westrup, 2014). This led to disappointment for many participants in this study as their hopes of being rid of

their unpleasant emotions were dashed. This mirrors Harrison's (2012) finding, that chronic pain sufferers struggled with the concept of acceptance in an ACT group due to the unpleasantness and impact of emotions. In the present study it was found that the concept of acceptance was difficult to comprehend and embrace as the control agenda had long been instilled in them and they continued to hear the message around them of control and change. Robert highlighted another difficulty of letting go of the control agenda. He saw himself as different from others, which led him to strive for change.

As these concepts are challenging for individuals, it is important to ensure that sufficient time is allowed for introducing these ideas and that this is done gently. Therapists should not rush into imparting an ACT tool or concept without there first being some loosening of the grip of the control agenda (Westrup, 2014). In my clinical experience, when delivering an ACT group for people with chronic pain, I have found it useful to directly ask individuals about the thoughts and feelings that are elicited when introducing these challenging concepts and to normalise them. I also present previous clients' experiences who completed the group, which reveals that they experienced similar negative perceptions and feelings early on but were ultimately happy that they completed therapy. Perhaps these ideas could be equally beneficial in ACT groups for people with depression and/or anxiety.

Transdiagnostic approaches, such as ACT, propose that individuals with various presenting difficulties can be treated within the same ACT group. This was the premise of the ACT groups under investigation in this study. However, the experiences of some participants in this study raise questions about the heterogeneous composition of the ACT group. For example, some participants

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expressed disappointment that certain difficulties they experienced had not been addressed by the end of therapy. Yalom & Leszcz (2005) propose that this is a common potential drawback of heterogeneous groups. Based upon their clinical observations, they suggest that group composition should be more homogeneous in nature in group therapies which are short term and where the aim is to help individuals develop skills, such as the ACT group under investigation in this study. They purport that generally homogeneous groups gel more quickly, offer more support, are better attended and tend to have fewer conflicts as opposed to heterogeneous groups. However, Yalom and Leszcz suggest a caveat; that groups that are more homogeneous in composition can lead to discussions remaining at a more superficial level and that heterogeneous groups are better in this regard.

It should be noted that all participants spoke about the benefits of being around others with similar difficulties. Thus despite the heterogeneous nature of the group, there seemed to be sufficient commonalities for group members to derive benefit from being in *"the same boat"*.

Richard seemed to struggle with the concept of acceptance in relation to his childhood difficulties. He appeared almost angered by receiving the message in therapy that he should accept seemingly traumatic events he had experienced. Walser and Hayes (2006) recommend that caution be taken when introducing ideas of acceptance in the treatment of individuals who have experienced trauma. They highlight that therapists should not pertain that individuals accept what happened to them but rather that they would benefit from accepting internal private events so that the difficult memories do not 'drive' them. Therefore, if therapists are aware that individuals who have been invited to an ACT group have faced a previous significant traumatic experience, it may be helpful to offer them

an individual session prior to the commencement of the group to help clarify which aspects of their difficulties may actually benefit from the individual learning to accept. As can be seen, it seems that Richard misconstrued the concept of 'acceptance' and he was sensitive to this word. Harrison (2012) also found that participants in her study disliked the use of the word 'acceptance' as it was associated with resignation. Therefore it was recommended for a different word to be used, which may be perceived by individuals as being more hopeful.

The majority of the participants reported that they acknowledged the importance of acceptance and some had been able to embrace this concept. This appeared to take some time, perhaps due to the challenging nature of the concept. The discussion of the following superordinate theme outlines the factors that may have facilitated this process.

Alison reported that the concepts around acceptance that were introduced in the group were *"easy"* to understand and apply. In contrast, others said that they continued to struggle with the concept and found difficulty in applying it. This is consistent with findings in other studies. For example, in Williams et al.'s (2014) study exploring brain injury caregivers' experience of an ACT group, some participants struggled to continue implementing ACT concepts and reverted back to the control agenda. In Bacon et al.'s (2014) study exploring individuals' experience of an ACT group for psychosis, it was also found that some individuals easily understood the therapy whereas others battled to understand and connect with the ACT concepts. Therefore, during therapy perhaps it may be helpful for therapists to regularly ask for feedback to monitor individuals' level of understanding of, and ability to embrace, the ACT tools and concepts. Alongside this, as suggested by Williams et al. (2014), therapists should keep in mind that

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people often develop their coping strategies during difficult times. Therapists should respect how and when they choose to cope with current difficulties. This is in keeping with the idea of choice that is promoted in ACT (Hayes et al., 2011).

**4.3 Usefulness of Therapy**

### 4.3.1 From Being "Alone" to the Empowerment of Being in "The Same Boat"

All participants described benefits of being in a group with others with similar problems. Some expressed that they often felt radically different from others and this resulted in them feeling *"alone"* with their difficulties. However, being among others with similar problems normalised their difficulties and seemed to reduce their sense of feeling *"alone"*. Other studies exploring individuals' experience of an ACT group corroborate this finding, that discovering others share similar problems is normalising, which helps to overcome their sense of feeling isolated for feeling different (Bloy, 2013; Boone & Manning, 2012; Cox, 2012; Harrison, 2012; Mathias et al., 2014; Shankar, 2014; Waters, 2012). For example, Bloy (2013) discovered that previously feeling different led individuals to feel isolated. Realising that others shared similar difficulties came as a relief as they learnt "it's not just me". For some participants in Bloy's study, this was more useful than some of the exercises which were introduced in the therapy. This corresponds to Yalom's (1970) idea that 'universality' is a major driving force for therapeutic change in therapy groups.

In this study, feeling *"different"* from others seemed to be one of the reasons why some participants were self-critical. Robert reported that perceiving himself as *"different"* led him to strive to change and be more like others. However, attending the group and learning that others faced similar problems seemed to lead

some participants to realise that they were not radically *"different"* and consequently some became more compassionate in their view of themselves. There were indicators that this helped some to let go of striving to change themselves and find a cure and, instead, be more open to the concept of acceptance. Bloy (2013) had a similar finding: exposure to others with similar difficulties facilitated learning that individuals do not need to change a part of themselves, but rather can allow experiences to just be. This process promoted self-acceptance and self-compassion. Harrison (2012) also found that being among others with similar difficulties and the mutual support they felt fostered acceptance as well as a sense of positivity. The above supports Boone and Canicci's (2013) suggestion; learning that others face similar difficulties can increase an individual's willingness to make space for unpleasant internal sensations, thus fostering acceptance.

Some participants found that being around others with similar problems was also beneficial as they could learn tips from them and problem solve together. In line with these findings, Cox (2012) found that one participant in their study of an ACT group for a transdiagnostic group found the sharing of ideas helpful. The above corresponds with another therapeutic process that Yalom (1970; 1995) suggests plays an important role in therapeutic change in therapy groups; 'imparting of information'.

### 4.3.2 Learning Acquired and Improvements Made

Participants reported that they found specific ACT processes helpful, including defusion, mindfulness and values. Several also described undertaking more and not letting unpleasant thoughts or emotions deter this, which is fitting with the ACT model and aims. This mirrors findings from other studies investigating ACT

groups, that the therapy helped participants to engage in more activities despite this being challenging and experiencing deterring thoughts (Bacon et al., 2014; Bloy, 2013; Cosham, 2013; Williams et al., 2014). Suzanne and Penny reported that mindfulness improved their anxiety, and Suzanne explicitly said this had helped her to do more. This supports studies which suggest that mindfulness plays an important role in therapeutic change using an ACT intervention (e.g. Kocovski et al., 2013). Another improvement that Suzanne stated she made due to the group was that she became more confident. Improvement in confidence after attending an ACT group has been found in other studies (Cosham, 2013; Harrison, 2012; Mathias et al., 2014). These improvements have been linked to developing new relationships with participants' inner selves (Mathias et al., 2014) and emotions (Cosham, 2013).

Some participants described using mindfulness and defusion in accordance, but also not in accordance, with how proponents of ACT suggest they should be used. For example, rather than using mindfulness to help create space for thoughts and emotions and view them in a non-judgemental manner, some participants seemed to use mindfulness as a form of distraction. A similar issue arose with regards to defusion in this present study. Robert and Suzanne seemed to use defusion in a way that more closely resembled thought challenging, a concept that is used in CBT. Using mindfulness and defusion in this manner has been found in other studies exploring individuals' experiences of an ACT group (Bacon, et al., 2014; Bloy, 2013; Wardley, Flaxman, Willig, & Gillanders, 2014; Williams et al., 2014). Proponents of ACT would suggest that mindfulness and defusion become avoidant strategies if used in these ways, which can have the paradoxical effect of giving more power to such thoughts and emotions (Cioffi & Holloway, 1993; Wegner, 1994).

There may be several reasons why participants used mindfulness and defusion in these ways. Perhaps the therapists running the groups under investigation in this study did not adequately teach mindfulness and defusion, leading participants to misunderstand their purpose. However, this is unlikely as the therapists had good knowledge and experience of delivering ACT. For those participants who had previously received CBT, such as Robert, they may have become confused with the distinction between ACT and CBT. It is possible that participants used mindfulness and defusion as avoidant strategies because they found their abstract nature difficult to grasp and it is difficult not to use them in this way. This may have been because getting rid of unpleasant sensations is a basic human drive (Craske & Hazlett-Stevens, 2002) and indeed, this study highlighted participants' struggle to bypass this drive. In addition, Arch and Craske (2008) suggest that individuals who are clinically anxious may face an even greater challenge of 'letting go' of thoughts, given the frequently threatening valence of their thought content. This leads to the question: is letting go of the change/control agenda possible? Arch and Craske (2008) also question whether this is even desirable as they highlight research that supports the notion that an increased sense of control has positive effects on mental health. This study corroborates this, whereby ACT processes were used as control strategies from which participants derived benefits. In considering another explanation as to why participants in this study described using mindfulness and defusion as avoidant strategies, Mathias et al. (2014) found that in some of their participants' discussions of acceptance they spoke about gaining greater control. One reason for this, that these authors proposed, was that participants used the word 'control' when perhaps they meant acceptance and coping because this is the language that lay people often use. This may also explain why participants in this current study used mindfulness to help them distract and they described defusion in ways that resembled thought challenging.

This is more in line with how they are used to managing their difficulties and, therefore, talking about managing their difficulties.

Taking another angle, perhaps participants used defusion in ways that are more in keeping with CBT because, as some argue, there is a degree of overlap between defusion and cognitive restructuring (Arch & Craske, 2008; Forman, Herbert, Moitra, Yeomans, & Geller, 2012). For example, defusion involves psychologically distancing oneself from one's thoughts and similarly, cognitive restructuring involves a degree of 'stepping back' from thoughts to analyse the content (Forman et al., 2012). In addition, ACT emphasises learning that thoughts are just thoughts and not truths. ACT also encourages individuals to assess the 'workability' of thoughts, for example, questioning whether they are helping one to work towards or away from their values. These processes have parallels with the thoughts disputation in cognitive restructuring (Forman & Herbert, 2009).

Some seemed to find the group motivating, for example, Penny explained that feeding back her progress towards her goals to the group was motivating. Bloy (2013) also found that identifying and committing to goals in the group domain helped motivate participants to achieve them. The above is in correspondence with Boone and Canicci's (2013) suggestion, that ACT groups can provide encouragement for individuals to take challenging moves towards valued directions.

There were variations in the degree to which participants found the therapy helpful. Some participants noted limitations of ACT tools and values. For example, Richard noted that mindfulness helped with anxiety but not depression. Bacon et al. (2014) also found in their study exploring individuals' experience of

an ACT group for psychosis that some struggled with ACT concepts, including, mindfulness. They concluded that mindfulness requires sufficient attention control, which may be too challenging when individuals are highly distressed. Bacon et al. suggest that this may be because the cognitive system is too overloaded and thus they are too overwhelmed to control their attention. This may help to account for Richard's struggle with mindfulness, as it seemed that the severity of his difficulties was somewhat greater than those of other participants who benefited from mindfulness. Therefore, when screening clients for ACT groups, particularly clients with severe and complex mental health difficulties as is often seen in CMHTs, it may be helpful to be cognisant that those who are highly distressed may struggle to benefit from certain aspects of the therapy.

Within several themes identified in this study it is indicated that participants benefited greatly from group processes. This suggests that sufficient time should be given to attend to and explore group processes. For example, being in "*the same boat*" helped participants to feel less alone, which seemed to foster acceptance. Therefore, in ACT groups, there should be sufficient time for group members to share their difficulties as well as discuss the development of new skills. Other studies exploring ACT groups have made this same suggestion based on their findings that mutual support was highly beneficial (Harrison, 2012; Williams et al., 2014). Additionally, transference processes were evident in the interviews that contributed to some not feeling comfortable to speak in the group, which elicited frustration in more active members. This can possibly reduce group cohesion which can have a detrimental impact upon the effectiveness of the therapy (Burlingame et al., 2011). In psychodynamic therapy, the primary principle of technique is to use the 'social microcosm' that the group therapy becomes by, for example, identifying such transferences and bringing these to

group members' awareness. This helps group members to recognise sub-optimal behavioural patterns which they are then helped to change (Ciarrochi & Mayer, 2007). As psychodynamic group therapy focuses on group processes to promote therapeutic change within group members and this study indicated that group processes played a significant role in ACT groups, it could be suggested that it would be helpful to integrate the two approaches. Psychodynamic approaches could be drawn upon to enhance the therapeutic potential of group processes within ACT groups. Some highlight the similarities between ACT and psychodynamic approaches (e.g. Stewart, 2014). For example, some psychodynamic approaches have explored concepts and processes that are central to ACT including, acceptance, mindfulness and issues of the self. It is suggested that this supports notions that they can be successfully integrated and attempts have been made to describe how this may be successfully done (Blackledge, Ciarrochi, & Deane, 2009; Ciarrochi & Bailey, 2011; Stewart, 2014). However, at present there is little literature on this. To effectively deliver group therapies that integrate these two approaches it is likely to require an experienced and skilled practitioner. This contradicts assertions that ACT groups can be delivered by inexperienced therapists (e.g. Eisenbeck, Scheitz, & Szekeres, 2016; Kohtala, Lappalainen, Savonen, & Tolvanen, 2013).

## 4.4 Recommendations for Future Research

The findings from this study highlight areas that may benefit from further research. This study recommended that clinicians consider having an introductory session or provide a leaflet to individuals before the ACT group. The aim of these is to help address individuals' concerns about the group and provide information about the group. Future research may wish to explore how well these are received and whether this reduces attrition.

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This study found that some participants seemed to use ACT tools as avoidant strategies, which is not how the proponents of the approach recommend for them to be used. Additionally, this study highlighted that participants found the ACT tools and concepts as well as the group processes helpful. Together, this suggests that it would be helpful for future research to further investigate the mechanisms behind therapeutic change in ACT and whether these are similar or different to the processes that lead to therapeutic change in CBT. This may enlighten the debate in the literature around whether ACT and CBT share distinct or similar characteristics.

An interesting finding was that learning that others shared similar difficulties led many to realise that they were not so *"different"* from others as they previously thought. This led some to be more open to the idea of acceptance. Due to the importance of group processes in group therapy that this and many other studies highlight, it may be fruitful for more research to be conducted to further investigate the interaction between group and ACT processes. As group processes are the central focus of psychodynamic group psychotherapy, in the 'Discussion' section the potential benefits of integrating psychodynamic approaches with ACT was suggested. Another fruitful avenue for future research may be to investigate the effectiveness of such an intervention.

Finally, as it seems there were variations in the degree to which participants benefitted from the ACT group, future research is recommended to explore predictors of treatment response, including severity of difficulties, particularly as research in this area is in its infancy (Landy, Schneider, & Arch, 2015).

## 4.5 Strengths and Limitations

This study had several strengths and limitations. Its strengths included the use of a qualitative analysis which allowed for an in-depth exploration and insight into participants' experiences of an ACT group for depression and/or anxiety. Another strength was that there seemed to be a good degree of variety within the sample which provided a rich variety of views. For example, there was variety in terms of how beneficial participants found the group and the period since they completed therapy. Half of the participants attended the interview shortly after completing the group whereas the other half completed the therapy almost one year ago. Initially I was concerned that the latter participants would not have a good memory of the group. However, this did not seem too problematic as they seemed to have relatively good recall of the group therapy, their interviews were rich and it provided an opportunity to see the degree to which participants maintained the gains they made during the group therapy.

The possible limitations of this study include the presence of social desirability whereby participants may have been giving me responses that they thought I wanted to hear. Social desirability may have been more present in the interviews with those whom I informed that I had begun working for the service which provided the groups. However, participants often spoke about their struggles in the group, aspects that were not helpful and negative perceptions of the group, which suggests that they were not overly withholding information and thus social desirability was perhaps not too much of an issue.

Another limitation related to the sample. All participants had completed therapy and attended a minimum of 6 sessions. As they had completed therapy they may have had a more positive experience of the group in comparison to those who

attended fewer sessions and dropped out. The latter may have had a different, and perhaps more negative, experience.

Another potential limitation was around me having prior knowledge and experience of ACT as well as ACT research. Although I enjoy using ACT, I also have some reservations, which I hoped helped me to hold more of a balanced perspective through the journey of this thesis. Nevertheless throughout completing this thesis I was mindful of my prior knowledge and what my beliefs were and whether they were leading to bias. I was aware that my bias was most likely to affect the analysis of the interviews and development of themes. Therefore, I regularly cross-checked my notes and themes that I developed with the transcripts. I also verified the themes with my supervisor and two participants who supported them.

Finally, another potential limitation of this study was that I noticed that at times I fell into more of a therapist mode as opposed to researcher mode. For example, I sometimes used reflective statements and summarised what participants said. I sometimes did this to clarify what participants had meant and to prompt them to talk further. Slipping into therapist mode was most likely due to having little experience conducting interviews for research and also I usually interviewed participants before and/or after having therapy sessions with clients. During the interviews, at times, I was aware that, as a therapist, I was particularly interested in certain issues that participants raised, such as when Richard spoke about acceptance and trauma. My natural curiosity led me to want to enquire further, however, I attempted to bracket this and think particularly carefully about my questions during these times.

**4.6 Conclusion**

It is hoped that this thesis has made a valuable contribution to knowledge, clinical practice and research for counselling psychologists, and other professions, by providing a rich insight into individuals' experiences of an ACT group for depression and/or anxiety. It is hoped that the findings that emerged will be particularly useful to clinicians delivering this intervention. The study highlights the potential challenges for individuals attending such a group, such as, a heightened fear of judgement as well as the struggle for individuals to move away from trying to control their difficulties and move towards a more accepting stance. The study also provided an insight into the impact of the group size and lack of contribution by some members. Prior perceptions of the group were also shown to be important.

Despite participants finding some aspects of the group context and ACT concepts challenging, all participants expressed various benefits of these. This can be harnessed by clinicians delivering ACT. Some participants noted drawbacks of the heterogeneous nature of the group, however, there seemed to be sufficient commonalities between group members from which benefits were derived. This supports the application of ACT in a group setting.

Following on from the above comment on homogeneity and heterogeneity, from a research point of view, an interesting observation was that there was great homogeneity between participants: they all attended a similar ACT group, they all had severe and enduring mental health difficulties and they were all adults. On the other hand, there was a degree of heterogeneity whereby some participants experienced specific difficulties that were not shared by others. In addition, half of the sample was male and half was female. Although I did not notice any

significant differences between the two genders with regards to their experiences of the ACT group, I was under the impression that perhaps the female participants were slightly more positive about their overall experience. Another observation was that, on some issues, all participants expressed similar experiences of the ACT group. However, on other issues, there was a mixture of opinions.

Given this study's findings, various considerations and recommendations to the delivery of ACT in this context are provided. This includes recommendations to address the struggles that individuals' experienced by, for example, offering an introductory session. In addition, as participants found both group processes and specific ACT tools and concepts beneficial, therapists need to ensure that sufficient weighting is given to these in therapy.

Recommendations for future research include exploring the processes which underlie therapeutic change in ACT and whether these are distinct to CBT. One finding that I found particularly interesting, as I had not previously considered it, was that for some participants, being among others with similar difficulties seemed to facilitate acceptance. More research could further investigate interactions between group and ACT processes. In addition, research has been recommended to investigate what factors, such as potentially severity of difficulties, predict treatment response. As yet, research in both of these areas is in its infancy.

## References

Akobeng, A. (2005). Understanding randomised controlled trials. *Archives of Disease in Childhood, 90,* 840-844. doi:10.1136/adc.2004.058222

Albee, G. (2000). The Boulder model's fatal flaw. *American Psychologist, 55,* 247-248.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Arch, J., Ayers, C., Baker, A., Almklov, E., Dean, D., & Craske, M. (2013). Randomized clinical trial of adapted mindfulness-based stress reduction versus group cognitive behavioral therapy for heterogeneous anxiety disorders. *Behaviour Research and Therapy, 51,* 185-196. doi: 10.1016/j.brat.2013.01.003

Arch, J., & Craske, M. (2008). Acceptance and commitment therapy and cognitive behavioral therapy for anxiety disorders: Different treatments, similar mechanisms? *Clinical Psychology: Science & Practice, 5*, 263-279.

Ashley, H. (2010). Humanistic contributions to pluralistic practice. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (pp. 123-138). London, UK: Wiley-Blackwell.

Avdagic, E., Morrissey, S., & Boschen, M. (2014). A randomised controlled trial of acceptance and commitment therapy and cognitive-behaviour therapy for generalised anxiety disorder. *Behaviour Change, 31,* 110-130. doi: 10.1017/bec.2014.5

Bach, P., & Moran, D. (2008). *ACT in practice: Case conceptualisation in acceptance and commitment therapy.* Oakland, CA: New Harbinger Publications, Inc.

Bacon, T., Farhall, J., & Fossey, E. (2014). The active therapeutic processes of acceptance and commitment therapy for persistent symptoms of psychosis: Clients' perspectives. *Behavioural and Cognitive Psychotherapy, 21*, 1-19.

Barlow, D. (2004). Psychological treatments. *American Psychologist, 59,* 869-878. doi: 10.1037/0003-066X.59.9.869

Barnes, B., Ernst, S., & Hyde, K. (1999). *An introduction to group work: A group-analytic perspective.* Hampshire, UK: Palgrave Macmillan.

Bhanji, S. (2011). Is it time we turn towards 'third wave' therapies to treat depression in primary care? A review of the theory and evidence with implications for counselling psychologists. *Counselling Psychology Review, 26,* 57-69.

Birch, M., & Miller, T. (2000). Inviting intimacy: The interview as "therapeutic opportunity". *Social Research Methodology-Theory and Practice*, *3*, 189-202.

Blackledge, J., Ciarrochi, J., & Deane, F. (2009). *Acceptance and commitment therapy: Contemporary theory, research and practice.* Queensland, Australia; Australian Academic Press.

Blackledge, J., & Hayes, S. (2001). Emotion regulation in acceptance and commitment therapy. *Journal of Clinical Psychology, 57,* 243-255.

Block, J. (2002). *Acceptance or change of private experiences: A comparative analysis in college students with public speaking anxiety.* New York, NY; University at Albany, State University of New York.

Block, J., & Wulfert, E. (2000). Acceptance or change: Treating socially anxious

    college students with ACT or CBGT. *The Behavior Analyst Today, 1*, 1-

    55.

Bloy, S. (2013). *Acceptance and commitment therapy for     individuals with*

    *psychosis: A grounded theory analysis* (Clinical Psychology Doctorate

    Thesis). Retrieved from:

    https://create.canterbury.ac.uk/12449/1/Sally_Bloy_MRP_2013.pdf

Boone, M. (2010). *Acceptance and Commitment Therapy (ACT) for Depression*

    *and Anxiety in College Counseling* (Unpublished group protocol). Cornell

    University, New York.

Boone, M., & Canicci, J. (2013). Acceptance and commitment therapy (ACT) in

    groups. In J. Pistorello (Ed.), *Mindfulness and acceptance for counselling*

    *college students* (Chapter 4). Oakland, CA: New Harbinger.

Boone, M., & Manning, J. (2012). *A pilot study of an acceptance and commitment*

    *therapy group for anxiety and depression in a college counseling center.*

    Manuscript in preparation.

Bosmans, J., van Schaik, D., de Bruijne, M., van Hout, H., van Marwijk, H., van

    Tulder, M., & Stalman, W. (2008). Are psychological treatments for

    depression in primary care cost-effective? *The Journal of Mental Health*

    *Policy and Economics, 11,* 3-15.

Britten, N., & Fisher, B. (1993). Qualitative research and general practice. *The*

    *British Journal of General Practice, 43,* 270-271.

Brown, T., Campbell, L., Lehman, C., Grisham, J., & Mancill, R. (2001). Current

    and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a

    large clinical sample. *Journal of Abnormal Psychology, 110,* 49-58. doi:

    10.1037//0021-843X.110.4.585

Bunge, M. (1993). Realism and antirealism in social science. *Theory and*

> *Decision, 35,* 207-235. doi: 10.1007/BF01075199

Burlingame, G., McClendon,D., & Alonso, J. (2011). Cohesion in group therapy.

> *Psychotherapy Theory Research Practice Training, 48,* 34-42. doi:
> 10.1037/a0022063

Butler, L., Johns, L., Byrne, M., Joseph, C., O'Donoghue, E.,…Oliver, J. (2016).

> Running acceptance and commitment therapy groups for psychosis in
> community settings. *Journal of Contextual Behavioral Science, 5,* 33-38.
> doi:10.1016/j.jcbs.2015.12.001

 Castore, G. (1962). Number of verbal relationships as a determinant of group

> size. *Journal of Abnormal and Social Psychology, 64,* 456-458.

Chapman, A., Gratz, K., & Brown, M. (2006). Solving the puzzle of deliberate

> self-harm: The experiential avoidance model. *Behaviour Research and*
> *Therapy,44*, 371-394.

Ciarrochi, J., & Bailey, A. (2011). *Psychodynamic therapy and ACT*. Queensland,

> Australia; New Harbinger Publications.

Ciarrochi, J., & Mayer, J. (2007). *Applying emotional intelligence: A*

> *practitioner's guide.* East Sussex, UK: Psychology Press.

Cioffi, D., & Holloway, J. (1993). Delayed costs of suppressed pain. *Journal of*

> *Personality and Social Psychology, 64,* 274-282.

Clark, D. (2009). Cognitive behavioral therapy for anxiety and depression:

> Possibilities and limitations of a transdiagnostic perspective. *Cognitive*
> *Behaviour Therapy, 38,* 29-34. doi: 10.1080/16506070902980745

Corey, M., & Corey, G. (2005). *Groups: Process and practice* (7th ed.). London,

> UK: Thomson Learning, Inc.

Cosham, S. (2013). *Acceptance and commitment therapy for borderline personality disorder: A qualitative exploration of the process of acceptance* (Unpublished Clinical Psychology Doctorate Thesis). University of Surrey, Surrey.

Cougle, J., Keough, M., Riccardi, C., & Sachs-Ericsson, N. (2009). Anxiety disorders and suicidality in the national comorbidity survey-replication. *Journal of Psychiatric Research, 43,* 825–829. doi: 10.1016/j.jpsychires.2008.12.004

Cox, M. (2012). *A pilot study investigating the effectiveness of 2 transdiagnostic acceptance and commitment therapy groups* (Unpublished MSc dissertation). The University of Huddersfield, England.

Craske, M., & Hazlett-Stevens, H. (2002). Facilitating symptom reduction and behavior change in GAD: The issue of control. *Clinical Psychology: Science and Practice*, *9,* 69–75.

Cullen, C. (2008). Acceptance and commitment therapy (ACT): A third wave behaviour therapy. *Behavioural and Cognitive Psychotherapy, 36*, 667-673. doi: 10.1017/s1352465808004797

Curry, L., Nembhard, I., & Bradley, I. (2009). Key issues in outcomes research: Qualitative and mixed methods provide unique contributions to outcomes research. *Circulation, 119,* 1442-1452. doi: 10.1161/ CIRCULATIONAHA.107.742775

Eatough, V., & Smith, J. (2008). Interpretative phenomenological analysis. In: C. Willing & W. Stainton-Rogers (Ed.), *The Sage handbook of qualitative research in psychology* (pp. 179-194). Los Angeles, CA: Sage.

Eddins, R. (2014). Acceptance and commitment therapy in group practice.

    *Houston     Group     Psychotherapy     Society*. Retrieved from

    http://www.hgps.org/newsletter/acceptance-commitment-therapy-in-

    group-practice/

Egan, T., Wade, D., & Shafran, R. (2012). The transdiagnostic process of

    perfectionism. *Revista de Psicopatología y Psicología Clínica, 17,* 279-

    294.

Eisenbeck, N., Scheitz, K., & Szekeres, B. (2016). A brief acceptance and

    commitment therapy –based intervention among violence-prone male

    inmates delivered by novice therapists. *Psychology, Society, & Education,*

    *8,* 187-199.

England, E., Herbert, J., Forman, E., Rabin, S., Juarascio, A., & Goldstein, S.

    (2012). Acceptance-based exposure therapy for public speaking anxiety.

    *Journal of Contextual Behavioral Science*, *1*, 66-72.

Erickson, D. (2003) Group cognitive behavioural therapy for heterogeneous

    anxiety disorders. *Cognitive Behaviour Therapy, 32*, 179–186.

Erickson, D., Janeck, A., & Tallman, K. (2007). Group cognitive-behavioral

    group for patients with various anxiety disorders. *Psychiatric Services, 58,*

    1205–1211.

Farber, B. (2006). *Self-disclosure in psychotherapy.* London, UK: The Guildford

    Press.

Fehr, S. (2003). *Introduction to group therapy: A practical guide.* New York, NY:

    The Haworth Press Inc.

Finlay, L. (2006). Mapping methodology. In L. Finlay & C. Ballinger (Ed.),

    *Qualitative research for allied health professionals: Challenging choices*

    (pp.    9-29). West Sussex, UK: John Wiley & Sons Ltd.

Finucane, A., & Mercer, S. (2006) An exploratory mixed methods study of the acceptability and effectiveness of mindfulness-based cognitive therapy for patients with active depression and anxiety in primary care. *Biomed Central Psychiatry, 6,* 1-14. doi:10.1186/1471-244X-6-14

Folke, F., Parling, T., & Lennart, M. (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., & Herbert, J. (2009). New directions in cognitive behavior therapy: Acceptance-based therapies. In W. O'Donohue & J. Fisher (Ed.). *General principles and empirically supported techniques of cognitive behaviour therapy* (pp. 77–101). Hoboken, NJ: Wiley.

Forman, E., Herbet, J., Moitra, E., Yeomans, P., & Geller, P. (2012). Using session-by-session measurement to compare mechanisms of action for acceptance and commitment therapy and cognitive therapy. *Behavior Therapy, 43,* 341-354. doi: 10.1016/j.beth.2011.07.004.

Freeman, A., Pretzer, J., Fleming, B., & Simon, K. (2004). *Clinical applications of cognitive therapy.* New York, NY: Springer.

Garcia, M. (2004). Effectiveness of cognitive-behavioral group therapy in patients with anxiety disorders. *Psychology in Spain, 8,* 89-97.

Geller, J., Norcross, J., & Orlinsky, D. (2005). *The psychotherapist's own psychotherapy: Patient and clinician perspectives.* Oxford, UK: Oxford University Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. New York, NY: Aldine de Gruyter.

Golsworthy, R. (2004). Counselling psychology and psychiatric classification: Clash or co- existence? *Counselling Psychology Review, 19*, 23-28.

Green, S., & Bieling, P. (2012). Expanding the scope of mindfulness-based cognitive therapy: Evidence for effectiveness in a heterogeneous psychiatric sample. *Cognitive and Behavioral Practice, 19*, 174-180. doi: 10.1016/j.cbpra.2011.02.006

Greenberg, L. (1994). Acceptance in experiential therapy. In S.C. Hayes, N.S. Jacobson, V.M. Follette, & M.J. Dougher (Ed.), *Acceptance and change: Content and context in psychotherapy* (pp. 53-67). Reno, NV: Context Press.

Greenberg, P., Sisitsky, T., Kessler, R., Finkelstein, S., Berndt, E., Davidson, J.,…Fyer, A. (1999). The economic burden of anxiety disorders in the 1990s. *Journal of Clinical Psychiatry, 60,* 427–35. doi: 10453795

Gaudiano, B. (2011). A review of acceptance and commitment therapy (ACT) and recommendations for continued scientific research. *The Scientific Review of Mental Health Practice, 8,* 5-22.

Hall, G., Hong, J., Zane, S., & Meyer, O. (2011). Culturally-competent treatments for Asian Americans: The relevance of mindfulness and acceptance-based psychotherapies. *Clinical Psychology: Science and Practice, 18,* 215-231. doi: 10.1111/j.1468-2850.2011.01253.x

Harrison, M. (2012). *A qualitative service evaluation of the usefulness of a group based acceptance and commitment therapy programme for chronic pain* (Unpublished Clinical Psychology Doctorate Thesis). The University of Hertfordshire, Hertfordshire.

Harvey, A., Watkins, E., Mansell, W., & Shafran, R. (2004). *Cognitive behavioural processes across psychological disorders: A transdiagnostic approach to research and treatment.* Oxford, UK: Oxford University Press.

Hayes, S. (1993). Analytic goals and the varieties of scientific contextualism. In S.C. Hayes, L.J. Hayes, H.W. Reese, & T.R. Sarbin (Ed.). *Varieties of scientific contextualism* (pp. 11-27). Reno, NV: Context Press.

Hayes, S. (2004). Acceptance and co mmitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35*, 639-665. doi: 10.1016/s0005-7894(04)80013-3

Hayes, S., Barnes-Holmes, D., & Roche, B. (2001). *Relational frame theory: A post-Skinnerian account of human language and cognition*. New York, NY: Plenum Press.

Hayes, S., Levin, M., Yadavaia, J., & Vilardaga, R. (2007). ACT: Model and processes of change. Paper presented at the annual meeting of the *Association for Behavioral and Cognitive Therapies*. Philadelphia, PA.

Hayes, S., Luoma, J., Bond, F., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44,* 1-25. doi: 10.1016/j.brat.2005.06.006

Hayes, S., Luoma, J., & Walser, R. (2007). *Learning ACT: An acceptance and commitment therapy skills-training manual for therapists.* Oakland, Canada: New Harbinger Publications Inc.

Hayes, S., Pistorello, J., & Levin, M. (2012). Acceptance and commitment therapy as a unified model of behavior change. *The Counseling Psychologist, 40*, 976-1002. doi: 10.1177/0011000012460836

Hayes, S., Strosahl, K., & Wilson, K. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change.* New York, NY: Guilford Press.

Hayes, S., Strosahl, K., & Wilson, K. (2011). *Acceptance and commitment therapy:* The process and practice of mindful change. New York, NY: Guilford Press.

131

Hayes, S., Wilson, K., Gifford, E., Follette, V., & Strosahl, K. (1996).

Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64,* 1152-1168. doi:10.1037/0022-006X.64.6.1152

Hill, C. (2005). Qualitative research. In J. Norcross, L. Beutler, & R. Levant (Ed.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions,* (pp. 74-80). Washington, DC: American Psychological Association

Hoffman, E., Dukes, E., & Wittchen, H-U. (2008). Human and economic burden of generalized anxiety disorder. *Depression and Anxiety, 25,* 72-90. doi: 10.1002/da.20257

Huntley, A., Araya, R., & Salisbury, C. (2012). Group psychological therapies for depression in the community: Systematic review and meta-analysis. *British Journal of Psychiatry, 200,* 184-190. doi: 10.1192/bjp.bp.111.092049

Husserl, E. (1931). *Ideas*: *General introduction to pure phenomenology*. (W.R. Boyce Gibson, Trans.). London, UK: George Allen and Unwin.

Johnstone, L. (2000). *Users and abusers of psychiatry: A critical look at psychiatric practice*. London, UK: Routledge.

Kabat-Zinn, J. (1982). An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. *General Hospital Psychiatry, 4*, 33–47.

Kasket, E. (2013). The counselling psychologist researcher. In G. Davey (Ed.), *Applied psychology*. London, UK: BPS Wiley Blackwell.

Katon, W., Von Korff, M., Lin, E., Lipscomb, P., Russo, J., Wagner, E., & Polk, E. (1990). Distressed high utilizers of medical care: DSM-III-R diagnoses and treatment needs. *General Hospital Psychiatry, 12*, 355–362. doi:10.1016/0163-8343(90)90002-T

Kessler, R., Chiu, W., Demler, O., Merikangas, K., & Walters, E. (2005). Prevalence, severity, and co-morbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62,* 617-627.

Kim, Y., Lee, S., Choi, T., Suh, S., Kim, B., Kim, C.,…Yook, K. (2009). Effectiveness of mindfulness-based cognitive therapy as an adjuvant to pharmacotherapy in patients with panic disorder or generalized anxiety disorder. *Depression and Anxiety, 26,* 601-606.

Kocovoski, N., Fleming, J., Huta, V., & Antony, M. (2013). Mindfulness and acceptance-based group therapy versus traditional cognitive behavioral group therapy for social anxiety disorder: A randomized controlled trial. *Behavior Research and Therapy, 51,* 889-898.

Kocovoski, N., Fleming, J., & Rector, N. (2009). Mindfulness and acceptance-based group for social anxiety disorder: An open trial. *Cognitive and Behavioral Practice, 16,* 276-289.

Kohtala, A., Lappalainen, R., Savonen, L., & Tolvanen, A. (2013) A four-session acceptance and commitment therapy based intervention for depressive symptoms delivered by masters degree level psychology students: A preliminary study. *Behavioural and Cognitive Psychotherapy, 43,* 1-14.

Kroenke, K., Spitzer, R., & William, J. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16,* 606-613.

Landy, L., Schneider, R., & Arch, J. (2015). Acceptance and commitment therapy for the treatment of anxiety disorders: A concise review. *Current Opinion in Psychology, 2,* 70-74.

Larsson, P., Brook, O., Loewenthal, D. (2012). Counselling psychology and diagnostic categories: A critical literature review. *Counselling Psychology Review, 27,* 55-67.

Lockwood, C., Page, T., & Conroy-Hiller, T. (2004). Comparing the effectiveness of cognitive behaviour therapy using individual or group therapy in the treatment of depression. *JBI reports, 2,* 185-206.

Marks, I., & Nesse, R. (1994). Fear and fitness: An evolutionary analysis of anxiety disorders. *Ethology and Sociobiology, 15*, 247-261.

Maslow, A. (1943). A theory of human motivation. *Psychological Review*, *50*, 370-96.

Mathias, B., Parry-Jones, B., & Huws, J. (2014). Individual experiences of an acceptance-based pain management programme: An interpretative phenomenological analysis. *Psychology & Health, 29,* 279-296. doi: 10.1080/08870446.2013.845667

McEvoy, P., & Nathan, P. (2007). Effectiveness of cognitive behavior therapy for diagnostically heterogeneous groups: A benchmarking study. *Journal of Consulting and Clinical Psychology, 75,* 344-350.

McEvoy, P., Nathan, P., & Norton, P. (2009). Efficacy of transdiagnostic treatments: A review of published outcome studies and future research directions. *Journal of Cognitive Psychotherapy: An International Quarterly, 23*, 20-33.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy.* London, UK: Sage.

McManus, F., Shafran, R., & Cooper, Z. (2010). What does a transdiagnostic approach have to offer the treatment of anxiety disorders? *British Journal of Clinical Psychology, 49,* 491–505.

McRoberts, C., Burlingame, G., & Hogg, M. (1998). Comparative efficacy of individual and group psychotherapy: A meta-analytic perspective. *Group Dynamics: Theory, Research, and Practice, 2,* 101-117. doi: 10.1037/1089-2699.2.2.101

Milton, M., Craven, M., & Coyle, A. (2010). Understanding human distress: Moving beyond the concept of 'psychopathology'. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues.* London, UK: Wiley-Blackwell.

Mintz, J., Mintz, L., Arruda, M., & Hwang, S. (1992). Treatment of depression and the functional capacity to work. *Archives of General Psychiatry, 49*, 761-768.

Morrow, S. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52,* 250-260. doi: 10.1037/0022-0167.52.2.250

Morrow, S. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist, 35*, 209-235.

Murdock, N., Duan, C., & Nilsson, J. (2012). Emerging approaches to counselling intervention: Theory, research, practice, and training. *The Counseling Psychologist, 40,* 966-975. doi: 10.1177/0011000012460663

National Institute for Health & Clinical Excellence (2009). *Depression: The treatment and management of depression in adults (update).* London: National Institute for Health and Clinical Excellence.

National Institute for Health & Clinical Excellence (2011). *Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care.* London: National Institute for Health and Clinical Excellence.

National Institute for Health & Clinical Excellence (2013). *Social anxiety: Recognition, assessment and treatment.* London: National Institute for Health and Clinical Excellence.

Norton, P. (2008). An open trial of a transdiagnostic cognitive-behavioral group therapy for anxiety disorder. *Behavior Therapy, 39,* 242-50.

Norton, P. (2012a). A randomized clinical trial of transdiagnostic cognitive-behavioral treatments for anxiety disorder by comparison to relaxation training. *Behavior Therapy, 43,* 503-517.

Norton, P. (2012b). Transdiagnostic group CBT for anxiety disorder: Efficacy, acceptability, and beyond. *Spanish Journal of Clinical Psychology, 17,* 205-217.

Norton, P., & Barrera, T. (2012). Transdiagnostic versus diagnosis-specific CBT for anxiety disorders: A preliminary randomized controlled non-inferiority trial. *Depression and Anxiety, 29,* 874-882.

Norton, P., & Hope, D. (2005). Preliminary evaluation of a broad-spectrum cognitive- behavioral group therapy for anxiety. *Journal of Behavior Therapy and Experimental Psychiatry, 36,* 79-97.

Norton, P., & Philipp, L. (2008). Transdiagnostic approaches to the treatment of anxiety disorders: A quantitative review. *Psychotherapy: Theory, Research, Practice and Training, 45,* 214-226.

O'Leary, D., & Lee, A. (1996). Seven year prognosis in depression. Mortality and readmission risk in the Nottingham ECT cohort. *British Journal of Psychiatry, 169,* 423-429.

Office for National Statistics (2013). *Measuring National Well-being-Health.*

London: Office for National Statistics. Retrieved from

http://www.ons.gov.uk/ons/dcp171766_310300.pdf

Orsillo, S., Roemer, L., Block-Lerner, J., LeJeune, C., & Herbert, J. (2005). ACT

With anxiety disorders. In S.C. Hayes, & K.D. Strosahl (Ed.), *A practical*

*guide to acceptance and commitment therapy* (pp. 103-132). New York,

NY: Springer Science & Business Media.

Ossman, W., Wilson, K., Storaasli, R., & McNeill, J. (2006). A preliminary

investigation of the use of acceptance and commitment therapy in group

treatment for social phobia. *International Journal of Psychology and*

*Psychological Therapy, 6*, 397-416.

Paulson, G., Everall, R., & Stuart, J. (2001). Client perceptions of hindering

experiences in counselling. *Counseling and Psychotherapy Research, 1*,

53-61.

Pellowe, M. (2007). *Acceptance and commitment therapy as a treatment for*

*dysphoria* (Unpublished Doctoral Dissertation). University of Wyoming,

Wyoming.

Pierson, H., & Hayes, S. (2007). Using acceptance and commitment therapy to

empower the therapeutic relationship. In P. Gilbert, & R. Leahy (Ed.), *The*

*therapeutic relationship in cognitive behavior therapy* (pp. 205-228).

London, UK: Routledge.

Pinto, R., Kleinhuis, M., Slevison, M., Chester, A., Schloss, A, & Yap, K. (2015).

The effective of an outpatient acceptance and commitment therapy group

programme for a transdiagnostic population. *Clinical Psychologist,* 1-11.

doi:10.1111/cp.12057

Ponterotto, J. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52,* 126-136. doi: 10.1037/0022-0167.52.2.126

Ponterotto, J., Kuriakose, G., & Granovskaya, Y. (2008). Counseling and psychotherapy. In C. Willig & W. Stainton-Rogers (Ed.), *The Sage handbook of qualitative research in psychology* (pp. 455-471). London, UK: Sage.

Pope, C., van Royen, P., & Baker, R. (2002). Qualitative methods in research on health care quality. *Quality and Safety in Health Care, 11,* 148–152. doi: 10.1136/qhc.11.2.148

Rafalin, D. (2010). Counselling psychology and research: Revisiting the relationship in light of our mission. In M. Milton (Ed.), *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues*, (pp.41-56). Oxford, UK: Wiley.

Ree, M., & Craigie, M. (2007). Outcomes following mindfulness-based cognitive therapy in a heterogeneous sample of adult outpatients. *Behavior Change, 24,* 70-86.

Rothwell, P. (2005). External validity of randomised controlled trials: "to whom do the results of this trial apply?" *Lancet, 365*, 82-93.

Rutan, S., Stone, W., & Shay, J. (2014). *Psychodynamic group psychotherapy.* London, UK: The Guildford Press.

Sachs, A. (2005). *Integrating acceptance with imaginal exposure to core schema: Process and outcome in generalised anxiety disorder*. (Unpublished doctoral dissertation): The University of Southern California, California.

Schmidt, N., Buckner, J., Pusser, A., Woolaway-Bickel, K., & Preston, J. (2012). Randomized controlled trial of false safety behavior elimination therapy (F-SET): A unified cognitive behavioral treatment for anxiety psychopathology. *Behavior Therapy, 43*, 518-532.

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

Shankar (2014). *The effectiveness of acceptance and commitment therapy for severe anxiety and depression.* (Unpublished small-scale research project). The University of Hertfordshire, Hertfordshire.

Smail, D. (2001). *The nature of unhappiness.* London, UK: Robinson.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. Smith, R. Hare, & L. Van Langenhove (Ed.), *Rethinking methods in psychology* (pp. 9-27). London, UK: Sage.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, *11*, 261-271. doi**:** 10.1080/08870449608400256

Smith, J. A. (2011). Evaluating the contribution of interpretative Phenomenological analysis. *Health Psychology Review, 5,* 9-27. doi**:** 10.1080/17437199.2010.510659

Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. In E. Lyons, & A. Coyle (Ed.), *Analysing qualitative data in psychology* (pp. 35-50). London, England: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London, England: Sage.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. Smith (Ed.), *Qualitative psychology* (pp. 51-80). London, England: Sage.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In

    J. Smith, (Ed.), *Qualitative psychology: A practical guide to research*

    *methods* (pp. 53-80). London, England: Sage.

Sperry, L., Brill, P., Howard, K., & Grissom, G. (1996). *Treatment outcomes in*

    *psychotherapy and psychiatric interventions.* New York, NY:

    Brunner/Mazel, Publishers.

Spitz, H., & Spitz, S. (1999). *A pragmatic approach to group psychotherapy.*

    London, UK: Brunner/Masel.

Spitzer, R., Kroenke, K., Williams, J., & Lowe, B. (2006). A brief measure for

    assessing generalized anxiety disorder. *Archives of Internal Medicine, 166,*

    1092-1097.

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of

    phenomenology, discourse analysis, and grounded theory. *Qualitative*

    *Health Research, 17,* 1372-1380

Stewart, M. (2014). *Mindfulness, acceptance, and the psychodyanmic evolution:*

    *Bringing values into treatment planning and enhancing psychodynamic*

    *work with Buddhist psychology.* California, USA; Newharbinger

    publications.

Swain, J., Hancock, K., Hainsworth, C., & Bowman, J. (2013). Acceptance and

    commitment therapy in the treatment of anxiety: A systematic review.

    *Clinical Psychology Review, 33,* 965-978.

Tamannaeifar, S., Gharraee, B., Birashk, B., & Habibi, M. (2014). A comparative

    effectiveness of acceptance and commitment therapy and group cognitive

    therapy for major depressive disorder. *Zahedan Journal of Research in*

    *Medical Science, 16,* 29-31.

Timonen, M., & Liukkonen, T. (2008). Management of depression in adults.

    *British Medical Journal, 23,* 435-439. doi: 10.1136/bmj.39478.609097.BE

Toneatto, T., & Nguyen, L. (2007). Does mindfulness meditation improve anxiety and mood symptoms? A review of the controlled research. *La Revue Canadienne de Psychiatrie, 52,* 260–266.

Tufford, L., & Newman, P. (2010). Bracketing in social work. *Qualitative Social Work, 11,* 80-96. doi: 10.1177/1473325010368316

Tull, M., Gratz, K., Salters, K., & Roemer, L. (2004). The role of experiential avoidance in posttraumatic stress symptoms and symptoms of depression, anxiety, and somatization. *Journal of Nervous and Mental Disease, 192,* 754-761.

Twohig, M., & Hayes, S. (2008). *ACT verbatim for depression and anxiety.* Oakland, CA: New Harbinger Publications, Inc.

Vinogradov, S., & Yalom, I. (1989). *A concise guide to group psychotherapy.* London, UK: American Psychiatric Press Inc.

Vøllestad, J., Sivertsen, B., & Nielsen, G. (2011). Mindfulness-based stress reduction for patients with anxiety disorders: Evaluation in a randomized controlled trial. *Behaviour Research and Therapy, 49,* 281-288.

Walser, R., & Hayes, S. (2006). Acceptance and commitment therapy in the treatment of posttraumatic stress disorder. In V. M. Follette, & J. I. Ruzek (Ed.), *Cognitive Behavioral Therapies Trauma* (pp. 146-172). New York, NY: Guildford Press.

Walser, R., & Pistorello, J. (2004). ACT in group format. In S. Hayes & K. Strosahl (Ed.), *A practical guide to acceptance and commitment therapy* (pp. 347-372). New York, NY: Springer.

Wardley, M., Flaxman, P., Willig, C., & Gillanders, D. (2014). 'Feel the feeling': Psychological practitioners' experience of acceptance and commitment therapy well-being training in the workplace. *Journal of Health Psychology*. doi: 10.1177/1359105314557977

Waters, C. (2012). *Acceptance and commitment therapy: Efficacy and mechanisms of therapeutic action.* (Unpublished Clinical Psychology Doctorate Thesis). Cardiff University, Cardiff.

Watson, H., McEvoy, P., Smith, L., Saulsman, L., Campbell, B., & Nathan, P. (2010). Affective disorders: Bridging the gap between efficacy and practice. In R.A. Carlstedt (Ed.), *Handbook of integrative clinical psychology, psychiatry, and behavioral medicine. Perspectives, practices, and research* (pp. 281-308). New York, NY: Springer publishing company.

Wegner, D. (1994). Ironic processes of mental control. *Psychological Review, 101,* 34-52.

Westrup, D. (2014). *Advanced acceptance and commitment therapy: The experienced practitioner's guide to optimizing delivery.* Oakland, Canada: New Harbinger Publications Inc.

Whitfield, G. (2010). Group cognitive–behavioural therapy for anxiety and depression. *Advances in Psychiatric Treatment, 16,* 219-227. doi: 10.1192/apt.bp.108.005744

Williams, J., Vaughan, F., Huws, J., & Hastings, R. (2014). Brain injury spousal caregivers' experiences of an acceptance and commitment therapy (ACT) group. *Social care and neurodisability, 5,* 29-40.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and  method*. Buckingham, England: Open University Press.

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). Berkshire, England: Open University Press.

Wittchen, H-U. (2002). Generalized anxiety disorder: Prevalence, burden and cost to society. *Depression and Anxiety, 16,* 162–171.

Yalom, I. (1970). *The theory and practice of group psychotherapy* (1st ed.). New

York, NY: Basic Books.

Yalom, I. (1995). *The theory and practice of group psychotherapy* (4th ed.). New

York, NY: Basic Books.

Yalom, I., Houts, P., Zimerberg, S., & Rand, K. (1967). Prediction of

improvement in group therapy: An exploration study. *Archives of General*

*Psychiatry, 17,* 159-168. doi:10.1001/archpsyc.1967.01730260031005

Yalom, I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy*

(5th ed.). New York, NY: Basic Books.

Yalom, I., & Vinogradov, S. (1993). Interpersonal group therapy. In H. Kaplan &

B. Sadock (Ed.) *Comprehensive group psychotherapy* (3rd ed.) (pp.185-

195). Baltimore, USA: Williams & Wilkins.

Yeh, C., & Inman, A. (2007). Qualitative data analysis and interpretation in

Counselling psychology: Strategies for best practices. *The Counselling*

*Psychologist, 35,* 369-403. doi: 10.1177/0011000006292596

Yonkers, K., Dyck, I., Warshaw, M., & Keller, M. (2000). Factors predicting the

clinical course of generalised anxiety disorder. *The British Journal of*

*Psychiatry, 176,* 544-549. doi: 10.1192/bjp.176.6.544

Zettle, R., & Rains, J. (1989). Group cognitive and contextual therapies in

treatment of depression. *Journal of Clinical Psychology, 45*, 438-445.

Zettle, R., Rains, J., & Hayes, S. (2011). Processes of change in acceptance and

commitment therapy and cognitive therapy for depression: A mediation

reanalysis of Zettle and Rains. *Behavior Modification, 35,* 265-283. doi:

10.1177/0145445511398344

Zhao, W., Zhou, Y., Liu, X., & Ran, L. (2013). Effectiveness of acceptance and

commitment therapy on depression. *Chinese Journal of Clinical*

*Psychology, 21,* 153-157.

**Appendix A**

Flow chart of route from referral to the CMHT to the ACT group

**Referrals in from GPs, Crisis Team, A&E etc.**

Signpost to others services

Refer back to GP if inappropriate or if more info is needed

**Triaged by Psychiatrist or Clinical Lead**

Criteria: Severe and Enduring Mental Health Difficulties

**Assessed by Psychiatrist or Care co-ordinator**

**MDT meeting**

**Individual Assessment with a Psychologist**

No further treatment offered

**Psychologists' meeting**

Signpost to others services

Psychological Awareness Group (optional)

Individual Psychological Therapy

Other Therapeutic Groups (PTSD, OCD, bipolar disorder and psychosis)

**ACT group for depression and/or anxiety**

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## Appendix B

### Inclusion and Exclusion Criteria

Inclusion criteria

- All participants will be aged between 18 and 65 years

- All participants must be English speaking

- All participants must have had a previous diagnosis of depression and/or anxiety prior to attending the ACT group (this is a requirement for inclusion into the ACT group)

- Participants will be included if they score below 12 on the Patient Health Questionnaire-9 and below 13 on the Generalised Anxiety Disorder-7

- All participants will have completed the ACT group within the last twelve months prior to being recruited. This is in order to increase the accuracy of participants' memories of their experiences

- All participants must have attended at least 6 of the 10 sessions in order for them to have had sufficient experience of the ACT group

Exclusion criteria

- Participants will be excluded if they are actively suicidal and/or they have a score of 12 and above on the Patient Health Questionnaire-9 and/or 13 and above on the Generalised Anxiety Disorder-7. This is as a precaution against the albeit temporary mild discomfort that may arise as a result of completing the questionnaires and/or being interviewed

Participant Information Sheet



**<u>Participant Information Sheet</u>**

Hello,

My name is Amy Smith and I am a Trainee Counselling Psychologist at London Metropolitan University. As part of my training I will be conducting a research project. This study is being undertaken for educational purposes, as part of my Doctorate in Counselling Psychology. I am writing to you because I am interested in understanding more about depression and anxiety management and I hope that you might be willing to take part in my research project which is called:

*Acceptance and Commitment Therapy for Depression and/or Anxiety*

Recent research has identified the benefits of Acceptance and Commitment Therapy (ACT) for depression and/or anxiety sufferers, however, there is less research focusing on how people with depression and/or anxiety find the experience of attending an ACT group to help them manage these difficulties. This study aims to explore the experiences of people who have attended such a group and allow them to voice this. It is hoped that this project will help professionals to improve therapy.

<u>What does taking part involve?</u>

You would be asked to take part in an audio recorded interview that will take place in a confidential setting at <location>. The interview will be confidential, it should take approximately 1 ½ hours and it will involve me, the researcher, asking you about your experiences of having attended an ACT programme for depression and/or anxiety. Some of the experiences that we may talk about could be upsetting due to the nature of your difficulties, however, you are encouraged to only participate if you feel able to share these experiences.

<u>Do I have to take part?</u>

You are under no obligation to take part in this study. If you do not wish to do so your routine care will not be affected in any way. If you decide to take part in this study, you can change your mind at any time without having to give a reason. Again your routine care will remain unaffected.

**Foreword:**

This study has been approved by the London Metropolitan University Research Ethics Committee and NHS Ethics Committee. The Ethics Committees role is to ensure that research is conducted in a safe and ethical manner.

**1. Confidentiality**

- Your participation will be confidential. The only circumstance under which confidentiality would be broken is if you disclose information that leads the researcher to have serious concerns about your safety, or that of others. In this instance, I will contact your care co-ordinator in order to discuss these concerns.

- Your audio recording and your personal details will be stored securely, in a separate location from the transcript, so as to further ensure confidentiality.

- Anonymised transcripts will only be viewed by the research supervisor (Dr Angela Loulopoulou), and by those responsible for assessing the work of the researcher.

- The results of all the interviews will form the basis of my Counselling Doctorate thesis and this will then become a public document. However, none of your identifiable information will be included in the document.

**2. The interview process**

- You will be asked to sign an informed consent form that will state that you have a right to withdraw from the project at any time.

- Your travel or car parking costs (if applicable) will be reimbursed in cash on the day of the interview.

- The interview will last for approximately 1 ½ hours.

- The interview will be audio recorded.

- The interviewer will address particular questions; however, the aim is to hear about your individual experience. What the interviewer is interested in includes:

-What have you learnt from attending the ACT group?

-What did you find difficult during the programme?

-How did you find the group setting?

-Suggestions for improvements to the programme?

**3. During the interview**

- You are not required to answer all of the questions however it would be preferred that you are able to offer your thoughts in relation to the questions asked.

- Further to this, if at any time, for any reason, you wish to take a break or terminate the interview, it is your right to do so.

- If you become upset at any stage during or after the interview, a member of the psychology team will be available to talk to you.

**4. Following the interview**

- After the audio recording has stopped you will be invited to talk about your experience of being interviewed and how it has left you feeling.

- There will also be the opportunity to ask questions. In the event that the researcher is unable to answer you, she will contact you with an answer following the interview.

- The researcher will then look over the transcript from the interview and will try to establish themes.

- Your data will be saved on an NHS computer and will be password protected and any written notes will be kept in locked

- Your data will be destroyed once the thesis has been published. However, if you withdraw your consent your data will be destroyed immediately

**5. What will happen to the results of this research study?**

- The results of the interviews will be reported in a thesis for the purpose of gaining a qualification in Counselling Psychology.

- The thesis will be held in the London Metropolitan University library and will be accessible to interested parties.

- It is planned that the results of the study will use direct quotes from your interview. However, your personal details will be kept anonymous in the write up of the project.

- Further to this, a summary of the main research findings may be published as an article.

**6. How will my personal information be kept and long will it be kept for?**

- Your personal information and audio recordings will be saved on an NHS computer and will be password protected. Any written notes will be kept in locked storage and will be destroyed, along with the interview transcripts and audio-recordings, as soon as the thesis has been completed. If you wish to withdraw your consent all data collected will be immediately destroyed.

**7. What if there is a problem?**

If you have concerns about any aspect of the research process or you wish to complain then please speak to the researcher. Alternatively, you can contact the Research Supervisor, Angela Loulopoulou, whose contact details are:

Senior Lecturer in Counselling Psychology

London Metropolitan University

School of Psychology

Faculty of Life Sciences and Computing

London Metropolitan University

166-220 Holloway Road

London N7 8DB

**E-mail:** [A.Loulopoulou@londonmet.ac.uk](mailto:A.Loulopoulou@londonmet.ac.uk)

**Tel:** 0207 133 2667

If you feel distressed and would like to speak with someone please speak with the researcher and an appointment can be scheduled for you with a psychologist within the psychology team.


**Do you have any questions?**

Thank you for taking time to read this information. If you are still happy to take part in the research please sign the enclosed opt-in form and return it to me in the enclosed stamped addressed envelope as soon as possible (given 2 week notice date).

My contact details are:

**E-mail:** amy.smith@XXXX.nhs.uk

**Tel:** XXXXX

Many thanks,


Amy Smith

Trainee Counselling Psychologist

Opt-in Form



**Opt-in Form**

**Project Title:** Acceptance and Commitment Therapy for Depression and/or Anxiety

**Name of researcher**: Amy Smith, Trainee Counselling Psychologist

I am interested in participating in the above study and agree to be contacted by Amy Smith to discuss the study further. My contact details are as follows:

Name…………………………………………………………..

Date of Birth………………………………………………….......

Telephone Number: ……………………………………………….

Address……………………………….............................................

Preferred method of contact……………………………..................

# Appendix E

Patient Health Questionnaire-9

## PHQ-9 Depression

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer"* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things......………. | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless.………..…… | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much.....................................………..…….. | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy......………..……… | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating.....................…………… | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down…………………….. | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television.……………………….. | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.............………………………………………….. | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way......………………………………… | 0 | 1 | 2 | 3 |

**Column totals**     ___ + ___ + ____ + __

= *Total Score*

Generalised Anxiety Disorder -7

| Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?<br><br>*(Use "✔" to indicate your answer")* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**Column totals:**     ___ + ___ + ___+

= ***Total Score*** _____

**Appendix G**

Consent form



**Consent Form**

<u>Title of the Study</u>:     Acceptance and Commitment Therapy for Depression and/or Anxiety.

<u>Name of researcher:</u>   Amy Smith

This consent form is to ensure that you are happy with the information that you have received about the study, and that you are aware of your rights as a participant, and that you are happy to participate in this study.

Please Tick Box

1.  I confirm that I have read and that I understand the information sheet

    for the above study.

2.  I have had the opportunity to consider the information about the study,

    ask questions about it and have had these answered satisfactorily.

3.  I have received enough information about the study to enable me to

    decide whether or not I want to take part in it.

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4. I understand that participation in the study is entirely voluntary. I understand that am free to decline entry into the study without my care being affected in any way. □

5. I understand that I have the right to withdraw from the study, for a period of up to six weeks following the interview. I understand that I do not have to provide a reason for this and my care will not be affected in any way. □

6. I understand that all the information that I reveal will be kept confidential. □

7. I understand that the principle of confidentiality cannot be maintained if the information disclosed leads to concern that I may cause harm to myself or to others. □

8. I understand that I will participate in a face-to-face interview that will last for about one and a half hours. I give permission for the use of audio recording of the interview which will later be transcribed by the researcher. □

9. I understand that the researcher will use quotations from my interview in the writing up and the publication of the study. □

10. I understand that both I and the researcher have the right to bring the interview to an end if undue distress is being experienced. □

11. I understand that I am free to decline to answer any questions that I do not wish to answer ☐

12. I understand that my identity will be completely anonymous and that my name will not be revealed at any point in time. ☐

13. I understand that the my data will be saved on an NHS computer and will be password protected and any written notes will be kept in locked storage. ☐

14. I understand that my data will be destroyed once the thesis has been published. However, if I withdraw my consent my data will be destroyed immediately ☐

15. I understand that this study has received ethical approval from the Research Ethics Committee at London Metropolitan University and the NHS Ethics Committee. ☐

16. I understand that the study will be carried out in accordance with both the London Metropolitan University's Code of Good Research Practice, and the British Psychological Society's ethical guidelines. ☐

17. Please tick the box if you would like to receive a summary of the results of the study. ☐

18. I hereby agree to take part in this study. ☐

Name of participant: _____

Date: _____

Signature: _____

Name of Researcher: _____

Date: _____

Signature: _____

**Appendix H**

Questions to Guide the Interviews

What was your experience of the acceptance and commitment therapy group?

What did you hope to learn from the therapy group?

Prompt: What did you learn/find helpful?

Prompt: What (if anything) did you find challenging?

How did you find the group setting?

Prompt: What did you find beneficial?

Prompt: What did you find difficult?

Would you recommend the group to a friend or family?

Prompt: Why?

Can you suggest any ways to improve the group?

# Appendix I

Section of one transcript with notes

Left margin handwritten notes:
- At first - unsure how it could help
- pessimistic
- Anx. talking in a group
- useful
- Others wouldn't speak → pressure → silence → to speak
- Difficult talking about one.+ diff. - confronting this is difficult
- Difficult talking about intimate things, particularly in a group
- Worry how others perceive her, judge → anxious
- v. anxious. didn't know what to expect how much to divulge

Right margin handwritten notes:
- Pessimism/uncertainty before the onset of group
- Group setting in a group - any. talking - silences - group members
- Other silence of group - silence/difficulty
- Dropping guard/facade - face fears - vulnerable? - challenge of ont.+ dip. - talking about - confronting - discussing intimate things
- Challenges/Group setting - judged → anxious
- Uncertainty about the therapy

1  Researcher: Ok. So can you tell me what your experiences
2  were of the group?
3  Penny: Umm generally or my personal kind of
4  Researcher: Both
5  Penny: Ok
6  Researcher: Anything that
7  Penny: Ummm
8  Researcher: Comes to mind
9  Penny: Initially I was very reluctant, couldn't see what it was
10  going to do to help
11  Researcher: Mmm hmm
12  Penny: Felt very anxious about talking in front of other people.
13  Umm. But by the end of it I felt it was very useful for me
14  personally. umm other people in the group didn't necessarily
15  open up very much and sometimes that was quite hard
16  because I then felt...there wasn't pressure that I was put on by
17  the people running the group but because there was silence
18  and no one would answer a question I kind of then would
19  feel...I hated the silence so I would feel I would need to answer
20  Researcher: Ok. And int-initially you said that you were
21  reluctant why were you feeling reluctant?
22  Penny: <Sigh> Umm it's not easy to talk about depression or
23  anxiety so I find that very difficult even though I come across
24  as very confident inside I'm not really so having to address,
25  confront all of that stuff is difficult..Umm. Yeh and so when I
26  was asked on my very first session how I felt I actually said I
27  would rather leave, I didn't want to be there. Umm...and I found
28  myself very very uncomfortable.
29  Researcher: Mmm hmm
30  Penny: Um because you're talking about stuff that's so, almost
31  intimate. It, you know to actually talk about those things that
32  you don't really want anyone else to know about to actually
33  have to voice them out loud it's hard enough in a one to one
34  session with the psychologist, it's ten times worse in front of a
35  group of people that you don't know
36  Researcher: Ok. And yo- you were saying you were reluctant
37  umm and you just explained why. You also said you were
38  feeling anxious about speaking in the group; is there anymore
39  you can tell me about being anxious?
40  Penny: Umm. When I feel anxious  get very hot and very
41  clammy and fidgety and uncomfortable and I felt all of those
42  feelings and then I feel people are going to judge me, and I
43  know rationally I know that with my rational head on that's not
44  true, but I do feel very yeh I do feel very very anxious that I
45  thought everyone would go oh <sigh> kind of a lot of my
46  anxiety is around how other people perceive me so, when I am
47  very very low when I'm really really badly depression
48  Researcher: Mmm
49  Penny: When I'm I just assume everybody's looking at me and
50  saying oh well wonder whatever because and all that kind of
51  stuff so in a group like that I kind of felt very similar, I kind of
52  thought people would kind of yeh judge me, I felt very anxious,
53  I had no idea, didn't know what to expect. Didn't know how
54  much of my personal experience of what led me to the group I
55  would have to umm go into and divulge I suppose I didn't know

56 umm how yeh I had no idea what to expect. That probably
57 sums it up.
58 Researcher: Mmm hmm
59 Penny: Even though I received the literature beforehand and
60 the psychologist who I'd met one to one said you know I think
61 this group might be useful for you and t- it was still fear of the
62 unknown I suppose umm. Yeh
63 Researcher: And so that's how you were feeling beforehand
64 and how did that kind of progress during the group?
65 Penny: Once the second week came and I knew what to
66 expect I felt less anxious, more comfortable umm. And I
67 suppose once we started doing exercises I then felt that there
68 was a a use and a benefit to it to begin with when it was just a
69 lot of sort of talking and I thought what am I doing here? Still,
70 you know? How is this going to help me? And I suppose the
71 name of it as well; acceptance and commitment-I didn't want to
72 accept the depression, I didn't want to accept the anxiety,
73 didn't want to accept how it makes me feel and by the end of it
74 I understood why it was called acceptance and commitment
75 therapy I suppose
76 Researcher: Ok
77 Penny: Although I still don't like accepting it but I know I have
78 to so, you know
79 Researcher: So initially you saw the word acceptance and you
80 thought I I just can't imagine accepting it but then how did that
81 change over time?
82 Penny: I suppose because as you go through the stuff in the
83 group and it was very well explained and I...because of the
84 silences I would fill them I would say well I don't I don't want to
85 accept this I don't like being like this I want to change it, I
86 thought the reason for coming to these groups was going to
87 help me change umm and obviously its changing your thinking
88 and how you deal with things so, I suppose by the end of it I
89 have learnt to accept that I and I suppose it's even hard voicing
90 it even now to accept that I will always suffer from anxiety and I
91 will always suffer with depression, but there isn't a quick fix and
92 that this is how I've been for however many years of my life
93 and I'll just have to, not learn to deal with it because I've learnt
94 coping mechanisms now from the group umm but yeh it it is a
95 case of having to accept that it is part of me
96 Researcher: Mm
97 Penny: And I don't still don't find that easy to say if I'm honest
98 Researcher: Ok mm hmm but it sounds like it's something you
99 have been able to take on board and been working on
100 Penny: Yeh
101 Researcher: From what you've been saying
102 Penny: I still don't like it though but I'm working on that <laugh>
103 Researcher: Anything else you can tell me about your
104 experience of the group, anything else that comes to mind
105 Penny: <sigh> I think I did find it hard that there were people
106 that appeared not to participate and I know that's probably their
107 anxieties but I feel that made the group made me more
108 anxious, it's quite hard to explain. Because if you're in a group
109 of people, and sort of like in a work setting, you're in a group of
110 people who are all discussing stuff everybody puts their two

111 pence worth in because that's the whole point but when there's
112 people in the group that never answer a question and never
113 say anything there were two of us that seemed to do all,
114 maybe three of us, that seemed to do...all of the giving of
115 ourselves and there were other people, I'm not saying they
116 ...they weren't active in the group and they may well have
117 taken a lot from it umm but it...um..it did feel..that it wasn't a
118 group participation
119 Researcher: Mmm hmm ok. And I know you said it made you
120 feel anxious when you were doing the talking?
121 Penny: Yeh
122 Researcher: When some people weren't. Why was it making
123 you anxious?
124 Penny: Just because when there are silence I feel I need to fill
125 them. And when someone sits there and then <therapist>
126 would say and how did that make you feel? And everyone sits
127 there. I'm like I'm not going to answer, I'm not going to answer,
128 Let someone else answer, I'm not going to answer, I'm not
129 going to answer, I'm not going to answer. Silence silence, and
130 then I'd have to answer. Just because it, I don't know maybe
131 it's my upbringing when someone asks me a question I have to
132 answer, I don't know, but it, and then the silence would just
133 almost kind of weigh down on me because it's like, someone
134 surely answer, it can't be me all the time.
135 Researcher: So silence is quite challenging for you?
136 Penny: Mm
137 Researcher: Yeh. Ok. Anything else you can tell me about your
138 experience of the a-, of the group?
139 Penny: Do you want sort of specifics of how I'v- particular
140 things have helped me since or?
141 Researcher: Anything
142 Penny: Ok
143 Researcher: That comes to mind yeh
144  Penny: <laugh> I found the mind mindfulness exercises really
145 useful umm but because I'm quite busy..the actual sitting down
146 in the quiet space in a chair
147 Researcher: Mmm hmm
148 Penny: And being able to shut my eyes and do all of that...isn't
149 very practical for me but what I learnt was how to...umm take
150 the philosophy of it if you like – it's probably the wrong word
151 but take the essence of it - I walk everywhere because I don't
152 drive because of my epilepsy, when I get anxious I do the
153 mindfulness stuff but through walking so I'm obviously not
154 shutting my eyes but I'm listening to sounds, I'm concentrating
155 on my breathing, each foot I lift up I'm feeling the muscle in my
156 thighs do the moving, I'm conscious of my knees, my feet, all
157 of that so very much we would do sitting down and that helps
158 with the anxious because I'm not focussing on it I'm focussing
159 on my legs or my feet or where I'm going or the birds singing or
160 the traffic, or, you know, and then I'm concentrating on my
161 breathing more, I'll be counting how many leg movements I
162 take and stuff like that and so..it's not the same but it it is the
163 same
164 Researcher: Ye it's still mindfulness
165 Penny: Yeh

166 Researcher: There's different types of mindfulness, there are
167 small sort of informal ways of using it, ok
168 Penny: And I suppose the other thing that's one of the things
169 that's really really worked for me is, I wrote myself a letter, at
170 the end of mindful-, at the end of the ACT sessions, one of the
171 things we talked about was how we could help ourselves when
172 we were very low and very depressed and I wanted to tell
173 myself how I feel when I'm well, and that when I'm not well th-
174 that it will get better so I wrote myself - it wouldn't make sense
175 to anybody else but it was a letter to me. And when I was low a
176 couple of weeks ago I read the letter and whilst I don't and I
177 wrote in my letter 'I know you're not going to believe me but it's
178 actually me so you have to believe me'
179 Researcher: Mm

180 Penny: I know that sounds all muddled. Because if anyone
181 else says to me 'you'll get through this, it'll get better, you know
182 you're stronger than that', I'm like, 'no I'm not, oh no I'm not'.
183 When I wrote it, 'this is me talking, you will, it does get better,
184 you have to remember', it did help because I was, it's probably
185 sounds really weird <laugh> but it actually made a big
186 difference. I mean that was one of the things along with the
187 goals and each time I would...I go into..self-destruct mode so
188 I'm useless, I'm fat, I'm thick, I'm stupid, I'm a rubbish mother,
189 the guilt, all of that stuff so when I then look at the goals, how
190 is all of that stuff actually helping me achieve some of the
191 goals that I wrote down that I wanted to do at the beginning I
192 can learn that it's actually taking me away from my goals and
193 not taking me to them. So there are lots of stuff that I use but
194 the letter was really really powerful for me.
195 Researcher: And wha- what led you to write that letter?
196 Penny: Well like I said at the end of the ACT therapy we talked
197 about umm different things we could do and different ideas and
198 I said that was something I thought would be useful
199 Researcher: Mmm
200 Penny: And other people said you know yes. <Therapist> said
201 'oh that's a good, good idea' and I wrote myself a letter and
202 then I will keep going back to it
203 Researcher: Lovely, ok. Anything else
204 Penny: Probably sounds really weird doesn't it?
205 Researcher: No at all
206 Penny: <Laugh>
207 Researcher: No
208 Penny: Um
209 Researcher: That's a that's a common thing to to bring into
210 therapy but amazing you just thought about it yourself
211 Penny: Umm anything else? Umm
212 Researcher: Anything you found particularly useful? Not so
213 useful?
214 Penny: I think one of the things that was quite useful in our
215 group was one of the psychiatrists came on the group with us
216 Researcher: Ok
217 Penny: And sat through it because, presumably he refers
218 people to ACT therapy and maybe didn't understand enough
219 about it and he did take part in the exercises and did answer
220 some of the questions. And I think that, initially I was like ohh I

221 don't think I want a psychiatrist here <laugh> he'll be carting
222 me off before you know by the end of the session but actually I
223 think he found it really useful and I think...and he wasn't able to
224 attend everyone but I think that was quite nice to have another
225 professional like that there
226 Researcher: Mmm hmm
227 Penny: To see how, you know, how it does make a difference
228 Researcher: Mmm. Absolutely, ok. Anything else you found
229 helpful, not so helpful?
230 Penny: Like I said, sorry I'm not I'm not looking at your paper, I
231 can't see that far away, I'm just concentrating umm. What else
232 did I find useful? <Pause> I used the, I'm probably not going to
233 remember the name of it. Is it the head space app?
234 Researcher: Ok, it sounds familiar
235 Penny: Which was recommended, and that was, you get ten
236 free sessions. And that was quite useful at night if I was
237 struggling to go to sleep. If I was feeling anxious I would just
238 put that on my phone and it would last ten minutes, it would be
239 the whole, again you're supposed to be sitting down I'd be
240 lying down doing my breathing
241 Researcher: Mmm
242 Penny: And stuff. Um so that was quite useful
243 Researcher: So is that meditation mindfulness exercises?
244 Penny: Mindfulness exercises yeh, just to try to shut out some
245 of the destructive thoughts that go through my head
246 Researcher: Mmm hmm. Great, ok. Anything you found
247 challenging?
248 Penny: <Sigh> There was a session I didn't make because I
249 had got myself into a bit of a state about ah. I felt I'd come
250 such a long way during the sessions and then I had a bit of a
251 blip. And I thought I can't go to the group because I'm a failure,
252 which is one of my, kind of, and I thought if I go and say, you
253 know, look at the state I'm in I've kind of failed. I didn't want the
254 group to see me fail or the group, yeh, so I found that hard. I
255 spoke to <therapist> for a long time on the phone and she kind
256 of said, you know, look you, sort of, its fine, there's no failure
257 and all that kind of stuff and I went back to the group and I was
258 able to voice that and say how that made me feel umm. I
259 suppose because I felt that other people had seen change in
260 me as well and I had grown in the group and then...I didn't
261 want other people to see me as a failure and then well, if she
262 can't do it then none of us can do it and so the guilt again, that
263 whole heap, it's all my fault, you know. I'm very good at piling
264 on the guilt
265 Researcher: Taking on lots of responsibility yourself
266 Penny: Yeh. Umm but it. But going back and I I think it's talking
267 about <sigh> like I say it's really difficult admitting to things and
268 not now so much because I'm doing really really well but when
269 I get very bad, getting out of bed in the morning is a huge
270 challenge for me, if I didn't work I don't think I would be able to
271 get out of bed. Um and it's breaking that I have to break it
272 down into the smallest steps, that's the only way I can do it. I
273 almost have to, right sit up, take breaths, sit, swirl legs round,
274 feet on floor, one step, two step, hand on the handle, that kind
275 of, I really, and when I say that's how I have to get up other

# Appendix J

Preliminary superordinate and subordinate themes

**Richard**

| Superordinate  Theme | Subordinate Theme |
|---|---|
| Challenge of group context | 1.  Large group size<br>2.  Upsetting listening to others<br>3.  Divulging and being judged<br>4.  Revert to childhood<br>5.  Over-compensate<br>6.  Effect of people not attending regularly<br>7.  Small group size |
| Group size | 1.  Benefits of a larger group<br>2.  Benefits of a smaller group<br>3.  Disadvantages of a smaller group |
| Easier in time | 1.  Divulging |
| Therapist's attributes | 1.  Relaxing<br>2.  Made to feel included/normalised difficulties |
| Limitations/ challenge of therapy/skills | 1.  Did not help with certain problems<br>2.  Doesn't help with severe problems<br>3.  Tired<br>4.  Homework – revert to childhood<br>5.  Group versus 1:1 therapy<br>6.  Present focused |
| Helpful things learnt | 1.  Breathing |
| Thoughts and feelings before the group | 1.  Uncertainty<br>2.  Worry (group setting, being judged)<br>3.  Low expectations/pessimistic |

| Practical challenges | 1. Timings<br>2. Venue |
|---|---|
| Benefit of group context | 1. Normalising |
| Acceptance | 1. Acknowledge the importance of acceptance<br>2. Difficulties accepting<br>3. Acceptance doesn't get rid of the problem |
| Difficulties in the early stages | 1. Large group |

Paul

| Superordinate Theme | Subordinate Theme |
|---|---|
| Pre therapy worry | 1. Difficult experience |
| Challenge of group context | 1. Difficulties expressing self<br>2. Being judged |
| Challenge of the therapy | 1. Difficult to apply the values work<br>2. Travelling to the group |
| Positive qualities of the therapist | 1. Warm, open, empathic |
| Group context/Practicalities | 1. Smaller group better |
| Limitations of the therapy | 1. Didn't address paranoia |
| Helpful skills learnt | 1. Defusion<br>2. Mindfulness |
| Benefits of group context | 1. Around people with similar problems<br>2. Reduces the burden<br>3. Relate to each other |

Penny

| Superordinate Theme | Subordinate Theme |
|---|---|
| Negative feelings/perceptions early on | 1. Uncertainty<br>2. Pessimism |
| Uncertainty | 1. What to expect?<br>2. Is this for me? |
| Difficulties accepting acceptance | 1. Acceptance versus change/getting rid of problems<br>2. Don't like the concept of acceptance |
| Challenge of the group setting | 1. Anxiety – talking about intimate things and being judged<br>2. Sense of responsibility<br>3. Dropping the façade<br>4. Mix of people<br>5. Group size |
| Practical issues | 1. Venue<br>2. Group size |
| Other group members | 1. Lack of participation<br>2. Being judged |
| Challenge of the therapy | 1. Dropping the façade<br>2. Discussing intimate things<br>3. The focus is not on change |
| Useful aspects | 1. Changes thinking<br>2. Tools<br>3. Around others with similar difficulties<br>4. Disclosing<br>5. Handouts |
| Benefits of the group context | 1. Around others with similar problems<br>2. Disclosing<br>3. Motivating |

Alison

| Superordinate Theme | Subordinate Theme |
|---|---|
| Practical difficulties | 1. Packed room<br>2. Unpredictable temperature |
| Positives of having two psychologists as facilitators | 1. Safe/Confident in expressing feelings |
| Challenges of the group | 1. Being around unfamiliar people<br>2. Poor memory<br>3. Lots to learn (but manageable) |
| Helpful aspects of the group context | 1. In the same boat/normalising |
| Things that were helpful | 1. Mindfulness/meditation<br>2. Learning to feel exposed<br>3. Overcoming avoidance<br>4. Kinder to self<br>5. Goals<br>6. Being around others with similar problems |
| Practical aspects that were beneficial | 1. Weekly sessions<br>2. Handouts |
| Improvements made over time | 1. Memory<br>2. Room being more spacious<br>3. People became more familiar<br>4. People talked more |
| Limitations of therapy | 1. Disappointing does not get rid of problems<br>2. Not long-lasting<br>3. Not helpful when problems are severe |
| Benefits of mindfulness/meditation | 1. Get out of head and be in here and now more<br>2. Manage uncomfortable feelings |

Robert

| Superordinate  Theme | Subordinate Theme |
|---|---|
| Benefits of group context | 1. Normalising being with people with similar issues<br>2. Distance self from difficulties better<br>3. Opened up thinking |
| Difficulties with group context | 1. Fear of being judged<br>2. Anxiety being around unfamiliar people<br>3. Outside issues entering the room |
| The experience of speaking in the group | 1. Negative<br>2. Helpful<br>3. Pushing self |
| Benefits of being around others with similar difficulties | 1. Normalising<br>2. Distance self from difficulties better<br>3. Explore difficulties in more detail |
| Negative feelings and perceptions | 1. Fear of being put on the spot<br>2. Fear of being judged<br>3. Being an outsider<br>4. Disappointment of therapy ending |
| Make-up of the group | 1. Males and females ratio |
| Easier in time | 1. Got to know others<br>2. Acceptance |
| Factors that are important to increase the usefulness of therapy | 1. Attending regularly<br>2. Readiness<br>3. Continuity<br>4. Sitting in a semi-circle<br>5. Regularly practicing what was learnt |

| Practicalities | 1. Group size<br>2. Continuity<br>3. Sitting in a semi-circle |
|---|---|
| Challenge of therapy | 1. Memory |
| Expectations | 1. It will lead to change/be the magic pill<br>2. High expectations and managing the disappointment |
| Challenge of acceptance | 1. Hoped for change<br>2. Takes time |
| Perceptions prior to therapy | 1. Unsure what to expect<br>2. High expectations |

Suzanne

| Superordinate Theme | Subordinate Theme |
|---|---|
| Limitations of therapy | 1. Doesn't deal with past issues and associated anger<br>2. Doesn't help when problems are more severe |
| Improvements made due to therapy | 1. Acceptance<br>2. Helped with here and now issues<br>3. Anxiety<br>4. Doing more<br>5. More self-confidence |
| Benefits being around others with similar difficulties | 1. Normalising<br>2. Share tips |
| Positives of therapists | 1. Made it easy/comfortable<br>2. Prompted but did not pressurise you to speak |
| Practicalities | 1. Group size<br>2. Sat in a semi-circle<br>3. Continuity |
| Easier in time | 1. Speaking in the group<br>2. Understanding acceptance |
| Benefits of group context | 1. Helped to gain confidence<br>2. Normalising (helped with acceptance?)<br>3. Share tips |
| How to make the most of the therapy | 1. Listen<br>2. Be open<br>3. Be patient |
| Negative experience of others | 1. Annoying when not open to the therapy |
| Challenge of the therapy | 1. Uncertainty<br>2. Took time<br>3. Didn't like it<br>4. Not good at accepting |

| Perceptions prior to therapy | 1. It will be a cure |
|---|---|
| | 2. It will deal with past issues |
| | 3. Uncertainty |
| Pessimism in the early stages of therapy | 1. Took time to click |
| | 2. Uncertainty |

## Appendix K

London Metropolitan University Ethical Approval

**London Metropolitan University,**
**School of Psychology,**
**Research Ethics Review Panel**

I can confirm that the following project has received ethical approval by one anonymous Reviewer, the Head of School of Psychology and the Dean of the FLSC to proceed with the following research study (Professional doctorate):

*Title:* An Interpretative Phenomenological Analysis Exploring Clients' Experiences of a Group Based on Acceptance and Commitment Therapy for Depression and Anxiety.
Revised proposal dated 1st December, 2014

*Student:* **Ms Amy Smith**

*Supervisor:* Dr. Angela Loulopoulou

Ethical clearance to proceed has been granted providing that the study follows the most recent Ethical guidelines to dated used by the School of Psychology and British Psychological Society, and follows the above proposal in detail.

The researcher and her supervisor are responsible for conducting the research and should inform the Ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: *Lange-Küttner*                    Date: 6 January 2015

Prof Dr Chris Lange-Küttner
(Chair - School of Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

# Appendix L

## NHS Ethical Approval

**NHS**

***Health Research Authority***

**NRES Committee Yorkshire & The Humber - Bradford Leeds**

Room 001
Jarrow Business Centre
Viking Industrial Park
Rolling Mill Road
Jarrow
NE32 3DT

Telephone: 0191 4283549

26 June 2015

Miss Amy Smith

[redacted]

Dear Miss Smith

| | |
|---|---|
| **Study title:** | **Acceptance and Commitment Therapy for Depression and Anxiety: Clients' Experiences in a Group Context** |
| **REC reference:** | 15/YH/0247 |
| **IRAS project ID:** | 168780 |

Thank you for your letter of 24th June, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Miss Christie Ord, nrescommittee.yorkandhumber-bradfordleeds@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the

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study.

<u>Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.</u>

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

<u>Registration of Clinical Trials</u>

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment.   We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**Ethical review of research sites**

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

| Document | Version | Date |
| --- | --- | --- |
| Covering letter on headed paper [Covering Letter] | 1 | 24 June 2015 |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [London Met Uni Insurance] | | 11 March 2015 |
| Interview schedules or topic guides for participants [Interview Questions] | | 04 April 2015 |
| IRAS Checklist XML [Checklist_24062015] | | 24 June 2015 |
| Other [Debriefing form] | 1 | 15 May 2015 |
| Other [Distress Protocol] | 1 | 15 May 2015 |
| Other [List of resources for further support] | 1 | 15 May 2015 |
| Other [Opt-in Form] | 1 | 11 May 2015 |
| Other [Critical Literature Review] | 1 | 11 May 2015 |
| Other [Response to Feedback] | 1 | 24 June 2015 |
| Participant consent form [Consent Form] | 1 | 15 May 2015 |
| Participant consent form [Consent Form] | 2 | 24 June 2015 |
| Participant information sheet (PIS) [Participant Information Sheet] | 1 | 15 May 2015 |
| Participant information sheet (PIS) [Participant Information Sheet] | 2 | 24 June 2015 |
| REC Application Form [REC_Form_11052015] | | 11 May 2015 |
| Research protocol or project proposal [Research Proposal] | 1 | 15 May 2015 |
| Summary CV for Chief Investigator (CI) [CV] | | 04 April 2015 |
| Validated questionnaire [Questionnaires] | 1 | 15 May 2015 |

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

**User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

**HRA Training**

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

| 15/YH/0247 | Please quote this number on all correspondence |
|---|---|

With the Committee's best wishes for the success of this project.

Yours sincerely

pp

**Dr Janet Holt**
**Chair**

Email:nrescommittee.yorkandhumber-bradfordleeds@nhs.net

| *Enclosures:* | "After ethical review – guidance for researchers" |
|---|---|
| *Copy to:* | *Dr Angela Loulopoulou, London Metropolitan University* |

London Metropolitan University Distress Protocol

**This protocol will be followed if participants become distressed during the interview process.**

This Distress Protocol is designed to deal with the possibility that some participants may become distressed during the interviews while discussing their experiences of therapy. As a Trainee Counselling Psychologist, the researcher has developed a set of skills for working with people with psychological difficulties, and this allows the researcher to ensure the safety of the participants and to manage situations where distress occurs. It is not expected that severe or extreme distress will occur during this research study, because every attempt will be made to ensure that potential participants such as psychotic, unstable and suicidal participants will be excluded from the study. In the situation where participants become unduly distressed, the following action will be taken to ensure the wellbeing of the participants.

**<u>Mild distress:</u>**

When mild distress occurs, it tends to be evidenced by signs such as tearfulness (watering and redness of the eyes), crying, difficulty in speaking, and the voice tends to become choked with emotion and the participant become distracted/restless.

In such cases appropriate action will be taken. The researcher will ask participants whether they are experiencing distress, and if they are then the researcher will offer them time to pause and compose themselves and whether the would like to continue with the interview.

**<u>Severe distress:</u>**

Severe distress can be identified by signs such as uncontrolled crying, uncontrollable tremors, inability to talk coherently, panic attacks, and hyperventilation.

In such cases appropriate action will be taken. The researcher will stop the interview, debrief the participant immediately and employ relaxation techniques

to regulate breathing and reduce agitation. The researcher will recognise the participants' distress, and will reassure the participants that their experiences are normal reactions to abnormal events and that most people recover gradually from such experiences. If any unresolved issues arise during the interview, the researcher will accept and validate the participants' distress, and suggest that they might want to discuss the experience with a mental health professional. Participants will be reminded that this research study is not designed as a therapeutic interaction and details of counselling/therapeutic services will be offered to the participants.

**<u>Extreme distress:</u>**

Extreme distress is manifested by signs such as severe agitation and possibly verbal or physical aggression. In extreme cases psychotic breakdown can take place where the participant relives the traumatic incident and begins to lose touch with reality.

In such cases appropriate action will be taken to maintain the safety of the participants and of the researcher, and if the researcher has concerns about the safety of the participants' or of others, then he will inform the participants that he has a duty to notify mental health services, such as a Community Psychiatric Nurse or the participant's General Practitioner. However, if the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask to be seen by the on-call Psychiatric liaison team. If the participant is unwilling to seek immediate help and becomes violent, then the Police may have to be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would be used only in an extreme emergency.)