Creating a Compendium of Third Wave Therapy Strategies

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ABSTRACT

Third Wave Cognitive Behavioural therapies have received much attention in the practice community recently. However, little has been done to understand how these therapies relate and diverge. Despite the varying theoretical models contributing to the Third Wave movement and their supposed varying therapeutic elements, studies have suggested that outcomes do not differ across these therapeutic approaches. This finding leaves room for the notion that shared or 'common' factors may be operating across these approaches. Exploration into common elements between these approaches is useful for identifying areas of overlap or uniqueness, shared processes of change, and perhaps components that may be particularly efficacious.

Goldfried argued the best way to identify the commonalities among diverse therapeutic approaches is to compare them by their principles of change, or change processes (Goldfried, 1980). Research has investigated change processes for many approaches, including those of the Behaviour and Cognitive tradition. However, such extensive investigations have not been applied to the Third Wave approaches. Further, a lack of quality comparisons across these approaches, even at the more specific level of therapeutic strategies, represents a gap in the field.

The present research first identified a set of strategies (84 items) within three Third Wave approaches: Dialectical Behaviour Therapy, Acceptance and Commitment Therapy and Mindfulness Based Cognitive Therapy. Strategies are sorted according to similarity in a card-sorting task, by two participant samples, a non-therapist sample (N=32) and a therapist sample (N=35). Sorting data were analysed using multidimensional scaling (MDS) to produce three three-dimensional models, representing each sample and a combined sample. The therapist sample was judged to represent the underlying relationships between strategies best.

Three dimensions were identified that classified strategies according to their internal or external orientation; response to experience (accepting or exploratory in nature); and the perspectives involved (clients or external such as therapists). Additionally, 17 clusters were identified that comprised strategies perceived to represent similar concepts, five of which contained strategies from all three paradigms

(Mindfulness; Noticing; Distress Tolerance and Acceptance; Therapist Style; and Observing and Perspective Taking).

Commonalities and differences observed across the approaches are discussed and suggestions made for future validation of this model. Applications are discussed around informing investigations of change processes in the Third Wave and the integration of Third Wave therapy elements. This research presents opportunities for mapping strategies to various characteristics of the client, therapist or disorder, for example, and then identifying effective strategy use among these variables.

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ABBREVIATIONS

3D	Three-dimensional
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behaviour Therapy
ACT	Acceptance and Commitment Therapy
MCBT	Mindfulness Based Cognitive Therapy
BPD	Borderline Personality Disorder
CANCORR	Canonical correlation
GOPA	Grouping, opposites, partitioning, adding
HCA	Hierarchical cluster analysis
MDS	Multi-dimensional scaling
MOSS	Method of Successive Sorts

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CHAPTER ONE

Introduction

Three Waves of Behavioural and Cognitive Therapy

Numerous psychological therapy approaches have been, and continue to be, developed, which can be classified within one or more philosophical or theoretical schools. These are generally considered to be psychoanalytic or psychodynamic; behavioural; cognitive; humanistic; integrative or holistic; and systemic therapies (Churchill, et al., 2010; Boswell, et al., 2011). Many approach are the product of integration across theoretical schools. One such example is Cognitive Behaviour Therapy (CBT), which is typically regarded as a family of related therapies that utilise theoretical models and procedures from both cognitive and behavioural schools (Mansell, 2008). Among these therapies, three distinct 'waves' have been proposed to classify the many approaches within the behavioural and cognitive tradition, each one representing a set of dominant beliefs, assumptions, procedures and goals to guide psychological research, theory and practice (Hayes, 2004). The Third Wave is a term given to the next emerging therapeutic tradition. Many common practice features are evident among the Third Wave therapies, despite their different theoretical underpinnings, and yet no study has investigated these therapeutic similarities or differences. The Third Wave encompasses many approaches, the most well known of which are Dialectical Behaviour Therapy (DBT; Linehan, 1993); Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999); and Mindfulness Based Cognitive Therapy (MBCT; Segal, Willilams, & Teasdale, 2002).

First Wave, Behavioural Therapy: Defining Characteristics

The first wave was Behaviour Therapy with its origins in the 1950s and 1960s, applying traditional principles from behaviourism to modify human behaviour (Kazdin, 1978), firmly rooted in learning theory (Beck, 1970). Behaviour Therapy was formed on scientifically established principles and offered an empirically-based alternative to the

traditional, non-empirical therapies of the time, including psychoanalysis and humanistic therapy. Behaviour Therapy is characterised as being heavily reliant on research and theory, particularly learning theory and conditioning principles, (Beck, 1970; Eysenck, 1959), as well as having a strong focus on overt behaviour. The emphasis on overt behaviour as the cause of behavioural problems, and the nearly exclusive use of Learning Theory to inform techniques comprised some of the main concerns with Behaviour Therapy. Eysenck (1959) compares Behaviour Therapy with Psychoanalytic Therapy in terms of the causes of behaviour: where Psychoanalytic Therapy implicates "unconscious causes", Behaviour Therapy points to "learned habits" as the function of behaviour. He describes Learning Theory's, and subsequently Behaviour Therapy's, characteristic approach to treatment in the example of treating an excess of conditioned responses with the extinction of these responses. This reduction of problematic behaviour into solely behavioural terms, with causal status primarily given to overt behaviours, was seen as neglecting non-behavioural underlying causes, such as thoughts, emotions, sensations and mood. Borne out of concern with the minimal focus on cognition came the next wave of the Behavioural and Cognitive Therapies, Cognitive Therapy.

Second Wave, Cognitive and Cognitive Behavioural Therapy: Defining Characteristics

Near the end of the 1960s, increasing importance was placed on the cognitive aspects of psychological functioning. Cognitive Therapy broadly, according to Beck (1970), is any technique which focuses on changing faulty thought patterns. Behaviour Therapy publications often avoided the subject of internal psychological states, as the discipline's theoretical framework - based on having observable behaviours which are both testable and reliable variables - was not suited to include such unobservable, unmeasurable internal states in their practice (Beck, 1970). Behaviour therapists nonetheless saw the importance of including these cognitions, such as thoughts and memories, in their practice (Hayes, 2004). Lazarus (1972, p. 165), for example, argued that correcting misconceptions – in other words, faulty thought patterns – comprised the major focus of therapeutic interventions, which he addressed by incorporating cognitive restructuring and modification into his work. Not only did behaviour therapists

increasingly recognise cognition as playing an important role in environmental systems along with overt behaviour, Beck highlights how in disorders like depression, cognition can be important on its own, quite separately from behaviour or the environment. However, the combination of both cognitive and behavioural factors was typical of the Second Wave, and Hayes (2004) describes many avoided taking sides by referring to the therapies as Cognitive Behaviour Therapy (CBT). Further, Lazarus claimed that cognitive modification worked in conjunction with behavioural change, both factors inevitably interacting with each other. The Second Wave is therefore characterised by the consideration of cognitions in psychological assessment, case formulation and treatment.

The Third Wave of Behavioural and Cognitive Therapy

Defining Characteristics

Hayes first described the category of the 'Third Wave of Behavioural and Cognitive Therapy' in 2004, with several defining characteristics. Firstly, they are empirical and focused on principles. Secondly, they emphasise the context and function of psychological events, such as thoughts and emotions, in addition to their form. For this reason, strategies are incorporated that focus on contextual features and experience, rather than purely direct, didactic strategies that focus on the form of psychological events. Further, Third Wave approaches place importance on developing broad behavioural repertoires that are flexible and promote the effectiveness of one's behaviours in a range of contexts or environments. This is presented in contrast to what Hayes describes as an eliminative approach often taken with problems that have been specifically defined. Another characteristic is the consideration of the Third Wave approaches' principles in relation to the therapist themselves. Finally, rather than discarding the knowledge and understandings produced by earlier waves of Behavioural and Cognitive Therapies, the Third Wave incorporates these into their own, newer understandings.

Context and Function. One of the most salient characteristics of Third Wave therapies is the focus on the context and function of an event, rather than simply their 'form'. Traditional CBT approaches tend to utilise strategies to change the form, frequency, validity or intensity of psychological events to alter their impact on an

individual's emotions and actions. These change targets represent the form of psychological events. Strategies may involve exploring the evidence for and against the accuracy of thoughts or altering the make-up of the thought. On the other hand, Third Wave therapies typically target the context of psychological events in an effort to change an individual's relationship to them. This represents the function of psychological events. Strategies are utilised to modify such contextual targets as: mindfulness, decentering, acceptance, values and commitment, among others (Hayes, Villatte, Levin, & Hildebrandt, 2011). Changes in these contextual factors are proposed to lead to a change in the relationship a person has with psychological events, such as their impact on other thoughts, emotions or overt actions.

Hofmann and colleagues, who advocate against the classification of therapies as Third Wave, agree that this is a core difference between therapies typically regarded as Third Wave and those of previous waves. He uses the example of 'decentering' in MBCT, involving taking a new perspective of thoughts as 'mental events' rather than facts, compared with changing the content of thoughts as in traditional CBTs (2011). They highlight how this difference can be described as different approaches to emotion regulation, where traditional CBT approaches use antecedent-focused strategies that regulate emotion before it is processed, involving a focus on form, and Third Wave therapies regulate the emotion after processing, involving a focus on the function of emotion.

To summarise this important distinction, Third Wave Therapies target context over content, and subsequently the function of a psychological event over its form. Changes in the content of psychological events or exploration of their validity are considered to occur indirectly throughout the process of therapy.

The importance of context in Third Wave therapies led to the proposal of a new name to replace the term "Third Wave". Hayes, Vilatte, Levin and Hildebrandt (2011) proposed "Contextual Cognitive Behavioural Therapy" as a more descriptive term which emphasised the assumptions of this group. Additionally, 'Third Wave' was criticised as implying that traditional Behavioural and Cognitive therapies were outdated, although its intention was to introduce a developing "strand of thinking" (Hayes, Villatte, Levin, & Hildebrandt, 2011) in the Behavioural and Cognitive tradition, with new assumptions, procedures and processes. A systematic review by

Dimidjian et al (2016), discussed further below, shows however that the use of the term "Third Wave" to identify these therapies remains in common use.

Experiential and direct change strategies. The Third Wave Therapies utilise strategies focusing on contextual and experiential change, as well as direct and didactic strategies as used in traditional CBT. Direct strategies may include reinforcement or identifying antecedents of problematic behaviour. Didactic strategies involve providing information or educating, such as explaining to clients the reasons for carrying out therapy activities or providing them information about their condition and the therapy process. These are incorporated into Third Wave therapies just as they are in the First and Second Waves, however, *contextual and experiential change strategies* are a unique and prominent feature of the Third Wave. These include strategies emphasising acceptance, mindfulness, cognitive defusion, values, and being in the present moment, among others (Hayes, 2004).

Importance of empirical evidence. Third Wave Therapies continue to place great importance on research, as in traditional CBT approaches. This is evident in the increasing amount of research conducted on Third Wave therapy processes and outcomes. Although the body of research on Third Wave therapies is increasing, it is still fairly small, especially in comparison with the previous waves. For instance, a Cochrane review (Hunot, et al., 2013) compared ACT and another Third Wave Therapy, 'Extended Behavioural Activation', with CBT for the treatment of depression. All approaches were equally effective, although they reported that the ACT studies were likely to have been affected by performance bias and researcher allegiance, as well as the fact that only two ACT studies, with a small sample size of 56, were included. Therefore, the equivalence of the approaches was not able to be accurately predicted beyond the final measurement in the study. A second example of empirical support for ACT is a large study conducted by Ritzert et al (2016). This involved 503 participants with anxiety-related diagnoses using an ACT workbook without any contact with a therapist. Measures of anxiety symptoms, quality of life, and ACT processes such as psychological flexibility were taken before the intervention, at 12 weeks, six months and nine months. All measures were significantly improved in the treatment condition as compared with the waitlist condition, and the waitlist condition showed the same results when they carried out the intervention.

Also receiving strong empirical support, DBT as compared with community treatment, was found to halve the likelihood of clients with parasuicidal behaviours attempting suicide, reducing medical risks, hospitalisation resulting from suicidal ideation, psychiatric hospitalisation, and psychiatric emergency department visits significantly. Further, drop-out rates were significantly lower in those receiving DBT compared with those receiving community treatments. These results were found even after one year follow up (Linehan, et al., 2006).

Finally, MBCT has evidenced its effectiveness. Across six studies with a total sample size of 593 participants who experienced three or more depressive episodes, MBCT, as compared with treatment as usual, showed a reduction in risk of relapse by 44%, and equal effectiveness when compared with anti-depressant treatment (Piet & Hougaard, 2011).

Developing flexible repertoires. Hayes (2004) describes another characteristic of Third Wave Therapies as developing broad and flexible repertoires. In other words, their approach makes them suitable for use in the treatment of a wide range of mental health conditions. With a focus on contextual factors, factors which are present throughout all situations such as mindfulness and acceptance, the skills and abilities learned in Third Wave Therapies can subsequently be applied to many different situations. This is in contrast to therapies such as CBT, where the focus tends to be on removing a specific problem, such as negative thoughts, or a specific pathology, such as a personality disorder. Additionally, the Third Wave Therapies' broad approach emphasises the importance of "empowerment and repertoire enhancement" (Hayes, 2004, pg. 881) over the identification of purely pathological features.

Building on previous understandings. Maintaining the empirical tradition of the Cognitive and Behavioural therapies, the Third Wave therapies incorporate and build on knowledge from the first and second waves (Guadiano, 2008). They continue the use of empirically supported strategies from behaviour and cognitive therapies, such as exposure and self-monitoring, because they are effective (Hayes, Villatte, Levin, & Hildebrandt, 2011). However, the reasons for using these strategies are often different in First and Second versus Third Wave therapies. For instance, in ACT, Hayes et al (2011) give an example of using exposure to increase behavioural flexibility during difficult psychological events, such as when experiencing difficult emotions. This is in

opposition to reducing emotional responding as it is used in CBT. Similarly, in ACT, thought recording is used to separate oneself from difficult thoughts, as opposed to challenging thoughts as in CBT. Additionally, the Third Wave welcomes concepts previously explored by non-empirical disciplines, giving rise to the introduction of such concepts as spirituality and mindfulness into therapy, but with the intent of underlying them with theory, scientifically investigated mechanisms and producing evidential outcomes.

Therapeutic considerations for clinicians. The Third Wave therapies also consider the clinician with regard to the important issues observed by each approach. The therapies in the present research encourage the clinician to undertake some similar form of therapy themselves, to enhance both their wellbeing and their ability to practice the therapy with their clients. MBCT encourages clinicians to develop mindfulness (Segal, Williams, & Teasdale, 2013), DBT utilises a peer consultation group to motivate and keep the clinician focused on helping their clients (Linehan, 1993, p. 118) and ACT emphasises the importance of its processes for the clinician, with Varra and colleagues (2008) showing that therapists who had ACT applied to them became increasingly open, willing and able to learn with regard to the use of evidence-based pharmacotherapy (Varra, Hayes, Roget, & Fisher, 2008). This characteristic aligns with the "radically non-hierarchical" stance these therapies often take (Hayes, 2004), placing the clinician and client as equals working toward the same goal, something which is emphasised especially in DBT strategies (Linehan, 1993).

What Approaches are considered Third Wave?

In their systematic review, Dimidjian, Arch and Schneider (2016) recorded the types and frequencies of cognitive and behavioural therapies identified as 'Third Wave' in their literature search. This consisted of the search terms "third wave" and "therapy" in the PsycINFO and PubMed databases. Literature was reviewed from between 2003, when the term 'third wave' was introduced, and 2015. Excluding duplicates and including only articles relevant to Third Wave Cognitive and Behavioural therapies, there were a total of 140 articles, which revealed 17 unique therapies classified as 'Third Wave'. In order of most frequently referenced, these included: Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT), Mindfulness-

Based Cognitive Therapy (MBCT), Functional Analytical Psychotherapy (FAP), Behavioural Activation (BA), Mindfulness, Metacognitive Therapy, Schema Therapy, Mode Deactivation Therapy, Integrative Behavioural Couple Therapy, Compassionate Mind Training, Mindfulness-Based Stress Reduction, Cognitive Behavioural Analysis System of Psychotherapy, Mindfulness-Based Training Group, Positive Psychotherapy, Unified Protocol of Barlow, and Compassion Focused Therapy.

Throughout 140 unique articles, ACT was identified as Third Wave in 66 articles, DBT 23 articles and MBCT 20 articles, FAP in 15 articles, BA in 11 articles and the remaining therapies fewer than ten articles. This suggests there is widespread agreement that DBT, ACT and MBCT not only fit the Third Wave classification, but appear to be the most well-known and researched of the Third Wave therapies, hence their inclusion in the present research.

Efficacious Components of Psychotherapy

In contrast to the development of different treatment approaches and waves of therapy is the argument that common features across approaches are more important than the specific features of individual approaches. Two central arguments comprise the ongoing debate about the primary components through which psychotherapy exerts its effects, namely, the Common Factors approach and the Specific Factors approach. The debate centres on the contributions of common factors – those elements present in most or even all approaches, and of specific factors – those attached to a specific model or approach (England, Butler, & Gonzalez, 2015). Briefly outlining the logic behind this debate, Marcus et al (2014) describe how if a particular treatment approach is found to be superior to another, the factors belonging to the superior treatment that are absent from the inferior treatment – so-called ‘specific factors’ – could be considered responsible for this difference in effectiveness. If the treatments obtain the same effects, however, they either have unique factors and mechanisms of change which happen to lead to similar outcomes, or perhaps more likely, the factors shared by both treatments – so-called ‘common factors’ – may be responsible for the similar effects. With research indeed suggesting the equivalent effectiveness of different therapeutic approaches, the investigation into these factors and efficacious components of therapy commenced.

Common Factors

The Common Factors approach aims to identify the core ingredients present across a range of psychotherapies. It has long been noted that different psychotherapy approaches have shared elements, referred to as 'common factors' (Goldfried & Newman, 1986). From this perspective, it is thought that the efficacy of psychotherapeutic treatment can be increased predominantly through the enhancement of these factors. This idea began when Rosenzweig observed the similar outcomes across different psychotherapy approaches. Labelling this phenomenon the 'Dodo Bird Verdict', he proposed that shared therapeutic elements are likely to explain this finding (1936). Since the 1970s, reviews and meta-analyses, utilising hundreds of unique studies and large sample sizes, have demonstrated virtually no differential effects between psychotherapy approaches (Luborsky et al, 1975; Smith and Glass, 1977; Wampold, 1997, Luborksy et al, 2002). This finding, fuelling the common factors argument, continued despite research addressing the methodological and conceptual concerns of opponents of the Common Factors approach. Subsequently, the notion that different approaches share common core elements, and that these elements are predominantly responsible for the beneficial outcomes of therapy is strongly supported (Lambert, 1986; Lambert & Bergin, 1994; Luborsky, et al., 2002; Wampold, 2015). Some have even suggested that common factors are necessary and sufficient components of therapy (Lambert, Garfield, & Bergin, 2004). However, both common and specific factors are acknowledged as important for therapeutic change, and the importance of their interrelations has been argued (Arkowitz, 2003; Wampold, 2015).

Specific Factors

The second argument in this debate is that of the Specific Factors approach. This posits that interventions specific to each approach, based on unique theoretical models of psychopathology and treatment, are responsible for the beneficial effects obtained in therapy. Thus, if each approach is different, different outcomes would also be expected. Given that these differences were not found, Specific Factors proponents explained these results by arguing that different approaches can achieve similar outcomes through different mechanisms - much like pharmacotherapy and psychotherapy have been

shown to obtain similar outcomes through clearly different mechanisms (Lambert and Ogles, 2004; Baker & McFall, 2014). Another suggestion is that therapy outcomes are generally measured based on their use across both a variety of psychological conditions and types of clients. Measuring the effects when averaged across different populations, rather than taking the population factors into account, could therefore explain the equal effect sizes (Blatt & Felsen, 1993). Supporting this idea is evidence that therapy approaches will vary in their effectiveness when applied to different conditions and different client populations (Beutler, Someah, Kimpara, & Miller, 2016).

Common Elements in the Present Research

In the psychotherapy literature, 'common factors' do not simply refer to any shared elements of therapy. They refer to factors such as therapist characteristics, the quality of the therapeutic alliance, and shared processes of change (Grencavage & Norcross, 1990; Goldfried M. R., 1980). Therefore, such 'common factors' should be delineated from the commonality that is discussed in the present research. The present research investigates the commonality amongst the specific strategies ('specific factors') endorsed by different therapeutic approaches. Identifying commonality at this level may in turn help to reveal shared processes of change, one type of 'common factor' as discussed in the literature (Baker & McFall, 2014; Goldfried M. R., 1980). Therefore, the importance of both the common and specific factors is acknowledged, and the ideas of each approach drawn on.

Specifically, it is entirely possible that 'specific factors' – the model-specific therapeutic elements that therapists use – do in fact have a significant impact on therapy outcomes. Masked by each approaches' unique theoretical model and labels, perhaps these strategies are not as model-specific as they appear. Exploring the commonality across these factors will help, then, to identify the degree of commonality among approaches. A high degree of commonality would provide one explanation for the similar outcomes found across psychotherapy approaches.

Alternatively, because of different theoretical underpinnings, strategies may really differ between approaches, yet share the same mechanisms of action (Baker & McFall, 2014). This represents the 'common change processes' explored by the Common Factors approach. Both explanations would account for why therapeutic

approaches appear to have distinct elements; but achieve similar results. This is discussed next in relation to the present research.

Additionally, identifying common therapeutic elements may indicate what the active ingredients or "curative" elements are (Lambert, 1986), which are largely responsible for psychotherapy outcomes. This reasoning was presented long ago by Goldfried, "to the extent that clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomenon, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases" (Goldfried, 1980, p. 996).

Change Processes

In 1980, Goldfried proposed three levels by which therapeutic approaches can be compared (1980). These ranged from the theoretical framework to the therapeutic techniques, between which resides an intermediate level which he termed "clinical principles". He argued that comparisons at the theoretical level are impeded by differences in language and philosophical orientations, and those at the technical level hide functional commonalities. He defined the role of clinical principles as "clinical heuristics that implicitly guide therapist efforts during the course of therapy" (p.994) and suggested analysing approaches at this level would help to reveal the commonalities shared by different approaches. Despite the passing of many decades, little research has been undertaken to analyse commonalities at the principle level (Wampold & Imel, 2015, p. 45). Further, robust investigations designed to quantify this commonality, beyond a surface review, are even rarer.

One investigation involved a literature review by Grencavage and Norcross (1990), to identify commonality amongst proposed common factors. Their review consisted of 50 publications and encompassed at least three therapeutic systems. These were not specified, however, the factors pertained to those of individual psychotherapy treatments. In total, they identified 89 common factors, and developed a new coding system to organise these into five categories: client characteristics; therapist qualities; treatment structure; relationship elements; and change processes. Their category of 'change processes' followed Goldfried's conception of 'clinical principles', defining it

as the "transtheoretical means by which change occurs in psychotherapy" (Prochaska, 1984, p. 374; Goldfried, 1980), and placing a change process between an approach's theory and its specific techniques. The other four categories of common factors are not the focus of investigation in the present research, and examples of these are given to highlight their differences. For instance, client characteristics included positive expectancies and hope; therapist qualities included the therapist's ability to enhance positive experiences and hope; treatment structure included the use of techniques and rituals; and the therapeutic relationship included developing a working alliance between therapist and client. In contrast, the category 'change processes' represents a comparison across the specific strategies of approaches, to determine what processes they work through. Given that each approach has many specific strategies, change processes can be identified within a single approach, and may highlight common factors amongst approaches, as well as reveal how approaches are distinct.

Common Change Processes

Grencavage and Norcross were particularly interested in those change processes that were common, in other words, shared, across all approaches. In their literature review, they identified the most commonly proposed common change processes as: catharsis; acquisition and practice of new behaviours; fostering insight or awareness; emotional and interpersonal learning; feedback or reality testing; success and mastery experiences; tension reduction; therapist modelling; desensitisation; and provision of information (1990). These should theoretically be found across all therapeutic paradigms then, including the Third Wave of Behavioural and Cognitive approaches. Given the Third Wave approaches are relatively new, the investigation of common elements or change processes has not received much attention.

However, common change processes have been proposed for specific therapeutic systems, including the Cognitive Behavioural Therapies (CBT). Mennin et al (2013) argue that focusing solely on comparing the efficacy of CBT approaches is likely to be a waste of resources, given their expected overlap. They recommend resources be put toward identifying the common characteristics among the CBT approaches, including the First, Second and Third Wave approaches, instead of focusing on their minor differences, or "faux uniqueness" (Castonguay, Psychotherapy,

psychopathology, research and practice: Pathways of connections and integration, 2011). They argue that creating a "collective language" and more efficient research investigations may be possible if we focus on the common characteristics, thus leading to improved understandings and treatment of psychopathology. As a result, this model precludes an analysis of processes that may be unique to each wave of CBT. However, it provides a related framework from which potential common elements and processes within the Third Wave approaches can be identified. It may also serve as a comparison tool for delineating more specific differences between the waves of CBT.

Mennin et al (2013) propose characteristics that they believe to be common across all CBT approaches, from traditional approaches such as Behavioural Therapy and Cognitive Therapy, to more recent approaches such as the Third Wave therapies. These comprised shared goals, change principles and therapeutic processes. A suggested shared goal is behavioural adaptation, whereby an individual becomes better able to succeed in their environment by attributing meaning to behavioural cues and then using those cues to act effectively. This goal can be seen in the descriptions below for DBT, ACT and MBCT. For example, the ultimate aim of ACT is to enhance flexibility, which involves adjusting to situational changes in a manner that result in effective and values-aligned functioning (Kashdan & Rottenberg, 2012). DBT emphasises skill building to enable individuals to act more effectively. MBCT aims to enhance one's awareness of their experiences so that they can respond to them effectively, particularly to prevent depressive relapse. This shared goal is thought to come about through three change principles, context engagement, attention change and cognitive change.

Context Engagement. They describe context engagement as "engaging new external and internal contexts to promote the imagining or enacting of novel responses" in place of an individual's old and dysfunctional patterns of associations and reinforcement. Deficits in context engagement are commonly evidenced by escape, avoidance and inactivity behaviours to prevent difficult emotional states (Lohr, 2007).

Behavioural exposure. Mennin and colleagues propose that context engagement is reflected in the therapeutic process 'behavioural exposure', where engagement in difficult contexts is targeted. In traditional CBT approaches, gradually increasing exposure to feared stimuli through in vivo or interoceptive exposure strategies, for example, facilitates exposure. The researchers presented ways that Third Wave

therapies present opportunities for exposure also. For instance, values and values-based behaviours are identified and encouraged, which in turn can result in difficult experiences. However, the approaches' encouragement to persist with valued-behaviour, even if difficult, serves to result in exposure situations. Mindfulness strategies may also enhance exposure-based interventions due to improved attention and the ability to notice fear cues (Treanor, 2011). Others have suggested that mindfulness interventions inherently result in exposure situations, as they direct attention to one's emotional experiences, and often promote non-judgmental or non-reactive responses to them (Tang, Holze, & Posner, 2015). Interestingly, acceptance strategies were not considered with regard to behavioural exposure in Mennin et al's model. Whereas Hayes parallels the active experiencing involved in ACT acceptance strategies with exposure protocols from behavioural therapy (2004). Acceptance strategies seem likely to contribute to exposure situations given their objective to target avoidance of discomfort and instead promote willingness to experience it.

Behavioural activation. 'Behavioural Activation' is another common therapeutic process suggested to enhance context engagement. This involves assisting an individual to engage in behaviours that in turn provide positive reinforcement, encouraging the maintenance of the behaviour. Mennin et al give the examples of contingency management, skills training and activity scheduling as interventions used in behavioural activation. Additionally, values work was suggested to contribute to behavioural activation (Kanter et al, 2010), and is a feature unique to the Third Wave. Yet, it may share this process with the previous waves of CBT. However, given its roots in the Third Wave, it may work through additional processes that are not evident in the previous waves. A comparison within the Third Wave approaches might help to reveal any uniquely Third Wave processes.

Attention change. A second change principle proposed is attention change, which involves flexibly directing attention in response to situational demands. This includes focusing attention, sustaining attention and redirecting wandering attention, and moving attention. This is important as attentional inflexibility and negative attention biases are thought to be key features of emotional disorders (Joorman & Gotlib, 2007).

Attention training. Mennin and colleagues propose attention change is promoted through the therapeutic processes, 'attention training'. They suggest this can be targeted with interventions such as mindful awareness of emotions, senses and the body.

Acceptance and tolerance. They propose a second therapeutic process within attention change, 'acceptance and tolerance', whereby an individual maintains contact with feelings and emotions instead of engaging in thought processes to avoid these. The authors suggest elements in ACT that may be relevant to distress tolerance and acceptance, such as increasing awareness of how their thoughts and behaviours can result in avoidance. For DBT, they suggest the 'wise mind' strategy contributes to acceptance and tolerance processes. Presumably, this relates to the potential discomfort that may be experienced in this strategy, whereby an individual is encouraged to sustain discomfort by balancing an unpleasant emotional experience with logical reasoning.

It is interesting that 'acceptance' and 'tolerance' are grouped together as representing the same process. While they share similar ideas of experiencing discomfort instead of avoiding it, these concepts may work through different processes themselves, which is discussed later in this section. Considering this, one must question how accurate the conceptualisation of this process is. Perhaps it is a case of being too broadly defined. This may be more likely to capture common processes across a range of different therapies, but at the expense of identifying specific processes that are well defined and potentially more useful.

Cognitive change. Finally, cognitive change is the third change principle in the model, comprising cognitive distancing – experiencing thoughts and feelings from a new perspective that acknowledges the subjective, rather than factual, nature of their contents (Fresco, Moore et al, 2007); and cognitive reinterpretation – reappraising events in a more objective, positive, or compassionate manner. They propose cognitive change is targeted with two therapeutic processes: 'decentring or defusion', and 'cognitive reframing'.

Decentring or defusion. Mennin and colleagues propose 'decentring and defusion' results in cognitive distancing, which traditional CBT approaches target via self-monitoring. They suggest recent CBT approaches such as the Third Wave target

this in mindfulness interventions, for example, by observing inner experiences or viewing them as aspects of experience, as opposed to defining characteristics of the self.

Cognitive reframing. The second therapeutic process, 'cognitive reframing', is commonly referred to as cognitive restructuring in traditional CBT approaches (Beck, Rush, Shaw, & Emery, 1979), where interventions can involve analysing the validity or logic of events and altering distorted cognitions,. They describe how this is also targeted in ACT by encouraging individuals to consider new perspectives whereby difficult experiences aren't seen as needing to be controlled, but rather as natural experiences that could be accepted and allowed.

Specificity of change processes. Mennin et al's model of common change processes across the CBT approaches demonstrates some overlap with regard to processes involved in each change principle, particularly distress tolerance and acceptance, and mindfulness. Some overlap is inevitable as strategies are likely to effect change in many areas and possibly work through more than one change mechanism. However, this overlap might suggest the processes themselves are too broad. Combining 'tolerance' and 'acceptance' into one process further supports this idea. Considering this model is intended to represent the common processes across all CBT approaches, including the First, Second and Third Waves, it seems likely that the processes would be conceptualised reasonably broadly. An improvement would be to have a larger range of change processes with a greater level of specificity and distinction from one another. This would allow for more focused, rigorous studies that can investigate the validity of change processes, as well as the production of a model that is maximally informative and useful. Analysing the strategies of the Third Wave therapies specifically may help to achieve this specificity.

A Gap in Common Factors Research

Systematic investigations. Systematic investigations of change processes, whether common or unique, within the CBT approaches are scarce. To the researcher's knowledge, there have been no attempts to *systematically* investigate common elements, or common change processes, in the Third Wave Therapies specifically. The closest representation of these is based on a literature review – the model presented by Mennin et al (2013), representing common change processes across all CBT approaches,

including the Third Wave. Comparisons in literature reviews are often at the theoretical level, which are limited by model-specific languages differences (Goldfried, 1980). These surface level analyses prevent measurable, quantitative comparisons to be made.

Third wave specific investigations. Given the differences outlined between the three waves of CBT, the possibility of uniquely Third Wave elements and change processes should be considered. Therefore, a focused analysis on the Third Wave approaches might produce different findings that are more relevant for the Third Wave, enabling more specific comparisons to be made with other therapeutic approaches and traditions. Most importantly, this would enable comparisons between approaches *within* the Third Wave. Thus far, these have taken the form of surface level reviews of the literature.

Addressing the Gap

Several steps are necessary before common elements such as strategies and processes of change in the Third Wave approaches can be identified, let alone compared with other approaches. The absence of a systematic attempt to conduct these steps represents a gap in the field, which the present research aims to address. These involve firstly identifying strategies used in the Third Wave approaches, and secondly identifying the relationships between strategies in terms of commonalities and differences. Findings from this may then highlight potential change processes. While elements of the Third Wave approaches have not yet been systematically compared, comparisons made in the literature might highlight expected commonalities between the approaches.

In summary, the Common Factors approach argues that psychotherapy approaches are equally effective, and views common factors as the efficacious components of treatment., ‘Specific factors’ are viewed as working primarily through common mechanisms, without exerting a significant, unique effect of their own. The Specific Factors approach maintains that psychotherapy approaches do in fact have different effects, due to unique strategies working through unique mechanisms. The present research may help to identify commonality across so-called ‘specific factors’ in the approaches investigated, providing one explanation for the similar outcomes found across approaches. These commonalities may reveal the use of the same strategies,

perhaps indicating active ingredients which are consistently found to be effective and explaining their popularity across approaches. Alternatively, they may indicate common change processes by which the approaches exert their effects. Differences between approaches in terms of their strategy use may also be revealed that distinguish between the Third Wave approaches.

Third Wave Therapies in the Present Research

Three therapeutic approaches are investigated in this research, namely Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT) and Mindfulness-based Cognitive Therapy (MBCT). These are widely regarded as 'Third Wave' and are among the most researched and practiced approaches within this classification (Dimidjian, Arch, & Schneider, 2016). For these reasons, they were included in the present research.

Dialectical Behaviour Therapy

The development of Dialectical Behaviour Therapy (DBT) began in the 1980s when Marsha Linehan and her research team investigated the effectiveness of Cognitive Behavioural Therapy (CBT) for parasuicidal patients, particularly those meeting the criteria for Borderline Personality Disorder (BPD; Linehan, 1993). Thus, DBT originated as a modification of CBT for these populations. BPD is thought to result from severe emotion dysregulation, described by Linehan's Biosocial Theory as resulting from vulnerable biological factors and an invalidating environment. DBT targets these factors by incorporating, among others, emotion regulation skills and validation strategies (Koerner, 2012). Principles from Behaviour Therapy can be seen in the change procedures used in DBT, including skills training to target skills deficits, contingency management to target problematic contingencies, exposure to target problematic emotional processing, and cognitive restructuring to target problematic cognitive factors (Rizvi, Steffel, & Carson-Wong, 2013; Linehan, 1993, p. 100). DBT is organised within a dialectical philosophy, where "dialectical" refers to the idea that any viewpoint has an opposing viewpoint, and between them is a balance or synthesis of ideas (Harned, Banawan, & Lynch, 2006). The goal is to encourage and establish

change and growth, whilst being careful not to push the client away. To achieve this, the therapist must consistently maintain an important dialect – that between change – emphasised by Behaviour Theory – and acceptance – which is introduced in the Eastern Zen principles. The focus on acceptance is a predominant reason for DBT's classification as 'Third Wave', as discussed next.

DBT as a Third Wave Therapy. DBT follows the behavioural and cognitive tradition, as seen in its use of behavioural and cognitive principles, procedures and theoretical models. This and its incorporation of concepts generally addressed by non-cognitive behavioural approaches places it as 'Third Wave' (Hayes, 2004). Specifically, the integration of metacognition, emotions, dialectics, the therapeutic relationship (Kahl, Winter, & Schweiger, 2012), mindfulness and acceptance (Tan, 2011), have been arguments for its classification as Third Wave. Mindfulness in particular has been suggested to be of central importance to the Third Wave classification (Baer, 2006), which DBT incorporates via skills training, validation strategies and radical acceptance (Jennings & Apsche, 2014). Eastern Zen principles from Buddhism practices inform the mindfulness and distress tolerance skills training modules, whereby patients learn to observe, describe and participate fully with their experiences (Swales, 2009), likened to psychological, behavioural equivalents of Eastern meditation practices (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991); radical acceptance involves individuals non-judgmentally allowing these experiences; and Zen principles guide validation, where the therapist acknowledges the patient's experiences and highlights the truth and wisdom in their responses, validating the valid and not the invalid aspects of behaviour (Swales, 2009). Being mindful and accepting of painful experiences is encouraged, as opposed to a sole focus on change, due to the tendency of individuals with BPD to experience change as invalidating (Linehan, 1998). This represents the Third Wave focus on form over content.

Acceptance and Commitment Therapy

ACT is considered a behavioural approach, particularly based in clinical behaviour analysis (Hayes, 2004). It was developed within Relational Frame Theory (RFT; Hayes, Barnes-Holmes, & Roche, 2001), a research programme that attempts to explain how we understand behaviour through language and cognitive processes. RFT,

and subsequently ACT, emphasise the role of contextual factors in events, positing that desired changes will be produced via the manipulation of contextual factors. Hence, they see behaviour as determined by one's context and environment. Further, RFT stipulates that the learning of language and cognition involves being able to "relate events under arbitrary contextual control" (Hayes, 2004), meaning that the function of individual stimuli occurring in one context can be transferred to other contexts where similar stimuli appear, enabling more efficient learning of their functions. However, when contextual control over language processes weakens, psychopathology can result whereby dysfunctional interactions between language & cognition, and thoughts, emotions & overt actions occur (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Such dysfunctional interactions present as an inability to act in the service of one's values, referred to as 'psychological inflexibility'. Thus, ACT aims to enhance 'psychological *flexibility'* by enhancing contextual control over the language processes (Hayes, 2004, p. 15).

The ACT model, the hexaflex, implicates six processes in psychological inflexibility. The first process is experiential avoidance, targeted by promoting 'acceptance' – embracing unwanted experiences and ceasing the struggle to change or remove them (Prevedini, Presti, Rabitti, & Moderato, 2011). Secondly, cognitive fusion is targeted by defusing, or creating distance, from the "literal products of language and cognition", rather seeing products such as thoughts, beliefs or judgments as they are, rather than as facts. The third process is ruminating on a conceptualised past and feared future, targeted by enhancing 'contact with the present moment' – being psychologically present and aware, and having non-judgmental contact with events as they are. The fourth process is attachment to a 'conceptualised self', targeted by identifying the 'self-as-context' – stepping back to observe one's self-conceptualisations formed through past experiences, which serve to restrict our behaviour (Prevedini, Presti, Rabitti, & Moderato, 2011). ACT works to undermine these labels and enable one to take perspective from the 'self-as-context'. The fifth process is lack of values clarity, targeted by 'values clarification' whereby an individual identifies what is important to them, and uses these values to provide direction for meaningful living. The final process is inaction, impulsivity or avoidance, targeted by 'committed action', which promotes the planning and undertaking of values-based behaviours. By utilising

ACT strategies and techniques, these processes can be altered to align behaviours with values (Hayes, 2004).

What makes ACT Third Wave? ACT's focus on the role of contextual factors in determining behaviour is a salient reason for its Third Wave classification, clearly emphasising the context over content characteristic. Third Wave therapies also build on the understandings from behavioural and cognitive therapies', which is evident in ACT – several techniques are carried forward from traditional behavioural and cognitive therapies, such as thought records and exposure techniques, albeit used in slightly different ways (Hayes, Villatte, Levin, & Hildebrandt, 2011).

As discussed earlier, mindfulness is an important concept shared by the Third Wave therapies. Mindfulness and acceptance are represented by four out of six processes described above from the ACT hexaflex: acceptance; defusion; contact with the present moment; and self-as-context (Hayes, Luoma, Bond, Masuda, & Lillis, 2006).

Mindfulness-Based Cognitive Therapy

Mindfulness-based cognitive therapy (MBCT) was developed by Segal, Williams and Teasdale in the early 1990s as a relapse prevention programme, with the primary goal of reducing depression relapse and recurrence in individuals previously treated for and recovered from depression (Segal, Williams, & Teasdale, 2013). Originally 'Attentional Control Training', it was renamed Mindfulness-based Cognitive Therapy to reflect its integration of CBT, especially Cognitive Therapy for treating depression (Beck, Rush, Shaw, & Emery, 1979), and mindfulness training from Jon Kabat-Zinn's approach, Mindfulness Based Stress Reduction (Kabat-Zinn, 1990).

Segal et al (1996) describe MBCT as based on a 'mindfulness-based cognitive vulnerability model of depressive relapse', whereby ruminative, negative thinking occurring with dysphoric moods in previous episodes of depression are likely to re-emerge with subsequent dysphoric moods. The familiar mood activates the same depressogenic thinking associated with the mood when it was experienced previously, which increases the chances of the temporary mood descending into a depressive relapse. Not only thought patterns, but feelings and physical sensations are reactivated via feedback mechanisms to place one at risk of relapse (Segal, Williams, & Teasdale,

2013). Repeated exposure to dysphoric moods and associated depressogenic thought patterns, thoughts, feelings and sensations strengthens these associations, increasing the likelihood of depression relapse following each episode. Lower amounts of stress have been found to trigger this relapse following each episode (Kendler, Thornton, & Gardner, 2000).

MBCT aims to stop the cycle whereby dysphoric mood and depressogenic thinking lead to relapse (Segal, Williams, & Teasdale, 2013). Specifically, MBCT aims to increase awareness of mood and thought patterns, reflecting the influence of MBSR. It is proposed that this should result in three benefits: firstly, it facilitates the prediction and identification of negative moods; secondly, depressogenic thinking and ruminating could be reduced and subsequently weakened by redirecting limited processing resources to focusing on awareness instead; lastly, increased awareness may allow one to "exit" from the depressogenic thought patterns brought on by the negative moods. Once a person is more aware of their experiences, Cognitive Therapy interventions can be utilised to respond to any difficult experiences (Segal Z. V., Williams, Teasdale, & Gemar, 1996). The goal is to react thoughtfully and effectively, without resorting to automatic, ineffective responses used in the past**.**

What Makes MBCT Third Wave? Again, mindfulness is heavily focused on in MBCT, as is evident from the focus on the modes of mind. The aim is to shift from 'doing mode', which represents being on automatic pilot, to 'being mode', where one is more aware of their moods, thoughts, feelings, sensations and actions (Segal, Williams, & Teasdale, 2013). Differences in theorised mechanisms of action, specifically involving a greater focus on context over content, distinguishes MBCT from the first and second waves of Behavioural and Cognitive therapies. The developers of MBCT, like other mindfulness approaches, felt that focusing on changing thoughts would increase the attention on problematic thoughts, reinforcing the urge to fix problems by ruminating on them, thereby risking the continuation of the very cycle thought to lead to depressive relapse (Segal, Williams, & Teasdale, 2013, p. 57).

Thus, MBCT's interventions are designed to change patients' relationships with difficult thoughts and feelings, as opposed to traditional CBTs which attempt to modify their content. Using a traditional Cognitive Therapy technique, such as identifying and evaluating thought content by using thought record forms – traditional Cognitive

Therapy (Beck, Rush, Shaw, & Emery, 1979) endorsed a mechanism of action involving changing thought content (Lau, 2016) or assessing the validity of thoughts (Sipes & Eisendrath, 2012). However, Segal, Williams and Teasdale proposed the main mechanism of action behind this process is the decentring, or distancing, from thoughts and feelings (2013; Ingram & Hollon, 1986), which involves seeing thoughts as 'mental events' and not facts about reality. Further, acceptance is encouraged in MBCT through the promotion of allowing difficult thoughts and feelings, rather than trying to change or avoid them, as is commonly carried out in CBT.

These brief descriptions highlight some areas of commonality between DBT, ACT and MBCT. For instance, both mindfulness and acceptance appear to be important components in all three approaches. One question might be then, are these characteristic Third Wave elements simply the same across all Third Wave approaches, and incorporated because they are thought to be effective? Alternatively, do their diverse theoretical models each present different ways of targeting mindfulness? In that case, do they represent unique or shared change processes? A good place to start to investigate these questions is by reviewing the comparisons that have been presented in the literature, as some commonalities and differences have already been identified.

Comparisons between ACT, DBT and MBCT

This section illustrates commonalities and differences between DBT, ACT and MBCT that have been proposed in the literature. Table 1 below summarises these areas and provides an outline of expected similarities and differences.

Table 1
Commonalities and Differences Likely to be Evidenced Across DBT, ACT and MBCT

Important Elements/Processes	**DBT**	**ACT**	**MBCT**
Mindfulness	✓	✓	✓
Experiential Contact	✓	✓	✓
Acceptance	✓	✓	✓
Distress Tolerance	✓		
Perspective Taking	✓	✓	✓
Separation from Thoughts		✓	✓
Dialectical Strategies	✓		
Activity Planning	✓		✓
Values	✓	✓	
Commitment to Action	✓	✓	

Note. Ticks indicate the element is likely present in the approach

Mindfulness. Mindfulness is a significant component in ACT, DBT and MBCT (Baer, 2006). Chapman highlights the similarities and differences across mindfulness in DBT and ACT (2006). In DBT, mindfulness takes the form of a behavioural skill set for clients, and a stance for therapists, who are encouraged to undertake mindfulness practices from Zen and other mindfulness traditions (Chapman, 2006). Clients are taught mindfulness skills in many skills modules, and the mindfulness module is specifically dedicated to this. It aims to enhance the client's ability to see reality for what it is, in the present moment, and be able to respond to it effectively (Chapman &

Linehan, 2005). Linehan proposes ‘mindfulness as a set of skills’ as an intervention unique to DBT (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006), which differentiates DBT from other mindfulness approaches. The mindfulness skills taught in DBT are ‘observing’ the present moment, ‘describing’ observations, and ‘participating’ by throwing oneself fully into present moment activities and experiences.

ACT, on the other hand, does not teach mindfulness in the form of behavioural skills, and subsequently the intent is not to increase one’s skill set, as in DBT. In ACT, mindfulness is developed to undermine the factors contributing to experiential avoidance, by carrying out strategies from the ACT process ‘acceptance’; and to enhance the client’s experience of direct contingencies in their environment, targeted by the ACT process ‘contact with the present moment’ (Chapman, 2006).

However, comparing the forms of teaching mindfulness, whether as a skill-set or otherwise, hardly seems relevant or helpful for identifying how similar or different these mindfulness components, their strategies, and mechanisms of action are. An analysis into the specific therapeutic components in the approaches is required to identify their commonalities and differences. Therefore, referring back to DBT’s mindfulness skills, ‘observing’, ‘describing’ and ‘participating’, we can compare these components to ACT and MBCT.

‘Observing’ is an important aspect in both ACT and MBCT. Notably ‘describing’ is not promoted in ACT or MBCT; therefore this element of mindfulness may be one point of difference. ‘Participating’ is another mindfulness element that is unique to DBT. Chapman and Linehan specifically highlight how this differs from ACT (2005). They describe ‘participating’ is promoted to achieve one of the DBT goals of mindfulness – to completely immerse oneself in their experience and become “one” with it. They contrast this with ACT’s promotion of distancing from an experience, in an attempt to view it more objectively. For example, an ACT strategy used to do this involves identifying a separate “observing self” or taking an “observer perspective” from which to view one’s experiences (Hayes, 2004). However, one of ACT’s central processes is ‘Acceptance’, which encompasses the idea of participating in one’s experiences. This brings into question the comparison made by Chapman and Linehan. Whilst ACT does utilise distancing strategies, it also highlights *avoidance* and the *lack*

of contact with experiences as pathological features, and subsequently has strategies to enhance one's contact with their experiences (Hayes, 2004).

As Chapman (2006) recognises that accepting and experiencing reality as it is in the present moment is important to both ACT and DBT, the question may then be about the degree to which 'participating' is encouraged in the strategies of each therapy. Whilst Chapman did not include MBCT in her comparison of DBT and ACT, MBCT also utilises mindfulness strategies to enhance experiencing reality as it is in the present moment (Segal, Williams, & Teasdale, 2013). DBT, ACT and MBCT, unsurprisingly, share this concept, but the distinctions between the approaches are not very clear. As a predominant element of the Third Wave therapies, it is important to delineate how and if mindfulness differs across these approaches.

Separation from Thoughts. One way that mindfulness helps people is in separating from thoughts. DBT, MBCT and ACT all have some focus on the distinction of thoughts from reality. In ACT, this is referred to as 'cognitive defusion'. This involves stepping back from the content of one's thoughts in order to see them simply as thoughts, rather than as reflections of reality (Hayes, 2004). This concept is similarly utilised in MBCT, referred to as 'decentring', whereby thoughts are seen as "mental events" instead of as reflections of "objective reality" (Zettle & Gird, 2017). Decentring, as measured by the Toronto Mindfulness Scale (Lau, et al., 2006) was indeed reported to increase in individuals following MBCT treatment (Green & Bieling, 2012). It is difficult to differentiate ACT's 'cognitive defusion' from MBCT's 'decentring'. Mennin et al (2013) argue that both ACT and MBCT promote 'cognitive distancing' through practices that involve viewing inner experiences as objects, or noticing one's inner experiences. Chapman (2006) notes how DBT also encourages experiencing a thought as a thought, rather than a fact. However, here the individual is encouraged, again, to become immersed in the experience of the thought, rather than separating or stepping back from it. While all approaches appear to encourage a new way of viewing thoughts, perhaps the particular methods through which this is done will reveal their differences.

Values and Pleasant Events. Close relations between the process 'values' in ACT, which involves strategies for clarifying what is important in an individual's life, and the MBCT strategies involving reflection of one's lifestyle by noticing and planning

for ‘nourishing’ and ‘depleting’ activities, have been highlighted. MBCT does not have an explicit focus on values, but rather on the increase of positive mood states by teaching clients to schedule and undertake actions likely to bring about a positive mood, and reduce actions likely to result in a negative mood (Segal, Williams, & Teasdale, 2013). In a study involving college students taking an MBCT course, researchers observed that participants spontaneously began to discuss their own “life meanings”, which was likened to ‘values’, following MBCT activities that focused on identifying and planning nourishing activities and reducing depleting activities (Foley & Renner, 2012). This observation, whilst not based on a systematic, experimental method, highlights the similarity between the concepts of identifying values and identifying nourishing activities.

DBT also encourages engaging in and planning pleasant events, although this strategy, like MBCT, is used to increase positive emotions as part of emotion regulation. Further indicating similarities between this concept and values, emotion regulation skills in DBT also emphasise identifying values, values-based goals, actions to work toward goals, as well as committing to these values-based actions (Linehan, 2015, pp. 385-386). Whilst these strategies are different, as values typically represent broader life priorities, whereas pleasant events are short-term activities with more immediate effects, they may achieve their effects through a shared change process. Emotion regulation, for instance, represents one link between these concepts.

Values and Commitment to Action. In another study, it was reported that MBCT may enhance the clarification of important goals (represented by a measure of ‘goal specificity’), as well as the ability to follow valued life directions (represented by a measure of ‘perceived likelihood to achieve goals’) (Crane, Winder, Hargus, Myanthi, & Barnhofer, 2012). These relate very closely to the ‘values’ and ‘committed action’ processes in ACT (Hayes, 2004, p. 879). The researchers reported an increase in goal specificity and reduction in depressed mood in the MBCT treatment group, and no change in the waitlist control group. However, goal specificity was mediated by an increase in autobiographical memory specificity, therefore the MBCT treatment may have caused an increase in general cognitive specificity, as opposed to goal specificity directly. Further, perceived likelihood of achieving one’s goals increased, but was correlated with the reduction in depressed mood, resulting from the MBCT treatment.

Therefore, a direct increase in the perceived likelihood of goal achievement may not have been the result of MBCT treatment, but rather the treatment's effect of improvement in mood. Despite these considerations, the outcomes for the participants in the MBCT treatment group were similar to what would be expected for individuals practicing ACT's values and committed action strategies. Thus, if both approaches bring about changes in values clarification and values-based living, this may reflect the presence of similar therapeutic strategies.

Regarding values, DBT and ACT appear to share identical strategies. As mentioned above, DBT encourages identifying values, values-based goals, action steps to work toward values-based goals, and committing to taking action steps (Linehan, 2015, pp. 385-386). ACT promotes all of these strategies across two of its processes, 'values' and 'committed action' (Hayes, 2004, p. 879), therefore these approaches may be expected to overlap in this regard.

Acceptance and Distress Tolerance. Chapman (2006) contrasts how acceptance is incorporated into both ACT and DBT. DBT's inclusion of acceptance arose through research and experience practicing with BPD patients, particularly from observations of patients dropping out or becoming overwhelmed by a sole focus on behavioural and cognitive change. Thus, acceptance strategies were adopted from other paradigms to enable the client's acceptance of reality in general and of themselves. Conversely, ACT's inclusion of acceptance originated from Hayes' theory of psychopathology whereby, through experiential avoidance – attempts to avoid unwanted thoughts, emotions or situations – one develops and maintains their suffering. Acceptance strategies, predominantly residing in the ACT process 'acceptance', were then developed specifically to target the pathological mechanism of experiential avoidance.

Further, Chapman notes how acceptance and change are similarly balanced in both ACT and DBT. This is reflected in DBT's dialectical philosophy, where the therapist pushes for the synthesis of change and acceptance, utilising change strategies to help the client to progress, while carefully preventing the client's resistance to therapy and subsequent growth by incorporating acceptance strategies into treatment. In ACT, Hayes considers that internal behaviours such as emotions and cognitions are not "readily changeable", and so they are instead subjected to acceptance-based strategies.

Change strategies in ACT are used to modify overt actions so that they follow more valued directions (Hayes, 2004).

Again, such comparisons at this level are broad and not likely to be addressed via an exploration of the more specific therapeutic elements, as is the focus of this research. They are acknowledged here nonetheless as they contribute to comparisons between the Third Wave approaches, which, as outlined in this review, are rare in the literature.

Distress tolerance, the perceived or actual capacity to withstand physical discomfort such as negative emotional or aversive states (Leyro, Zvolensky, & Bernstein, 2010), is an important module in DBT group skills training and is also used in individual psychotherapy. Distress tolerance in DBT and acceptance in ACT have been likened as involving the ability to function despite facing difficult emotional and mental experiences (Gootzeit, 2014). The ACT process of 'acceptance' involves ceasing the struggle with unwanted thoughts, emotions, feelings and sensations, or ceasing "efforts to change one's self or history" (Hayes, 2004). Hayes specifically explains that acceptance is not simply "tolerance" but "active, non-judgmental embracing of experience", and is typically characterised by more openness and willingness (Wilson & Dufrene, 2010). Therefore, the degree of openness might distinguish these concepts. The definition of acceptance in ACT, above, bears a close resemblance to DBT's conceptualisation of mindfulness, in which acceptance is one goal. This encourages participating in and being "one" with experience. An important question is then, despite different origins, are these therapies offering anything unique in the ways they promote acceptance, or is this an identical overlap between DBT and ACT?

Leyro et al (2010) suggest that distress tolerance is targeted directly or indirectly in MBCT as well. Measured with the Distress Tolerance Scale (Simons & Gaher, 2005), researchers reported significant increases in the distress tolerance of nurses following completion of an MBCT course, compared with control group nurses who did not take the course (Motaghedi, Donyavi, & Mirzaian, 2016). Another study reported the outcomes of acceptance following MBCT treatment. Researchers found a significant, mediating correlation between pain acceptance, as measured with the Chronic Pain Acceptance Questionnaire (McCracken, Vowels, & Eccleston, 2004), and reduced pain interference following MBCT treatment (Day & Thorn, 2016). Indeed, the developers of

MBCT report the important objective of developing an "open and acceptant mode of response" and to "intentionally face and move in to difficulties and discomfort" (Teasdale, et al., 2000). These resemble elements of openness, as in acceptance in DBT and ACT. Therefore, commonalities are expected across MBCT, ACT and DBT in acceptance. By analysing specific strategies however, as opposed to broad concepts and equally broad definitions, it is more likely that any differences will be revealed across the approaches, as well as between acceptance and distress tolerance.

Dialectical Strategies. Linehan proposes dialectical strategies are unique to DBT (1993). These form a foundational principle within DBT and involve the balancing of opposing positions. One example is the balancing of acceptance with change, although this is also said to occur in ACT (Chapman, 2006). However, other elements that do appear to be unique to DBT include the therapists' abrupt changing of tone and communication styles from one extreme to another, to keep the client alert and off balance; and those that encourage the client to reach a synthesis of different or opposite perspectives by identifying alternative valid ones (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). These strategies are aligned with the dialectical philosophy underpinning DBT, therefore it is expected that they represent a unique element that distinguishes DBT from both ACT and MBCT. However, these investigations have not yet been carried out.

Implications for the Integration of Third Wave Therapies

The comparison of strategies used in Third Wave approaches has the potential to inform a new organisational framework of Third Wave strategies, as described by Dimidjian et al (2016). This has implications for the integration of Third Wave approaches. Integration can take many forms, including integrating the approaches' theoretical models as well as its specific strategies, termed theoretical integration; or using elements from different approaches which are expected to be effective, without considering their theoretical basis, as in technical eclecticism; and common factors models also represent a form of integration (Norcross & Goldfried, 2005). The design of the present research should enable the integration of Third Wave approaches in any of these ways.

Chapter One
Introduction

Psychotherapy integration has many potential benefits, including enhanced understandings and subsequent advances in psychotherapy by promoting consideration of other approaches' perspectives (Castonguay & Goldfried, 1994). Additionally, it can support therapists in matching interventions to an individual's characteristics, problems and contexts (Zarbo, Tasca, Cattafi, & Compare, 2015). This is important as the range of factors that vary across people, disorders and contexts mean one approach does not always work for a specific diagnosis, thus requiring modifications to suit the individual. The wide range of disorders that DBT, ACT and MBCT are used to treat, described above, highlights the potential increased applicability of their integration.

The implications of this research for psychotherapy integration are potentially quite significant based on the substantial amounts of therapists who use integrative approaches. As early as 1998, Kazantzis and Deane reported 31 percent of their sample of 221 psychologists in New Zealand used an eclectic approach. Further, 86 percent of psychologists reported using multiple theoretical orientations (Kazantzis & Deane, 1998). Norcross & Goldfried (2005) reviewed rates of therapist endorsement of eclectic or integrative psychotherapy across the United States, Australia, Britain, Ireland, New Zealand, Spain and Portugal, reporting a range of 7-42 percent endorsement. In support of a Third Wave integrated model, nearly 10 percent of therapists in a society for psychotherapy integration reported integrating mindfulness or Third Wave approaches into their practice, the fourth most endorsed therapeutic system of nine in total (Norcross, Kosman, & Fernandez-Alvarez, 2016).

Recommendations from the Literature

In line with the findings in this review, Dimidjian et al (2016) highlight the limited research that has been conducted on the Third Wave therapies. In terms of the classification of Behavioural and Cognitive therapies into 'waves', they state the need to identify sets of therapies and their relationships to each other with greater precision. Specifically, research must address the extent to which the so-called Third Wave therapies have shared, common elements; the uniqueness of these elements to the Third Wave; and the effectiveness of these elements; with the hope that the findings will allow more thoughtful use of organising frameworks for the therapies and their elements.

Conclusions and Research Needs

This review illustrates the lack of rigorous, systematic research that has been conducted to compare the Third Wave therapies. A significant proportion of the literature compares them only at a surface level, commenting on areas of overlap or difference in the philosophical and theoretical backgrounds. There are few comparisons at the more specific level of therapeutic elements such as strategies or techniques, although these appear to also be carried out at a surface level. What appears to be missing is an in-depth analysis that follows a systematic, investigative process to identify and organise elements of therapies. This kind of investigation would be more likely to quantify the degree of commonality across therapies, and outline what the commonalities and differences are, rather than qualitatively speculating what they might be.

By comparing therapy approaches by their specific therapeutic elements such as strategies, it should be possible to identify their degree of similarity. An additional benefit of analysis at the strategy level is the possibility of identifying shared processes of change that these strategies may work through to bring about their effects, described as an optimal way to compare approaches (Goldfried, 1980). Investigating the common and unique elements of therapy approaches should contribute to their reorganisation and potential renaming to enable a common language of therapeutic strategies. This should also support more focused, efficient research that is able to investigate the processes behind the strategies, leading to improved understandings and treatment of various psychopathologies.

The Present Research

Approaches from the Third Wave, specifically Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT) and Mindfulness Based Cognitive Therapy (MBCT), are the focus of investigation in the present research. Of particular importance is the identification of the similarities and differences between

these therapies. This is undertaken in a more systematic manner that, to the researcher's knowledge, has not previously been carried out.

The approach used to do this involves the identification of strategies used in the Third Wave therapies, DBT, ACT and MBCT from the literature. This is followed by the validation of these strategies by experts in the field of mental health. Therapist and non-therapist samples will then sort these strategies to produce a three-dimensional conceptual model that represents the perceived relationships between strategies. The purpose of the model is to identify the degree of similarity between strategies, based on their proximity from each other. Thus, clustering of strategies should represent a group of conceptually similar strategies. Further, dimensions of therapeutic strategies may be revealed by identifying strategies or clusters of strategies that lie opposite each other, made possible by the three-dimensional nature of the model.

The aim of the present research is firstly to identify strategies central to DBT, ACT and MBCT; and secondly to determine the commonalities and differences across these strategies, and subsequently the approaches. No hypotheses are made as the investigation is an exploration of the relationships between strategies, as perceived by therapist and non-therapist samples. However, certain findings are expected, as outlined in table 1 above. Specifically, the therapy approaches are expected to overlap in the areas of mindfulness contact with experience; acceptance; and perspective taking; Expected differences include distress tolerance, which may be more prominent in DBT; distancing strategies, which appear to be absent from DBT but important components of both ACT and MBCT; activity planning around pleasant and unpleasant activities, which appears to be more important in DBT and MBCT than ACT; values planning, encouraged in DBT and ACT; and finally, dialectical strategies, which appear unique to DBT.

CHAPTER TWO

Method

The present involves two separate stages. The first stage was item generation, whereby strategies used by therapists in ACT, DBT and MBCT were identified. The second stage used a card sort procedure to explore the commonalities and differences between these strategies. This procedure was conducted by therapist and non-therapist samples. Data from the card sort were used to create three models showing how the therapies' strategies were perceived to relate by the samples: an expert (therapist) model; lay (non-therapist) model; and a combined model whereby data from both the expert and lay samples were combined.

Item Generation

Defining 'Strategy'

For the purposes of this research, a strategy was conceptualised as a concept to be worked on by the client, under the guidance of the therapist, by carrying out one or more techniques, exercises or activities in an attempt to achieve a particular therapeutic outcome. Some items represent styles the therapist uses in order to do this, such as changing their tone abruptly. Strategies were conceptualised on a level between specific techniques or exercises, and broader processes of therapy. These conceptual boundaries were used to guide the identification of strategies in the initial literature search. To guide therapists in validating these strategies, examples of these boundaries specific for each therapy paradigm were provided. These included:

MBCT

- Example of item on the **correct** level: 'non-judgmentally experiencing and allowing unpleasant thoughts, emotions or sensations'
- This is conceptually a level **above**: the actions involved in exercises such as 'three-minute breathing space' (which can be used as part of this strategy)

- This is conceptually a level **below**: the broader process of 'allowing' or 'letting be' (this strategy could be utilised throughout this process)

DBT

- Example of item on the **correct** level: 'accepting and holding opposing ideas'
- This is conceptually a level **above**: the action of identifying the use of "and" instead of "or" (which can be used as part of this strategy)
- This is conceptually a level **below**: the broader process of balancing perspective (this strategy could be utilised throughout this process)

ACT

- Example of item on the **correct** level: 'undertake willingness to experience thoughts'
- This is conceptually a level **above**: the exercises 'Tin Can Monster' or 'Physicalising Exercise' (which can be used as part of this strategy)
- This is conceptually a level **below**: the process of acceptance (this strategy could be utilised throughout this process)

As can be seen from the above examples, several techniques can be employed to carry out a strategy, and strategies in turn are drawn on within particular therapy 'processes'. The therapist initiates and guides the use of strategies throughout therapy, although some strategies are used by the therapist without the involvement of the client. For instance, when trying to convey acceptance of the client, a therapist might employ validation strategies whereby they demonstrate they are paying attention or that they understand the client's response.

Approach to Identify Items

The aim of the search was to identify the strategies of central importance to ACT, DBT and MBCT, that a therapist would utilise throughout the course of this therapy approach. Identifying these strategies involved searching through publications

on ACT, DBT and MBCT. Publications were chosen that were written by the developers of the therapies, as well as others experienced in the research, training and/or practice of the therapy. The publications described in detail the approaches' theoretical models, strategies and techniques, as well as providing detailed descriptions of the purpose of the strategies and how to implement them. This provided the researcher with a good understanding of the therapeutic elements to ensure the correct meaning was transferred when strategies from the book were re-written as the items used in this study. For a reference list of the publications used in item generation, see Appendix A, Item generation references. Additionally, a literature search using the databases 'PsycINFO' and 'Discover' was conducted prior to this research. This involved identifying strategies across a broader range of therapeutic approaches. While this encompassed an initial search for DBT, ACT and MBCT strategies, fewer strategies were identified and the publications used above were judged as more appropriate sources. In supporting this, those strategies identified in the previous search were also identified in the above publications.

DBT. For DBT, *Cognitive Behavioural Treatment for Borderline Personality Disorder* (1993), by clinical psychologist and creator of DBT, Marsha Linehan, was consulted. In addition, the *DBT Skills Training Manual 2nd edition* (Linehan, 2015) was reviewed. This resulted in a first draft of DBT strategies (see Appendix B, DBT strategies, first draft). A third publication was suggested by a clinical psychologist on the DBT validation panel, called *Doing DBT* (2012), by Kelly Koerner, a clinical psychologist who conducted research on DBT alongside Marsha Linehan. A second draft was created using this publication and compared with the first to ensure the inclusion of all DBT concepts from both drafts (see Appendix B, DBT strategies, second draft). To increase confidence that a complete coverage of DBT strategies was achieved, the strategies from both publications were compiled systematically according to categories, namely dialectical strategies; 'core' strategies including problem solving and validation strategies; stylistic strategies; case management strategies; and change procedures.

ACT. For ACT, the publication *ACT Made Simple: An Easy-To-Read Primer on Acceptance and Commitment Therapy* by Russ Harris was chosen (Harris, 2009). Russ Harris is a medical doctor, and after retraining as a psychotherapist, particularly in ACT,

has become widely recognised internationally for his ability to teach ACT to therapists in a manner that is simple and effective. To ensure the essential elements were captured, an additional publication was consulted, *A Practical Guide to Acceptance and Commitment Therapy* (2004) including two of the developers of ACT, Steven Hayes and Kirk Strosahl. A core model of ACT is the 'hexaflex', comprising six 'processes' that each represent a continuum from psychological *inflexibility*, whereby pathological features can arise and negatively impact one's life, to psychological flexibility, whereby pathological features are less likely to occur. These processes include: contact with the present moment; values; committed action; self-as-context; defusion; and acceptance. Strategies were systematically extracted for each process to ensure a range of strategies were incorporated (see Appendix C, ACT strategies).

MBCT. For MBCT, the publication used was *Mindfulness Based Cognitive Therapy for Depression* (2013) by the originators of MBCT, Zindel Segal, Mark Williams and John Teasdale. MBCT typically follows an eight-session structure where each session has a specific focus and incorporates the relevant strategies. In the 2013 publication, these sessions are labelled: 'awareness and automatic pilot'; 'living in our heads'; 'gathering the scattered mind'; 'recognising aversion'; 'allowing/letting be'; 'thoughts are not facts'; 'how can I best take care of myself'; and 'maintaining and extending new learning'. Strategies were extracted from this text session by session to ensure a good coverage of strategies from MBCT (see Appendix D, MBCT strategies).

Due to the discursive descriptions of strategies within the publications, labelling the strategies for this research required rewording them as the items needed to be about six words or less. The original wording was retained as much as possible to ensure the meaning was conveyed accurately by the strategy.

Item Exclusion Criteria

Strategies specifically excluded from the first stage of item generation include those strategies which are termed 'common factors'. These are strategies occurring across most or all therapies, regardless of their theoretical orientation or goals, such as those contributing to the enhancement of the therapeutic alliance. 'Incidental aspects' were also excluded. These are therapeutic elements that are not central to the approach's theory, and may or may not be common to all or most therapies (Wampold & Imel,

2015). These exclusions helped to ensure that only the core strategies – those considered specific, unique and/or essential to ACT, DBT and MBCT, were included. This was thought to provide the most meaningful comparison across ACT, DBT and MBCT. Secondly, this would limit the amount of strategies to be sorted in the card sort and result in a shorter item set. A longer item set can create problems with cognitive load on participants and can mean that it is more likely that items are sorted using surface criteria (e.g. individual words) rather than item meaning.

Where common factors are present in the item set, this is because they are considered a core component of the therapy approach. Wampold and Imel (2015) describe how common factors are usually incidental elements of most therapies; however these same elements can be characteristic or central to the theory of other therapies. For example, validation strategies are likely to be used across many therapy approaches, however they comprise the 'core strategies' within DBT, and are seen as having greater importance in DBT than other approaches. In these instances, the common factors were included.

The first stage of item generation resulted in a total of: 20 ACT strategies; 30 DBT strategies; 28 MBCT strategies.

Initial Descriptor Validation

The researcher and clinical psychologists who supervised the research assessed the strategies for any therapy-specific terminology, clarity, whether they represented more than one strategy, and their length. Therapy-specific words were replaced with neutral words as far as was possible, being careful to not change their meaning. Items thought to represent more than one strategy were split into two or more items. Lastly, items were shortened with an aim of less than six words per item.

This second iteration resulted in 28 ACT strategies; 53 DBT strategies; and 43 MBCT strategies (see Appendix B, DBT strategies; Appendix C, ACT strategies; and Appendix D, MBCT strategies).

Expert consensus

Items were reviewed and validated by a separate panel of experts for each therapy, in several stages. They edited items based on the same criteria involved in the Item generation stage. The following criteria were given to them in the instruction sheet:

- Items should be central to the therapy
- Item wording should accurately represent the strategy
- Each item should represent a single strategy
- Items should be written in an easy to understand language and should not contain technical language or language specific to the therapy. E.g., 'distance' instead of 'defuse'
- Items should collectively represent the full range of strategies central to the therapy
- Items should be fixed at a similar level. They should represent a cluster or grouping of specific actions, not one single action.

Specific examples of 'strategy', given above in 'Item generation', were listed underneath these criteria, specific to each therapy approach. The panel were instructed to record in the response form whether an item should be removed, modified or remain unchanged, along with what the proposed modified or added items should be (see Appendix E, Validation panel instructions).

First stage validation. The first stage involved sending the items to psychologists with extensive training and experience in each of the therapy approaches. Where available, Massey University psychologists reviewed the item set for the first stage.

The ACT item set was reviewed by two clinical psychologists from a Massey University Psychology Clinic. They each made changes directly to the validation panel instructions form (see Appendix E, Validation panel instructions). The DBT item set was reviewed by one clinical psychologist from a Massey University Psychology Clinic. These were discussed via phone consultation between the psychologist and researcher, which lasted one hour. The revised item set was sent to the psychologist and confirmed. As there were no MBCT-trained psychologists available at Massey University to review the items, these were reviewed by another clinical psychologist in New Zealand. The researcher and psychologist had a phone consultation, lasting one

and a half hours, to record these changes. These changes were sent to the psychologist and confirmed.

This stage resulted in a total of: 27 ACT items, 42 DBT items and 42 MBCT items (see Appendix B, DBT validation panel first stage; Appendix C, ACT validation panel first stage; and Appendix D, MBCT validation panel first stage).

Second stage validation. This stage involved having a second validation panel review the items revised by the first validation panel (first stage of expert consensus). The second ACT panel consisted of two therapists with extensive experience in the practice of ACT and the training of ACT to therapists. The second MBCT panel consisted of one MBCT-trained therapist, involved in the practice and training of MBCT. The therapist and researcher discussed the items over a two-hour phone call, and the items were again confirmed by the therapist. The second DBT panel consisted of one psychiatrist and one clinical psychologist, both DBT trainers affiliated with Marsha Linehan's training institute, Behavioral Tech, and both involved with DBT research.

Changes. Changes made to the items by the panels in this stage were accepted, except for one suggestion where one item was considered to be too broad – "develop flexible perspective taking". Therefore, a new, more specific item was added to represent the concept, "identify observing-self to view experiences from". Where there were two experts and they each suggested a different change, the clearer of the two changes was kept. For example, in ACT, "noticing thoughts that lead to avoidance behaviour" was suggested to be changed to "noticing thoughts that precede avoidance behaviour" by one expert, and "noticing thoughts that are antecedents to rigid, inflexible behaviour" by another. The item "noticing thoughts that lead to rigid, inflexible behaviour" was kept, as 'lead to' was decided by the researcher and supervisors of the study to be clearer than 'antecedents'. 'Rigid, inflexible behaviour' was also considered to be more accurate than 'avoidance behaviour', in accordance with the view of an expert from the validation panel who pointed out that 'avoidance behaviour' could be workable, and therefore useful, at times.

In ACT, the two experts suggested adding several items. Many of these were considered to be incongruent with ACT and aligned more closely with traditional CBT approaches. This was noted by the expert who suggested them and presented as a

decision for the researcher to either exclude or include. Such items were not added. As noted earlier, items that could be used in a therapy, but that aren't central to its theory, would not be included in order to have the item set consisting of the core strategies belonging to the approach. For example, one ACT expert suggested adding exposure and skills training such as goal-setting skills. However, these concepts were judged by the researcher and supervisors to have been included in the item set, and in a more ACT-congruent manner, such as "developing willingness to experience thoughts/feelings" and items that inherently involve skills training, such as "setting values-based goals".

This stage resulted in a total item set of: 29 items for ACT, 50 items for DBT and 47 items for MBCT. MBCT evidenced repetition of strategies throughout the set, so was subsequently condensed by the researcher to reduce repetition of similar concepts. These items were confirmed by the expert from the second stage validation panel. This resulted in a total of 27 items, which made up the MBCT item set for the third validation panel (see Appendix B, DBT validation panel second stage; Appendix C, ACT validation panel second stage; and Appendix C, MBCT validation panel second stage).

Third stage validation. This involved a third panel reviewing the item sets revised by the second validation panels, for MBCT and DBT. ACT had already been reviewed by four experts over two validation panel stages, and therefore no more experts or revisions were sought. DBT was reviewed by a clinical psychologist from a Massey University Psychology Clinic. Changes were discussed by the expert and researcher over the phone, which lasted for two hours, and these items sent to the expert and confirmed. MBCT was reviewed by three MBCT trained clinical psychologists in New Zealand. Changes were made directly to the response sheets.

Changes. For DBT, this stage was important to consolidate the responses from the two experts in the second validation panel. All suggestions were kept, including suggestions to remove items not considered to be important. For example, "explain relevance of therapy to client's difficulties" was removed as it was considered to be a common strategy across all approaches. Other changes involved shortening items from the second validation panel stage.

For MBCT, suggested word changes were very slight and so these were followed, even if the other experts responded that they were correct. For example, "controlling where attention is focused" was considered correct by two out of three experts, and the remaining expert suggested "choosing where attention is focused", therefore this change was made.

This stage resulted in a total item set of: 43 DBT items and 25 MBCT items (see Appendix B, DBT third stage validation panel and Appendix D, MBCT third stage validation panel).

Post-Validation Panel Revision

First Iteration. The researcher and supervisors assessed the item sets from the final validation panel stages – the third stage for DBT and MBCT and second stage for ACT. Items were reviewed for any jargon that had been introduced by the validation panel experts. For example, "accommodate unwanted thoughts" was changed to "make room for unwanted thoughts". Furthermore, items that could be combined, such as "make room for unwanted thoughts" and "make room for unwanted feelings" were combined to form "make room for unwanted thoughts and feelings". This was in order to reduce the number of items, and to ensure that items were sorted in the card-sort by the main concept, "make room for", to prevent sorting purely by thoughts or feelings.

This resulted in a total of 25 ACT items; 44 DBT items and 25 MBCT items.

Post-Validation Panel Revision

Second iteration. The researcher and supervisors reviewed all three item sets to identify strategies resembling similar concepts. Duplicate items with identical wording were removed, and items with slight wording differences which were considered to have identical meanings were removed, leaving only one item to represent the concept. For example, "commit to actions aligned with values" from ACT and "commit to valued actions" from DBT changed to "commit to valued actions" for both approaches as this was deemed to have the same meaning, but with simpler wording. This process resulted in a total number of 17 unique ACT items, 39 unique DBT items and 20 unique MBCT items. 8 items were found to repeat across two or more therapy approaches (see Appendix F, Similar items across therapy approaches).

Chapter Two
Method

Card-sort Procedure

Approach

Two samples were used in this task, a therapist sample and non-therapist sample. The therapist sample was essential to ensure the accurate understanding of the strategies. This should produce a more accurate sort where similar concepts are recognised as such and differentiated from different concepts. As technical language was removed from the items as far as possible whilst still retaining the intended meaning, a non-therapist sample was recruited to compare with the therapist sample. This served two validation purposes.

Firstly, therapists' interpretations may be influenced by their diverse theoretical training. That is, a therapist's interpretation of a therapeutic strategy may be dependent on the paradigm they practice within. The non-therapist sample are not trained in any therapeutic paradigms. Therefore, similar therapist and non-therapist maps would indicate the absence of this theoretical bias. The non-therapist map then serves as a validation of the therapist map.

Secondly, the non-therapist data may be useful for secondary applications. For example, in research that involves client (i.e. non-therapist) reporting of strategies used in therapy sessions, similar maps would support the reliability of client responses. Comparing the maps may also highlight differences in client (i.e. non-therapist) versus therapist perceptions of therapeutic strategies. Different understandings of, for example, the purpose of a strategy, may have implications for the client's perceived outcomes from the use of the strategy.

Alternatively, given the specialised knowledge of the therapist sample, differences in the maps may highlight greater accuracy, reliability and validity of the therapist data. This conclusion may be supported if relationships identified in the non-therapist map are similar, but not as clear or coherent as in the therapist map. In turn, the differences may be less likely to represent meaningful distinctions, and more likely to represent the non-therapists' reduced understanding of therapeutic strategies. If both maps are highly similar, the data may be combined to increase the sample size,

enhancing the reliability of the data, and validating the model in two different populations.

Participants

Therapists. A sample of 35 therapists was recruited through a number of sources. Advertisements were placed in New Zealand mental health organisations' newsletters, such as the New Zealand Association for Counsellors and the Psychology Association of New Zealand (see Appendix G, Therapist recruitment advertisement). Other mental health organisations forwarded emails to their members, including the New Zealand College of Clinical Psychologists. Emails were also sent internationally via email listservs, such as the Association of Contextual Science listserv, as well as ACT-, DBT- and MBCT-specific listservs. Recruitment resulted in 53 people contacting the researcher, of which 35 completed the card-sort procedure and returned results by the final cutoff date of data collection.

Demographic information including age, gender, country of residence, ethnicity, discipline of practice, years practicing in a mental health occupation and experience in Third Wave therapies was collected.

Therapists' ages ranged from 27-66 years (M = 45.2, SD = 10.86). Males made up one third of the therapist sample, with 11 males therapists and 24 female therapists participating. Therapists participated from the following countries, in order of most to least: New Zealand (11), Australia (9), United States (7), United Kingdom (3), Germany (2), Canada (1), India (1) and Brazil (1). Therapists were predominantly of Western European ethnicity (28), followed by North American (3), Eastern European (3) and Indian (1).

Therapists came from the following disciplines of practice: psychologist (21), psychotherapist (5), counsellor (4), psychiatrist (3), social worker (1) and one other (from a pain management, health behaviour change background, with inclusion of CBT and ACT work). Thirty-four therapists had experience practicing with a Third Wave approach, only one did not.

Non-therapists. A convenience sample of 32 non-therapists was recruited. Demographic information including age, gender, country of residence, ethnicity, and occupation was collected.

The non-therapist sample ranged in age from 18-60 years old (M = 31.9, SD = 12.2). Thirty-two participated from New Zealand and two from Australia. The non-therapist sample had an equal split of males and females. Non-therapists were predominantly of Western European ethnicity (29), then Indian (2) and Asian (1). The sample covered a range of occupational backgrounds, none of which included mental health roles.

Materials

Therapists. The recruitment emails and advertisements used for recruiting therapists contained a brief description of the research purpose and procedures involved, contact details for the researcher, and a link to a Massey University website in order to view the information sheet and register an expression of interest. Participants were asked to send their address details so further materials could be posted. An information sheet was emailed to therapists upon receiving their expression of interest, outlining the study purpose and objectives, a detailed description of their role as a participant in the study, and contact details for myself and the research supervisors. Accompanying this was a Participant Details Form to complete demographic and occupational information, and a Consent Form to confirm their understanding of the research procedures and to leave their contact details should they wish to receive a summary of the results. A link to a card-sort demonstration video was also emailed. A hard copy of the full study pack including information sheet, consent form, participant details form, GOPA card-sort instruction and response sheets, and cards with the strategies on them were sent to the physical addresses provided by the participants. The GOPA card-sort instruction and response sheets were based on Kirkland and Bimler's template for conducting GOPA card-sorts (see Appendix H, Therapist participant forms).

Each strategy card measured 10 x 3.2cm and had a single strategy typed on them in Bold Verdana, font size 16. Each strategy had a number printed in the corner which participants used to record their sorting arrangements.

Non-therapists. An email was sent to non-therapists outlining the research aims and procedures involved, and inviting them to participate. The card-sort demonstration video link was also provided. Those interested in participating were provided with the study pack which included the information sheet, consent form, participant details form,

card-sort instruction and response forms, and cards with strategies on them. The consent form, card-sort instruction and response forms were identical between therapists and non-therapists (see Appendix H, Therapist participant forms). The information sheet and participant details form had minor differences. For example, therapists were asked if they were experienced in the practice of any Third Wave therapies, whereas non-therapists would not have any experience practicing therapy (see Appendix I, Non-therapist participant forms).

Procedure

A description of the research procedures was evaluated by peer review by the Massey University Human Ethics Committee and judged to be low risk. Consequently, it did not require full review by a Massey University Human Ethics Committee and was recorded in the low-risk database (see Appendix J, Ethical approval).

All participants completed the GOPA card-sort, a procedure developed by Bimler and Kirkland (2007). The first phase, *Grouping*, has participants arrange the cards into distinct groups based on shared themes, as judged by the participant. In the next phase, *Opposites*, participants determine the groups most dissimilar from each other. In the *Partitioning* phase, participants create subgroups of similar items within the original groups from the Grouping phase. Finally, in the *Adding* phase, the most similar groups from the Grouping phase are joined together. The card sort was estimated to take 60-90 minutes per participant, although the majority of participants in both therapist and non-therapist samples took around 90-120 minutes. Responses were recorded on the GOPA Response Form and then emailed back to the researcher.

Analysis

Multidimensional Scaling

Multidimensional scaling is a form of analysis used to geometrically represent relationships among a set of stimuli, such as strategy items (Bimler & Kirkland, 2007). Stimuli similarity judgments inform these relationships, which can be modelled separately for different groups. In this research, this enables the comparison between the expert and lay samples regarding perceived underlying strategy relationships. High

similarity would suggest a single model of strategy relationships is valid for both expert and lay samples. Any differences may be explained by the samples' differing level of understanding of therapy strategies.

Data Transformation

Similarity judgments from the GOPA sorting task are transformed into similarity data, for use in MDS. These data represent similarity scores between all combinations of item pairs, determined by the number of times these pairs were grouped together. Similarity scores range from 0-1, where higher values indicate pairs are frequently grouped together, especially in the partitioning phase where partitioned items represent the highest level of similarity. Thus, higher scores indicate greater perceived similarity (Bimler & Kirkland, 1998).

Using MDS algorithms developed by Kruskal (1964), similarity data are transformed into ordinal proximity data. This allows representation of the data in a Euclidean space, within which data is linked to distance via an inverse monotonic relationship (Kruskal & Wish, 1978). That is, closer spatial proximity equates to greater similarity.

Map Development and Verification

The location of each item in this space (the 'map') is determined by its dimensional coordinates. There can be numerous dimensions, which represent the number of axes in the model. However, optimal dimensionality should be determined. This has been described as that which produces the least stress in the model. High stress indicates the configuration of the model does not represent the data well (Kruskal, 1964). However, minimising stress requires increasing dimensionality. This results in increasingly difficult comprehension and usability of the model, which may serve to reduce its meaningfulness. One method of determining the optimal dimensionality is to chart the stress values corresponding to different numbers of dimensions, and then identify the 'elbow' where increasing dimensionality no longer significantly reduces stress (Kruskal, 1964). The acceptability of stress values is also considered, to ensure the dimensional configuration accurately represents the data. Kruskal recommends

stress values of below 0.1 as acceptable (1964). These considerations should help to produce a map that is both accurate and meaningful.

Map Stability

One map was produced for each sample: an expert map; a lay map; and combined map representing the samples' combined data. Statistical analyses were conducted to assess the consistency between these maps. These included a cophenetic correlation, *r*, revealing the correlation between maps in terms of the distances between all combinations of items pairs in each map; Procrustes distances revealed the degree of dissimilarity between maps in terms of the locations of corresponding points; and Canonical correlations compared the dimensional similarity between maps (Bimler & Kirkland, 2007).

Additionally, the reliability of responses within each map was assessed by calculating the split-half reliability for each map independently.

CHAPTER THREE

Results

This section describes the processes that were followed in analysing the data in this research, as well as the results. The steps in this process are explained briefly below.

1. Participants' responses from the card sort of Third Wave Therapy strategies were entered into a computer program. These produced values representing the similarity of items, as perceived by participants from two samples, a therapist (expert) sample, and a non-therapist (lay) sample;
2. The consistency of the samples' data was compared by calculating the following: canonical correlation; Procrustes distance; and cophenetic correlation. Split half reliability was calculated to assess the internal consistency of responses within each sample. Stress values were also calculated to inform the optimal number of dimensions present in each samples' model;
3. Two statistical analyses, Hierarchical Cluster Analysis (HCA) and Multidimensional Scaling (MDS) were conducted using the similarity values to produce two visual models of the participants' data, for each sample separately;
4. The models were interpreted for each sample separately. The expert sample demonstrated superior stress values, split half reliability and generally more coherent groupings and placements of concepts. Therefore, the dominant focus in this section is on the expert model. The lay model is also presented, however, and the differences between the lay and expert models outlined.

Statistical Analysis

The Raw Data

Participants organised the set of 84 cards containing strategies from Third Wave therapies into groups based on face value in accordance to the GOPA procedure,

described in the Methods section. The item deck was independently sorted by participants from two samples, a therapist (expert) sample and non-therapist (lay) sample. Participants recorded the results from their card sort on the GOPA response sheet, which comprised the raw data used in this research.

The raw data were entered into a computer program, Data Organiser (Graybill, 2009), by the researcher. This program enabled detection of a number being incorrectly entered twice, requiring the researcher to look at the participant's response sheet to identify and reconcile the error. In these cases, the incorrectly repeated number was identified by matching the grouping phase and partitioning phase numbers. Where a number was not found to be present in either phase, it was deemed to be a mistake. Identified errors were changed to the correct values by the researcher. Errors predominantly consisted of repeated numbers (e.g., typing '11' instead of '1') or participants failing to partition every group from the grouping phase. This latter error was observed in two expert participants. Two lay participants recorded the same pair of numbers in both the adding and opposites phases. These numbers were therefore removed. In the remaining stages of data analysis, the statistician identified two participants who did not record the full set of 84 items. Based on the sample's results, it appeared that the missing items formed whole groups that were not recorded. Regardless, missing data from these participants were not included in the results, although the remainder of their data were.

Entering the raw GOPA data into the program produced a set of numbers for each participant, representing participants' grouping, opposites, partitioning and adding phases of the card sort. The statistician who conducted much of the analysis in this research, Dr. David Bimler, used these data to extract a matrix of similarity values. These values represent the similarity between two items across all possible pairs of the 84 items, averaged across the participants in each sample. Similarity values ranged from 0 to 1, where 0 indicates no similarity – items are never paired together even at the broadest level of grouping, and 1 indicates absolute similarity – items are always paired together, even at the most specific level of partitioning. An 84 x 84 matrix of similarity values was formed for each sample, which were used in the next two analyses.

Chapter Three
Results

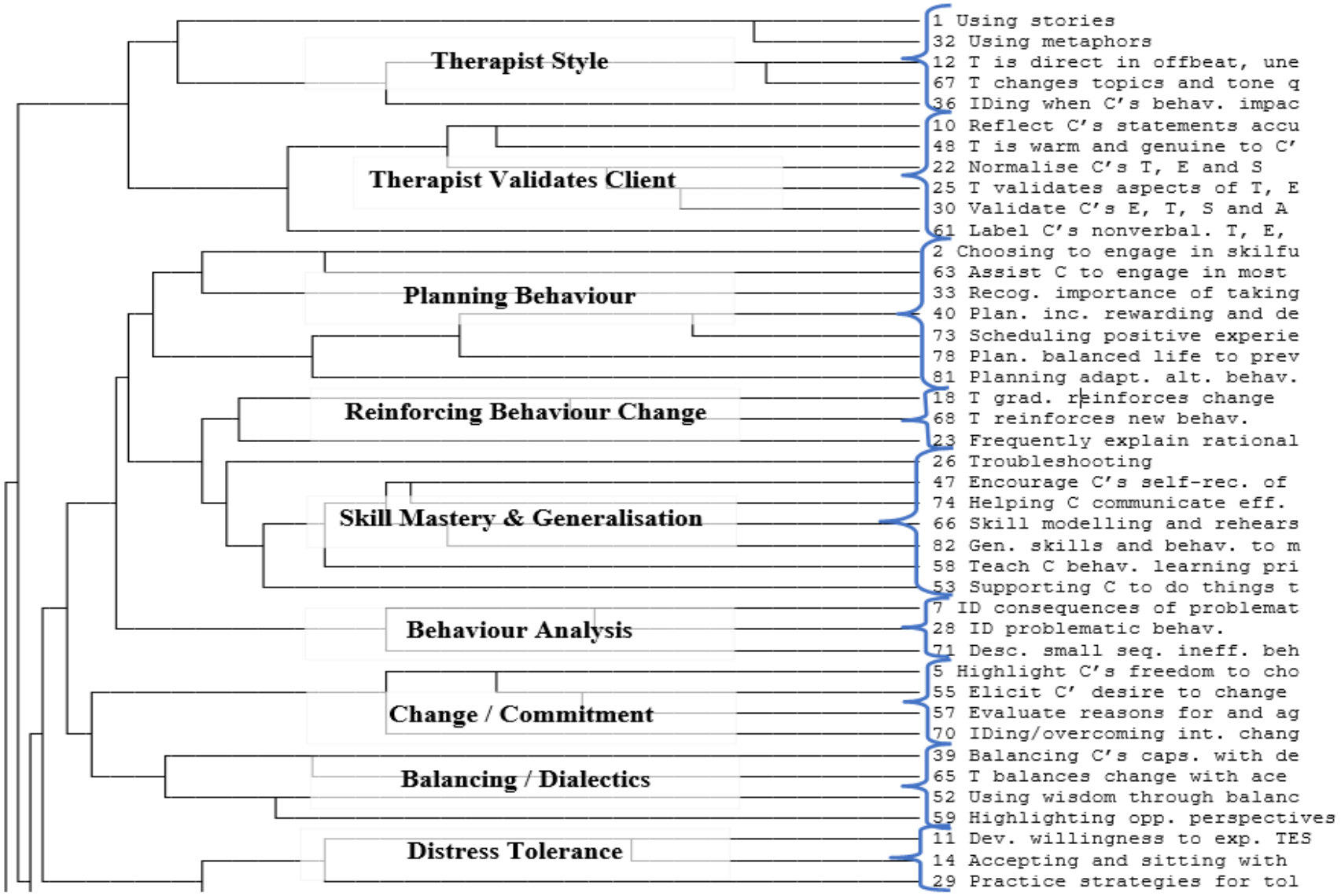
Data Analysis

Separate analyses were conducted on the expert and lay samples, as well as a third sample consisting of the combination of these samples' data (combined sample). Two analytical methods were used to interpret the data, namely Hierarchical Cluster Analysis (HCA) and Multidimensional Scaling (MDS). Both methods resulted in a visual model from which the results could be interpreted. HCA produced a dendrogram and MDS produced a multidimensional map of the Third Wave strategies. Further analyses were undertaken to determine the consistency across samples and to determine the reliability of responses. These analyses and their interpretations are described below.

Hierarchical Cluster Analysis. HCA uses the matrix of similarity values extracted from the GOPA data to display the items' similarity in a hierarchical cluster tree, known as a dendrogram. One dendrogram was produced for each sample. Figure 1 represents the expert sample dendrogram (see Appendix K for lay sample dendrogram and Appendix L for combined sample dendrogram). Items next to each other are perceived by participants to be most similar. Clusters forming on the left end represent broad groupings of similar items, or in other words, the sample's average results from the grouping and adding phases of the card sort. The smaller clusters forming closer to the right end represent specific groupings of items that are considered most similar to each other. In other words, these smaller clusters represent the sample's averaged results from the partitioning phase.

HCA was used to help identify clusters of similar items. As can be seen in Figure 1, groups are noticeable due to the lines leading into them on the left end. There are many levels of grouping that could be made based on these lines, however the meaningfulness of the groups and the coherence of the concepts represented by the items were taken into account when deciding on the groups. Therefore, whilst informed by the HCA, this process was subjective. For example, the cluster 'Attention and Awareness' down to and including 'Function of Thoughts/Emotions' could comprise one large cluster that represents several similar concepts. However, it is more meaningful to separate it into several clusters, with each cluster representing one concept, and labelling it accordingly.

HCA, whilst helpful in informing these clusters, does not demonstrate the relationships between the clusters themselves and between all the items within the clusters. This was revealed through the second analysis, MDS.


Therapist Style
Therapist Validates Client
Planning Behaviour
Reinforcing Behaviour Change
Skill Mastery & Generalisation
Behaviour Analysis
Change / Commitment
Balancing / Dialectics
Distress Tolerance
1 Using stories
32 Using metaphors
12 T is direct in offbeat, une
67 T changes topics and tone q
36 IDing when C's behav. impac
10 Reflect C's statements accu
48 T is warm and genuine to C'
22 Normalise C's T, E and S
25 T validates aspects of T, E
30 Validate C's E, T, S and A
61 Label C's nonverbal. T, E,
2 Choosing to engage in skilfu
63 Assist C to engage in most
33 Recog. importance of taking
40 Plan. inc. rewarding and de
73 Scheduling positive experie
78 Plan. balanced life to prev
81 Planning adapt. alt. behav.
18 T grad. reinforces change
68 T reinforces new behav.
23 Frequently explain rational
26 Troubleshooting
47 Encourage C's self-rec. of
74 Helping C communicate eff.
66 Skill modelling and rehears
82 Gen. skills and behav. to m
58 Teach C behav. learning pri
53 Supporting C to do things t
7 ID consequences of problemat
28 ID problematic behav.
71 Desc. small seq. ineff. beh
5 Highlight C's freedom to cho
55 Elicit C' desire to change
57 Evaluate reasons for and ag
70 IDing/overcoming int. chang
39 Balancing C's caps. with de
65 T balances change with ace
52 Using wisdom through balanc
59 Highlighting opp. perspectives
11 Dev. willingness to exp. TES
14 Accepting and sitting with
29 Practice strategies for tol

Chapt
Result

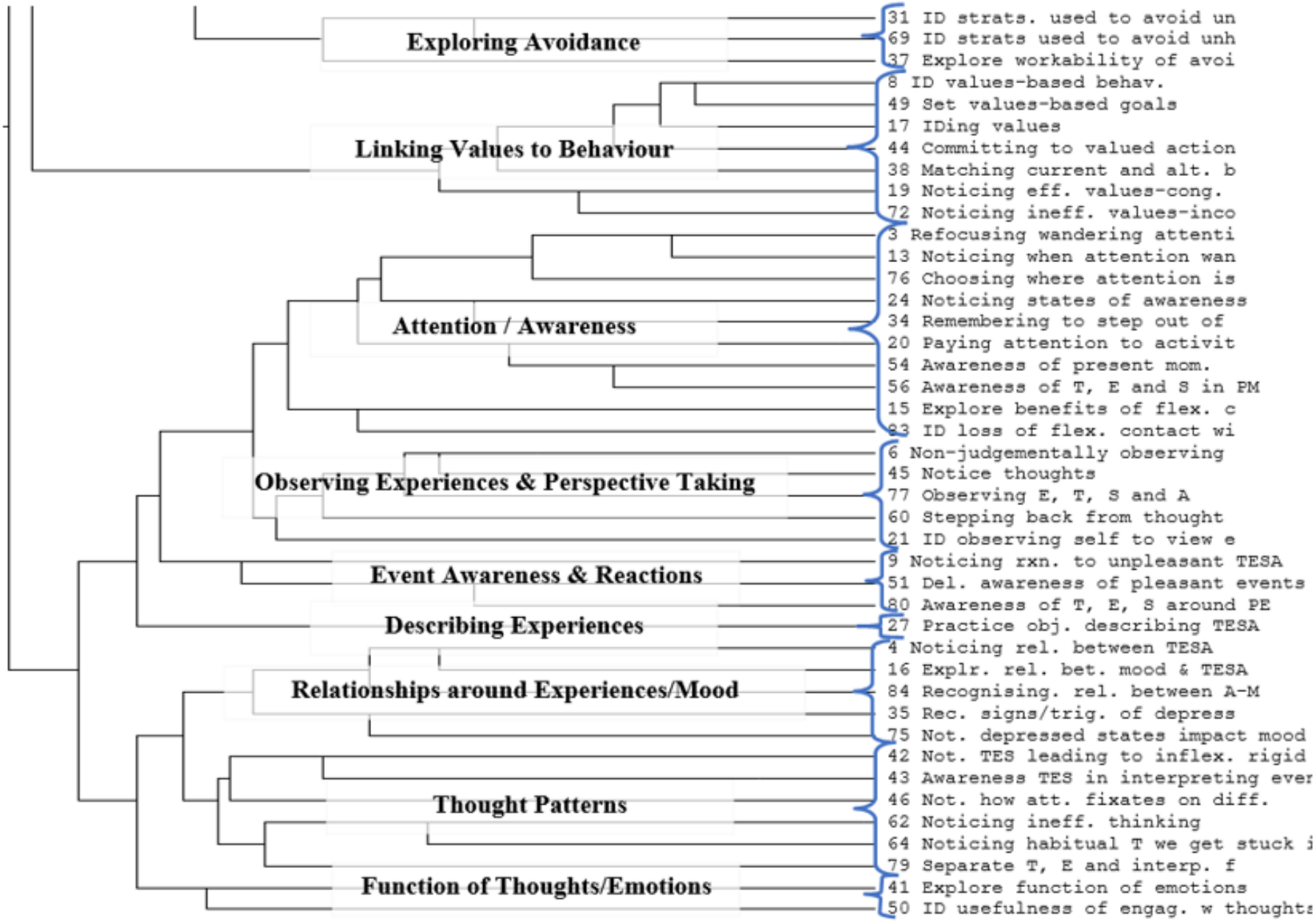


Figure 1. Expert model dendrogram showing preliminary clustering

Multidimensional Scaling. The matrix of similarity values extracted from the GOPA data were converted to proximity values for MDS, which represent the distances between items. Therefore, items could be accurately represented in a 3D space that allows interpretation of the relationships between items. MDS produces a model within which each item is represented by a single point in a spatial "map", where the distance between points equates to the dissimilarity between items (Bimler & Kirkland, 2003). This enables one to infer the relationship between items by identifying both clusters of items and the dimensions underlying each MDS solution (referred to here as a "map"). Ascertaining the relationships within a map is a subjective process carried out by examining the arrangement of items, then labelling specific clusters and dimensions according to what makes most sense practically (Ding, 2006). This map offers several benefits, including: the organisation of a large set of concepts, in this case 'Third Wave strategies', into a simpler, more workable number of main themes (dimensions); providing a visual display of the relationships between items; and providing a quantitative measurement of the similarity of items, as judged by the participants (Hout, Papesh, & Goldinger, 2013).

Stress. Stress represents how well the input data for each samples' solution, in this case the similarity matrix, corresponds to data as they are displayed in the spatial map. This calculation is based on the dimensions in the map – the core relationships underlying the items. A distorted representation of data (low correspondence between input data and the map) is evidenced by a high stress value. By increasing the number of dimensions in the data, this stress value lowers. But, with increasing dimensions comes an increasingly complex dataset and reduced interpretability.

Therefore, balance must be attained between a model's practicality and its statistical accuracy (Kruskal & Wish, 1978). Analysing the trend in stress at various levels of dimensionality can help to determine the optimal number of dimensions. This was computed for each sample and can be seen in the scree plot in Figure 2 below.

The 'elbow' (bend) that can be seen at three dimensions (3D) shows where increasing dimensionality starts to result in smaller decreases in stress. Stress values at 3D were 0.173 for the expert sample; 0.217 for the lay sample; and 0.174 for the combined sample.

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Compared with the lay sample, the expert and combined samples show a very similar and consistently lower level of stress, indicating less internal noise and more internal stability than the lay sample.

The stress values attained for all samples was greater than that recommended by Kruskal (1964), whereby stress values of 0 are perfect, 0.1 are fair and 0.2 are poor. However, others have suggested that a stress value of 0.15 is acceptable when the number of items is greater than the number of dimensions. Further, values greater than 0.15 may be acceptable if the number of items is at least 10 times greater than the number of dimensions (Borg & Groenen, 2005). In this case, the number of items is 28 times greater than the number of dimensions. Thus, these stress values, especially for the expert and combined samples, were considered to be within an acceptable range. Furthermore, it was decided that the increasing complexity of a model with four dimensions was not worth the slight decrease in stress, and the 3D models were used.

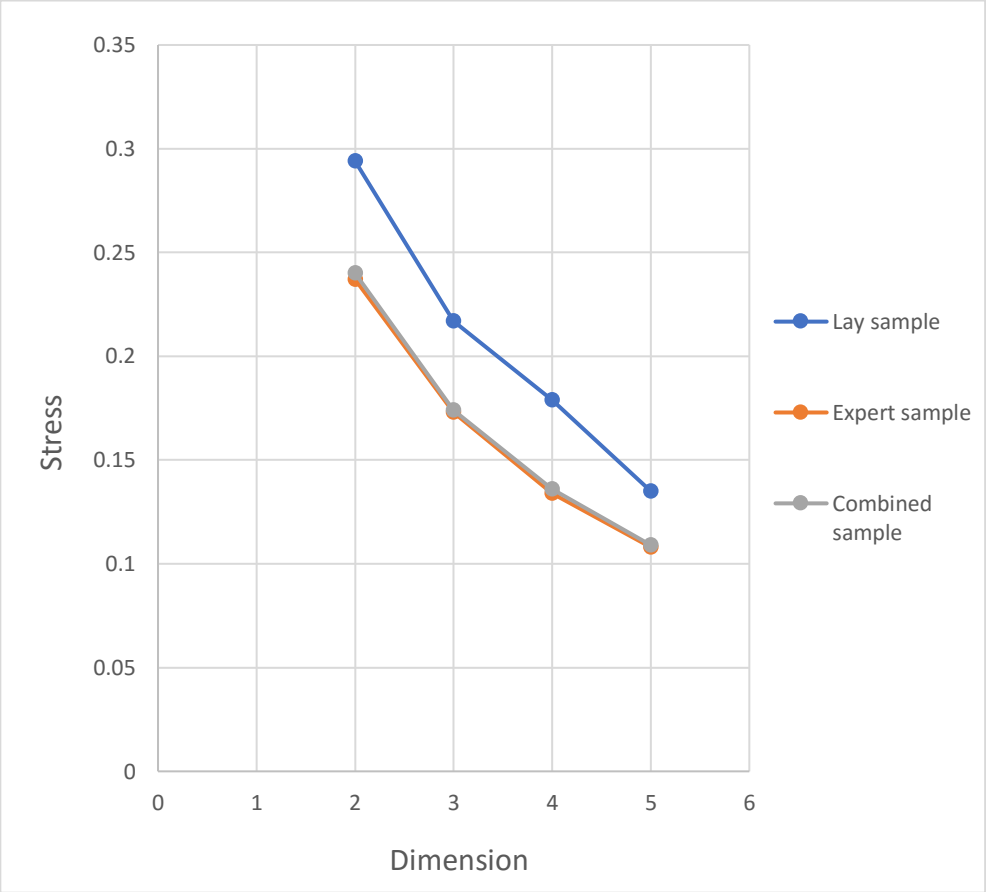

Figure 2. Scree plot showing stress and dimensionality for expert, lay and combined samples

Consistency Between Samples

Several analyses were conducted to compare the expert and lay samples' results. Firstly, the canonical correlation computes the relationship between dimensions in the expert and lay sample. Secondly, the Procrustes distance indicates the degree of dissimilarity of item positions between the expert and lay samples. Thirdly, the cophenetic correlation indicates the similarity of inter-point distances between the expert and lay samples. Additionally, the split half reliability is calculated for each sample, which indicates whether the data (responses) from that sample are stable. A high value indicates greater stability and a satisfactory sample size. The results of these analyses are reported next.

Canonical correlation. A canonical correlation represents the relationship between the dimensions within the expert and lay samples' MDS solutions. This analysis identifies dimensions within each solution and, essentially, realigns the solutions until the best fit between their dimensions is achieved. A separate canonical correlation is derived for every dimension in the solutions. Firstly, the dimension with the best fit (highest possible correlation) between solutions is identified (R_C). After this, dimensions are identified at a point of 90 degrees rotation from the first dimension (orthogonal). This is because orthogonal dimensions represent the most differentiated dimensions. This reduced rotational freedom leads to subsequent dimensions that are less and less highly correlated.

This analysis demonstrated the presence of three mutually-recognisable dimensions in both the expert sample and lay sample models, which were significantly correlated with each other: $R(_C) = .953$, $R(_2) = 0.813$, $R(_3) = 0.401$ ($p<.001$). The first two dimensions (R_C and R_2) are highly correlated between samples, whereas the third dimension (R_3) represents a low, albeit significant, correlation between samples.

Procrustes distance. This value represents the dissimilarity of points between the expert and lay sample MDS solutions. Thus, a smaller value indicates greater congruence, or similarity, between solutions (Zhou, et al., 2017).
Firstly, the solutions are superimposed, rotated and rescaled so that the total distance between all corresponding points is as small as possible. Then the distance between corresponding items in each solution is calculated for each dimension. This 'Euclidian' distance is calculated for all corresponding items with the formula: (x1-y1, x2-y2, x3-y3), where 'x' and 'y' represent the expert and lay sample MDS solutions, and '1', '2' and '3' represent the dimensions. These differences are squared, and then the squared differences of all items are summed together. Finally, the square root of this value is calculated, giving the Procrustes distance.

The Procrustes distance between the expert and lay sample solutions was 0.116, indicating a very close match of items between solutions.

Cophenetic correlation. This is a product-moment correlation, represented by Pearson's *r*, between the inter-point distances in the expert solution and those of the lay solution (Bimler, Skwarek, & Paramei, 2013). A higher cophenetic correlation indicates

greater similarity between the expert and lay solutions. The statistic showed a moderate correlation of $r = 0.69$, indicating a high degree of similarity (Cohen, 1992).

Overall Inter-map Similarity

The canonical correlation, Procrustes distance and cophenetic correlation statistics reveal a significant, moderate to large amount of similarity between the expert and lay solutions. These statistics provide support for the combined sample, that is, the expert and lay samples share a level of overlap that legitimates the use of their combined data.

However, differences between samples are apparent, as indicated by the Procrustes distance of 0.116. Similarly, one of three canonical correlations was 0.401, revealing a reasonably large difference in at least one dimension between the expert and lay samples. Despite a moderate cophenetic correlation of 0.69, this value highlights that these samples are not the same, as would be indicated by a value of 1.

Given these findings, the samples will be analysed and discussed separately. Firstly, this is to ensure their practical use is maximised for each sample. For instance, the expert sample will be of greater use for experts than the combined sample. Secondly, by discussing the results of the samples' individually, group differences can be highlighted.

Reliability. A split-half reliability was computed for the expert, lay and combined solutions. This involves splitting participants' data from each sample in half, then comparing the similarity of the two halves within the sample.

Results of the split-half reliabilities were 0.74 for the expert sample; 0.55 for the lay sample; and 0.84 for the combined sample. The combined sample reliability is best as it has a larger sample size – all the participants from both the expert and lay samples. The expert and combined samples' reliability values represent high and moderate levels, respectively, of internal consistency between responses, indicating that the number of participants in each sample is adequate. Increasing the sample size of each sample would not likely produce a significant change in the results. A low reliability of 0.55 for the lay sample, despite having two more participants than the expert sample, reflects the increased variance in the participants' responses – likely a result of the greater variance

of knowledge of therapeutic processes. Therefore, the lay map is less accurate and requires a larger sample size to improve this.

Map Interpretation

Interpreting the map consisted of identifying clusters and dimensions. Both HCA and MDS analyses were used to identify clusters. MDS alone was used to identify underlying dimensions within the models. Defining clusters and dimensions are subjective tasks that involve consideration of the models' outputs, interpretability and practicality.

Clusters

The dendrograms informed the initial clustering of items on the 3D maps. Based on the maps' spatial display of items, membership to the initial clusters was adjusted according to the proximity of items and their coherence in terms of representing the same concept. In this respect, this was a subjective process.

The clusters and their item content are displayed in Table 2 below. Cluster items were recorded in descending order from the most central and outermost item in the cluster to the least central and innermost item in the cluster. The items located most centrally and toward the outside of the map represent the most defining items within the cluster. Using this organisation of items, the clusters were labelled based on the researcher's perception of the concept they represented. Concepts already used within the field of psychology and psychotherapy were used where appropriate to optimise understanding and usability for therapists. The item content for the final clusters was subsequently validated by two clinical psychologists, the supervisors of this research.

As mentioned above, the findings of each samples' maps will be described separately, although the expert sample will comprise the predominant focus. This decision was based on the belief that the experts participants' understanding of therapeutic elements is likely to be more accurate than the lay participants' understanding, given their training and experience of practicing therapy. This was also evident throughout map analysis, as the experts' item organisation appeared to be the most conceptually coherent.

Expert Clusters

A total of 17 clusters were identified in the expert sample, as well as eight items that appeared to be isolated with no nearby items. Of these isolated items, two were MBCT strategies (*choosing to engage in skilful action*, and *recognise importance of taking action despite mood*), two were ACT strategies (*identify strategies used to avoid unhelpful thoughts*, and *explore function of emotion*) and four were DBT strategies (*using wisdom through the balance of emotions and cognitions*; *identifying when client's behaviour impacts therapists' ability to provide therapy; practice objectively describing thoughts, emotions, sensations and actions*; and *label client's nonverbalised thoughts, emotions, sensations and actions*). These items are noteworthy as they may highlight concepts that have not received much attention within the field. They may also indicate important differences between therapeutic paradigms. These ideas are discussed more thoroughly in the next chapter.

The 17 clusters comprised between two to 11 items, with an average of just over four items per cluster. Seven clusters contained five or more items, and ten smaller clusters contained less than five items. The large proportion of smaller clusters reflects the specificity of concepts in each cluster. For example, two clusters centred around values, with one emphasising the identification and planning of values and values-based behaviour (Planning Values-based Behaviour), and the other noticing the values-congruence of behaviours (Noticing Values-based Behaviour). Additionally, two seemingly similar concepts appeared on almost opposite sides of the 3D map, and therefore comprised separate clusters. These were 'Confronting Experiential Avoidance' and the item *identify strategies used to avoid unhelpful thoughts,* which despite both involving the identification of avoidance strategies, were separated into avoiding 'uncomfortable feelings' and avoiding 'unhelpful thoughts, respectively'.

Lay Clusters

A total of 19 clusters were identified in the lay map, and four isolated items. One item was an ACT strategy, which was also isolated in the expert map, (*identify strategies used to avoid unhelpful thoughts*), one was an MBCT strategy (*recognising the importance of taking action*), and two were DBT strategies (*reflect client's*

statements accurately; and *focus on balancing client's capabilities with deficits*). The 19 clusters contained between two and ten items, with an average of four items per cluster, like the expert sample.

Sample Comparison. Table 3 below shows the clusters present in each sample, and asterisks show where groups have different item content, despite having identical cluster labels. Between the expert and lay samples, six clusters had identical item content, namely 'Activity Planning', 'Confronting Experiential Avoidance', 'Commitment to Change', 'Therapist Style', 'Awareness of Pleasant Events', and 'Distress Tolerance and Acceptance'. The main differences between samples were the clustering of items related to identifying the relationships around, or simply observing, emotions; thoughts; sensations; and actions. The expert sample clearly separates items that relate to thought patterns ('Noticing') from items relating to emotional and mood patterns ('Emotional Knowledge'), and from items that involve observing ('Observing and Perspective Taking').

The lay sample broadly clusters items about identifying emotional relationships with those about thought patterns into one large cluster ('Noticing Behavioural Relationships'). They have a second large cluster ('Identifying Thought Patterns') that comprises thought pattern items, as well as items that involve simply observing or noticing thoughts or other experiences. Additionally, they have a third cluster that involves an observing item, as well as a describing item and a perspective taking item ('Observing Experiences').

Thus, despite overall similarity, some themes in the lay sample clusters tend to be overlapping and not as clear as those in the expert sample clusters. Overall, the inter-sample differences are subtle and likely reflect the expected differences in understanding between therapists and non-therapists. Differences are discussed further in the next chapter.

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Table 2

Cluster Item Content for the Expert, Lay and Combined Samples

Cluster	**Expert**	**Lay**	**Combined**
Solution Analysis		Planning of adaptive alternative behaviours, Troubleshooting potential problems with an agreed upon action-plan, Choosing to engage in skilful action (81, 26, 2)	Planning of adaptive alternative behaviours, Troubleshooting potential problems with an agreed upon action-plan (81, 26
Behavioural Analysis		Identify consequences of problematic behaviour, Describing small sequence of ineffective behaviour in detail, Identify problematic behaviour, Noticing ineffective, values-incongruent behaviour, Noticing effective, values-congruent behaviour (7, 71, 28, 72, 19)	Identify consequences of problematic behaviour, Identify problematic behaviour, Describing small sequence of ineffective behaviour in detail (7, 28, 71)
Behavioural and Solution Analysis	Identify consequences of problematic behaviour, Identify problematic behaviour, Planning of adaptive alternative behaviours, Troubleshooting		

	potential problems with an agreed upon action-plan, Describing small sequence of ineffective behaviour in detail (7, 28, 81, 26, 71)		
Activity Planning	Planning balanced lifestyle to prevent emotional sensitivity, Scheduling positive experiences, Planning to increase rewarding and decrease draining activities (78, 73, 40)	Planning balanced lifestyle to prevent emotional sensitivity, Scheduling positive experiences, Planning to increase rewarding and decrease draining activities (78, 73, 40)	Planning balanced lifestyle to prevent emotional sensitivity, Scheduling positive experiences, Planning to increase rewarding and decrease draining activities (78, 73, 40)
Planning Values-based Behaviour (including identifying values and values-based behaviour)	Identifying values, Identify values-based behaviour, Set values-based goals, Committing to valued actions, Matching current and alternative behaviours to goals and/or values (17, 8, 49, 44, 38)	Set values-based goals, Matching current and alternative behaviours to goals and/or values, Committing to valued actions (49, 38, 44)	Set values-based goals, Matching current and alternative behaviours to goals and/or values, Committing to valued actions (49, 38, 44)
Identifying Values & Values-based Behaviour		Identify values-based behaviour, Identifying values (8, 17)	Identify values-based behaviour, Identifying values (8, 17)

Noticing Values-based Behaviour	Noticing effective, values-congruent behaviour, Noticing ineffective, values-incongruent behaviour (19, 72)		Noticing ineffective, values-incongruent behaviour, Noticing effective, values-congruent behaviour (72, 19)
Confronting Experiential Avoidance	Identify strategies used to avoid uncomfortable feelings, Explore workability of avoidance strategies (37, 31)	Identify strategies used to avoid uncomfortable feelings, Explore workability of avoidance strategies (37, 31)	Identify strategies used to avoid uncomfortable feelings, Explore workability of avoidance strategies (37, 31)
Confronting Thought Avoidance	Identify strategies used to avoid unhelpful thoughts (69)	Identify strategies used to avoid unhelpful thoughts (69)	Identify strategies used to avoid unhelpful thoughts (69)
Commitment to Change	Elicit client's desire to change, Evaluate reasons for and against change, Highlight client's freedom to choose whether they change or not, Identifying and overcoming internal barriers to change (55, 57, 5, 70)	Highlight client's freedom to choose whether they change or not, Elicit client's desire to change, Identifying and overcoming internal barriers to change, Evaluate reasons for and against change (5, 55, 70, 57)	Elicit client's desire to change, Highlight client's freedom to choose whether they change or not, Evaluate reasons for and against change, Identifying and overcoming internal barriers to change (55, 5, 57, 70)
Therapist Style	Therapist is direct in an offbeat and unexpected manner, Therapist changes topics and emotional tone	Using stories, Using metaphors, Therapist is direct in an offbeat and unexpected manner, Therapist changes topics and emotional tone quickly	Therapist is direct in an offbeat and unexpected manner, Therapist changes topics and emotional tone quickly, Using stories, Using metaphors

	quickly, Using stories, Using metaphors (12, 67, 1, 32)	(1, 32, 12, 67)	(12, 67, 1, 32)
Awareness of Pleasant Events	Deliberate awareness of pleasant events, Awareness of thoughts, emotions and sensations around pleasant events (51, 80)	Deliberate awareness of pleasant events, Awareness of thoughts, emotions and sensations around pleasant events (51, 80)	Deliberate awareness of pleasant events, Awareness of thoughts, emotions and sensations around pleasant events (51, 80)
Taking Action	Recognising importance of taking action despite mood (33)	Recognising importance of taking action despite mood (33)	Recognising importance of taking action despite mood (33)
Distress Tolerance and Acceptance	Accepting and sitting with discomfort, Develop willingness to experience thoughts, emotions and sensations, Practice strategies for tolerating distress (14, 11, 29)	Accepting and sitting with discomfort, Practice strategies for tolerating distress, Develop willingness to experience thoughts, emotions and sensations (14, 29, 11)	Accepting and sitting with discomfort, Practice strategies for tolerating distress, Develop willingness to experience thoughts, emotions and sensations (14, 29, 11)
Dialectical Strategies * (various combinations)	Therapist balances change with acceptance strategies, Focus on balancing client's capabilities with deficits, Highlighting opposing perspectives and identifying how they can both be true (65, 39, 59)	Highlighting opposing perspectives and identifying how they can both be true, Using wisdom through balance of emotions and cognitions (59, 52)	

Opposing Perspectives (Dialectical)			Highlighting opposing perspectives and identifying how they can both be true (59)
Encouraging Wise Mind (Dialectical)	Using wisdom through the balance of emotions and cognitions (52)		Using wisdom through the balance of emotions and cognitions (52)
Observing Limits	Identifying when client's behaviour impacts therapist's ability to provide therapy (36)		Identifying when client's behaviour impacts therapist's ability to provide therapy (36)
Observing Limits (and orienting)		Identifying when client's behaviour impacts on therapist's ability to provide therapy, Frequently explain rationale for a task/action (36, 23)	
Observing experiences		Non judgementally observing our experiences, Practice objectively describing thoughts, emotions, sensations and actions, Identify observing self to view experiences from (6, 27, 21)	

Observing and Perspective Taking	Stepping back from thought content, Identify observing self to view experiences from, Notice thoughts, Non judgementally observing our experiences, Observing emotions, thoughts, sensations and actions (60, 21, 45, 6, 77)		Notice thoughts, Observing emotions, thoughts, sensations and actions, Identify observing self to view experiences from, Practice objectively describing thoughts, emotions, sensations and actions, Non judgementally observing our experiences, Stepping back from thought content (45, 77, 21, 27, 6, 60)
Objectively Describing Experiences	Objectively describing experiences (27)		
Validation of Client*	Normalise client's thoughts, emotions and sensations, Validate client's emotions, sensations, actions, thoughts based on history/circumstances, Therapist validates aspects of thoughts, emotions and sensations and valid actions, Therapist is warm and genuine to client's experiences, Reflect client's statements accurately (22, 30, 25, 48, 10)	Normalise client's thoughts, emotions and sensations, Validate client's emotions, sensations, actions, thoughts based on history/circumstances, Therapist validates aspects of thoughts, emotions and sensations and valid actions, Therapist is warm and genuine to client's experiences, Label client's nonverbalised thoughts, emotions, sensations and actions (22, 30, 25, 48, 61)	Normalise client's thoughts, emotions and sensations, Therapist is warm and genuine to client's experiences, Validate client's emotions, sensations, actions, thoughts based on history/circumstances, Therapist validates aspects of thoughts, emotions and sensations and valid actions, Reflect client's statements accurately, Label client's nonverbalised thoughts, emotions, sensations and actions (22, 48, 30, 25, 10, 61)
Reflecting		Reflect client's statements accurately (10)	

Labelling Nonverbal Experiences	Label client's nonverbalised thoughts, emotions, sensations and actions (61)		
Skill Mastery*	Encourage client's self-recording of target behaviours and skills-use, Assist client to engage in most effective action Skill modelling and rehearsal in session, Teach client behavioural learning principles, Helping client communicate effectively in multiple environments, Generalise skills and behaviour changes to multiple environments/relevant contexts, Supporting client to do things for themselves (47, 63, 66, 58, 74, 82, 53)	Teach client behavioural learning principles, Skill modelling and rehearsal in session, Supporting client to do things for themselves, Encourage client's self-recording of target behaviours and skills-use, Assist client to engage in most effective action, Generalise skills and behaviour changes to multiple environments/relevant contexts, Helping client communicate effectively in multiple environments (58, 66, 53, 47, 63, 82, 74)	Teach client behavioural learning principles, Skill modelling and rehearsal in session, Encourage client's self-recording of target behaviours and skills-use, Supporting client to do things for themselves, Assist client to engage in most effective action, Generalise skills and behaviour changes to multiple environments/relevant contexts, Helping client communicate effectively in multiple environments, Focus on balancing client's capabilities with deficits (58, 66, 47, 53, 63, 82, 74, 39)
Balancing Capabilities with Deficits		Focus on balancing client's capabilities with deficits (39)	
Reinforcing Behaviour*	Therapist gradually reinforces change toward desired behaviour, Frequently explain rationale for a task/action,	Therapist balances change with acceptance strategies,	Therapist balances change with acceptance strategies,

	Therapist reinforces new behaviour (18, 23, 68)	Therapist gradually reinforces change toward desired behaviour, Therapist reinforces new behaviour (65, 18, 68)	Therapist gradually reinforces change toward desired behaviour, Therapist reinforces new behaviour, Frequently explain rationale for a task/action (65, 18, 68, 23)
Noticing Behavioural Relationships		Noticing thoughts, emotions and sensations that lead to rigid, inflexible behaviour, Noticing relationship between thoughts, emotions, sensations and actions, Recognise signs and/or triggers of depression, Exploring relationship between mood and thoughts, emotions, sensations and actions, Recognising relationship between activity and mood, Noticing how depressed states impact thought believability, Noticing reaction toward unpleasant emotions, thoughts and bodily sensations, Explore function of emotions, Separating thoughts, emotions, interpretations from facts	

		(42, 4, 35, 16, 84, 75, 9, 41, 79)	
Emotional Knowledge	Exploring relationship between mood and thoughts, emotions, sensations and actions Noticing how depressed states impact thought believability Recognise signs and/or triggers of depression Recognising relationship between activity and mood (16, 75, 35, 84)		Noticing how depressed states impact thought believability, Exploring relationship between mood and thoughts, emotions, sensations and actions, Recognise signs and/or triggers of depression, Separating thoughts, emotions, interpretations from facts, Explore function of emotions, Recognising relationship between activity and mood (75, 16, 35, 79, 41, 84)
Emotion Function	Explore function of emotion (41)		
Identifying Thought Patterns		Notice thoughts, Noticing habitual thoughts we get stuck in, Observing emotions, thoughts, sensations and actions, Noticing ineffective thinking, Noticing how attention can fixate on the difficult, Identify the usefulness of engaging with thoughts, Awareness of T, E and S in interpreting events, Stepping back from thought content (45, 64, 77, 62, 46, 50, 43, 60)	Noticing habitual thoughts we get stuck in, Noticing ineffective thinking, Noticing relationship between thoughts, emotions, sensations and actions, Noticing thoughts, emotions and sensations that lead to rigid, inflexible behaviour, Awareness of thoughts, emotions and sensations involved in interpreting events, Noticing how attention can fixate on the difficult, Noticing reaction toward unpleasant emotions, thoughts and bodily sensations,

			Identify the usefulness of engaging with thoughts (64, 62, 4, 42, 43, 46, 9, 50)
Noticing	Noticing relationship between thoughts, emotions, sensations and actions, Awareness of thoughts, emotions and sensations involved in interpreting events, Noticing habitual thoughts we get stuck in, Noticing ineffective thinking, Noticing how attention can fixate on the difficult, Separating thoughts, emotions, interpretations from facts, Noticing thoughts, emotions and sensations that lead to rigid, inflexible behaviour, Identify the usefulness of engaging with thoughts (4, 43, 64, 62, 46, 79, 42, 50)		
Mindfulness	Noticing when attention wanders, Awareness of thoughts, emotions and sensations in present moment, Noticing states of awareness and "automatic pilot", Remembering to step out of "automatic pilot", Paying attention to activities in the present	Awareness of present moment, Paying attention to activities in the present moment, Remembering to step out of "automatic pilot", Refocusing wandering attention, Noticing when attention wanders, Explore benefits of flexible contact with the present	Remembering to step out of "automatic pilot", Awareness of present moment, Paying attention to activities in the present moment, Awareness of thoughts, emotions and sensations in present moment, Noticing states of awareness and "automatic pilot", Noticing when attention wanders

	moment, Awareness of present moment, Choosing where attention is focussed Refocusing wandering attention, Identify loss of flexible contact with the present moment, Explore benefits of flexible contact with the present moment, Noticing reaction toward unpleasant emotions, thoughts and bodily sensations (13, 56, 24, 34, 20, 54, 76, 3, 83, 15, 9)	moment, Identify loss of flexible contact with the present moment, Awareness of thoughts, emotions and sensations in present moment, Noticing states of awareness and "automatic pilot", Choosing where attention is focussed (54, 20, 34, 3, 13, 15, 83, 56, 24, 76)	Identify loss of flexible contact with the present moment, Explore benefits of flexible contact with the present moment, Refocusing wandering attention, Choosing where attention is focussed (34, 54, 20, 56, 24, 13, 83, 15, 3, 76)

Note. Items are in descending order from most central and outermost item (most defining item of the cluster concept) to least central and innermost item. Brackets comprise item numbers in order of the written item description. * indicate where clusters with identical labels have some different items.

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Therapeutic Paradigm Overlap

The degree to which ACT, DBT and MBCT overlap in terms of their strategy content is a very important question in this research, and cluster identification using the 3D map helped to determine this. In the expert sample, of 17 clusters, eight had multiple therapeutic paradigm involvement. Three out of eight clusters involved just two paradigms, and five out of eight involved all three paradigms.

In the lay sample, of 19 clusters, ten had multiple paradigm involvement, four of which involved two therapies, and six of which involved all three. Paradigm involvement for the expert and lay samples is shown in Table 3 below, excluding the isolated items. Only identical or very similar clusters were placed adjacent to each other for ease of comparison between samples. The nature of the overlap amongst paradigms is discussed further in the next chapter.

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Table 3

Paradigm Overlap in the Expert and Lay Samples

Expert Sample		Lay Sample	
Clusters	**Paradigm Involvement**	**Clusters**	**Paradigm Involvement**
Therapist Style	ACT, DBT and MBCT	Therapist Style	ACT, DBT and MBCT
Distress Tolerance and Acceptance	ACT, DBT and MBCT	Distress Tolerance and Acceptance	ACT, DBT and MBCT
Observing and Perspective Taking	ACT, DBT and MBCT	Observing Experiences	ACT, DBT and MBCT
Noticing	ACT, DBT and MBCT	Noticing Behavioural Relationships	ACT, DBT and MBCT
Mindfulness*	ACT, DBT and MBCT	Mindfulness*	ACT, DBT and MBCT
		Identifying Thought Patterns	ACT, DBT and MBCT
Activity Planning	MBCT and DBT	Activity Planning	MBCT and DBT
Planning Values-based Behaviour*	ACT and DBT	Planning Values-based Behaviour*	ACT and DBT
Commitment to Change	ACT and DBT	Commitment to Change	ACT and DBT
		Behavioural Analysis	ACT and DBT
Dialectical Strategies*	DBT	Dialectical Strategies*	DBT
Validation of Client*	DBT	Validation of Client*	DBT
Skill Mastery*	DBT	Skill Mastery*	DBT
Reinforcing Behaviour	DBT	Reinforcing Behaviour	DBT
Behavioural and Solution Analysis	DBT	Solution Analysis	DBT
Emotional Knowledge	MBCT		
Awareness of Pleasant Events	MBCT	Awareness of Pleasant Events	MBCT
Noticing Values-based Behaviour	ACT	Identifying Values and Values-based Behaviour	ACT
Confronting Experiential Avoidance	ACT	Confronting Experiential Avoidance	ACT
		Observing Limits and Orienting	DBT

Note. Isolated items excluded. * indicates clusters with identical names have some different items

Table 4

Clusters Present in the Expert, Lay and Combined Samples

Expert	**Lay**	**Combined**
Activity Planning	Activity Planning	Activity Planning
Planning Values-based Behaviour*	Planning Values-based Behaviour Identifying Values & Values-based Behaviour	Planning Values-based Behaviour Identifying Values & Values-based Behaviour
Noticing Values-based Behaviour	Noticing Values-based Behaviour	
Confronting Experiential Avoidance *Identify strategies used to avoid unhelpful thoughts*	Confronting Experiential Avoidance *Identify strategies used to avoid unhelpful thoughts*	Confronting Experiential Avoidance *Identify strategies used to avoid unhelpful thoughts*
Commitment to Change	Commitment to Change	Commitment to Change
Therapist Style	Therapist Style	Therapist Style
Awareness of Pleasant Events	Awareness of Pleasant Events	Awareness of Pleasant Events
Recognise importance of taking action despite mood	*Recognise importance of taking action despite mood*	*Recognise importance of taking action despite mood*
Distress Tolerance and Acceptance	Distress Tolerance and Acceptance	Distress Tolerance and Acceptance
Dialectical strategies *	Opposing Perspectives	Dialectical strategies *

Encouraging Wise Mind	Encouraging Wise Mind	
Observing limits	Observing limits	
		Observing Limits (and orienting)
		Observing Experiences
Observing and Perspective Taking *	Observing and Perspective Taking *	
Objectively describing experiences		
Validation of Client *	Validation of Client *	Validation of Client *
		Reflecting
Labelling Nonverbal Experiences		
Skill Mastery*	Skill Mastery*	Skill Mastery*
		Balancing Capabilities with Deficits
Reinforcing behaviour *	Reinforcing behaviour *	Reinforcing behaviour *
		Noticing behavioural relationships
Emotional Knowledge *	Emotional Knowledge *	
Emotion Function		
	Identifying thought patterns*	Identifying thought patterns*
Noticing		
Mindfulness*	Mindfulness*	Mindfulness*
	Solution Analysis *	Solution Analysis *
	Behavioural Analysis *	Behavioural Analysis *
Behavioural and Solution Analysis		

Note. * indicates the clusters have some different items (item content shown in Table 2 above). Colours indicate groupings of similar cluster

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Dimensions

Analyses of the 3D maps were required to identify potential dimensions underlying the set of therapy strategies. The first dimensions were identified by finding the densest cluster, a large cluster with closely-spaced items. By rotating and looking 'through' the map, the cluster directly opposite this can be identified. This process was difficult at times due to some gaps in coverage of items in each 3D map. Thus, some clusters may not have a cluster directly opposite them, and the axes of each dimension may not precisely intersect each other at 90 degree angles (which would represent the most distinct dimensions possible). Another important consideration in deciding which clusters should represent each pole of the three dimensions is which clusters would provide a useful distinction for therapists. Therefore, both meaningfulness and positions in space were considered.

The densest opposing clusters comprised the first dimension. For the expert sample, this was between 'Skill Mastery' and 'Observing and Perspective Taking'. Picture these as connected by a straight line. The second dimension represents a line that intersects the first line at a 90 degree angle. The clusters that represent the poles of this second dimension are positioned roughly at the ends of the second line. For the expert sample, these were 'Validation of Client' and 'Planning Values-based Behaviour'. The third dimension was found similarly by imagining a third line that intersects the first two lines at 90 degree angles. Clusters at each end of this third line represent the poles of the third dimension. For the expert sample, these were the 'Distress Tolerance and Acceptance' cluster, and an isolated item, 'explore function of emotion'. These clusters served as markers of the extreme ends (poles) of each dimension, the characteristics of which could be used to ascertain prominent relationships present between Third Wave strategies.

The dimensions and their polar meanings are shown in Table 5 below. The same dimensions were judged to best describe the underlying relationships across all three samples. The expert sample results comprise the dominant focus on dimensions, however, and differences in the lay sample results are briefly outlined following these.

Chapter Three
Results

Table 5

Dimensions and Polar Meanings

Dimension	**Polar Meaning**
X: Strategy Orientation	X+ Internally oriented X- Externally oriented
Y: Response to Experience	Y+ Accepting experiences Y- Exploring experiences
Z: Perspective	Z+ Insider perspective Z- Outsider perspective

Table 6
Dimensional Characteristics and Relevant Clusters from the Expert Sample

Octant	Dimensional Characteristics	Relevant Clusters
1	X+ Internally oriented Y+ Accepting experience Z+ Insider perspective	Distress Tolerance and Acceptance* Confronting Experiential Avoidance* Noticing Values-based Behaviour
2	X+ Internally oriented Y+ Accepting experience Z- Outsider perspective	Encouraging Wise Mind Mindfulness* Observing and Perspective Taking*
3	X+ Internally oriented Y- Exploring experience Z+ Insider perspective	Awareness of Pleasant Events Confronting Thought Avoidance Emotional Knowledge Noticing*
4	X+ Internally oriented Y- Exploring experience Z- Outsider perspective	Noticing* Objectively describing experiences
5	X- Externally oriented Y+ Accepting experience Z+ Insider perspective	Confronting Experiential Avoidance* Planning Values-based Behaviour Choosing Skilful Action Commitment to Change* Taking Action*
6	X- Externally oriented Y+ Accepting experience Z- Outsider perspective	Dialectical Strategies Therapist Style
7	X- Externally oriented Y- Exploring experience Z+ Insider perspective	Behavioural and Solution Analysis Activity Planning
8	X- Externally oriented Y- Exploring experience Z- Outsider perspective	Skill Mastery* Reinforcing Behaviour Validation of Clients Emotion Function Labelling Nonverbal Experiences Observing Limits

Note. * indicates items are located in multiple octants, the majority of which are located in the specified octant

Rotation. Figures 3-6 below illustrate the approximate positions of items when converted from the 3D map to a 2D 'split hemisphere' display. In these displays, the Z, Y and X axes can be seen at 90 degree angles to each other, with the vertical line representing the Y dimension, the horizontal line the Z dimension, and the central clusters represent each pole of the X dimension. The position of the axes is arbitrary, and they were rotated to align as closely as possible to the dimensions identified in the 3D map. However, during rotation, all items remained in the same position relative to each other, and axes were simply rotated to optimise the meaningfulness of their display.

Expert Sample Dimensions. The first dimension (X) can be seen in the centre of the 2D maps below. The positive pole of the X dimension (X+, 'Observing and Perspective Taking) is shown in Figure 3, and the negative pole (X-, 'Skill Mastery') is shown in Figure 4.

Based on the clusters at X+ and X-, a continuum characterised by *behavioural orientations* appeared to exist. Specifically, X+ denotes an *internal behavioural orientation*, whereby behaviours consist of cognitive activities, such as mindfulness and awareness. Examples of these internally orientated behaviours include: *stepping back from thought content; identify "observing self" to view experiences from; notice thoughts; non-judgmentally observing our experiences; observing emotions, thoughts, sensations and actions;* and *awareness of thoughts, emotions and sensations in the present moment'*.

X- denotes an external strategy orientation, whereby strategies emphasise more traditional 'behaviour' and overt actions. Examples of these externally oriented strategies include *encourage client's self-recording of target behaviours and skills use, skill modelling and rehearsal in session, generalise skills and behaviour changes to multiple environments/relevant contexts* and *assist client to engage in most effective action.* However, some of the 'Skills Mastery' strategies can be applied to internally oriented behaviour such as mindfulness. Therefore, this cluster may not be the most accurate representation of the X- pole for this dimension. However, there is support for the internal versus external orientation of strategies in the overall item content of each hemisphere.

The X+ chart shows items that are generally internally oriented, and the X- chart shows items that are generally externally oriented. To illustrate internal versus external strategies, the X+ hemisphere has the cluster 'Noticing Values-based Behaviour' in the left upper quadrant, and in the same quadrant in the X- hemisphere, 'Planning Values-based Behaviour' can be seen. This contrasts the internal process 'noticing', from the external process 'planning', whereby one actively works on the performance of the behaviour. Similarly, the X+ hemisphere has 'Awareness of Pleasant Events' in the lower left quadrant, which involves increasing one's awareness of and during pleasant events. Contrasting this, the X- hemisphere has 'Activity Planning' in the same position, which involves planning to increase involvement in pleasant activities.

The second dimension (Z) lies between the clusters 'Planning Values-based Behaviours' (Z+ pole) and 'Validation of Client' (Z- pole). This highlights a continuum between perspectives involved in the strategies. On the left side of both hemispheres (Z+), strategies are carried out by the client from their perspective (with direction from the therapist). Examples of such strategies include those in the 'Planning Values-based Behaviours' and 'Noticing Values-based Behaviour' clusters, which involve what is important to the client, such as: *identifying values; set values-based goals; committing to valued actions;* and *noticing effective, values-congruent behaviour*; those in the 'Activity Planning' cluster, whereby activities are planned that the client considers to be personally rewarding, such as *planning to increase rewarding and decrease draining* activities; and those in the 'Behaviour and Solution Analysis' cluster, which focus on the client's specific behaviours that need to be altered, such as *identify consequences of problematic behaviour*.

On the right side (Z-), the 'Validation of Client' cluster items, such as *therapist validates aspects of thoughts, emotions and sensations and valid behaviours*, nicely contrast the concept of values with the involvement of the therapist's (outsider) perspective, in terms of which behaviours are 'valid' and should be validated, or 'invalid' and should be invalidated. The 'Validation of Client' cluster also includes the item *normalise client's thoughts, emotions and* sensations, which is to highlight the similarity of the client's behaviour to that of others' and to highlight what is generally accepted as normal, thus taking an 'outsider' perspective. The 'Dialectical Strategies', 'Observing Limits', 'Reinforcing Behaviour', 'Labelling Nonverbal Experiences' and

'Therapist Style' clusters are appropriate on the right side of the map as they are carried out entirely by the therapist, inherently taking an outsider perspective. *Practice objectively describing thoughts, emotions, sensations and actions* sits on the Z- pole also, which could be due to its 'objective' nature, which requires an outsider perspective. 'Observing and Perspective Taking' sits in the centre of this dimension, although all items are just positioned within the Z- octants. This central positioning is appropriate as the perspective taking items involve stepping away from oneself and trying to take a more distanced, or outsider, perspective, yet one that is still the perspective of the client.

The third dimension (Y) lies between the cluster 'Distress Tolerance and Acceptance' (Y+ pole) and the item *explore functions of emotion* (Y- pole). This forms a continuum representing one's response to experiences, with accepting experiences at the Y+ pole and exploring experiences at the Y- pole. Items representing the Y+ pole of accepting experiences include: *accepting and sitting with discomfort; develop willingness to experiences thoughts, emotions and sensations; and practice strategies for tolerating distress.* Clusters in the Y+ side, such as 'Distress Tolerance and Acceptance'; 'Commitment to Change', 'Dialectical Strategies' and 'Mindfulness', and isolated items *using wisdom through the balance of emotions and cognitions;* and *choosing to engage in skilful action* are well-suited as they encompass accepting experiences as they are, including the acceptance of change.

Items representing the Y- pole of exploring experiences include: *explore functions of emotion,* as well as items from the nearby clusters, 'Emotional Knowledge' and 'Noticing', namely *recognise signs and/or triggers of depression; noticing relationship between thoughts, emotions, sensations and action;* and *noticing how depressed states impact thought believability*. Clusters on the Y- side include 'Activity Planning' and 'Behaviour and Solution Analysis' and 'Awareness of Pleasant Events', which are appropriately positioned as they involve an exploration of one's experiences, the relationships between them, or their consequences.

Model Inconsistencies. Table 6 above shows the cluster placement within one of eight octants across the two split hemisphere maps. This was based on where the majority of items within each cluster were located. While most clusters were positioned in expected octants, described by well-suited dimensional characteristics, some

inconsistencies were found. 'Confronting Experiential Avoidance' items *identify strategies used to avoid uncomfortable feelings* and *explore workability of avoidance strategies* are in octants 1 and 5, representing accepting experiences, however they are arguably more exploratory in nature. 'Planning Values-based Behaviour' is in octant 5, classified as accepting experiences, yet its items *identifying values; identifying values-based behaviour*; and *matching current and alternative behaviours to goals and/or values* appear more exploratory. Its remaining items *set values-based goals* and *committing to valued actions* are, however, appropriate in an acceptance-focused octant. Conversely, 'Activity Planning' resides in octant 7, characterised by exploring experiences. However, its items *planning balanced lifestyle to prevent emotional sensitivity; scheduling positive experiences;* and *planning to increase rewarding and decrease draining activities* represent a form of acceptance in that one plans to have these experiences. They could be considered exploratory in the sense that activities need to be classified as either rewarding, positive or draining, however. Similarly, 'Noticing Values-based Behaviour' items *noticing effective, values-congruent behaviour;* and *noticing ineffective, values-incongruent behaviour* narrowly reside in octant 1, characterised by accepting experiences, where exploration may have been more suitable given the need to link behaviours to values and goals.

'Validation of Client' items, whilst they involve the therapist's analysis of the clients' behaviours and their acceptability, are aimed at reassuring clients by conveying the therapist's acceptance. For example, the items *normalise client's thoughts, emotions and sensations; validate client's emotions, sensations, actions and thoughts based on history/circumstances;* and *therapist is warm and genuine to client's experiences* are very much focused on accepting the client. Therefore, this cluster would be more appropriate in octant 6. Finally, *explore the function of emotion* is located in octant 8, characterised as an external behavioural orientation, where perhaps internal behavioural orientation would be more accurate. A more thorough review of the inconsistencies and possible explanations for these findings will be given in the next chapter.

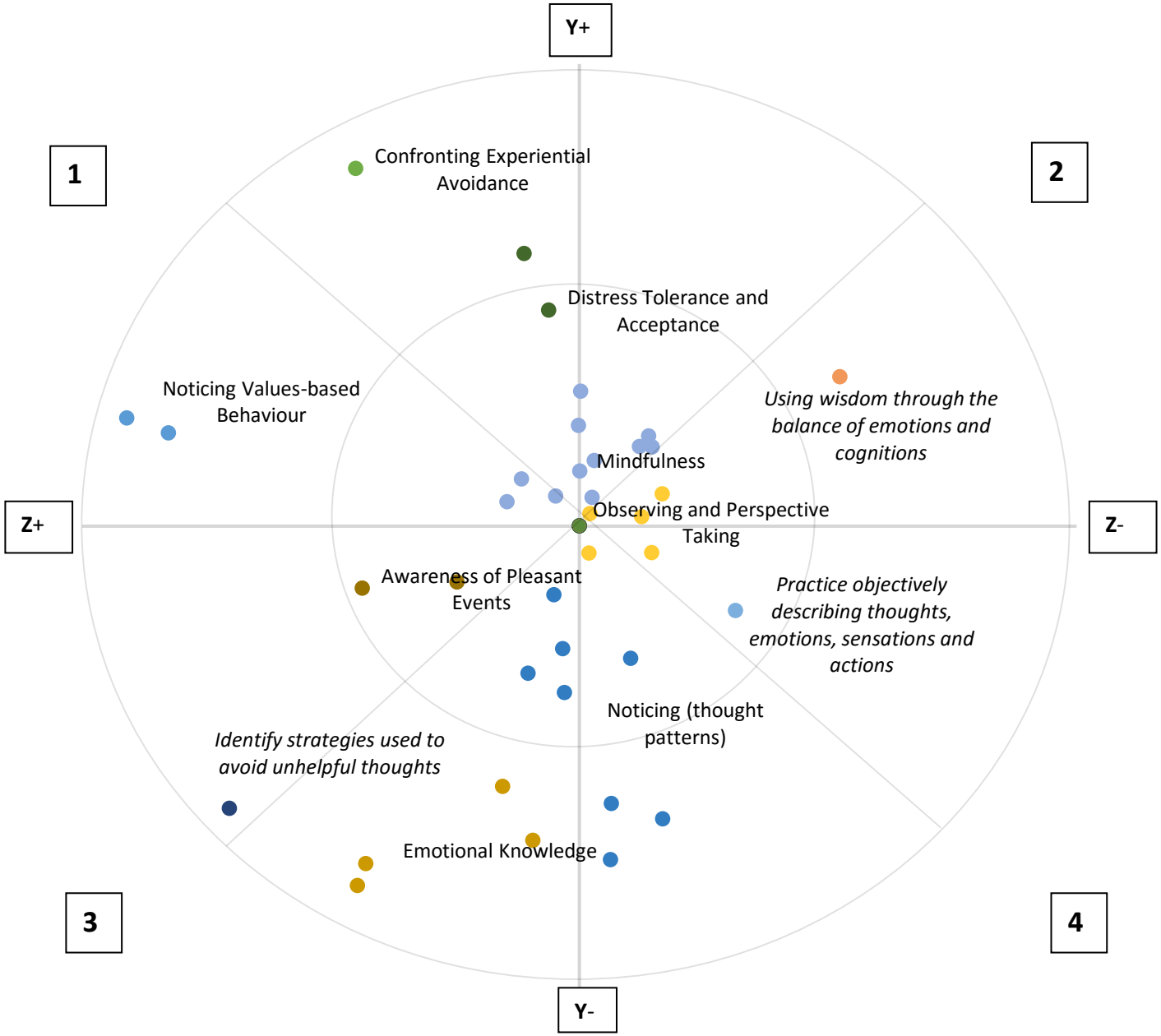

Figure 3. Expert sample model showing the Internally Oriented (X+) hemisphere, octants 1-4. Italicised items show isolated items

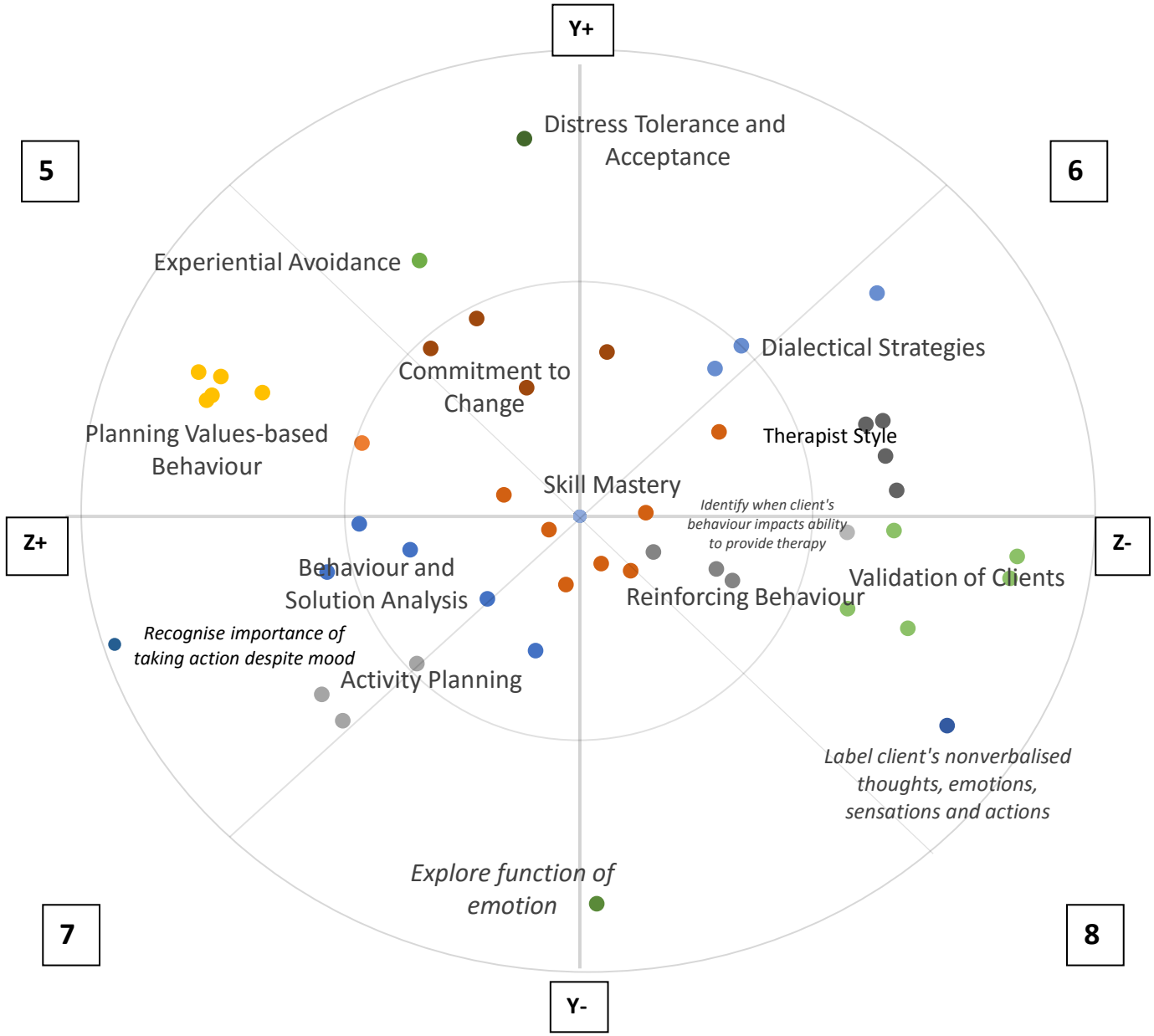

Figure 4. Expert sample model showing the Externally Oriented (X-) hemisphere, octants 5-8. Italic items represent isolated items.

Lay Sample Dimensions. The lay sample results produced a 3D map with fewer gaps and a more spherical shape, indicating its coverage was slightly better than the expert map. Whilst this should allow for clearer identification of dimensions and clusters, it was difficult to decide which clusters were directly opposite one another, and which clusters made the most sense as representing the poles of each dimension. Thus, best judgment was used to balance adequate positioning of clusters (clusters in each dimension should be opposite each other, and the axes of each dimension should intersect each other at 90 degree angles), as well as which clusters represented the most meaningful relationship between strategies. Figures 5 and 6 below show the 2D split hemisphere maps for the lay sample, which illustrate the positions of items in the positive and negative hemispheres, respectively.

The first dimension (X) has clear opposing clusters, 'Skill Mastery' (X+) and 'Noticing Behavioural Relationships' (X-). This is similar to the expert sample, which placed 'Skill Mastery' (X-) opposite 'Observing and Perspective Taking' (X+). When identifying the relationship represented by these clusters, it was notable that the X- hemisphere in the lay sample comprises mostly externally oriented behaviours, and the X+ hemisphere comprises mostly internally oriented behaviours. Therefore, the X dimension in the lay sample appears to represent *behavioural orientations*. This distinction is also seen in the expert sample hemispheres (although the hemispheres are reversed so that the X- hemisphere in the expert sample more closely resembles the X+ hemisphere in the lay sample. This reversal is not important).

The second dimension (Z) distinguishes an 'insider' perspective' from an 'outsider perspective', as in the expert sample. 'Activity Planning' represents one pole (Z+) and 'Validation of Client' the other (Z-). The Z- pole is therefore the same in both the lay and expert samples. The expert Z+ pole was represented by 'Planning Values-based Behaviour', however this is adjacent to 'Activity Planning', and both concepts relate to ones' values and valued activities. Thus, this dimension is very similar between lay and expert samples.

Finally, the third dimension (Y) lies between 'Distress Tolerance and Acceptance' (Y-) and 'Behavioural Analysis' (Y+). 'Distress Tolerance and Acceptance' also comprised one pole in the expert sample's Y dimension, however the pole was reversed. Whereas the expert sample's Y dimension consisted of 'Distress

Tolerance and Acceptance' and 'Noticing', both the expert and lay samples' Y dimensions appear to distinguish the exploration of one's experience from the acceptance of one's experience.

The 'Validation of Client' cluster is spread across the negative and positive hemispheres in the lay sample, whereas the entire cluster is present in the externally oriented hemisphere of the expert sample. Other inter-sample differences are the position of clusters within the hemispheres. Most notable are the positions of clusters in the Y dimension, which appear to have reversed. For example, the direction of 'Distress Tolerance and Acceptance', 'Confronting Experiential Avoidance', 'Reinforcing Behaviour' and 'Validation of Client' have reversed. The overall relationship, then, is very similar between the expert and lay sample models.

Other differences include the expert cluster 'Noticing Values-based Behaviour', close to the Z+ pole in the expert map, which is represented by two points in the 'Behavioural Analysis' cluster in the lay sample, at the Y+ pole. They remain in the same quadrant, however. The 'Planning Values-based Behaviour' and 'Identifying Values and Values-based Behaviour' clusters are clearly separated in the lay sample, but comprise a single, closely-spaced cluster called 'Planning Values-based Behaviour' in the same quadrant in the expert sample. Finally, 'Commitment to Change' is located on the Z+ side in the expert sample, but the Z- side in the lay sample.

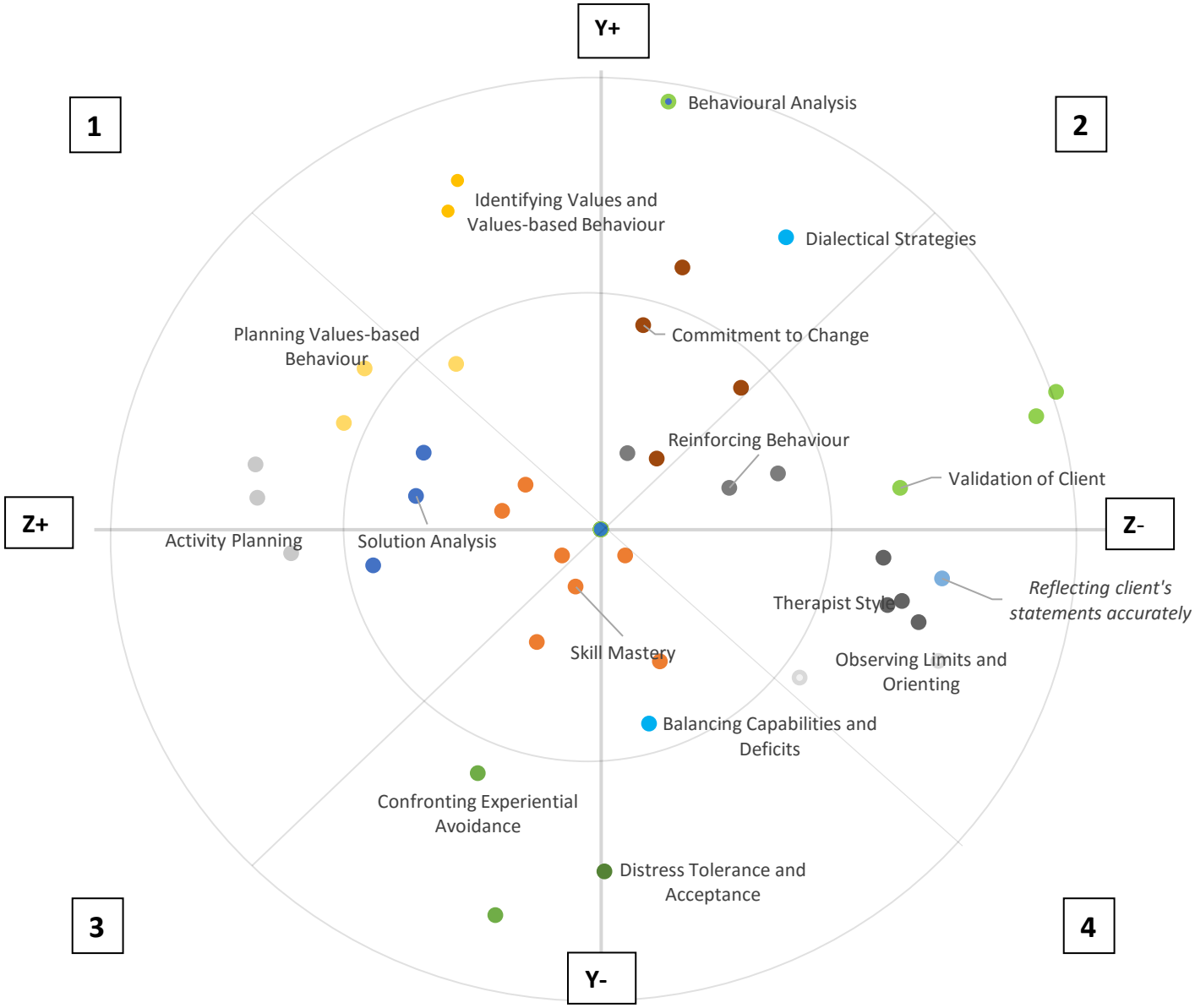

Figure 5. Lay sample model showing Externally Oriented (X+) hemisphere, octants 1-4. Italicised items represent isolated items

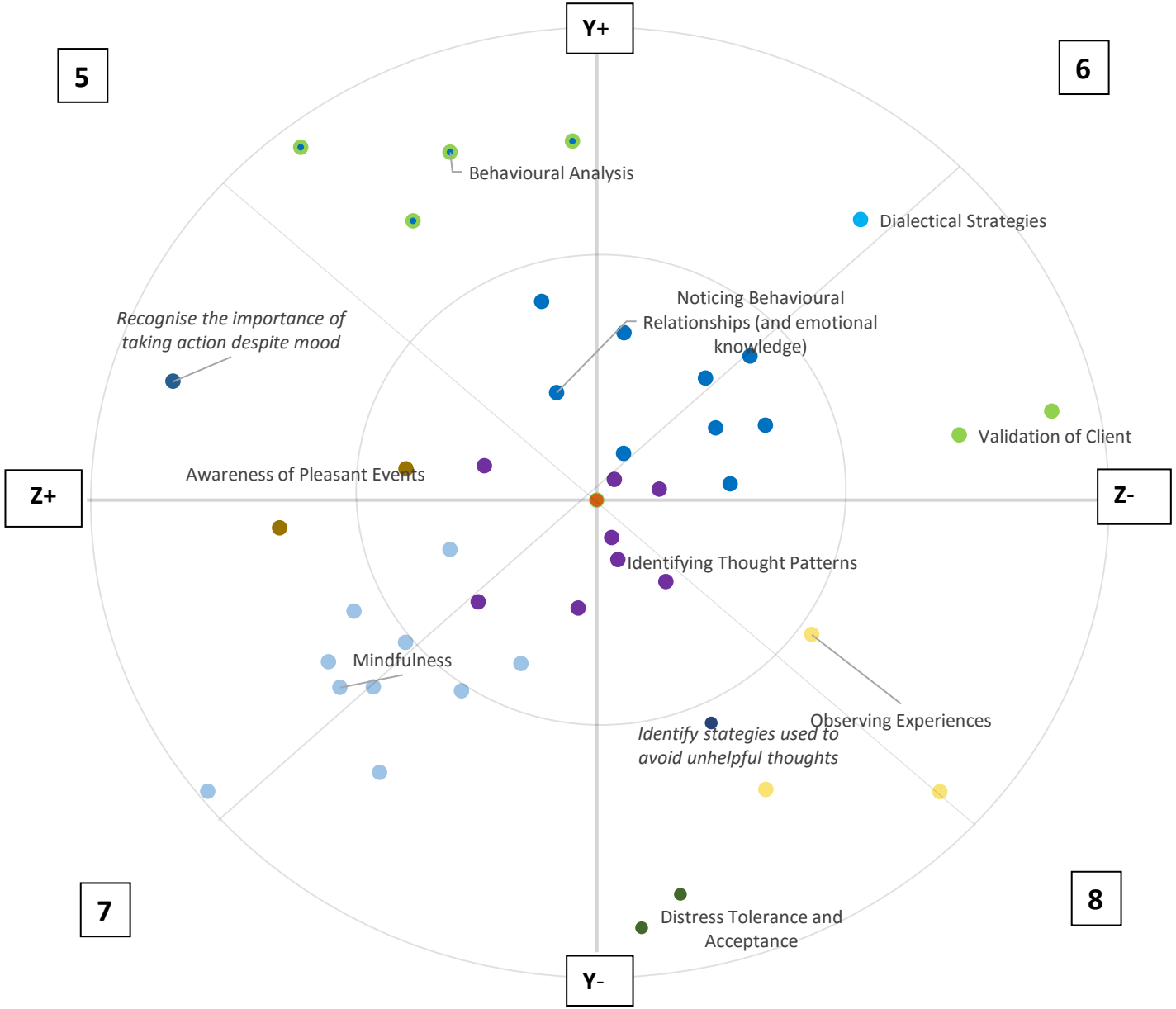

Figure 6. Lay sample model showing Internally Oriented (X-) hemisphere, octants 5-8. Italicised items represent isolated items

CHAPTER FOUR

Discussion

The Need for a Compendium of Third Wave Therapy Strategies

The longstanding argument around common and specific factors in therapeutic paradigms is an important theme in the present research. This argument compares the contributory effects of 'common' factors, belonging to many or all therapies, with those of 'specific' factors, belonging to fewer therapies. Conclusions drawn from this argument in turn impact where resources are allocated. For instance, should resources be used to continue developing new therapy approaches and strategies, or instead focus on investigating the suite of existing strategies to determine shared elements that may represent the active ingredients responsible for therapeutic outcomes?

Common factors proponents such as Goldfried (1980) have long argued the importance of identifying common factors, and many have since been identified (Grencavage & Norcross, 1990; Mennin, Ellard, Fresco, & Gross, 2013). Such investigations are virtually non-existent for the relatively new Third Wave of Behavioural and Cognitive Therapies, and any comparisons between therapies have been non-systematic. Mennin et al (2013) have proposed common factors of the Behavioural and Cognitive Therapies, which include the First, Second and Third Wave approaches. The criticism here however, is these have also not followed a systematic process.

To identify commonality across approaches, it has been suggested that comparisons be made at the change process level (Goldfried M. R., 1980). Comparing specific therapeutic elements that contribute to change represent one way of identifying these change processes, which can then be compared across approaches to determine their commonality. The Third Wave therapies have not received such a comparison of therapeutic elements, at least not in any systematic manner. The present research sought to improve on this.

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In the present research, items were identified that represent therapeutic elements at the strategy level, as used by therapists and their clients in the Third Wave therapies: DBT, ACT and MBCT. A set of items was identified for each paradigm and validated by experts according to specific criteria: items accurately represent a single strategy; each set collectively represents the full range of strategies central to the therapy; and items are fixed at a similar level. In subsequent phases of item generation, strategies considered to be traditional common factors were removed, resulting in strategies central to DBT, ACT and MBCT. With these, a map of Third Wave therapeutic strategies was produced to highlight the overlap, similarities and differences, both between and within the approaches. This map not only provides an organisation of Third Wave strategies based on similarity, it may highlight common strategies that are indicative of potential active ingredients or processes of change relevant to DBT, ACT and MBCT, and perhaps other approaches. It also has the potential to highlight strategies unique to the individual Third Wave approaches investigated.

Expert and Lay Sample Comparisons

The inclusion of a lay sample and an expert sample in this research enabled assessment of model validity across therapist and non-therapist populations. The lay sample also served as a validation of the expert sample map. Given the different theoretical backgrounds of those in the therapist sample, there is likely to be some variation in semantics – the meanings attributed to words. To identify whether this affected the therapist model, a sample from a different population was required. The lay sample served as this population due to the participants' reduced knowledge of therapeutic processes. The samples were well matched in terms of other characteristics likely to impact each model, such as cultural factors, age, gender and education level. The maps were very similar, supporting the idea that the therapist map was not significantly affected by differences in theoretical orientation.

Overall, differences seem to represent the therapist model as conveying a deeper understanding of the technical intricacies of strategies, contrasting a more surface level understanding expected in non-therapists. Supporting this expectation, the lay sample model reflects some influence from particular words, as opposed to the overall meaning of items. For instance, the lay sample cluster 'Identifying Thought Patterns' appears to

represent items containing the word ‘thought’. Whereas a similar cluster in the expert model, ‘Noticing’, includes items containing the word ‘thought’, as well as the words ‘emotions’, ‘sensations’ and ‘actions’. Rather than representing a specific word, the expert cluster appears to represent the concept of noticing how thoughts, emotions, sensations and actions impact one another.

Additionally, another cluster in the expert sample, ‘Observing and Perspective Taking’, also has items containing these words, however they represent the distinct concept of perspective taking. This concept was not clearly represented in the lay sample model. Further, while the three lay sample dimensions are described as matching those in the expert model (Results section), these relationships are not well supported by the cluster placement in the lay model, and more suitable relationships were not identified. This speaks to the lay sample’s reduced knowledge of therapy strategies, in that general themes can be derived, leading to similar clusters. However, the more challenging task of identifying relationships between strategies is apparent in that clear meanings could not be derived from the lay model dimensions. These technical differences indicate that the expert model, when applied by therapists or researchers in therapy-related contexts, is likely to be more useful than the lay model. Therefore, the expert model is the primary focus of this discussion.

Clusters

The methodology employed in the present research enabled the organisation of Third Wave strategies into clusters of similar concepts. Following the processes described in the Results section, 17 clusters were identified in the expert sample, as well as eight isolated items (Table 3, Results). Items were designated to clusters so that, as much as possible, they share a common concept that represents the overarching theme of the cluster, as denoted by the cluster label. While there are certain factors that limit the meaning that can be assigned to clusters, as discussed later, the initial clusters presented here reveal several important features. First and foremost, their item composition enables a review of concept overlaps between the paradigms, as well as within the paradigms. A potential implication of this overlap is that it might reflect which elements are effective, based on the extent of their use across the paradigms. Further, these overlaps may represent similar or shared change processes, targeted via

the use of each different strategy. Additionally, the proximity between clusters reveals the relationships between clusters and the concepts they represent, where similar clusters are positioned closer together.

Overlap of Therapeutic Paradigms

The findings from the present research regarding paradigm overlap and paradigm uniqueness are discussed here in relation to overlaps suggested in the literature.

Mindfulness is a central concept within the Third Wave approaches (Baer, 2006) and is promoted in DBT, ACT and MBCT. As expected, the present research supports this. For example, each paradigm contributes items to mindfulness-related clusters, such as 'Mindfulness', 'Noticing' and 'Observing and Perspective Taking'. A benefit of the study design is the ability to delineate any similarities or differences in the ways the paradigms approach the concept of mindfulness.

Chapman (2006) describes how DBT teaches this as a skillset for clients and a stance for therapists, whereas ACT does not teach 'skills' but rather encourages increasing contact with one's experiences and environment. The nature of the present research however, does not allow a distinction to be made between the *form* of strategies. Another difference suggested between these approaches is the emphasis in DBT on participating fully and becoming "one with" experience, compared with the emphasis in ACT and MBCT on attaining an objective distance from experience (Chapman & Linehan, 2005). The present research does not reflect this predominance in DBT on participating in the experience. This is unsurprising as MBCT and ACT also have theoretical models that emphasise being in the present moment in a state of full awareness. Unexpectedly however, significantly fewer items representing 'participating' in the moment are contributed by DBT.

Another under-represented element in DBT involves enhancing control over attentional processes – one of the goals of mindfulness in DBT (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). While this is apparent in some DBT items, attention control is represented predominantly and more directly by ACT and MBCT in this model – namely the 'Mindfulness' cluster. One reason for these under-representations in DBT may be that mindfulness items are more prominent in the additional group skills

training that DBT offers separately from individual psychotherapy sessions. Therefore, as items in this study represent strategies used by therapists in the individual psychotherapy sessions, this may explain their underrepresentation here. A consideration for future research might be to incorporate items from the skills components, although the objective of the present research was to focus on research applications and practice applications for traditional, individual psychotherapy sessions. Albeit, items were validated for the individual setting, suggesting that mindfulness elements may be relatively less important in DBT than ACT or MBCT in this setting.

Aligning with Chapman and Linehan's comparison, findings in this research suggest that the concept of distancing is present in ACT and MBCT exclusively. Distancing is used to encourage objective mindfulness in both ACT and MBCT. In ACT, this is done via 'cognitive defusion' and in MBCT this is termed 'decentring'. Both involve stepping away from an experience to view it for what it is, rather than as reality (Zettle & Gird, 2017). ACT and MBCT items were found to represent this in the present research, and within the same cluster - namely *stepping back from thought content* and *identify "observing self" to view experiences from.* These strategies represent perspective taking, which is revealed in this research as a common element across all three approaches. However, while perspective taking is also strongly incorporated into DBT strategies, a distancing approach is not drawn on – as shown in the DBT items: *observing thoughts, emotions, sensations and actions;* and *using wisdom through the balance of emotions and cognitions.* Therefore, different processes, such as distancing, might distinguish perspective taking across these approaches.

Foley and Renner (2012) highlighted the similarity between ACT strategies involving values, and MBCT strategies involving planning activities, namely increasing nourishing and decreasing depleting activities. Clusters representing these concepts are positioned at the 'insider perspective' pole, indicating perceived similarity. This might reflect the subjective nature of both an individual's values and the activities they consider to be nourishing or depleting. However, the lack of overlap of these concepts within a cluster suggests they may differ in some meaningful way. Zettle (2010) points out that, in contrast with ACT, planning or increasing activities in MBCT is not guided by values – instead the purpose is to regulate mood – by increasing mood-enhancing activities and decreasing mood-depleting activities. In ACT, an individual is encouraged

to use their values to direct their behaviour, in order to live a meaningful life (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Therefore, both ACT and MBCT have strategies that serve to direct behaviour, but perhaps values-oriented versus mood-oriented strategies distinguish unique methods of doing so.

The absence of values in MBCT has been highlighted before (Zettle, 2010), and in line with this, no items from MBCT in the present research explicitly use the term 'values'. However, two MBCT items neighbour the values-based cluster, suggesting some element of values in MBCT - *recognise the importance of taking action despite mood*, and *choosing to engage in skilful action*. The elements of 'importance' and 'skilful' resemble similarities with values. Therefore, further exploration of values-based strategies in this paradigm is warranted. DBT evidences a great degree of overlap with ACT regarding values - *committing to valued actions* is shared by both paradigms, and the remaining items are very similar in terms of identifying values, identifying values-based behaviours, making values-based goals and committing to valued actions. Therefore, values-based strategies may represent a common element across the Third Wave, and perhaps an underlying common process of change.

A related theme to factors involved with directing behaviour is commitment to change, which researchers suggest may be common to both ACT and MBCT Crane and colleagues (2012). While others argue for a greater emphasis on commitment to behaviour change in ACT than MBCT (Zettle, 2010), Linehan considers commitment strategies to be unique to DBT (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006). However, items from all three paradigms in the present study reflect this concept. A different mechanism for enhancing commitment to action might be reflected in these separated clusters. For instance, DBT, ACT and possibly MBCT might promote this via values, and DBT and MBCT may promote this through mood-regulating activity planning, just as these may be involved with directing behaviour. A third mechanism for committing to change may be utilised by both DBT and ACT. Together, they represent the cluster 'Commitment to Change', which appears to comprise strategies that target commitment directly, rather than as a secondary outcome of planning values-based or mood-regulating activities. Therefore, these strategies may be used early on in treatment to establish a commitment, whereas values and mood regulation strategies might be used to support commitment when it has already been established. An important finding

here is that specific commitment strategies, which were considered unique to DBT (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006), may also be represented by ACT.

Similarities have been suggested between ACT and DBT regarding their respective elements 'acceptance' and 'distress tolerance' (Gootzeit, 2014), and researchers have reported changes in individuals' acceptance and distress tolerance levels following MBCT treatment (Motaghedi, Donyavi, & Mirzaian, 2016; Day & Thorn, 2016). Given both promote continued functioning through difficulty, it makes sense that experts grouped these concepts together, forming the cluster 'Distress Tolerance and Acceptance'. The item, *accepting and sitting with discomfort,* is shared by all three paradigms. This reveals a commonality in responding to discomfort with openness, willingness, allowance and acceptance. Tolerance conveys a forced experience and reduced openness, and is represented by DBT exclusively in the item *practice strategies for tolerating distress.*

The model appears to capture these differences as tolerance is represented in the externally oriented hemisphere – reflecting the need to forcefully initiate skills or behaviours. Conversely, the positioning of the acceptance strategies in the internally oriented hemisphere reflects their internally-governed state of openness. The exclusivity of distress tolerance in DBT makes sense, given the populations and disorders it typically treats. For instance, people with borderline personality disorder have been found to experience emotions more intensely, likely making acceptance more difficult. Therefore, alternative strategies must be drawn on in order to help the individual cope effectively with a situation. In the model presented here, tolerance is absent from ACT and MBCT. Instead, these paradigms seem to emphasise openness to experience to a greater extent, revealed by their predominance in the 'exploration of experience' dimensional pole. While acceptance is also incorporated in DBT, tolerance may comprise one important distinction between the paradigms.

Paradigm Uniqueness. Several clusters consist of items from one paradigm, which are important as they point to unique strategies or unique concepts specific to that paradigm. Additionally, the grouping of multiple 'unique' items means they share a common concept, and perhaps exert their effects through a shared process of change. The clusters in this study provide an organising structure to investigate these further.

'Skill Mastery' is represented solely by items from DBT. This cluster captures the idea of teaching the client skills and supporting skill enhancement through practice and generalisation to different environments. 'Reinforcing Behaviour' and 'Behaviour and Solution Analysis' are also DBT-specific clusters. All three clusters are reflected in traditional CBT approaches, particularly traditional Behaviour Therapy. This pattern suggests that perhaps DBT is more closely aligned with traditional CBT than are ACT or MBCT. Indeed, the pronounced focus of DBT on behaviour change through change procedures has been pointed out (Dimeff & Koerner, 2007). Further, DBT's place in the Third Wave category has been critiqued, suggested instead to be an extension of CBT (Hofmann, 2008). While this position is coherent with some of the findings in this research, other findings reported here reveal DBT items representing Third Wave characteristics – such as mindfulness, acceptance and values. The Third Wave classification acknowledges and invites the inclusion of interventions from previous waves of CBT (Harris, 2009). Therefore, this should not preclude DBT from the Third Wave. Although the extent of the inclusion of CBT interventions may highlight one difference between the Third Wave paradigms. Despite the knowledge that any behaviour change interventions can be used in ACT (Hayes, Luoma, Bond, Masuda, & Lillis, 2006), experts involved in validating the ACT items did not include these, whereas DBT experts did. Therefore, the model may reveal the relative importance or frequency of use of First and Second Wave CBT interventions in these paradigms. This is an important finding, with implications for research investigating common elements that extend across all CBT approaches. Incidentally, this represents the work of Mennin and colleagues (2013), which is discussed in the next section.

The cluster, 'Dialectical Strategies', comprise only DBT items, and these represent a unique feature of DBT. They were specifically incorporated into Linehan's treatment to counteract the pitfalls of CBT in its use with clients exhibiting self-harm and suicidal behaviour (Linehan, 1993). For the same reason, 'Validation of Clients' is an important component in DBT and this cluster is represented only by DBT in the present research. Items in these DBT clusters convey a greater level of involvement from the therapist. This may be an important point of difference between DBT, ACT and MBCT. Given the degree and types of problems experienced by many individuals

undergoing DBT treatment (Linehan, 1993), it makes sense that DBT strategies require significantly more involvement from the therapist.

'Noticing Values-based Behaviour' is made up of ACT items, reflecting an ACT emphasis on values. Whilst DBT also promotes values work, this is in the cluster 'Planning Values-based Behaviour', shared by ACT and DBT items. They formed a separate cluster, likely due to the internally-oriented, experiential nature of the first cluster, and the externally-oriented, more direct nature of the latter. These differences are reflected in their positioning on different hemispheres. The relatively fewer internally oriented strategies in DBT, as shown in both values and mindfulness concepts, suggests this may be a salient difference between ACT and DBT.

The findings in the present research demonstrate several areas of overlap across DBT, ACT and MBCT, which are mostly congruent with those suggested in the literature. Also evidenced are clusters comprising items from only one paradigm, which represent differences between the approaches. These clusters are consistent with the theoretical models upon which each approach was developed and therefore are not overly surprising. The systematic method used to identify these paradigmatic overlaps and differences, and the participation of experts in the sorting task, represent methodological improvements on previous paradigmatic comparisons made. Overlapping strategies, represented by clusters, are discussed next in relation to proposed common factors, namely common change processes.

Change Processes

An important premise of the sorting procedure and analyses used in the present research is that items positioned closely together in the map, thereby forming clusters, are considered conceptually similar. This perceived similarity indicates areas of potential construct overlap, where a construct is common to all the items within the cluster. Clusters in the present research that comprise strategies from DBT, ACT and MBCT may represent a form of 'common factors'. One classification of common factors that was discussed earlier is common change processes, described as the "transtheoretical means by which change occurs in psychotherapy" (Prochaska, 1984, p. 374; Goldfried, 1980). Many clusters identified in the present research appear to relate to change processes that have been identified in the literature. Mennin and colleagues

(2013) propose a model of change processes common to all CBT approaches, including Third Wave therapies. The findings from the present research are discussed in relation to this model, and Table 7 summarises these relations.

Table 7

Clusters in the Present Research in Relation to a CBT Common Factors Model (Mennin et al, 2013)

Change Principle	**Therapeutic Process**	**Clusters Relevant to Change Process (*italic* – isolated items)**	**Paradigms Comprising Cluster**	**Clusters that may be Relevant (*italic* – isolated items)**
Context Engagement	Behavioural Exposure	Planning Values-based Behaviour	DBT ACT	Observing and Perspective Taking, Noticing, Emotional Knowledge *Practice objectively describing thoughts, emotions, sensations and actions*
		Distress Tolerance and Acceptance	DBT ACT MBCT	
		Mindfulness	DBT ACT MBCT	
	Behavioural Activation	Planning Values-based Behaviour	DBT ACT	*Recognise importance of taking action despite mood* *Choosing to engage in skilful action*
		Activity Planning	DBT MBCT	
		Behavioural and Solution Analysis	DBT	
		Skill Mastery	DBT	
		Reinforcing Behaviour	DBT	
		Commitment to Change	DBT	

			ACT	
Attention Change	Attention Training	Mindfulness	DBT ACT MBCT	
		Awareness of Pleasant Events	MBCT	
		Noticing	DBT ACT MBCT	
		Emotional Knowledge	MBCT	
	Acceptance and Tolerance	Distress Tolerance and Acceptance	DBT ACT MBCT	
		Confronting Experiential Avoidance	ACT	
		Identify strategies used to avoid unhelpful thoughts	ACT	
		Explore function of emotion	ACT	
		Using wisdom through the balance of emotions and cognitions	DBT	
		Dialectical Strategies	DBT	

Cognitive Change	Decentring or Defusion	Observing and Perspective Taking	DBT ACT MBCT	Mindfulness Noticing Awareness of Pleasant Events Noticing Values-based Behaviours *Practice objectively describing thoughts, emotions, sensations and actions* *Explore function of emotion*
	Cognitive Reframing	Dialectical Strategies	DBT	Noticing strategies: *Awareness of thoughts, emotions and sensations involved in interpreting events;* *Separating thoughts, emotions, and interpretations from facts*
		Using wisdom through the balance of emotions and cognitions	DBT	
		Therapist Style	DBT ACT MBCT	
		Practice objectively describing thoughts, emotions, sensations and actions	DBT	
		Identify strategies used to avoid unhelpful thoughts	ACT	
		Confronting Experiential Avoidance	ACT	
		Distress Tolerance and Acceptance	DBT ACT	

			MBCT	

Context Engagement. The first change principle proposed by Mennin and colleagues is 'context engagement', suggested to comprise of therapeutic processes: behavioural exposure and behavioural activation (2013). Behavioural exposure is reflected in the present research in the cluster 'Planning Values-based Behaviour'. Mennin et al describe values-based behaviours as opportunities for exposure by promoting engagement in behaviours that may be uncomfortable, but persisting in these because they are identified as being important. This persistence with discomfort represents exposure. A second cluster was identified as representing exposure, although this connection was not made by Mennin and colleagues. This was 'Distress Tolerance and Acceptance', which represents sustained and full contact with experiences, especially difficult ones. Mindfulness may promote exposure indirectly by increasing attentional capacities (Treanor, 2011), and directly by encouraging awareness of and non-reactive responses to one's experiences (Tang, Holzel, & Posner, 2015). In the present research, a related cluster is 'Mindfulness', where both attentional abilities and awareness of one's experiences are developed.

Behavioural activation is reflected in the clusters 'Planning Values-based Behaviour' and 'Activity Planning'. Here, planning behaviours promotes engagement in them, and positive reinforcement is likely to result as these clusters encourage individuals to do what is important to them and what is rewarding for them, respectively. 'Behavioural and Solution Analysis' involves planning alternative behaviours to replace ineffective or dysfunctional behaviours. 'Skill Mastery' promotes the learning and practicing of new behaviours to enhance an individual's confidence to engage in them. 'Reinforcing Behaviour' involves positive reinforcement in order to promote maintenance of a behaviour. Finally, 'Commitment to Change' addresses motivation for engaging new behaviours. Subsequently, all paradigms in this research contribute strategies representing behavioural activation, although DBT strategies dominate this process. This again reflects the potential greater emphasis in DBT on traditional behavioural strategies, which behavioural activation has its roots in. Conversely, ACT and MBCT are underrepresented in behavioural activation in this model, which may reflect gaps in these approaches.

Whilst no clear dimension of 'context engagement' is indicated in the present research, clusters representing behavioural activation are exclusively located in the

externally oriented strategies pole, and clusters representing behavioural exposure are predominantly in the internally oriented strategies pole. It may be that strategies that provide opportunities for exposure predominantly attend to the emotional aspect of an experience; therefore, their focus is oriented internally. Whereas behavioural activation focuses on carrying out and maintaining new behaviours, which are often external actions. This highlights an inconsistency in the present research – behaviours can also be internally oriented, such as mindfulness activities. This means that clusters representing 'behavioural activation' should also be represented in the internally oriented strategies pole. For example, items in the 'Skill Mastery' cluster may be considered as both externally and internally oriented, yet they are entirely in the externally oriented strategies dimension

Perhaps not a predominant dimension in this model, clusters support the presence of context engagement in the Third Wave approaches, namely through behavioural exposure and behavioural activation processes. Because all paradigms contribute strategies that relate to these processes, this research supports the idea that they are 'common change processes', as proposed by Mennin et al (2013). Further, this research may represent further refining of these processes. That is, clusters may indicate more specific processes within those proposed by Mennin et al, and depending on the paradigms within the clusters, might additionally indicate those processes unique to the Third Wave, or unique to individual Third Wave paradigms.

Attention Change. The second change principle proposed in Mennin et al's model is 'attention change', promoted via the therapeutic processes: attention training; and acceptance and tolerance. Attention training is exhibited predominantly through the 'Mindfulness' cluster, as described above, where attention is paid not only to one's thoughts, emotions, sensations, actions and activities in the present moment, but also to where attention is held, where it wanders, the refocusing of wandering attention, the extent of one's awareness, and the regaining of awareness when it has been lost. This cluster shows a very clear conceptual link to attention training as a therapeutic process and attention change as a broader change principle. The clusters 'Awareness of Pleasant Events' and 'Noticing' promote awareness of experiences, such as thoughts, emotions, sensations and actions, but also of the relations between these experiences. Therefore, using Mennin et al's description of attention change – the ability to flexibly direct

attention in response to situational demands – 'Noticing' and 'Awareness of Pleasant Events' encourage this by helping an individual to move their attention to various different aspects of experiences. The cluster 'Emotional Knowledge' also promotes attention change by practicing moving attention from one's mood to other aspects of experience.

The second therapeutic process described as contributing to 'attention change', acceptance and tolerance, is reflected in the 'Distress Tolerance and Acceptance' cluster, unsurprisingly. It is important to remember that Mennin and colleagues' definition of 'attention change' involves the focusing and sustaining of attention, as well as the moving of attention. In this sense, strategies in the 'Distress Tolerance and Acceptance' cluster may reflect attention change by encouraging sustained attentional focus on specific experiences, particularly difficult ones. Further, exploring the function of emotion and in particular any attempts to avoid or control difficult experiences is said to contribute to attention change (Mennin, Ellard, Fresco, & Gross, 2013), which is reflected in the cluster 'Confronting Experiential Avoidance', and in the isolated items *identify strategies used to avoid unhelpful thoughts,* and *explore function of emotion.* Mennin and colleagues propose the 'wise mind' strategy from DBT encourages tolerance of a difficult experience through the balance of one's emotional experience with their logical reasoning. This strategy is indeed represented in the present research and is situated near the 'Distress Tolerance and Acceptance' cluster, highlighting the close relations between these concepts.

Attention change is the most well-represented change principle in the present research, in that clusters relevant to attention change comprise one dimension identified in the expert map. This is the 'Response to Experience' dimension, characterised by the poles: exploring experience; and accepting experience. The therapeutic process, attention training, is reflected in the clusters at the exploring acceptance pole, and the 'Mindfulness' cluster in the middle of this dimension. The second therapeutic process, acceptance and tolerance, is largely reflected in the clusters at the accepting experiences pole. Whilst the 'Response to Experience' dimension was interpreted by the researcher of the present study as representing a range of strategic methods for responding to one's experiences, attention change emphasises enhancing attentional abilities, such as changing or sustaining attention in response to situational demands (Mennin, Ellard,

Fresco, & Gross, 2013). While both interpretations may be valid, additional support is given for the 'Response to Experience' dimension below.

Cognitive Change. The final change principle proposed by Mennin and colleagues is 'cognitive change'. They propose the therapeutic processes decentring or defusion, and cognitive reframing as producing cognitive change. Decentring and defusion are reflected predominantly in the cluster 'Observing and Perspective Taking' by ACT and MBCT strategies - *stepping back from thought content* and *identify "observing self" to view experiences from*. These encourage an individual to distance themselves from their experience in order to see it more objectively and as an experience, rather than as an individual's defining feature. As discussed earlier, DBT items do not appear to emphasise distancing, therefore, the therapeutic process of decentring or defusing may not be 'common' as proposed by Mennin et al (2013).

Cognitive reframing is also supported as a relevant process in the present research. Related clusters include 'Dialectical Strategies', which promotes the development of a new perspective or appraisal, by balancing two extreme perspectives. For example, the isolated item *using wisdom through the balance of emotions and cognitions,* as described above, also promotes appraising situations in a balanced manner, that is not dominated solely by one's emotions, nor solely by a removed, logical stance. Cognitive reframing is reflected in the 'Therapist Style' cluster, where the therapist's use of metaphors or stories acts to reframe an event, enabling the client to view it in a new way. Objective appraisals are promoted through the isolated item *practice objectively describing thoughts, emotions, sensations and actions*. The isolated item, *identify strategies used to avoid unhelpful thoughts*, and the cluster 'Confronting Experiential Avoidance' involve reframing by having an individual explore avoidance and consider how useful it is, with the aim of fostering a new perspective of acceptance and allowance instead of control. Thus, the cluster 'Distress Tolerance and Acceptance' could also represent cognitive reframing.

The concept of cognitive change is therefore represented in the present research by a range of clusters and isolated items. Interestingly, these clusters are predominantly positioned in the same area in the expert map, conceptualised as the 'Outsider Perspective' pole. This supports the identification of this pole as an important theme

among the set of Third Wave strategies in this study, and increases reliability of clusters in this pole coherently representing one predominant theme.

The expert map produced in the present research evidences several commonalities with the change and therapeutic processes proposed by Mennin et al (2013). This supports the representation of the Third Wave approaches in their model. While Mennin et al highlight few processes, these are necessarily broad to capture the commonality across all CBT approaches, as they intended. Broad conceptualisations of change processes may be less helpful for research involved in investigating these processes, for therapists and researchers involved in designing new treatments, and for therapists deciding which interventions to use with their clients to effectively target their needs.

The present research elaborates on this model by producing distinct strategy clusters that seem to reflect similar processes. Therefore, these clusters may represent change processes on a more specific level. These may or may not also be represented in other CBT approaches, but at this level, this comparison is made possible. For instance, the clusters already illustrate some differences between the included Third Wave paradigms, indicating they are not all 'common' to the Third Wave. Further research will be required to validate and confirm these clusters.

The present model also expands on the CBT common factors model by illustrating an organisation of the strategies in relation to each other. With similarly themed clusters positioned together, and differently themed clusters positioned apart, the result is continuums of themes, called dimensions. These serve as markers that can further inform what the likely change processes may be. Therefore, the model has provisions for further identification and refinement of change processes of the Third Wave therapies, as new strategies are added to the model. These are outlined below.

Dimensions

Statistical analyses revealed the presence of three distinct dimensions in the set of items used in the present research. These dimensions are representative of the most prominent themes among this set, and they provide one possible classification system for organising strategies in other Third Wave approaches going forward. Importantly, the map produced in this research is the first systematic attempt to organise the

therapeutic components of Third Wave therapies, and as such this initial model is intended to represent the Third Wave therapies specifically.

The first dimension, strategy orientation, distinguishes externally oriented strategies from internally oriented strategies. In addition to this, a second theme emerged alongside this dimension distinguishing experientially linked strategies from direct strategies. Whilst the Third Wave approaches use direct change strategies, they are frequently characterised by the increased emphasis on contextual and experiential change strategies (Hayes, 2004). Experiential change strategies involve altering the function of psychological events, such as one's awareness of and relationship to them. Conversely, direct change strategies involve altering the content of psychological events. The internally oriented pole may reflect experiential change strategies as we anticipate internally oriented strategies such as mindfulness and perspective taking will enhance awareness, in turn altering one's relationships to psychological events. The externally oriented pole may reflect direct change strategies. For example, behavioural analysis involves identifying specific problematic behaviours to change, which are commonly externally oriented behaviours, such as fighting or substance abuse. Therefore, whilst the internal versus external orientation of behaviour most clearly represents this dimension, there is also evidence of an experiential versus direct change approach.

These themes have implications around client preferences of therapeutic style. For instance, client preferences have been linked to treatment effectiveness; specifically those matched with a preferred treatment style demonstrated better outcomes and reduced dropout rates (Swift & Callahan, 2009). Therefore, where appropriate, clients who prefer to work through problems through more internal, cognitive tasks may be better suited to strategies at the internally oriented pole. Conversely, those preferring external behavioural approaches or approaches that target more specific psychological events may be better suited to strategies at the externally oriented pole. Additionally, particular diagnostic features may be better suited to internal versus external orientations of behaviour, and to experiential versus direct strategies. For example, individuals with coping styles characterised by external features, such as acting out, have been found to benefit from behavioural change focused treatment, which is more congruent with externally oriented strategies. Whereas those with internalising coping

styles, such as self-blame, were found to benefit more from self-exploration and insight promoting treatments, which are congruent with internally oriented strategies (Castonguay & Beutler, 2006).

A second dimension, response to experience, distinguishes exploring experiences from accepting experience. Another theme emerging in this dimension is mindfulness. Bishop and colleagues (2004) suggest mindfulness consists of two constructs, namely attending to one's experiences in the present, reflecting the exploring experiences pole; and having an accepting attitude toward them, reflecting the accepting experiences pole. Mindfulness strategies are used to enhance one's contact with their experience, targets the pathological feature of experiential avoidance – a concept strongly emphasised in the Third Wave, particularly DBT, ACT and MBCT (Chawla & Ostafin, 2007). Therefore, a mindfulness dimension is expected and may help to distinguish important, unique components within mindfulness. Further, it has prospects for therapists treating clients with problems related to avoidance. Many dysfunctional behaviours have been connected to experiential avoidance, including substance abuse, self-harm, sexual promiscuity, binge eating, and aggression (Kingson & Remington, 2010). Mindfulness has indeed been studied for its impact on such disorders, and change has been suggested to arise through several processes, some of which align with those identified in the present research. The present research may then reinforce or add to knowledge about the underlying change processes of mindfulness.

For example, Brewer and colleagues suggest that mindfulness works by reducing affective biases (2013), which are believed to lead to emotional distortions in memory and attention (Elliott, Zahn, Deakin, & Anderson, 2010). In relation to smoking, they propose several processes involved in mindfulness. Namely, mindfulness helps one identify triggers for smoking; identify the short-lasting effects smoking has on the trigger; accentuate the negative effects of smoking; and ultimately highlight and reduce the emotional distortions one has around the positive and negative effects of smoking. This in turn allows an individual to see smoking for what it is. This is reflected in distinct clusters in the response to experience dimension. 'Emotional Knowledge' and 'Noticing' clusters reflect the identification of triggers for problematic behaviour, as they emphasise relationships between experiences. The 'Mindfulness' cluster reflects the enhancement one's ability to notice the negative effects of the

problematic behaviour and its limited positive effects, as it focuses specifically on attentional abilities and enhancing awareness. Finally, seeing the behaviour and its impact more objectively rather than from a distorted perspective is reflected in the 'Observing and Perspective Taking' cluster. Garland et al further suggest emotional distortions can be reduced by promoting non-evaluative contact with experiences (2009), which is also conveyed in the latter cluster. This dimension is more visually apparent at the internally oriented strategies pole than the externally oriented strategies pole, reflecting the conceptual congruence of mindfulness strategies as internally oriented. Similarly, the relative absence of these strategies in the negative hemisphere provides conceptual validity for the distinction between externally versus internally oriented behaviour.

The final dimension represents the source of perspectives involved in strategies, distinguishing an insider perspective from an outsider perspective. The 'insider', or client, perspective reflects strategies that involve clients analysing and appraising their personal behaviours and values. The 'outsider' or therapist perspective reflects strategies that involve appraisal of the client's behaviour by an external source, such as the therapist's validation of the client. The therapist's perspective must be externalised to the client, therefore it is consistent that the outsider perspective clusters predominantly reside on the externally oriented strategies pole. Strategies that specifically promote the client's perspective taking abilities also comprise this continuum, positioned between the middle and the 'outsider' perspective pole. This is suitably positioned, reflecting the idea that the perspective observed is still the client's. However despite this, through the process of therapy, clients identify a different perspective, perhaps akin to that of another person.

This dimension may have implications for therapists with regard to matching client preferences and individual needs with an optimal level of support. For instance, if a client's ability to analyse and appraise their experiences is poor, the therapist may express their 'outsider' perspective to the client in order to support them in developing this skill. It is consistent, then, that the central cluster in this dimension is 'Skill Mastery', where client and therapist contribute shared efforts to enhance the client's learning and eventual engagement in skills or behaviours. Thus, the dimension may also represent a balance between low and high levels of support. Analysing the items within

the clusters at the ‘outsider perspective’ pole reveals they are predominantly from DBT. This suggests that DBT may involve relatively more therapist support, which is reflective of the types of clients who are generally treated using DBT (Linehan, 1993). This dimension could subsequently serve as a guide for therapists, where particular strategies are drawn upon depending on the level of support required by the client.

Holes in the Model

The map provides a visual display of the representation of concepts in this research, illustrated by the spatial coverage of items over the map surface. Each broad area of the model is represented by items or clusters of items. Each octant has between 10-13 items, with the exception of octant eight with only seven items. Dimensional coverage is also consistent, indicated by the balance of items on each side of the dimensions: 43/41 for the Y dimension (exploring versus accepting experiences), 45/39 for the Z dimension (insider versus outsider perspective), and 38/46 for the X dimension (internally versus externally oriented strategies). Despite this, some gaps can be seen which indicate areas of therapeutic strategies that are, according to the present research, under-represented in both the literature and therapeutic practice. In validating this model, it will be particularly important to replace these gaps with appropriate strategies. The dimensional characteristics provided in this model will help to guide this process. Additionally, the eight isolated items are inherently central to these holes. Therefore, they can provide direction for investigating these under-represented, or non-represented, therapeutic strategies. Another possibility is that they represent a limitation of the present research regarding concept coverage during item identification, which is discussed in the limitations section below.

A noticeable hole can be seen in octant three. Strategies that would be appropriate in this area include those that: are internally oriented; have an insider perspective; and involve exploring experiences. Additional characteristics may include a requirement of less therapist support and that experiential change is encouraged. Surrounding concepts may further indicate missing strategies: ‘Noticing Values-based Behaviour’, ‘Awareness of Pleasant Events’, and *identify strategies used to avoid unhelpful thoughts*.

Octant eight is largely unrepresented, containing only seven items. Strategies suited to this octant include those that: are externally oriented; involve an outsider perspective; and involve exploring experiences. The nearby isolated ACT item *explore function of emotion* may indicate related strategies. A review of the literature around this concept suggests this is a new, emerging area in psychological research. This area involves exploring how functional, in other words – effective, different emotions can be, and the degree to which functionality differs across different situations (Lench, Tibbett, & Bench, 2016). Strategies might encourage exploring the effectiveness of changes that occur as a result of emotions, as a function of the specific situations they occur in. Therefore, the emphasis is on how useful emotions can be, even traditionally negative ones. This is consistent as a concept that defines the exploring experiences pole, which sits opposite the accepting experiences pole. Rather than accepting or tolerating uncomfortable experiences, they may be appreciated and utilised if their positive aspects are realised. As more is learned about this concept, relevant strategies may emerge that could replace this hole in the model. Given that *explore the function of emotion* is a strategy from ACT, this paradigm may be worth revisiting to identify any similar strategies.

A gap in octant two reveals an under-representation of strategies that involve accepting experiences; internal orientation and an outsider perspective. Strategies to replace this gap may involve developing new perspectives of the self that are accepting of one's experiences, past and present, as opposed to those that are self-defeating and focused on a need to change. Perspective taking strategies are represented in this model that promote objective appraisals; and acceptance strategies are represented that promote openness to discomfort. However, the combination of perspective taking and acceptance are not represented here, which may highlight an important concept and could enhance this model.

DBT evidenced several isolated items. One example is *using wisdom through the balance of emotions and cognitions.* The item reflects elements of tolerance (Mennin, Ellard, Fresco, & Gross, 2013) and perspective taking, which are supported by its position halfway between these dimensional poles. Further research might investigate the existence of other strategies that involve these elements from an internal orientation, as the externally oriented pole is well represented in this regard. Similarly,

strategies that are internally oriented and have an outsider perspective, but that are exploratory in nature are under-represented, in octant four.

Isolated MBCT items included *recognise importance of taking action despite mood* and *choosing to engage in skilful action*. Perhaps these items differ from traditional behavioural activation techniques that promote action by external reinforcement or practice, in that they promote action through an internal realisation of its importance, and a conscious decision to carry it out. Behavioural activation is indeed represented more strongly by externally oriented strategies in this research. Identification of internally oriented behavioural activation strategies would provide therapists with alternative options for their clients who prefer and respond better to cognitive strategies.

Model Inconsistencies

The majority of clusters appeared within expected areas, as determined by the dimensional characteristics of each octant. The majority of items within each cluster were also coherent with the overall theme representing it. Further, the model evidenced item and cluster coverage across all eight octants and a good level of internal consistency. However, there are a few instances where items or clusters appeared in unexpected octants, serving to undermine the validity of the model and the dimensional qualities assigned to it by the researcher. Reasons for these inconsistencies are explored here.

'Confronting Experiential Avoidance' items, *identify strategies used to avoid uncomfortable feelings* and *explore workability of avoidance strategies*, are in octants one and five, respectively. These octants represent the accepting experiences pole. Both identifying strategies and exploring their workability seem to align with exploring experiences; however in interpreting these items, experts may have focused instead on the avoidance element. It is possible that experts sorted these items based on their purpose, which is to consider accepting the experience rather than avoiding or controlling it. What is more difficult to explain is the positioning of the similar item *identify strategies used to avoid unhelpful thoughts* opposite these items. The obvious distinction in these items is between thoughts and feelings. However, this distinction does not correspond with the dimensional characteristics that the items are suggested to

have. Using this distinction to represent a dimension would not be accurate, given both poles of the dimension contain items involving both thoughts and feelings. One possible explanation is that the items were interpreted in two opposing ways: firstly, that the use of avoidance strategies is encouraged in order to reduce negative experiences; and secondly, that their use is discouraged. Given the theoretical origin of these items is ACT, differences in familiarity with ACT may be one reason for different interpretations.

Another inconsistency is the placement of 'Planning Values-based Behaviour' in an accepting experiences octant. The items central to this cluster appear more exploratory in nature. As values are integral to an individual, perhaps they are not viewed as needing to be explored, but are already known. Instead, acceptance is promoted in order to facilitate a commitment to values-based behaviours. This same inconsistency occurred with the 'Noticing Values-based Behaviours' cluster, involving items noticing effective, values-congruent behaviour; and noticing ineffective, values-incongruent behaviour. The expected octant would have been defined by exploring experiences, due to the requirement here to link behaviours to values and their effectiveness. Like the previous values cluster, if values are conceived as being well known to the client, whether that is true or not, this may explain their position in the accepting experiences octant. Both clusters are, however, reasonably close to their expected octant. Further, they define the pole of a separate dimension. This means they carry less weight for the 'Response to Experience' dimension.

In contrast, the 'Activity Planning' cluster, in octant seven, is characterised by exploring experiences. Its items, *planning balanced lifestyle to prevent emotional sensitivity; scheduling positive experiences;* and *planning to increase rewarding and decrease draining activities,* may be seen as suiting the acceptance of experiences, rather, in that the behaviours to be carried out have been accepted by the client. However, determining which experiences are rewarding, draining, positive or negative for the client may be an exploratory process.

Another cluster only marginally away from its expected octant is the 'Validation of Client' cluster. Positioned in an octant characterised by the exploring of experiences, it is unexpected as the strategies are often used to convey acceptance of a client's experiences. However, as was described earlier, this may facilitate the client's

exploration of the validity of their experiences and of new perspectives. Therefore, the cluster is consistent in both accepting and exploring experiences, and its close proximity to the middle of these octants may be representative of the two elements.

Finally, the item, *explore the function of emotion,* appears on the hemisphere characterised by an external orientation of behaviour. Expected on the internally oriented behaviour hemisphere, one possible explanation is that the word 'function' carried more weight in the experts' interpretation than the element of 'explore', where 'function' can involve external events.

Most of the clusters described as being in unexpected octants involve the 'Response to Experience' dimension, bringing the validity of the dimension's characteristics into question. However, an analysis of their positions in relation to this dimension reveals they are not in proximally significant positions. That is, clusters and items closest to the end (pole) of each dimension are the most defining features of that pole, while items further away are less defining. Therefore, overall, the clusters do not pose strong threats to the validity of the presented model.

Implications and Applications of the Present Research

Dimidjian and colleagues (2016) state the need to identify, with greater precision, the relationships between sets of therapies, specifically the Third Wave therapies. Of particular importance is identifying the extent of shared, common elements of the Third Wave approaches, their specificity to the Third Wave, and their effectiveness. While not aiming to address all of these needs, the present research is an important step in identifying the extent of shared, common elements across Third Wave therapies. To the researcher's knowledge, the present research is the most systematic attempt in this endeavour. The findings from this research suggest there is a significant degree of overlap across DBT, ACT and MBCT, as well as unique areas in each. For example, several items overlapped identically across one or more approaches; ten clusters comprised more than one approach; and the remaining seven clusters and eight individual items were unique to just one approach.

The model produced offers an organisational structure from which to understand interrelations between types of strategies along continuums of important dimensional

features. Distinguishing strategies with an external versus internal orientation of behaviour, for example, may have relevance for guiding interventions according to client suitability. The exposed overlap and organisational structure of dimensions then enables insight into the mechanical workings by which change occurs by isolating strategies into specific groups.

The findings from this research have potential for use in many domains, including therapist practice and training, therapy development and advancement, and research.

Therapist Practice

This research has provisions for the development of a new, integrated therapy approach. This has the benefit of providing a wider range of strategies from which to draw, which means it may be applicable to a wider range of individuals and circumstances. As mentioned above, Castonguay and Beutler reported specific client factors that responded differently to different styles of treatment (2006). These styles of treatment were not related to particular approaches. Therefore, integrating different approaches could provide a greater range of strategies to draw on, and the selective use of those most appropriate for the client. For example, Castonguay and Beutler's research indicates that individuals with internalising coping styles may benefit from specific inclusion of strategies from 'insider perspective' and 'exploring experience' poles. The present research thus provides an initial framework of dimensions spanning across DBT, ACT and MBCT, which can be used to guide therapists in applying interventions that are most likely to benefit the client.

Of the sample of thirty-five experts in the present research, thirty-four reported being trained in and using at least one Third Wave approach, with the majority using more than one. Information on their integration of different approaches was not collected. However, this research provides one potential organisational framework that these and other therapists could use to integrate strategies from DBT, ACT or MBCT into their practice.

Chapter Four
Discussion

Research Applications

The present research identified clusters that represent overlapping constructs between DBT, ACT and MBCT. These paradigm overlaps, may indicate areas of common change processes. As well as therapeutic paradigm overlaps, the clusters that contained many items from only a single paradigm represent one or more shared constructs. Therefore, they may also represent change processes that are worthy of investigation.

The identification of overlaps and clusters provides direction for future researchers in designing studies to investigate the processes of change involved in them. This endeavour is made simpler in the present research by the organisation of strategies into likely shared change processes, based on their sorting by similarity. This is supported by the fact that strategies were sorted by experienced therapists, most of whom have training and experience in Third Wave approaches.

Limitations

Certain elements were identified in this research that are important to consider, as they have the potential to limit the reliability and validity of the findings presented. These are discussed with suggestions for improvements in future research.

Item Representativeness

The conclusions drawn from the 3D model, namely the constructs represented by clusters and the relationships conveyed by dimensions, are largely determined by the items used in the sorting task. To increase the likelihood that true underlying patterns of clusters and dimensions emerge, items should accurately portray DBT, ACT and MBCT strategies, as well as collectively represent all the constructs incorporated into these treatments. If this is not achieved in the item generation stage, important constructs will not be considered during interpretation of the model, leading to reduced validity. Outlined in the Methods section are steps that were taken to limit the absence of important constructs. Despite these steps and the expert validation that items underwent, one notable factor may have restricted the full range of strategies from being identified in this research. That is, the need to maintain as small and manageable an item set as

possible, to minimise the difficulty of the sorting task. A difficult sorting task has increased risk of being completed poorly. This threatens the reliability of the results, rendering their use in further applications questionable. Conversely, accurately sorted strategies are more reliable, meaning accurate conclusions can be drawn.

Two elements may have led to an under-representation of relevant constructs. Firstly, the item criteria (Methods section) stated items should not represent any strategies that *can* be used, but rather those that are *central* to each approach, including those that are unique or essential. As each approaches' item set was validated independently by different experts, the sets inevitably reflect a range of influences and opinions about the degree to which a particular strategy is essential or even unique to a given approach. Therefore, the model presented in this research may highlight the degree of importance of strategies in each paradigm, rather than their absolute inclusion or non-inclusion in the paradigm. For example, ACT maintains that any traditional behavioural techniques can be used in its interventions, provided they align with the ACT processes. However, the expert model in this research portrays traditional behavioural therapy techniques as largely contributed by DBT as opposed to either ACT or MBCT. Rather than highlighting ACT or MBCT's non-inclusion of these techniques, it likely reflects a greater importance or emphasis on them by DBT (Rizvi, Steffel, & Carson-Wong, 2013; Linehan, 1993, p. 100).

Secondly, in order to reduce the total number of items, strategies representing very similar constructs were combined into one item. This may have resulted in the presence of two constructs in one item, which excludes the possibility of those constructs being delineated. Alternatively, two valid constructs may have been translated into a new, invalid or inaccurate one. Following validation by experts, items thought to represent identical strategies between paradigms were combined to reduce redundancy of items. It was thought that these items would negatively impact the sorting methods of participants, whereby the few identical strategies would be grouped together, distorting the potential overlapping relationships between them and other similar, but not identical, strategies.

However, one example was noted where the combining of strategies may have restricted the information gathered from the model. '*Make room for unwanted emotions, thoughts and sensations', 'experiencing and allowing unpleasant thoughts, emotions*

and sensations', and *'accepting and sitting with discomfort'* were replaced by '*accepting and sitting with discomfort'*. However, these items may differ in important ways – perhaps regarding the emphasis on acceptance. The included item also arguably combines acceptance ('accepting') with tolerance ('sitting with'), meaning these concepts cannot be delineated. The item criteria stated items were to represent single strategies, and this was assessed at each stage in item generation. Despite this, further attempts to validate this model should include investigating whether items contain multiple strategies and delineating them, and also identifying whether any items excluded due to redundancy may have enhanced the model, rather than detracted from it.

Item Consistency

In addition to helping identify whether the full range of strategies has been captured, MDS can reveal information about the consistency of the *kind* of construct represented by the items. This is given by measuring the distance of each item from the origin of the map. Items particularly close to the origin indicate perceived similarity with all other items, perhaps resulting from a broader description as compared with other more specific items. Therefore, they are pulled closer toward all items, and subsequently the origin. Conversely, items further away from the origin indicate they are substantially different to the other items. This could occur if items are overly specific, or if items represent a different level of conceptual classification. Items significantly close to or far away from the origin were identified based on their standard deviations from the mean. Most items were within one standard deviation from the mean, suggesting good consistency among the types of items in the model.

Only three items were greater than two standard deviations from the mean. These were *therapist is warm and genuine to client's experiences,* from the 'Validation of Client' cluster, *therapist is direct in an offbeat and unexpected manner* and *therapist changes topics and emotional tone quickly,* both from the 'Therapist Style' cluster. These items reside closely together, and although they are spread across two clusters, they are similar in that they are all DBT strategies that describe behaviours specific to the therapist.

As outlined in the Methods section, a small proportion of the items involve therapist-specific behaviours. When reviewing whether items were all conceptualised on a similar level, these items represented a more pronounced difference to the rest of the set. This could explain their increased distance from the origin. It may be that these strategies are less well known by therapists unfamiliar with DBT, affecting their ability to appropriately organise them in the sorting task. Considering items in the 'Therapist Style' cluster in the lay sample are also more than two standard deviations further from the origin, it is likely that these items require further clarification, or that they represent a different kind of concept altogether. An important next step would be to investigate these strategies and their conceptual fit in the model presented here.

Item Interpretation

During item identification, strategies from DBT, ACT and MBCT were assessed for paradigm-specific jargon or confusing terminology, and where possible, such words were replaced with neutral, everyday language. This was to aid understanding for both the lay sample participants and participants in the expert sample who may be unfamiliar with the paradigms. This was also an attempt to discourage biased sorting by paradigm. For example, the DBT strategy "activating wise mind" (Linehan, 1993, p. 206) was translated to *'using wisdom through the balance of emotions and cognitions'.* Despite these efforts to maximise understanding, it is not possible to know how participants interpreted each item. However, there is support for the accuracy and consistency of interpretations among participants. That being, items were generally clustered together in an expected manner, items within clusters appear to share a central theme, and the split-half reliability directly supports a good level of internal consistency. Considering the lay sample model, clusters were generally comparable to those of the expert sample, indicating consistent interpretations among groups with varying knowledge of the subject matter.

Discussed earlier was the unexpected placement of the item, *identify strategies used to avoid unhelpful thoughts*. Positioned opposite an almost identical strategy, *identify strategies used to avoid uncomfortable feelings*, and not easily explained by the different polarities their positions represent, it is possible that inconsistent interpretations explain this finding. While not assessed in the expert sample,

unstructured discussion with participants in the lay sample revealed an unintended interpretation of the item. This involved seeing avoidance strategies to draw on when needed as beneficial, whereas the intended meaning is the need to identify avoidance strategies because they may be *problematic.* Misleading wording leading to two different interpretations may have impacted the item's placement in the expert map also. As an ACT item, the experts' interpretations may be determined in part by whether or not they are trained in ACT.

To further elucidate the consistency among item interpretation, future validation studies should investigate differences in the sorting patterns of expert participants trained in different approaches. This could highlight biases, such as 'purist' therapists intentionally grouping items by therapeutic paradigm, rather than similarity. It could also reveal the presence of different understandings of strategies based on an expert's training, which threaten the reliability of the results. This would prompt further item modification to simplify the language, or perhaps highlight the need to list practical examples of each strategy to enhance participants' understanding. Future studies should also consider conducting pilot sorting tasks, where participants verbalise their interpretations of items to enable assessment of the consistency of interpretations and to clarify confusing terminology.

External Validity

It is important to consider the specific contextual characteristics that contributed to the model presented in this research, as these determine the extent of its usability. Firstly, the items themselves represent therapeutic strategies as applied in Western contexts of therapy. Secondly, these strategies were sorted predominantly by participants who identify as Western European and reside in countries with a Western-dominant culture, and all of whom are English-speaking. Therefore, at this stage, the model is representative of Western perceptions of strategy relationships. An important task for future research will be to identify the validity of the model, both its strategy content and the relationships between strategies, in other contexts. For instance, the use of ACT and DBT in Asian populations is very low, and adaptions to these approaches have been suggested to enhance their acceptability among Asian people (Te Pou, 2010). Therefore, the present model may have limited use in such populations. Morita Therapy

is an approach that incorporates similar elements to the Third Wave therapies, particularly ACT. For example, it emphasises mindfulness, awareness and 'decentralizing' (Ishiyama, 1986). Comparing the model presented in this research with strategies from Morita Therapy may highlight several commonalities, in turn indicating some validity of the present model in populations where Morita Therapy is widely used. However, it would be important to validate this model in the populations within which it is to be used.

A final limitation of the conclusions drawn from this study is the extent of subjective analysis relied upon. The placement of each item is objective in that it directly represents the similarity data, as produced using the sorting task responses. However, the assignment of items to clusters, the cluster definitions, and the meaning attributed to the dimensions, are all dependent on the researcher's subjective interpretation. Accuracy and meaningfulness were important objectives in the interpretations made. Additionally, these were reviewed by two psychologists as a form of validation, supporting the final interpretations. However, these may differ among individuals. Therefore, a final consideration in validating these results concerns the meaning attributed to them – alternative meanings may be explored in future research.

Future Directions

Several domains have already been suggested as potential implications or applications of this research. However, there are a number of tasks that should be carried out before these are realised.

Validation

A prerequisite for the use of this model as a foundation of future research or therapist practice is its validation, as well as validation of the interpretations made regarding its qualities. As has been mentioned in the limitations, the item set in the model is likely incomplete due to efforts to minimise difficulty in the sorting task. Gaps in the model suggest this is the case. Therefore, to improve the completeness of the item set, one method would be to identify the strategies that appropriately fill these gaps. Areas that are likely under-represented here were discussed earlier in terms of the

isolated items. By knowing the characteristics of the isolated items, they can be used as indicators to direct the identification of strategies absent from this model. One such example is to identify strategies related to the function of emotion.

Following identification of under-represented strategies, another sorting task would be required to produce the 3D model. The sorting method employed in the present research would benefit from splitting the item set among a larger number of participants, so that each item is sorted an acceptable number of times, but each participant has a more manageable set to sort. This would improve the quality of participant's sorting methods in terms of the themes they use to differentiate items, therefore improving the reliability of the data and subsequent claims made about them.

Further validation can then be achieved through practice-based research efforts. Specifically, practicing therapists could be approached and invited to indicate which strategies they employ in each therapy session, recording this in reference to the item set as well as recording any other strategies they used. Strategies added by the therapists that were absent from the item set form a subset of potentially under-represented items, that subsequently could be validated by a larger group of therapists for their acceptability in the item set.

Future Research

Following validation of the item set, further research avenues include identifying which strategies therapists use in their practice. This would involve using the item set as a reference upon which therapists indicate which strategies they employed. These data could be supplemented by requesting further information relating to the therapy session that the strategies were used in. For example, useful information would include therapist and client characteristics such as age, gender, culture, preferences, as well as information about the client's problems and specific disorder characteristics.

This additional data captured can be analysed to identify relationships between these important factors and the use of particular strategies. Such relationships could be identified by the use of another sorting method known as the Method of Successive Sorts (MOSS; Kirkland, Bimler, Drawneek, McKim, & Scholmerich, 2003). Therefore, MOSS would enable the development of strategy models based on, for example, client, therapist and disorder characteristics.

With this method, there is potential to identify many important patterns of strategy use. Firstly, strategies used with particular client types and disorders can be identified. Secondly, patterns of therapy integration or eclecticism may emerge based on the knowledge of the theoretical origin of each strategy, for example, patterns showing that strategies from MBCT are commonly combined with strategies from DBT or ACT. It would also be possible to identify whether particular patterns of therapy integration are commonly used with particular therapist, client or disorder characteristics.

To supplement the relationships identified through MOSS methodology, therapists could provide outcome data for each client. Therefore, not only are important characteristics matched with strategy use, but the efficacy of this strategy use can be identified. Efficacy data can in turn help researchers and practicing therapists understand more about the mechanisms underlying specific disorders, leading to the development of even more efficacious treatments.

CHAPTER FIVE

Conclusion

While investigations of common factors represent a great proportion of research in the field of psychotherapy, gaps are evident among particular approaches. This was apparent in the Third Wave of Behavioural and Cognitive Therapies. Where the literature suggests overlaps are likely among the Third Wave therapies, methods utilised to investigate these have so far lacked rigour. Limited to reviews of the approaches' theoretical models, comparisons are flawed by the possibility that different models use terminology in different ways. Thus, language barriers pose a risk to the validity of these kinds of analyses.

Methodological rigour was therefore of upmost importance in each stage of this research. This began with the identification and expert validation of strategies central to three prominent Third Wave approaches, DBT, ACT and MBCT. Following this, strategies were systematically sorted, producing a model of Third Wave strategy relationships. This informative structure presents a reliable classification of strategy types among these therapies, and addresses the central aim of this research in identifying the areas of commonality and difference among these approaches. Many of these findings supported comparisons made in the literature, however the model also points to some new areas of commonality and difference.

Dimensions were identified that serve to classify the strategies according to three characteristics: their orientation type; the nature of their response to experience; and the perspectives they draw upon. The dimensions identified in this model may be indicative of salient, defining features specific to the Third Wave approaches. Indeed, alternative interpretations of these dimensions were discussed that align with characteristics thought to define the Third Wave approaches. Additionally, if these relationships are observed in many approaches across highly diverse theoretical orientations, they may represent common factors that can classify strategies according to various points along the dimensions.

Chapter Five
Conclusion

Specific types of strategies across DBT, ACT and MBCT are also depicted by 17 clusters, as well as eight isolated items (in the expert model). Clusters may denote similar or shared processes through which each of their strategies produce change – providing therapists with multiple different methods from which to target a particular area of change. Further research is required to identify whether clusters represent change processes, however. As this model is further validated, and strategies are identified to replace the gaps, more will be revealed about the nature of the underlying dimensional relationships and the distinct strategy types that are represented by clusters. In turn, this information will help refine our understanding of the strategies.

The greater therapists' understandings are of therapeutic elements, such as strategies and change processes, the more likely they are to effectively implement them in therapy. A model of this kind has prospects for validation with different client groups. Linking strategy use within this model to particular client, disorder or therapist factors, for example, and measuring their effectiveness, would contribute greatly to knowledge about what the most efficacious components of therapy are for a given client. Following investigations like these, this model may be used as a guide for therapists to match their clients' characteristics with those strategies that are most likely to benefit the client. This model may provide a suitable structure for guiding such investigations.

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APPENDICES

Appendix A: Item Generation References

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Appendices

Appendix B: DBT Strategies

Table B1
DBT strategies, first draft

First Iteration	Second Iteration
Focus on polarities of treatment strategy / balance treatment strategy with opposite strategy (EG acceptance with change, capabilities with deficits)	Balance treatment strategies
	Balance acceptance with change
	Balance capabilities with deficits
	Balance flexibility with stability
	Balance nurturing with challenging
Focus on synthesis of oppositions (instead of verifying accuracy of one side of point) (move from either-or to both-and)	Option 1: Work on synthesis of points Option 2: Allow both sides of a point Option 3: Accept multiple points of view Option 4: Synthesise viewpoints
Present paradoxical statement	Option 1: Present paradoxical statement Option 2: Present contradictory statement
Explain something to patient using metaphor	Explain something using metaphor
Argue for extreme propositional statement	Argue for extreme propositional statement
Exaggerate seriousness of patient's statement	Exaggerate seriousness of patient's statement
Highlight benefits in problems	Highlight benefits in problems
Allow inconsistencies in therapeutic environment to proceed naturally (EG appointment times)	Allow changes within therapeutic environment

Listen actively and show sympathy for pain	Listen actively
	Show sympathy for pain
Observe and describe sensations, thoughts, desires and specific behaviour (not inferred motives/judgments)	Identify actual sensations
	Identify actual thoughts
	Identify actual desires
	Identify actual behaviour
	Describe actual sensations
	Describe actual thoughts
	Describe actual desires
	Describe actual behaviour
Highlight and explore validity of self-imposed unrealistic standards	Identify self-imposed unrealistic standards
	Investigate validity of self-imposed standards
Communicate that emotional response or behaviour is understandable	Communicate emotional response is understandable
	Communicate behaviour is understandable
Identify and describe thought processes (thoughts, assumptions, expectancies, guiding rules)	Option 1: Identify thought processes Option 2: Identify thoughts, assumptions, expectancies and guiding rules
	Option 1: Describe thought processes Option 2: Describe thoughts, assumptions, expectancies and guiding rules
Discriminate facts about events from interpretations and validate interpretation	Discern facts from interpretations (about events)
	Validate interpretations
Identify and focus on valid part of patient's thoughts/behaviour	Accentuate reasonable aspects of thoughts
	Accentuate reasonable aspects of behaviour
Encourage and express confidence in patient	Express confidence in patient
Direct attention from problems to specific capabilities	Highlight capabilities over problems

Describe problem behaviour	Describe problem behaviour
Identify antecedents, problem and consequences of one part of problem behaviour	Split behaviour into segments
	Identify antecedents, problem and consequences
Highlight behavioural observation, recurrent behavioural or environmental patterns and their validity	Highlight recurrent behavioural patterns
	Validate behavioural patterns
Offer empirical explanation of patient's behaviour/problems instead of self-blaming explanations	Explain behaviour using empirically-based theory
	Substitute self-blame with empirically-based explanation for behaviour
Identify wants, needs and goals	Identify wants, needs and goals
Redefine problem behaviour as problem solving	Redefine problem behaviour as problem solving
Brainstorm problem solutions and evaluate consequences and barriers	Identify solutions for particular problem
	Evaluate solutions' consequences
	Evaluate solutions' barriers
Highlight pros and cons of commitment to change	Explore consequences of commitment to change
Clarify commitments	Clarify commitments
Express interest and active involvement in interaction	Actively participate in interaction
Disclose personal information or experience of therapeutic relationship	Disclose personal information
	Discuss experience of therapeutic relationship
Reframe patient statement in unexpected manner	Reframe patient statement unexpectedly
Confront dysfunctional behaviour directly	Confront dysfunctional behaviour directly

Table B2
DBT strategies, second draft

First Iteration	**Second Iteration**
Explain intervention rationale frequently throughout intervention	Frequently explain therapy activity
Provide instructions frequently during therapy task	
Provide information relevant to client's difficulties	Explain relevance of therapy to client's difficulties
Explain therapy process' relevance to client	
Teach client behavioural learning principles	Teach client behavioural learning principles
Compare reasons for and against change/no change	Evaluate reasons for and against change
Highlight undesirable consequences of not changing	
Therapist argues for no change / Therapist highlights drawbacks of change	
Argue for maladaptive/dysfunctional behaviour/thoughts/emotions	
Weigh pros and cons / consider consequences of tolerating versus not-tolerating distress	
Identify reasons for not changing emotions	
Explore whether change fits client goals/values	Matching current and alternative behaviours to goals and/or values
Link problematic behaviours to goals	
Link alternative behaviours to client's goals	
Highlight inconsistencies in client's actions/beliefs/values	
Highlight client's choice to change/not change	Highlight client's freedom to choose whether they change or not
Choose acceptance over non-acceptance	
Link successful changes to current change commitments	Reinforce change behaviour
Present contemplated change in overly-simplistic manner	
Describe the necessary change without reservation	
Reinforce progress rather than maladaptive behaviour	

Identify barriers to alternative behaviours	Planning of adaptive alternative behaviours
Discuss adaptive alternative behaviours	
Therapist confronts maladaptive alternative behaviours	
Identify steps to achieve desired behaviours/outcomes / Identify alternative behaviours/solutions for problematic behaviour	
Define problematic behaviours	Identify problematic behaviours
Review occurrence of problematic behaviours and DBT skills	
Identify controlling variables in problematic behaviour	Identify contingencies of problematic behaviour
Identify repeated patterns across problematic behaviour	
Identify triggers for problematic behaviour	
Generalise alternative behaviours to daily life	Generalise skills/behaviour changes to daily life
Relate skills to daily life	
Increase behavioural opportunities which favour change	
Client rehearses skills in-session	Skill modelling and rehearsal in session
Therapist demonstrates skills	
Remain with trigger without escaping/avoiding	Experience triggers without avoiding
Noticing ineffective thinking	Noticing ineffective thinking
Client evaluates using intuitive knowledge	Enabling use of intuitive knowledge
Encourage reasoning with intuitive knowledge	
Observe and label client emotions	Reflect and label client's emotions and behaviours
Observe and label client behaviours	
Elicit and reflect client's thoughts/assumptions/values	
Rephrase client statements without interpreting/evaluating	
Directly validate emotions and expression	Validate client's emotions, self-imposed standards, thoughts and behaviours
Identify client's nonverbalised emotions/thoughts/behaviour patterns	

Identify client's self-imposed standards	
Highlight truth in client's self-imposed standards	
Highlight truth in client's cognitions	
Highlight how client history explains response	
Highlight how current circumstances explain response	
Focus on client's strengths	Focus on client's strengths
Realistically assess client capabilities	
Show statement can be both true and untrue / accepting both sides of argument / exploring opposing ideas and points of view	Accepting and holding opposing ideas
Therapist presents contradictory statement	
Identify benefits in client's problematic circumstances	Evaluate benefits and problems in client's circumstances
Accept situation without resisting (accepting/sitting with discomfort)	Non-judgmentally accepting and sitting with discomfort
Stay with painful emotions, events and behaviours	
Experience thoughts, emotions, events and behaviours without judgment or avoidance	
Refrain from making evaluations	
Discern facts from interpretations (about events)	Separate thoughts, emotions and interpretations from facts
Challenging ineffective thinking	
Differentiate thoughts and emotions from facts	
Therapist discloses personal information	Genuinely accepting client's internal experiences and behaviour
Therapist uses warm engagement and genuineness	
Communicate respectfully to client as equal	
Therapist listens actively without prejudging	
Non-judgmentally accepting client's emotions, thoughts and behaviours	

Reframe client's statement unexpectedly / Respond to unintended aspect of client's statement	Elicit client's desire to change
Therapist matter-of-factly confronts sensitive topics	
Therapist uses confrontational tone	
Therapist abruptly changes their posture/voice tone	
Therapist shows defeat /Therapist appears to give up/Therapist admits their ineffectiveness/gives up	
Therapist acts all-knowing and effective	
Therapist calls client's bluff	
Explain using metaphors	Using metaphors
Balance change with acceptance strategies	Balance change with acceptance strategies
Balance capabilities with deficits	Balance capabilities with deficits
Observe emotions, thoughts, events and behaviours	Assist client to observe emotions, thoughts, events and behaviours
Identify emotions	
Describe situation objectively	Rehearse objectively describing internal experiences
Describe emotions and thoughts	
Describe behaviour and events	
Pay attention to current moment	Awareness of present moment
Place full attention on task	
Respond to environmental demands with awareness	
Act effectively, ignoring what is 'right' / do what is needed, not what is right	Enabling effective action
Let go of being right (same idea as allowing and not changing?)	
Accept and do what is needed	
Maintain values and position	Committing to valued actions

Comfort oneself (ie self-soothing)	Organising self-care strategies
Undertake self-care to prevent emotional sensitivity	
Interact gently and non-judgmentally	Enhancing client's interpersonal communication
Be fair to self and others	
Assert confidence with voice and posture	
Clearly state opinions/feelings	
Clearly state wishes	
Acknowledge others' feelings/wishes/opinions	
Listen intently	
Substitute negative events with positive events	Planning towards positive experiences
Increase positive experiences/emotions	

Appendices

Table B3

DBT validation panel, first stage

Item Number	**Item**	**Proposed change (if any)**	**Reason for change**
1	Frequently explain therapy activity	Correct	
2	Explain relevance of therapy to client's difficulties	Correct	
3	Teach client behavioural learning principles	Yes, definitely right	
4	Evaluate reasons for and against change	Yes, definitely DBT.	
5	Matching current and alternative behaviours to goals and/or values	Yes fine.	
6	Highlight client's freedom to choose whether they change or not	Yes, definitely DBT.	
7	Reinforce change behaviour	Reinforces benefits of change behaviour.	
8	Planning of adaptive alternative behaviours	Yes, really clear.	
9	Identify problematic behaviours	Combine 9 and 10	
10	Identify contingencies of problematic behaviour	Combine 9 and 10	
11	Generalise skills/behaviour changes to daily life	Generalise skills/behaviour changes to multiple environments/all relevant contexts	
12	Skill modelling and rehearsal in session	Really important.	

13	Experience triggers without avoiding	Yes.	
14	Noticing ineffective thinking	Yes.	
15	Enabling use of intuitive knowledge	Enabling use of innate wisdom/understanding Not sure about knowledge	
16	Reflect and label client's emotions and behaviours	Yes	
17	Validates client's emotions, self-imposed standards, thoughts and behaviours	Remove	Include six validation levels instead. 'Self-imposing' doesn't sound right.
18	Accepting and holding opposing ideas	Accepting the possibility of simultaneously holding apparently opposite cognitions or feelings.	
19	Evaluate benefits and problems in client's circumstances	Yeap.	
20	Focus on clients' strengths/capabilities	Yeap.	
21	Balance capabilities with deficits	Not necessary. Especially with the inclusion of item 20.	
22	Elicit client's desire to change	Fine	
23	Using metaphors	Using metaphors and stories	

24	Balance change with acceptance strategies	Yes	
25	Separating thoughts, emotions, interpretations from facts	Yes	
26	Rehearse objectively describing internal experiences	Practice instead of ‘rehearse’	
27	Non-judgmentally accepting and sitting with discomfort	Yeap	
28	Genuinely accepting client’s internal experiences and behaviour	Therapist is warm and accepting about client’s internal experiences and behaviour	Clearer
29	Assist client to observe emotions, thoughts, events and behaviours	‘Encourage client to repeatedly observe emotions, thoughts, events and behaviours’.	‘Encourage’ better than ‘assist’
30	Awareness of present moment	Yeap.	
31	Enabling effective action	Assist client to discern most effective action	
32	Organising self-care strategies	Two different strategies here: 1. Have things we know we have practiced so that we don’t self harm EG helping client to sit with distress and plan strategies in advance. ‘First aid kit’ idea. Ie use distress tolerance when you need it right now, as opposed to long term.	

		2. Other one about self-care - lifestyle balance – staying out of emotion mind	
33	Committing to valued actions	Yeap.	
34	Planning towards positive experiences	Not sure about ‘planning towards’. Maybe some other wording	Not clear
35	Enhancing client’s interpersonal communication	Helping client with skilful interpersonal communication. Effectiveness.	Incorporate having/teaching skills but also knowing which environment to use it in.

Table B4

DBT validation panel, second stage

		Expert 1		Expert 2	
Item Number	**Item**	**Proposed change**	**Reason for change**	**Proposed change**	**Reason for change**
1	Frequently explain therapy activity	Correct		Frequently explain rationale for a task/action	More accurate
2	Explain relevance of therapy to client's difficulties	Correct		Correct	
3	Teach client behavioural learning principles	Correct		Correct	
4	Evaluate reasons for and against change	Correct		Correct	
5	Matching current and alternative behaviours to goals and/or values	Correct		Correct	
6	Highlight client's freedom to choose whether they change or not	Correct but would not rate this as a core strategy, rather as one of several commitment strategies		Correct	
7	Reinforce benefits of change behaviour	Correct		Reinforce new behaviour	

8	Planning of adaptive alternative behaviours	Correct		Correct	
9	Identify problematic behaviours	Correct		Correct	
10	Identify contingencies of problematic behaviour	Correct		Correct	
11	Generalise skills and behaviour changes to multiple environments/relevant contexts	Correct		Correct	
12	Skill modelling and rehearsal in session	Correct		Correct	
13	Experience triggers without avoiding	Correct, but in DBT there are exceptions. E.g. occasionally if triggers will lead to emotions that lead to suicide, then will be skilful to avoid (distract). I.e. avoid as little as possible but as much as necessary		Correct	

14	Noticing ineffective thinking	Correct		Correct	
15	Enabling use of innate wisdom/understanding	Not sure. Is it innate or is it about choice to consider wisdom from emotions and cognitions synthesised	(Uncertainty about whether wisdom is innate. Marsha teaches that wisdom is in us even if we don't know it, but also that we have to use skills to get to that wisdom) → Perhaps 'enabling use of wisdom'	Correct	
16	Reflect and label client's emotions and behaviours	Correct		Correct	
17	Validate client's emotions, self-imposed standards, thoughts and behaviours	Correct		Correct but may want to say acknowledge rather than validate	DBT language
18	Listen actively without prejudging	Correct		Correct, although change 'listen actively'	Description not behaviourally concise
19	Reflect client's statements accurately	Correct		Correct	
20	Label client's nonverbalised experiences	Correct		Correct	

21	Validate client's experiences based on history/circumstances	Correct		Correct	
22	Normalise client's experiences	Correct		Correct	
23	Therapist is warm and accepting about client's internal experiences and behaviour	Incorrect. Separate radical acceptance 'accepting reality as it is' (including when it is distressing to do so), - skills for both client and therapist, from being warm (some overlap with acceptance but sometimes therapist will choose to not be overly warm).	Incorrect as too absolute. Therapist does not validate ineffective (invalid) actions, although can find something in the invalid (ineffective) action to validate	Correct	
24	Validate only valid parts of client's experiences	Incorrect	Validate **all** of experience but not all actions	Correct	

25	Accepting the possibility of simultaneously holding apparently opposite cognitions or feelings	Correct		Accepting the possibility of simultaneously holding apparently opposite cognitions or feelings	More accurate and less wordy
26	Evaluate benefits and problems in client's circumstances	'Finding meaning in lousy circumstances'	I do not understand this comment. Does it refer to advantages and disadvantages of an action or to finding something about a lousy experiences that might have meaning	Remove	I don't see this as specific to DBT, unless you replace evaluate with identify – then it is a dialectical strategy
27	Focus on clients' strengths/capabilities	'Focusing on client strengths and problems'	Yes, and also focus on problems	Correct	
28	Balance capabilities with deficits		Do you mean, the therapist balances working with strengths and weaknesses	Balance acknowledging capabilities with deficits	More accurate
29	Elicit client's desire to change	Correct		Correct	
30	Using metaphors and stories	Correct		Correct	

31	Balance change with acceptance strategies	Correct		Correct	
32	Separating thoughts, emotions, interpretations from facts	Correct		Correct	
33	Practice objectively describing internal experiences	Correct		Correct	
34	Non-judgmentally accepting and sitting with discomfort	Correct		Correct	
35	Assist client to observe emotions, thoughts, events and behaviours	Correct. 'Assist client to observe thoughts, sensations, emotions, actions'	I think this can be made more precise as behaviours to a DBT therapist includes thoughts, body sensations, emotions and actions (anything an organism does)	Correct	
36	Awareness of present moment	Correct		Correct	
37	Assist client to discern most effective action	Correct		Correct	But ACT language
38	Practice strategies for tolerating distress	Correct		Correct	
39	Committing to valued actions	Correct		Correct	DBT, but ACT language. DBT

					would be ‘actions in line with values’
40	Scheduling positive experiences	Correct		Correct	
41	Helping client communicate effectively in multiple environments	Correct		Correct	
42	Planning balanced lifestyle to prevent emotional sensitivity	Correct		Correct	

Additions

	Expert 1	**Expert 2**
43	Encourage client’s self-recording of target behaviours and skills-use	Changing topics and emotional tone quickly
44	Therapist gradually reinforces change toward desired behaviour	Highlighting opposing perspectives and identifying how they can both be true
45	Identifying when client’s behaviour impacts on therapist’s ability to provide therapy	Focussing on supporting client to do things for themselves rather than providing case management
46		Getting a minute and detailed description of a sequence of ineffective behaviour
47		Being direct in an offbeat and unexpected manner
48		Troubleshooting what could go wrong with an agreed-upon action-plan

Appendices

Table B5

DBT validation panel third stage

Item Number	**Item**	**Proposed change (if any)**	**Reason for change**
1	Frequently explain therapy activity	Frequently explain rationale for a task/action	
2	Explain relevance of therapy to client's difficulties	Remove	Common strategy
3	Teach client behavioural learning principles		
4	Evaluate reasons for and against change		
5	Matching current and alternative behaviours to goals and/or values		
6	Highlight client's freedom to choose whether they change or not		
7	Therapist reinforces new behaviour		
8	Planning of adaptive alternative behaviours		
9	Identify problematic behaviours		
10	Identify contingencies of problematic behaviour	Identify consequences of problematic behaviour	Consequences – easier to understand for lay sample
11	Generalise skills and behaviour changes to multiple environments/relevant contexts		
12	Skill modelling and rehearsal in session		

13	Experience triggers without avoiding	Remove	Overlaps with 'accepting and sitting with discomfort'
14	Noticing ineffective thinking		
15	Enabling use of innate wisdom/understanding OR Enabling use of wisdom	Using wisdom through balance of emotions and **cognitions**	
16	Reflect and label client's emotions and behaviours	Remove	Covered by 18-24
17	Validate client's emotions, self-imposed standards, thoughts and behaviours	Remove	Covered by 18-24
18	Therapist listens intently without judgment	Keep or remove	Common strategy
19	Reflect client's statements accurately		
20	Label client's nonverbalised experiences	Label client's nonverbalised thoughts, emotions, sensations and actions	
21	Validate client's experiences based on history/circumstances	Validate client's emotions, sensations, actions, thoughts based on history/circumstances	(elaborated)
22	Normalise client's experiences	Normalise client's thoughts, emotions and sensations	(elaborated)
23	Therapist is warm and accepting about client's internal experiences and behaviour	Therapist is warm and genuine to client's experiences	

24	Validate only that which is valid	Therapist validates aspects of thoughts, emotions and sensations and valid actions	
25	Accepting the possibility of simultaneously holding opposing cognitions or feelings	Highlighting opposing perspectives and identifying how they can both be true	
26	Finding meaning in lousy circumstances	Remove	Covered in evaluating reasons for and against change
27	Focus on clients' strengths and problems	Remove	Covered in 28
28	Balance acknowledging capabilities with deficits	Focus on balancing client's capabilities with deficits	
29	Elicit client's desire to change		
30	Using metaphors and stories		
31	Balance change with acceptance strategies	Therapist balances change with acceptance strategies	
32	Separating thoughts, emotions, interpretations from facts		
33	Practice objectively describing internal experiences	Practice objectively describing thoughts, emotions, sensations and actions	Elaborated Also includes external experiences
34	Non-judgmentally accepting and sitting with discomfort	Accepting and sitting with discomfort	
35	Observing emotions, thoughts, sensations and actions		

36	Awareness of present moment		
37	Assist client to discern most effective action	Assist client to engage in most effective action	Skill-use is implicit, also need to work on engaging
38	Practice strategies for tolerating distress		
39	Committing to valued actions		
40	Scheduling positive experiences	Can keep or combine with 42 to 'practice strategies to develop balanced lifestyle and prevent emotional sensitivity' **Keep**	
41	Helping client communicate effectively in multiple environments		
42	Planning balanced lifestyle to prevent emotional sensitivity	See 40 **Keep**	
43	Therapist changes topics and emotional tone quickly		
44	Therapist is direct in an offbeat and unexpected manner		
45	Focusing on supporting client to look after themselves as alternative to case management	Supporting client to do things for themselves	Shorter
46	Producing a minute and detailed description of sequence of ineffective behaviour	Describing small sequence of ineffective behaviour in detail	Shorter
47	Troubleshooting what could go wrong with agreed-upon action-plan	Troubleshooting potential problems with an agreed upon action-plan	Shorter

48	Encourage client's self-recording of target behaviours and skills-use		
49	Therapist gradually reinforces change toward desired behaviour		
50	Identifying when client's behaviour impacts on therapist's ability to provide therapy		

Appendices

DBT final item set

1. Frequently explain rationale for a task/action
2. Teach client behavioural learning principles
3. Evaluate reasons for and against change
4. Matching current and alternative behaviours to goals and/or values
5. Highlight client's freedom to choose whether they change or not
6. Therapist reinforces new behaviour
7. Planning of adaptive alternative behaviours
8. Identify problematic behaviours
9. Identify consequences of problematic behaviour
10. Generalise skills and behaviour changes to multiple environments/relevant contexts
11. Skill modelling and rehearsal in session
12. Noticing ineffective thinking
13. Using wisdom through balance of emotions and cognitions
14. Reflect client's statements accurately
15. Label client's nonverbalised thoughts, emotions, sensations and actions
16. Validate client's emotions, sensations, actions, thoughts based on history/circumstances
17. Normalise client's thoughts, emotions and sensations
18. Therapist is warm and genuine to client's experiences
19. Therapist validates aspects of thoughts, emotions and sensations and valid actions
20. Highlighting opposing perspectives and identifying how they can both be true
21. Focus on balancing client's capabilities with deficits
22. Elicit client's desire to change
23. Using metaphors
24. Therapist balances change with acceptance strategies
25. Separating thoughts, emotions, interpretations from facts
26. Practice objectively describing thoughts, emotions, sensations and actions
27. Accepting and sitting with discomfort
28. Observing emotions, thoughts, sensations and actions
29. Awareness of present moment
30. Assist client to engage in most effective action
31. Practice strategies for tolerating distress
32. Committing to valued actions
33. Scheduling positive experiences
34. Helping client communicate effectively in multiple environments
35. Planning balanced lifestyle to prevent emotional sensitivity
36. Therapist changes topics and emotional tone quickly
37. Therapist is direct in an offbeat and unexpected manner
38. Supporting client to do things for themselves
39. Describing small sequence of ineffective behaviour in detail
40. Troubleshooting potential problems with an agreed upon action-plan
41. Encourage client's self-recording of target behaviours and skills-use
42. Therapist gradually reinforces change toward desired behaviour
43. Identifying when client's behaviour impacts on therapist's ability to provide therapy
44. Using stories

Appendix C: ACT strategies

Table C1

ACT strategies

First Iteration	**Second Iteration**
Identify attempts to eliminate *negative* thoughts and feelings	Identify strategies to avoid negative thoughts
	Identify strategies to avoid negative feelings
Identify workability of strategies to eliminate *negative* thoughts and feelings	Identify usefulness of avoidance strategies
Commit to acceptance of and willingness to experience *negative* thoughts and feelings	Undertake willingness to experience thoughts
	Undertake willingness to experience feelings
Notice thoughts	Notice thoughts
Identify (workability) impact of thoughts on behaviour and feelings	Identify usefulness of thoughts for behaviour
	Identify usefulness of thoughts for feelings
Distancing from (unworkable) thoughts that prompt problematic behaviour and feelings	Step back from problematic thoughts
Allowing and making room for unwanted private experiences (thoughts, memories, feelings, urges and sensations) / accept unwanted private experiences without a change agenda	Accommodate unwanted thoughts
	Accommodate unwanted feelings
	Refrain from change of thoughts
	Refrain from change of feelings

Emphasise normality of negative thoughts and feelings	Normalise thoughts
	Normalise feelings
Educate on usefulness of emotions in different contexts	Teach function of emotions
Observe something in the present moment / bring attention to present moment	Pay attention to now
Paying attention to what you're doing	Pay attention to actions
Point out when client drifts off	Highlight when attention is diverted
Notice thoughts and feelings that prompt/precede problem/avoidance behaviour	Identify antecedent thoughts of avoidance or problem behaviour
	Identify antecedent feelings of avoidance or problem behaviour
Educate how paying attention to present moment helps one act more effectively	Teach benefits of paying attention
Pay attention to awareness/consciousness	Attend to awareness itself
Defuse from conceptualised self/ Distance from self-evaluations and contents of consciousness and consciousness itself	Step back from self-evaluations
Identify what gives meaning to client	Identify client's values

Identify actions/behaviour that is aligned with values (rather than avoidance)	Identify values-based behaviour
Set values-based goals	Set values-based goals
Planning to do what matters and commit to valued living	Undertake values-based behaviour

Appendices

Table B2

ACT validation panel, first stage

		Expert 1		**Expert 2**	
Item #	**Item**	**Proposed change (if any)**	**Reason for change**	**Proposed change (if any)**	**Reason for change**
1	Identify strategies to avoid negative thoughts	Identify strategies to avoid unhelpful thoughts.	ACT would not refer to thoughts as being positive or negative	Correct	
2	Identify strategies to avoid negative feelings	Identify strategies to avoid uncomfortable feelings	Again emotions are neither positive or negative it depends on context.	Correct	
3	Identify usefulness of avoidance strategies	Correct		Correct	
4	Undertake willingness to experience thoughts	Correct		Correct	
5	Undertake willingness to experience feelings	Correct		Correct	

6	Notice thoughts	Correct		Correct	
7	Identify usefulness of thoughts for behaviour	Identify the usefulness of engaging with thoughts	It's not about the inherent usefulness of a thought. It's about the usefulness of engaging with it and allowing it to dictate behaviour	Correct	
8	Identify usefulness of thoughts for feelings	Identify the relationship between thoughts and feelings	The previous item was a bit ambiguous	Correct	
9	Step back from problematic thoughts	Step back from unhelpful thoughts	From an ACT perspective thoughts are only problematic if we choose to fuse with and act on them. Thoughts have no power unless we allow them to dictate action.	Correct	
10	Accommodate unwanted thoughts	Correct		Correct	

11	Accommodate unwanted feelings	Correct		Correct	
12	Refrain from change of thoughts	Correct		Correct	
13	Refrain from change of feelings	Correct		Correct	
14	Normalise thoughts	Correct		Correct	
15	Normalise feelings	Correct		Correct	
16	Teach function of emotions	Correct		Correct	
17	Pay attention to now	Correct		Correct	
18	Pay attention to actions	Correct		Correct	
19	Highlight when attention is diverted		Diverted by what? It's very broad	Correct	

20	Identify antecedent thoughts of avoidance or problem behaviour	Correct		Noticing thoughts that seem to lead to avoidance behaviour	More aligned to CBT. If kept, I suggest removing the word ‘antecedent’, which is jargon-ish
21	Identify antecedent feelings of avoidance or problem behaviour	Correct		Noticing feelings that seem to lead to avoidance behaviour	More aligned to CBT. If kept, I suggest removing the word ‘antecedent’, which is jargon-ish
22	Teach benefits of paying attention	Correct		Correct	
23	Attend to awareness itself	Correct		Correct	
24	Step back from self-evaluations	Remove	Self-evaluations kind of fall into the thoughts category. I’m not sure if you need this one	Correct	
25	Identify client’s values	Correct		Correct	
26	Identify values-based behaviour	Correct		Correct	

27	Set values-based goals	Correct		Correct	
28	Undertake values-based behaviour	Correct		Modify. For example: "Willingness to undertake actions in the service of values" or "moving in the direction of identified values"	Add the word 'willingness' or 'committed/commit', - to better convey the idea of doing something even when that seems difficult to do (in the interest of moving towards an identified value).

Table B3

ACT validation panel second stage

		Expert 1		**Expert 2**	
Item Number	**Item**	**Proposed change (if any)**	**Reason for change**	**Proposed change (if any)**	**Reason for change**
1	Identify strategies to avoid unhelpful thoughts	Be clear that this "helping the client to identify strategies to avoid thoughts" or it could be referring to the clinician.			
2	Identify strategies to avoid uncomfortable feelings	Be clear that this "helping the client to identify strategies to avoid thoughts" or it could be referring to the clinician.			
3	Identify usefulness of avoidance strategies			Explore workability of avoidance strategies	
4	Undertake willingness to experience thoughts			Develop (rather than undertake)	
5	Undertake willingness to experience feelings			Develop (rather than undertake)	
6	Notice thoughts				
7	Identify the usefulness of engaging with thoughts				

8	Identify the relationship between thoughts and feelings				
9	Step back from unhelpful thoughts				
10	Accommodate unwanted thoughts	Change ‘accommodate’	Unclear	Accommodate unwanted thoughts without trying to change them	
11	Accommodate unwanted feelings	Change ‘accommodate’	Unclear	Accommodate unwanted feelings without trying to change them	
12	Refrain from change of thoughts			Remove	Thoughts do change in ACT – profoundly
13	Refrain from change of feelings			Remove	Feelings do change in ACT – profoundly
14	Normalise thoughts				
15	Normalise feelings				
16	Teach function of emotions				
17	Pay attention to now			Flexible contact with the present moment	‘Now’ is wishy washy

18	Pay attention to actions				
19	Point out when client is no longer present			Identify loss of flexible contact with the present moment	
20	Noticing thoughts that lead to avoidance behaviour	"Noticing thoughts that precede avoidance behavior"	Lead has a feeling of the causal	Noticing thoughts that are antecedents to rigid, inflexible behaviour	The main problem in ACT is rigid, inflexible behavior – not 'avoidance behavior'. Avoidance behavior can be very workable at times
21	Noticing feelings that lead to avoidance behaviour	"Noticing feelings that precede avoidance behavior"	Lead has a feeling of the causal	Noticing feelings that are antecedents to rigid, inflexible behaviour	The main problem in ACT is rigid, inflexible behavior – not 'avoidance behavior'. Avoidance behavior can

					be very workable at times
22	Teach benefits of paying attention			Explore benefits of flexible contact with the present moment	
23	Attend to awareness itself			Develop flexible perspective taking	
24	Identify client's values	Will be identifying how to do it (skill) in that. Noticing thought eg – teaching noticing thoughts			
25	Identify values-based behaviour				
26	Set values-based goals				
27	Commit to actions aligned with values				

Additions from Second Stage Validation Panel

	Expert 1		**Expert 2**	
	Added Item	**Reason**	**Added Item**	**Reason**
28	Promote hope	I think two self-concepts we try to strengthen in act, and indeed in any therapy, is the belief that you can achieve your goals(hope), and	Noticing when behaviour is effective, values congruent and flexible	

		the belief that you are a person who is worthy of friendship and love (self-esteem)		
29	Promote self-esteem		Noticing when behaviour is ineffective, values incongruent and inflexible	
30	Challenge thoughts	Maybe you need act incongruent stuff in their too. Though this could be congruent in some contexts	Developing/accessing a transcendent sense of self	
31	Reassurance	May or may not be act congruent	Exposure Skills training Problem-solving skills Goal-setting skills Action-planning skills/behavioural activation	
32	Engages in problem solving	May or maybe won't be act congruent	Identifying and overcoming internal barriers to change	
33	Promote effective problem orientation	Help clients to see things as problem to be solved or worked on, rather than an insurmountable threat		
34	Social support building	Helping client to build supportive social networks		
35	Life skills training	Helping clients to develop practical skills, e.g., complete a		

		job application…may fall under problem solving		
36	Encouraging positive self-talk	Probably act incongruent		

Appendices

ACT final item set

1. Identify strategies used to avoid unhelpful thoughts
2. Identify strategies used to avoid uncomfortable feelings
3. Explore workability of avoidance strategies
4. Develop willingness to experience thoughts, emotions and sensations
5. Notice thoughts
6. Identify the usefulness of engaging with thoughts
7. Identify the relationship between thoughts and feelings
8. Step back from unhelpful thoughts
9. Make room for unwanted emotions, thoughts and sensations
10. Normalise client's thoughts, emotions and sensations
11. Explore function of emotions
12. Pay attention to the present moment
13. Pay attention to actions
14. Identify loss of flexible contact with the present moment
15. Noticing thoughts, emotions and sensations that lead to rigid, inflexible behaviour
16. Explore benefits of flexible contact with the present moment
17. Identify observing self to view experiences from
18. Identifying values
19. Identify values-based behaviour
20. Set values-based goals
21. Commit to actions aligned with values
22. Noticing ineffective, values-incongruent behaviour
23. Noticing effective, values-congruent behaviour
24. Identifying and overcoming internal barriers to change
25. Using metaphors

Appendix D: MBCT strategies

Table D1
MBCT strategies

First Iteration	**Second Iteration**
Recognising and stepping out of automatic pilot	Recognise "automatic pilot"
	Stepping out of "automatic pilot"
Intentionally shift awareness	Intentionally shift awareness
Recognise difference between automatic pilot and awareness	Distinguish "automatic pilot" from awareness
Identify when the mind wanders / acknowledge where and when the mind wanders / notice where and when the mind wanders and refocus on breath	Notice when attention is diverted
	Option 1: Notice where attention shifts/diverts to Option 2: Notice source of diversion Option 3: Notice source of distractions
Bring attention to the breath/body as vehicle for sustaining attention	Shift attention to breath or body
Breathe in and out from different body regions	Breathe into body regions
Identify the thought linked to feelings and events	Identify thoughts associated with feelings and events
Identify automatic thoughts	Option 1: Identify reflexive thoughts Option 2: Identify reactive thoughts Option 3: Identify spontaneous thoughts Option 4: Identify involuntary thoughts
Identify impact of mood on thoughts and feelings / identify oncoming depression through negative thinking	Option 1: Recognise impact of mood on thoughts Option 2: Recognise depression through thoughts
	Option 1: Recognise impact of mood on feelings Option 2: Recognise depression through feelings
Identify pleasant events and associated thoughts, feelings and body sensations	Identify pleasant events
	Identify thoughts around pleasant events

	Identify feelings and/or sensations around pleasant events
Return focus to the present moment using breath as anchor / by focusing on breath	Return attention to 'now' with breath
Substitute awareness of breath for ruminative thinking	Return attention to 'now' with breath
Observe events and thoughts from a broader perspective by attending to body/breath	View events from body or breath
Identify habitual patterns of mind	Identify habitual habits of mind
Observe reactions/signs of aversion	Option 1: Identify signs of resistance Option 2: Identify manifestation of resistance
Notice how aversion distracts from intended focus	Notice how resistance pulls attention
Reflect on beliefs in 'automatic thoughts questionnaire' statements at present and in depressed state	Option 1: Compare reflexive thoughts in depressed and non-depressed state Option 2: Compare reactive thoughts in depressed and non-depressed state Option 3: Compare involuntary thoughts in depressed and non-depressed state Option 4: Compare spontaneous thoughts in depressed and non-depressed state
Identify depression symptoms as universal features of depression and not personal truths about oneself (give alternative perspective on symptoms)	Acknowledge depression symptoms as universal
Allow unwanted experiences to just be	Permit unwanted experiences
Notice how a thought or feeling's intensity changes in the body as it allowed to be (fades)	Notice the subsiding intensity of a permitted thought
	Notice the subsiding intensity of a permitted feeling

Open up/soften to body sensations by releasing tension, contraction or aches	Ease body sensations
	Release tension and contractions
View thinking as activity without getting lost in content	Step back from thought content
	View thoughts in written format
	View thoughts as mental events, not facts
	Watch thoughts enter and leave awareness
Recognise and list signs of depression relapse (relapse signatures)	Recognise signs of depression
Recognise daily activities which nourish and deplete energy	Option 1: Recognise valuable daily activities Option 2: Recognise rewarding daily activities
	Option 1: Recognise negative daily activities Option 2: Recognise draining daily activities Option 3: Recognise taxing daily activities
Plan to do more nourishing and less depleting activities (relapse prevention plan)	Plan daily rewarding activities
	Option 1: Plan to reduce negative activities Option 2: Plan to reduce draining activities Option 3: Plan to reduce taxing activities
Acknowledge depressed frame of mind's limited motivation to perform activities (Ie – when planning to do MBCT practice and planning to incorporate more pleasant events and less draining events, consider what one's motivation will be like (reduced) when one is actually depressed and account for this)	Option 1: Consider motivation whilst depressed Option 2: Plan for depressed motivation levels Option 3: Plan for motivation whilst depressed
Commit to incorporating MBCT practices into daily life	Undertake MBCT practice regularly
	Undertake more rewarding experiences
	Undertake less draining experiences

Link MBCT practice and relapse prevention plans to a positive reason for sustaining practice	Identify motive for undertaking MBCT practice
	Option 1: Identify motive for undertaking relapse prevention Option 2: Identify motive for increasing rewarding and decreasing draining activities

Table D2

MBCT validation panel, first stage

Item Number	**Item**	**Proposed change (if any)**	**Reason for change**
1	Recognise "automatic pilot"	Notice automatic pilot	Need to be in present moment (recognise is retrospective)
2	Stepping out of "automatic pilot"	No change	
3	Intentionally shift awareness	Intentionally shift*ing* awareness	Needs to be present tense
4	Distinguish "automatic pilot" from awareness	Distinguish*ing* "automatic pilot" from awareness	Needs to be present tense
5	Notice when attention is diverted	"Notice when your attention is no longer on the body/breath"	Was retrospectively observing.
6	Option 1: Notice where attention diverts to Option 2: Notice source of diversion Option 3: Notice source of distractions	Option 3: Notice source of distractions	
7	Shift attention to breath/body	"Shift 'your' attention to breath/body"	
8	Breathe into body regions		
9	Identify thoughts associated with feelings/events		
10	Identify spontaneous thoughts	"Notice the thoughts that are there now".	Interested in power/strength of the thoughts. – How much did the thoughts pull you off your centre?

11	Option 1: Recognise impact of mood on thoughts Option 2: Recognise depression through thoughts	"Notice how your mood has affected your thoughts"	Retrospective wording. 'Impact' is intellectual
12	Option 1: Recognise impact of mood on feelings Option 2: Recognise depression through feelings	"Notice how your mood has affected your feelings"	Retrospective wording. 'Impact' is intellectual
13	Identify pleasant events	"Notice pleasant events"	Exercise on inviting people to notice pleasant and **unpleasant** events (the whole).
14	Identify thoughts around pleasant events	"Notice thoughts around pleasant events"	More present tense
15	Identify feelings/sensations around pleasant events	"Notice feelings/sensations around pleasant events"	More present tense
16	Return attention to 'now' with breath	"Bring attention to the breath"	Present tense
17	View events from body/breath	"Notice any sensations in the body"	
18	Identify habitual habits of mind	"Notice thoughts"	"Habitual habits of mind" sounds intellectual
19	Option 1: Identify signs of resistance Option 2: Identify manifestation of resistance	"Notice barriers"	MBCT uses word 'barriers'
20	Notice how resistance pulls attention	"Notice resistance/barriers" and "notice where attention is"	Several strategies: Noticing resistance Noticing pull Noticing where attention is

21	Compare spontaneous thoughts in depressed and non-depressed state		We don't compare things. We talk about the strength of things
22	Acknowledge depression symptoms as universal		Not right... but no suggestion
23	Permit unwanted experiences	"Allow whatever is there to be there" or "Embrace what is there"	Language issue
24	Notice the subsiding intensity of a permitted thought		'Permitted' is judgmental – says you have unwanted experiences but are being told to permit them. Also expectation that everyone will experience decrease in intensity.
25	Notice the subsiding intensity of a permitted feeling	For both 24 and 25: "What did you notice when you were with the thoughts of X". "What did you notice when you were with a pain"	Inevitably, people notice the intensity is not the same. But there shouldn't be an expectation.
26	Ease body sensations	"Allow any tension you notice to move out" Or split into: "Notice tension" "Allow tension to move out"	Might say in therapy if doing body scan for example "If you notice any tension on the outbreath, allow the tension to move out on the outbreath" – keywords are allowing and noticing
27	Release tension and contractions	Remove (similar to 26)	Sounds like relaxation practice
28	Step back from thought content	No suggestion (28-30 basically the same)	Are we observing self or are we one and the same and noticing what is happening in the self? – We notice observing, but we notice

			observing in presence of whole self rather than seeing self as the object.
29	View thoughts in written format	"Noticing part of thought we get caught up in"	Theme is, 'thoughts are not facts'
30	View thoughts as mental events, not facts	"Thoughts are not facts" or something nicer... "Notice thoughts...is the thought a fact?... Thoughts are thoughts"	
31	Watch thoughts enter and leave awareness	Good – no change	
32	Recognise signs of depression	We don't want MBCT terms	MBCT uses term 'personal signature'
33	Option 1: Recognise valuable daily activities Option 2: Recognise rewarding daily activities	Option 2	
34	Option 1: Recognise negative daily activities Option 2: Recognise draining daily activities Option 3: Recognise taxing daily activities	Option 2	
35	Plan daily rewarding activities	Yes	
36	Option 1: Plan to reduce negative activities Option 2: Plan to reduce draining activities Option 3: Plan to reduce taxing activities	Option 2	
37	Option 1: Consider motivation whilst depressed Option 2: Plan for depressed motivation levels Option 3: Plan for motivation whilst depressed		

38	Undertake MBCT practice regularly	"notice signs of depression" and "increasing rewarding experiences" is fine, so remove this	
39	Undertake more rewarding experiences	Increasing rewarding experiences	
40	Undertake less draining experiences	Increasing draining experiences	
41	Identify motive for undertaking MBCT practice		Depends on success of programme for person
42	Identify motive for undertaking relapse prevention		How you want to live with your depression

Table D3

MBCT validation panel, second stage

Item Number	**Item**	**Proposed change (if any)**	**Reason for change**
1	Option 1: Recognise "automatic pilot" Option 2: Notice "automatic pilot"	Recognis*ing* "automatic pilot"	
2	Stepping out of "automatic pilot"	Step*ping* out of "automatic pilot"	
		Reengaging with present moment awareness through direct experience	
3	Intentionally shifting awareness	Intentionally shifting awareness to the body	
		Intentionally shifting attention to different regions of the body (intentionally shifting attention between body regions)	
		Focusing, holding and letting go of attention	
4	Distinguishing "automatic pilot" from awareness	Noticing modes/states of awareness and "automatic pilot"	
5	Option 1: Notice when attention is diverted Option 2: Notice when your attention is no longer on the body/breath	Notice when your attention is no longer on the body/breath	
6	Option 1: Notice where attention diverts to Option 2: Notice source of diversion Option 3: Notice source of distractions	Becoming aware of where attention has been taken	

7	Shift attention to breath/body	Shift attention to breath/body/intentionally shifting awareness to breath/body	
		Bringing attention back to breath/body without judgment	
		Recognising that wandering attention is natural	
8	Breathe into body regions	Breathe into body sensations	
		Explore sensations without changing them	
		Anchor attention to present through body/breath	
9	Identify thoughts associated with feelings/events	Identifying thoughts/ emotions/sensations involved in interpreting events	
		Noticing relationship between thoughts, emotions, sensations and behaviour	
10	Option 1: Identify spontaneous thoughts Option 2: Identify the thoughts that you notice right now Option 3: Identify the thoughts that are there now	Remove	
11	Option 1: Recognise impact of mood on thoughts	Recognise impact of mood on thoughts	

	Option 2: Notice how your mood affects your thoughts		
12	Option 1: Recognise impact of mood on feelings Option 2: Notice how your mood affects your feelings	Recognise impact of mood on feelings	
13	Option 1: Identify pleasant events Option 2: Notice pleasant events	Becoming more aware of pleasant events	
14	Option 1: Identify thoughts around pleasant events Option 2: Notice thoughts around pleasant events	Identifying thoughts/emotions/sensations around pleasant events	
15	Option 1: Identify feelings/sensations around pleasant events Option 2: Notice feelings/sensations around pleasant events	Remove (above)	
16	Option 1: Return attention to 'now' with breath Option 2: Bring attention to the breath	Repeated above (paying attention to present with body/breath)	
17	Option 1: View events from body/breath Option 2: Notice any sensations in the body	Remove 1 2 covered above Recognising aversion toward intense sensations	
18	Option 1: Identify habitual habits of mind Option 2: Notice thoughts	Identify habitual habits of mind	
19	Option 1: Identify signs of resistance Option 2: Identify manifestation of resistance Option 3: Notice barriers	Exploring aversion toward the unpleasant/difficult/unpleasant emotions/thoughts/sensations Recognising reactions toward the difficult	

20	Notice how resistance pulls attention	Noticing how attention can fixate on the difficult	
21	Option 1: Compare spontaneous thoughts in depressed and non-depressed state Option 2: Compare thoughts in depressed and non-depressed state	Recognising depressed states can make thoughts seem like facts / Recognising thoughts seem true when depressed	
22	Acknowledge depression symptoms as universal	Remove (below)	
23	Option 1: Permit unwanted experiences Option 2: Allow whatever is there to be there Option 3: Embrace what is there	Allow whatever is there to remain	
24	Option 1: Notice the subsiding intensity of a permitted thought Option 2: Notice any changing intensities of permitted thoughts	Practicing sitting with the difficult/thoughts, emotions or sensations Experiencing difficult thoughts/emotions/sensations/'the difficult' through body and allowing sensations	
25	Option 1: Notice the subsiding intensity of a permitted feeling Option 2: Notice any changing intensities of permitted feelings	Above	
26	Option 1: Ease body sensations Option 2: Allow tension you notice to move out Option 3: Notice tension Option 4: Allow tension to move out	Easing into body sensations	

27	Release tension and contractions	Becoming aware of emotions, thoughts, sensations, events in present moment (repeated)	
		Choosing to engage in skilful action	
28	Option 1: Step back from thought content Option 2: Noticing thoughts we get caught up in	Stepping back from thought content	
		Noticing habitual thoughts we get stuck in	
29	View thoughts in written format	Remove	
30	Option 1: View thoughts as mental events, not facts Option 2: Notice that thoughts are not facts	Recognising thoughts as mental events	
31	Watch thoughts enter and leave awareness	Remove	
32	Recognise signs of depression	Recognise signs of depression	
33	Recognise rewarding daily activities	Recognising relationship between activity and mood	
34	Recognise draining daily activities	Remove	
35	Plan daily rewarding activities	Planning balance between nourishing and draining activities / balancing nourishing and draining activities	

36	Plan to reduce draining activities	Increasing nourishing and decreasing draining activities	
		Exploring ways to do activities mindfully / engaging mindfully in activities / practicing activities more mindfully	
37	Option 1: Consider motivation whilst depressed Option 2: Plan for depressed motivation levels Option 3: Plan for motivation whilst depressed	Recognising need to take action despite mood / recognising importance of taking action despite mood	
38	Undertake MBCT practice regularly	Commitment to home and course practice	
39	Increasing rewarding experiences	Remove	
40	Decreasing draining experiences	Remove	
41	Identify motive for undertaking MBCT practice	Identifying values supporting commitment to practice	
42	Identify motive for undertaking relapse prevention	Remove	
43		Becoming aware of thoughts, emotions, sensations in present moment	
		Expanding awareness of body as whole	

Table D4

MBCT validation panel, third stage

		Expert 1		**Expert 2**		**Expert 3**	
Item Number	**Item**	**Proposed change**	**Reason for change**	**Proposed change**	**Reason for change**	**Proposed change**	**Reason for change**
1	Awareness of thoughts, emotions and sensations in present moment	Correct		Correct		Correct	
2	Controlling where attention is focused	Choosing where attention is focussed	Attentional focus is a choice, 'controlling' invites judgement	Correct		Correct	
3	Noticing loss of attention	Noticing when attention wanders	We are always paying attention to something	Change	Attention is always somewhere	Correct	
4	Noticing states of awareness and "automatic pilot"	Correct		Correct		Correct	
5	Stepping out of "automatic pilot"	Remembering to step out of automatic pilot	You need to be aware of it and	Correct		Correct	

			remember to step out of it				
6	Non-judgmentally allowing experiences to be experiences	Non judgementally observing our experiences	Was a bit 'psycho-babble'?	Correct		Correct	
7	Accepting and refocusing wandering attention	Correct		Correct		Refocusing wandering attention	Accepting not big part of MBCT
8	Identifying thoughts, emotions and sensations involved in interpreting events	Awareness of thoughts, emotions and sensations	Encouraging the 'observer self'	Correct		Correct	
9	Noticing relationship between thoughts, emotions, sensations and behaviour	Correct		Correct		Correct	

10	Exploring relationship between mood and internal experiences	Exploring relationship between mood and experience	Mood impacts on internal & external experience	Correct		Correct	
11	Increasing awareness of pleasant events	Deliberate awareness of pleasant events	In MBCT we need to direct the attention in this regard	Correct		Correct	
12	Identifying thoughts, emotions and sensations around pleasant events	Awareness of thoughts, emotions and sensations around pleasant events	Identifying may encourage thinking about rather than experiencing	Correct		Correct	
13	Identify habitual habits of mind	Remove (similar to item 20)		Correct		Correct	
14	Exploring aversion toward unpleasant emotions, thoughts and sensations	Noticing reaction toward unpleasant emotions and bodily sensations	Cues the appraisal network towards negative judgement	Correct		Correct	

15	Noticing how attention can fixate on the difficult	Correct		Correct		Correct	
16	Non-judgmentally experiencing and allowing unpleasant thoughts, emotions or sensations	Correct		Correct		Experiencing and allowing thoughts, emotions and sensations	Remove 'non-judgmentally' as some form of judgment is always used
17	Choosing to engage in skilful action	Correct		Correct		Correct	
18	Noticing how depressed states impact thought believability	Correct		Correct		Correct	
19	Stepping back from thought content	Correct		Correct		Correct	
20	Noticing habitual	Correct		Correct		Correct	

	thoughts we get stuck in						
21	Recognise signs of depression	Recognise triggers of depression	Triggers may be recognised before signs (symptoms) arise	Correct		Correct	
22	Recognising relationship between activity and mood	Correct		Correct		Correct	
23	Planning to increase rewarding and decrease draining activities	Correct		Correct		Correct	
24	Paying attention to activities in the present moment	Correct		Correct		Correct	
25	Recognising importance of	Correct		Correct		Correct	

	taking action despite mood						
26	Identifying values supporting commitment to practice therapy activities	Remove	ACT rather than MBCT	Remove	Not covered	Remove	Not central to MBCT
27	Commit to practicing therapy activities	Correct		Correct			Remove – common to all therapies

Appendix D: MBCT, final item set

1. Awareness of thoughts, emotions and sensations in present moment
2. Choosing where attention is focussed
3. Noticing when attention wanders
4. Noticing states of awareness and "automatic pilot"
5. Remembering to step out of "automatic pilot"
6. Non judgementally observing our experiences
7. Refocusing wandering attention
8. Awareness of thoughts, emotions and sensations involved in interpreting events
9. Noticing relationship between thoughts, emotions, sensations and actions
10. Exploring relationship between mood and thoughts, emotions, sensations and actions
11. Deliberate awareness of pleasant events
12. Awareness of thoughts, emotions and sensations around pleasant events
13. Noticing reaction toward unpleasant emotions, thoughts and bodily sensations
14. Noticing how attention can fixate on the difficult
15. Experiencing and allowing thoughts, emotions and sensations'
16. Choosing to engage in skilful action
17. Noticing how depressed states impact thought believability
18. Stepping back from thought content
19. Noticing habitual thoughts we get stuck in
20. Recognise signs and/or triggers of depression
21. Recognising relationship between activity and mood
22. Planning to increase rewarding and decrease draining activities
23. Paying attention to activities in the present moment
24. Recognising importance of taking action despite mood
25. Using metaphors

Appendix E: Validation panel instructions

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Creating a Compendium of Third Wave Therapy Strategies: DBT Instruction Sheet

Thank you for your interest in this study. The following is a description of what the project involves. If you have any further questions, please do not hesitate to contact myself or my supervisors. If you choose to be involved, on completion of the study, I will email you a summary of the findings.

***Aim*:** The aim of this study is to create a compendium of items representing strategies from third wave therapies

***What we need you to do*:** We need you to tell us whether we have

a) captured the full range of strategies within **DBT** and

b) accurately worded these to represent the strategy in an easy to understand manner

Instructions:

1. Please review the items below, keeping in mind the following:
   - Items should be central to the therapy
   - Item wording should accurately represent the strategy
   - Each item should represent a single strategy
   - Items should be written in an easy to understand language, and should not contain technical language or language specific to the therapy. E.g., 'distance' instead of 'defuse'
   - Items should collectively represent the full range of strategies central to the therapy
   - Items should be fixed at a similar level. They should represent a cluster or grouping of specific actions, not a single action. E.g., 'allow both sides of a point' or 'accept multiple points of view' (item 6) is an example of an item on the correct level
     - It is conceptually a level **above** the action of identifying the use of "and" instead of "or"
     - It is conceptually a level **below** the process of balancing perspective
   - If you change or add an item, it should be no more than six words long

2. Please respond with any proposed **changes** as follows:
   - If the item does not belong in the therapy, write "remove" as the proposed change
   - If changing the item, write the whole proposed item as the proposed change
   - If adding a new item, write this at the bottom of the form in the spare rows, in the 'item' column. Feel free to add more rows as needed.

- Where multiple options are listed, please indicate your preferred option number, or write a new item as the proposed change. Alternatively, write the word "remove" as the proposed change.

3. If you think an item should remain as it is, write "correct" as the proposed change

4. Briefly comment on the reasons for any changes. These may be from the criteria above in instruction 1, or another reason.

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Creating a Compendium of Third Wave Therapy Strategies: ACT Instruction Sheet

Thank you for your interest in this study. The following is a description of what the project involves. If you have any further questions, please do not hesitate to contact myself or my supervisors. If you choose to be involved, on completion of the study, I will email you a summary of the findings.

***Aim*:** The aim of this study is to create a compendium of items representing strategies from third wave therapies

***What we need you to do*:** We need you to tell us whether we have

a) captured the full range of strategies within **ACT** and

b) accurately worded these to represent the strategy in an easy to understand manner

Instructions*:*

1. Please review the items below, keeping in mind the following:
   - Items should be central to the therapy
   - Item wording should accurately represent the strategy
   - Each item should represent a single strategy
   - Items should be written in an easy to understand language and should not contain technical language or language specific to the therapy. E.g., 'distance' instead of 'defuse'
   - Items should collectively represent the full range of strategies central to the therapy
   - Items should be fixed at a similar level. They should represent a cluster or grouping of specific actions, not one single action. For example, 'develop willingness to experience thoughts, emotions and sensations' is an item on the target level
     - It is conceptually a level **above** the exercises: 'Tin Can Monster' or 'Physicalising Exercise', which can be used to 'develop willingness to experience thoughts, emotions and sensations'
     - It is conceptually a level **below** the processes of the hexaflex, such as acceptance. Rather, the item is used in this process
   - If you change or add an item, it should be no more than six words long
2. Please respond with any proposed **changes** as follows:
   - If the item does not belong in the therapy, write "remove" as the proposed change
   - If changing the item, write the whole proposed item as the proposed change
   - If adding a new item, write this at the bottom of the form. Feel free to add more rows as needed.
3. If you think an item should remain as it is, write "correct" as the proposed change
4. Briefly comment on the reasons for any changes. These may be from the criteria above in instruction 1, or another reason.

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Creating a Compendium of Third Wave Therapy Strategies: MBCT Instruction Sheet

Thank you for your interest in this study. The following is a description of what the project involves. If you have any further questions, please do not hesitate to contact myself or my supervisors. If you choose to be involved, on completion of the study, I will email you a summary of the findings.

***Aim*:** The aim of this study is to create a compendium of items representing strategies from third wave therapies

***What we need you to do*:** We need you to tell us whether we have

a) captured the full range of strategies within **MBCT** and

b) accurately worded these to represent the strategy in an easy to understand manner

Instructions:

1. Please review the items below, keeping in mind the following:
   - Items should be central to the therapy
   - Item wording should accurately represent the strategy
   - Each item should represent a single strategy
   - Items should be written in an easy to understand language and should not contain technical language or language specific to the therapy. E.g., 'distance' instead of 'defuse'
   - Items should collectively represent the full range of strategies **central** to the therapy
   - Items should be fixed at a similar level. They should represent a cluster or grouping of specific actions, not one single action. For example, 'non-judgmentally experiencing and allowing unpleasant thoughts, emotions or sensations' is an item on the target level
     - It is conceptually a level **above** the specific tasks involved in exercises such as the 'three minute breathing space', which can be used in 'non-judgmentally experiencing and allowing unpleasant thoughts, emotions or sensations'
     - It is conceptually a level **below** the broader process of 'allowing' or 'letting be'. Rather, the item is focused on as a part of the process of allowing or letting be
   - If you change or add an item, it should be no more than six words long

2. Please respond with any proposed **changes** as follows:
   - If the item does not belong in the therapy, write "remove" as the proposed change
   - If changing the item, write the whole proposed item as the proposed change
   - If adding a new item, write this at the bottom of the form in the spare rows, in the 'item' column. Feel free to add more rows as needed.

3. If you think an item should remain as it is, write "correct" as the proposed change

4. Briefly comment on the reasons for any changes. These may be from the criteria above in instruction 1, or another reason

Appendix F: Similar items across therapy approaches

Table F1
Similar items across therapy approaches

ACT	**MBCT**	**DBT**
Pay attention to the present moment / awareness of the present moment **Get rid of act, keep other two**	Awareness of thoughts, emotions and sensations in present moment **Keep**	Awareness of present moment **Keep this for DBT and ACT**
Pay attention to actions	Paying attention to activities in present moment **Keep this one**	
Make room for unwanted emotions, thoughts and sensations	Experiencing and allowing unpleasant thoughts, emotions or sensations	Accepting and sitting with discomfort **Keep this one**
Identify the relationship between thoughts and feelings	Noticing relationship between thoughts, emotions, sensations and actions **Keep**	
Step back from unhelpful thoughts	Stepping back from thought content **Keep for ACT and MBCT**	Separating thoughts, emotions and interpretations from facts **Keep for DBT**
Identify loss of flexible contact with the present moment **Keep**	'Noticing states of awareness and "automatic pilot"' **Keep**	

Identify "observing self" to view experiences from **Keep**	Non-judgementally observing our experiences **Keep**	Observing emotions, sensations, thoughts and actions **Keep**
Noticing thoughts, emotions and sensations that lead to rigid, inflexible behaviour **Keep**	Noticing habitual thoughts we get stuck in **Keep**	
Using metaphors	Using metaphors	Using metaphors and stories **Keep 'using metaphors' and 'using stories' for all three approaches**
Commit to actions aligned with values		Committing to valued actions **Keep – same meaning, simpler wording**
	Planning to increase rewarding and decrease draining activities **Keep**	Planning balanced lifestyle to prevent emotional sensitivity **Keep**
	Choosing to engage in skilful action **Keep**	Assist client to engage in most effective action **Keep** (skilful different to effective)
Normalise (client's) thoughts, emotions and sensations		Normalise client's thoughts, emotions and sensations **Keep**
Identify values-based behaviour **Keep**		Matching current and alternative behaviours to goals /values **Keep**

Appendices

Appendix G: Therapist recruitment advertisement

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UNIVERSITY OF NEW ZEALAND

Have you ever wondered how Third Wave Therapies overlap?

We welcome all therapists to participate in our study

You will:

- Contribute to practice-relevant research and receive the study results before publication
- Enhance our understanding of Third Wave Therapies - therapies that emphasise the contextual and experiential aspects of psychological events, from a Behavioural and Cognitive Therapy background
- Support research facilitating the measurement of therapist practice
- Complete a sorting procedure:
  - From any location
  - Takes around one hour

For more information, or to register your interest and receive your study pack, go to: http://psych-research.massey.ac.nz

Or contact Michelle at thirdwavestudy@gmail.com with your name and postal details to receive your study pack

Thanks for your support ☺

This research is being conducted by Psychology Master's student, Michelle Rous, under the supervision of Dr Don Baken and Dr Shane Harvey from Massey University, New Zealand.

"This project has been evaluated by peer review and judged to be low risk. Consequently it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director (Research Ethics), email humanethics@massey.ac.nz*."*

Appendix H: Therapist Participant Forms

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Creating a Compendium of Third Wave Therapy Strategies

INFORMATION SHEET

Researcher Introduction
This research is being conducted by Michelle Rous for fulfilment of the requirements for the degree of Master of Science in Psychology with endorsement in Health Psychology. The academic supervisors involved are clinical psychologists Dr Don Baken and Dr Shane Harvey (Massey University Psychology Clinic, Palmerston North). This project contributes to the growing body of Third Wave Therapy research, firstly by identifying strategies from three evidence-based third wave therapies which has prospects as a measure for identifying and recording therapist practice in these areas, and secondly, by investigating relationships between strategies from these Third Wave Therapies, thus identifying areas of overlap, similarity and difference.

Project Description and Invitation
Firstly, strategies were identified from three Third Wave Therapies, namely Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT) and Mindfulness-Based Cognitive Therapy (MBCT). Following this, the strategies were validated by being reviewed and edited by therapists experienced in these therapies.

Your participation in this study involves completing a card-sorting procedure, where each card presents a single strategy. Data generated from participants' strategy arrangements will enable the creation of a model depicting how these strategies relate. The distance between strategies on the model represent how similar (or dissimilar) the strategies are, as judged by the overall group of participants. The map will reveal groups of strategies considered to be more similar to each other than other strategies in the model. Groups lying next to each other represent similar groups, and groups lying opposite each other represent groups considered to be most dissimilar.

We would like to invite all therapists from mental health disciplines to participate in this sorting procedure, to further our understanding of Third Wave Therapies. If you would like to participate, please complete the informed consent form after reading through this information sheet.

Participant Identification and Recruitment
Participants for the expert sample will be recruited via email; snowballing through networks of Massey University staff and potential participants; and newsletter advertisements of New Zealand organisations in mental health disciplines. Participants whose contact information is freely available or which is given to the researcher will be contacted directly, otherwise those invited to participate will be unknown to the researcher. They will be contactable and sent the required materials and information only upon their response to the recruitment advert with their contact details.

- **Selection criteria:** therapists from a mental health discipline (for example, psychologists, psychiatrists, psychotherapists, counsellors, youth workers and social workers), English-speaking
- **Exclusion criteria:** therapists from unrelated disciplines (EG occupational therapist, physiotherapists)

30 therapists will be recruited to achieve sufficient power for the statistical analysis being used. 30 participants will also be recruited from a lay sample to check the reliability of responses across different language groups (to check for the presence of different understandings of terms between therapists and non-therapists)

A summary of the findings from this study will be emailed to participants, should they request this.

Project Procedures
Should you choose to participate, you will be asked to complete a participant details form, indicating your name, age, gender, ethnicity and details regarding your professional discipline and practice.

You will be sorting a set of strategies identified from the three therapies. There are four phases involving grouping strategies based on levels of similarity. Instructions for this procedure will be provided by mail along with a link for a demonstration video. This procedure should take you around 60 minutes, up to a maximum of 90 minutes, including recording the sort-arrangement on the response form.

Once you have finished the procedure and recorded your arrangements for all phases in the response form, please scan the consent form, participant details form and response form to your computer and email to the researcher at thirdwavestudy@gmail.com.

Data Management
Data from participants' combined sorting arrangements will enable the generation of a model of third wave therapy strategies for each sample. All non-identifiable information (including age, gender, ethnicity, educational and occupational details) will be reported to describe the demographics of each sample as a whole. A summary of the findings will be emailed to you should you request this.

Your contact details will not be reported and all efforts will be made to ensure this information is accessible only to the researcher. All data will be kept in a locked computer owned by the researcher and printed and kept in a locked storage cupboard owned by one of the supervisors.

Participant's Rights
You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*
- *Completion and return of the required forms implies consent. You have the right to decline to answer any particular question.*

Project Contacts
Researcher
Michelle Rous: thirdwavestudy@gmail.com

Supervisors (Clinical Psychologists)
Dr. Don Baken: D.M.Baken@massey.ac.nz
Dr. Shane Harvey: S.T.Harvey@massey.ac.nz

Please contact us if you have any questions.

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director, Research Ethics, telephone 06 356 9099 x 86015, email humanethics@massey.ac.nz".

Appendices

Te Kunenga
ki Pūrehuroa

School of Psychology - Te Kura Hinengaro Tāngata
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Creating a Compendium of Third Wave Therapy Strategies

PARTICIPANT DETAILS SHEET

Please complete the information requested below for the purposes of reporting the demographic information of the samples in this research. Your information will be kept confidential and will not be reported in any publication. Only the information of the samples **as a whole** will be published. Thus, identifiable information such as names and contact details will not be published.

Name: _____

Age: _____

Gender: (enter 'yes' next to your gender) Male Female

What country do you live in? _____

Ethnicity: (enter 'yes' next to your ethnicity)

Western European	North American	Pacific
Eastern European	South American	Asian
Middle Eastern	African	Other (please specify):

Discipline of practice: E.g. social work, youth work, counselling, psychology, psychiatry, psychotherapy

_____

Number of years practicing in a mental health occupation: _____

Are you experienced in practicing any of ACT, DBT or MBCT? (enter 'yes' next to your choice/s)

DBT ACT MBCT No Third Wave

Other Third Wave Therapy: (Please specify) _____

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PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet

* **YES / NO**

Yes, I would like to receive a summary of the findings from this study. Please email a summary of the findings to:

_____

Signature: ..... **Date:** .....

Full Name - printed .....

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INSTRUCTION SHEET

This sorting procedure follows the method of the GOPA technique (Bimler & Kirkland, 2007). It involves four phases: grouping; opposites; partitioning; and adding, and should take about 60-90 minutes. It does not require any knowledge related to psychology or therapy, and technical terms have been removed. You only need to understand the meaning of the words in their everyday use. How you complete this task is based on your understanding of the items, so your responses will likely be different from others'.

Important: The items represent strategies used by therapists with clients in Acceptance and Commitment Therapy, Mindfulness-Based Cognitive Therapy and Dialectical Behaviour Therapy.

→ **Please read through these instructions and the response form** to get an idea about what this procedure involves. Ideally, use a large work surface. Feel free to take a photo of the cards after each phase, in case they are moved around unintentionally.

PLEASE NOTE: When sorting the cards, pay attention to the **meaning of the item as a WHOLE**, rather than focusing on **any single word. For example, DO NOT** group items simply because they involve 'identifying'. Look at the meaning of the whole item.

→ **Start by shuffling the cards and have your response form and pen ready**

Phase 1: Grouping

1. Sort the item cards into groups comprised of items which you think are most similar. What makes the items similar is a theme you think the items share. You do **not** need to describe this shared theme to anyone.
2. **Please pay attention to the meaning of the item as a whole, rather than any single words**
3. Place one card at the top, left corner of your workspace. Read the next card and either add it to the same group if you think it is similar, or start a new group. Begin each new group in a new column to the right of existing groups. Place items you think belong in a group below one another in a **descending** fashion (item cards of the same group go down, not across).
4. *Aim* to have 8-16 groups, with between 1-7 items per group.
5. **Record** the groups you have made in the Response Form under 'phase one'. For each **group**, write the numbers of the item cards on one **row** (across).
6. Keep these groups intact on your workspace, as they are required for the following phases

Phase 2: Opposites

7. For this phase, leave the cards in the same place on the workspace. Using the groups you made in phase one, pair groups with a group you think is very different to it (opposite).
8. If you do not think a group has an 'opposite' group or a group very different from it, do not pair it up.
9. Aim to create **at least two pairs** of opposite groups.
10. **Record** these opposites in the Response Form. Label each opposite pair by recording the number of **any** one item card from each group in the pair. Make sure to record both groups in each pair, for as many pairs as you have.

Phase 3: Partitioning

11. Using, and retaining, the groups you made in the **grouping phase**, sort items which you think are most similar to each other **within** each group. These are called 'partitions'. Physically move the similar items comprising a partition together (in a descending fashion, still within their overall group), leaving clear gaps between each partition. Partitions can consist of any number of items.
12. **Record** partitions by writing the numbers of all items in each group (from top to bottom) into rows in the Response Form, and then place brackets () around the within-group items you think belong in a partition. Compare your overall phase three groups with your phase one groups, ensuring the item numbers are the same. The order may have changed as you rearranged items within groups into partitions.

Phase 4: Adding

13. Using the groups you made in the **grouping phase**, find the **two groups** most similar to each other. Two groups are preferable, however if you feel strongly that another group(s) should be added to this pair, you may do so.
14. If you do not think a group is similar to another group, do not add it to another group.
15. Move the group(s) above or below the group you want to add it to, so that all the cards are still visible. Separate the groups you have added with a small space.
16. **Record** added groups in the Response Form. Label each group you have added together by writing the number of any one item card in the group. Make sure to include both groups in each pair (or all groups if you have more than two), for as many pairs as you have.

Thank you for your support ☺

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Creating a Compendium of Third Wave Therapy Strategies

RESPONSE FORM

Phase One: Grouping

Place most **similar** items together in groups. **Pay attention to the meaning of the item as a whole, not any single word.** Record all of the group's item numbers in one row (across), *aiming* for 8-16 groups and no more than 7 items per group. Do not number groups. Please print neatly and leave adequate space between the item numbers.

Phase Three: Partitioning

Find **within-group** items which are **most similar** and place them together *within* their groups. Record by placing brackets around item numbers representing the partitions. The item numbers and total number of items in each group should be the same in phase three and phase one, as in the example below. Partitions can have any number of items.

Phase One	Phase Three
Example: 6 7 9 2 13 24 (items in a group)	Example: (9 2 24 6) (7 13) (partitions in a group)

Phase Two: Opposites

Find pairs of ***whole groups*** **you think are opposite, or very different**. Record opposites by labelling each group with the number of any one item from the group, on the lines below. Ensure you record both groups in a pair for as many opposite pairs as you have. If you don't think a group has an opposite, don't pair it up. Try to make at least two opposite pairs.

Opposite pair: ____ ____ Opposite pair: ____ ____ Opposite pair:____ ____

Opposite pair: ____ ____ Opposite pair: ____ ____ Opposite pair:____ ____

<u>Phase Four:</u> Adding

Find whole groups most similar to another group. Move them on your workspace so they form one longer list, separated by a small space to show they are two separate groups. Record by writing the number of any one item in each group below. Try to make at least 2 similar/added pairs. If you added more than two groups together, record the number of one item from the extra group(s) too.

Similar pair: Similar pair: Similar pair:
Similar pair: Similar pair: Similar pair:

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Appendices

. Appendix I: Non-therapist participant forms

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Creating a Compendium of Third Wave Therapy Strategies

INFORMATION SHEET

Researcher Introduction
This research is being conducted by Michelle Rous for fulfilment of the requirements for the degree of Master of Science in Psychology with endorsement in Health Psychology. The academic supervisors involved are clinical psychologists Dr Don Baken and Dr Shane Harvey (Massey University Psychology Clinic, Palmerston North). This project contributes to the growing body of Third Wave Therapy research, firstly by identifying strategies from three evidence-based third wave therapies which has prospects as a measure for identifying and recording therapist practice in these areas, and secondly, by investigating relationships between strategies from these Third Wave Therapies, thus identifying areas of overlap, similarity and difference.

Project Description and Invitation
Firstly, strategies were identified from three Third Wave Therapies, namely Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT) and Mindfulness-Based Cognitive Therapy (MBCT). Following this, the strategies were validated by being reviewed and edited by therapists experienced in these therapies.

Your participation in this study involves completing a card-sorting procedure, where each card presents a single strategy. Data generated from participants' strategy arrangements will enable the creation of a model depicting how these strategies relate. The distance between strategies on the model represent how similar (or dissimilar) the strategies are, as judged by the overall group of participants. The map will reveal groups of strategies considered to be more similar to each other than other strategies in the model. Groups lying next to each other represent similar groups, and groups lying opposite each other represent groups considered to be most dissimilar.

We would like to invite non-therapists to participate in this sorting procedure, to further our understanding of Third Wave Therapies. If you would like to participate, please complete the informed consent form after reading through this information sheet.

Participant Identification and Recruitment
Participants for the lay sample will be recruited via convenience sampling, consisting of people known to the researcher. They will be sent the advert and those expressing interesting in participating will be sent the required materials and information.

- **Selection criteria:** non-therapist, completing third year of high school, English-speaking
- **Exclusion criteria:** therapists from mental health discipline, non-completion of third year high school

30 non-therapists will be recruited to achieve sufficient power for the statistical analysis being used. 30 therapists will also be recruited to assess the reliability of responses across different language groups (to check for the presence of different understandings of terms between therapists and non-therapists)

A summary of the findings from this study will be emailed to participants, should they request this.

Project Procedures

Should you choose to participate, you will be asked to complete a participant details form, indicating your name, age, gender, ethnicity and details regarding your professional discipline and practice.

Appendices

You will be sorting a set of strategies identified from the three therapies. There are four phases involving grouping strategies based on levels of similarity. Instructions for this procedure will be provided by mail along with a link for a demonstration video. This procedure should take you around 60 minutes, up to a maximum of 90 minutes, including recording the sort-arrangement on the response form.

Once you have finished the procedure and recorded your arrangements for all phases in the response form, please scan the consent form, participant details form and response form to your computer and email to the researcher at thirdwavestudy@gmail.com.

Data Management

Data from participants' combined sorting arrangements will enable the generation of a model of third wave therapy strategies for each sample. All non-identifiable information (including age, gender, ethnicity, educational and occupational details) will be reported to describe the demographics of each sample as a whole. A summary of the findings will be emailed to you should you request this.

Your contact details will not be reported and all efforts will be made to ensure this information is accessible only to the researcher. All data will be kept in a locked computer owned by the researcher and printed and kept in a locked storage cupboard owned by one of the supervisors.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *decline to answer any particular question;*
- *withdraw from the study;*
- *ask any questions about the study at any time during participation;*
- *provide information on the understanding that your name will not be used unless you give permission to the researcher;*
- *be given access to a summary of the project findings when it is concluded.*
- *Completion and return of the required forms implies consent. You have the right to decline to answer any particular question.*

Project Contacts

Researcher
Michelle Rous: thirdwavestudy@gmail.com

Supervisors (Clinical Psychologists)
Dr. Don Baken: D.M.Baken@massey.ac.nz
Dr. Shane Harvey: S.T.Harvey@massey.ac.nz

Please contact us if you have any questions.

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director, Research Ethics, telephone 06 356 9099 x 86015, email humanethics@massey.ac.nz".

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Creating a Compendium of Third Wave Therapy Strategies

Participant Details Form

Please complete the information requested below for the purposes of reporting the demographic information of the samples in this research. Your information will be kept confidential and will not be reported in any publication. Only the information of the samples **as a whole** will be reported. Thus, identifiable information such as names and contact details will not be published.

Name: _____

Age: _____

Gender: Male ☐ Female ☐

What country do you live in? _____

Ethnicity:

Western European ☐	North American ☐	Pacific ☐
Eastern European ☐	South American ☐	Asian ☐
Middle Eastern ☐	African ☐	Other (please specify)

Highest level of education: (please tick)

Year 11 ☐	Year 12 ☐	Year 13 ☐
Diploma ☐	Bachelor's ☐	Postgraduate ☐

Occupation: _____

Appendices

Appendix J: Low risk ethics confirmation

Date: 05 May 2017

Dear Michelle Rous

Re: Ethics Notification - **4000017704 - Creating a Compendium of Third Wave Therapy Strategies**

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please contact a Research Ethics Administrator.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:
"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

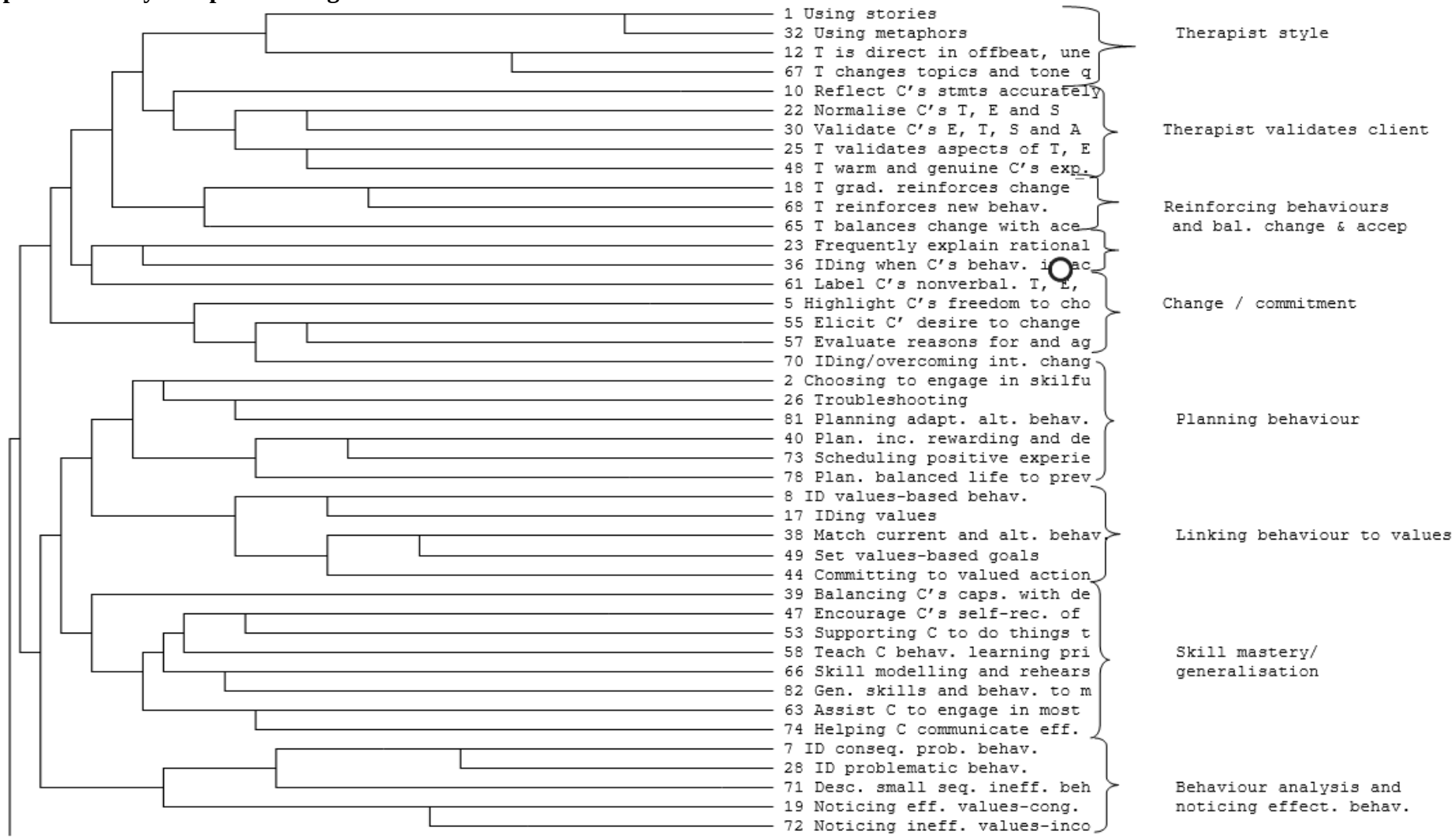
If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director - Ethics, telephone 06 3569099 ext 86015, email humanethics@massey.ac.nz. "

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

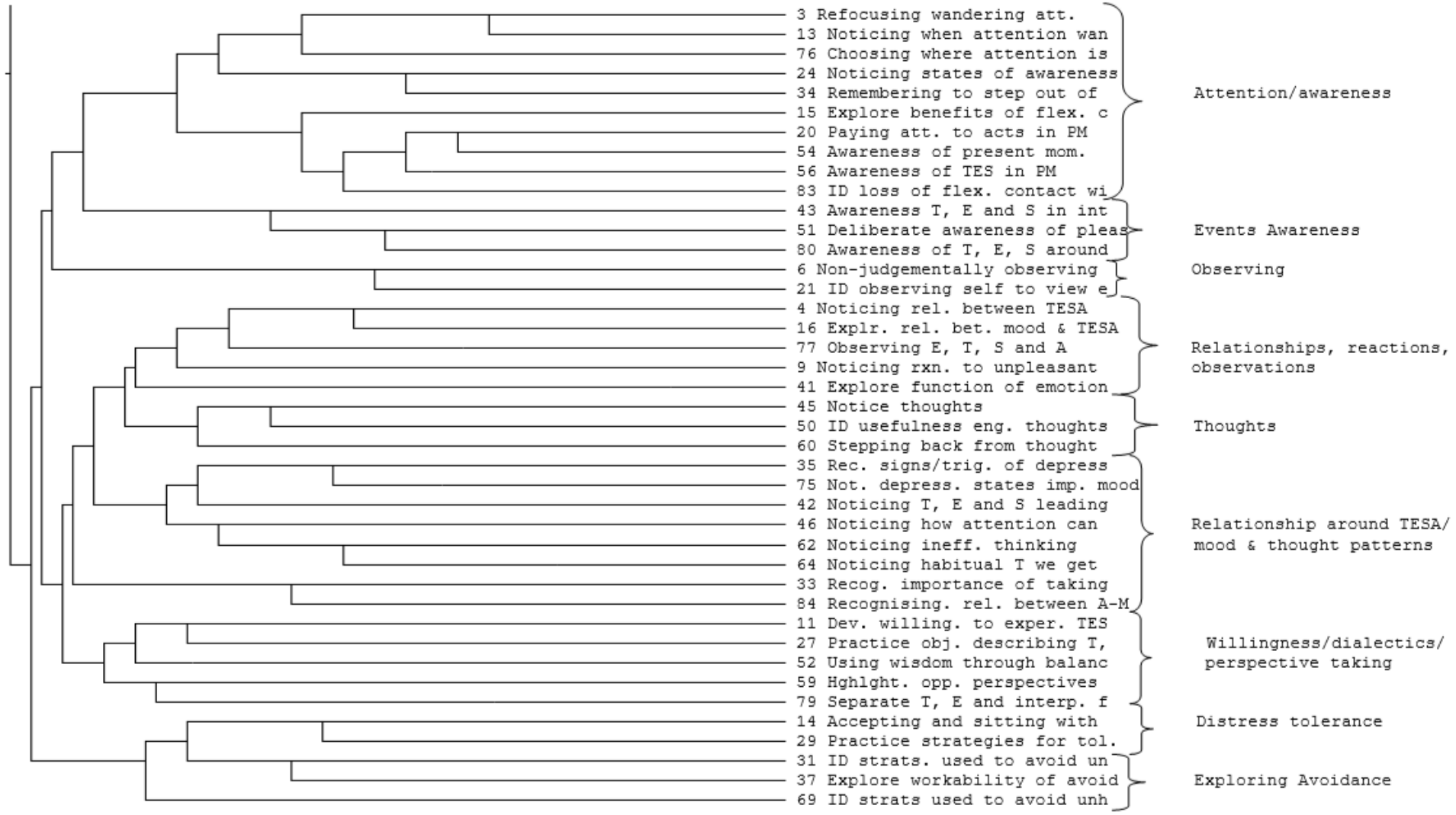
Yours sincerely

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

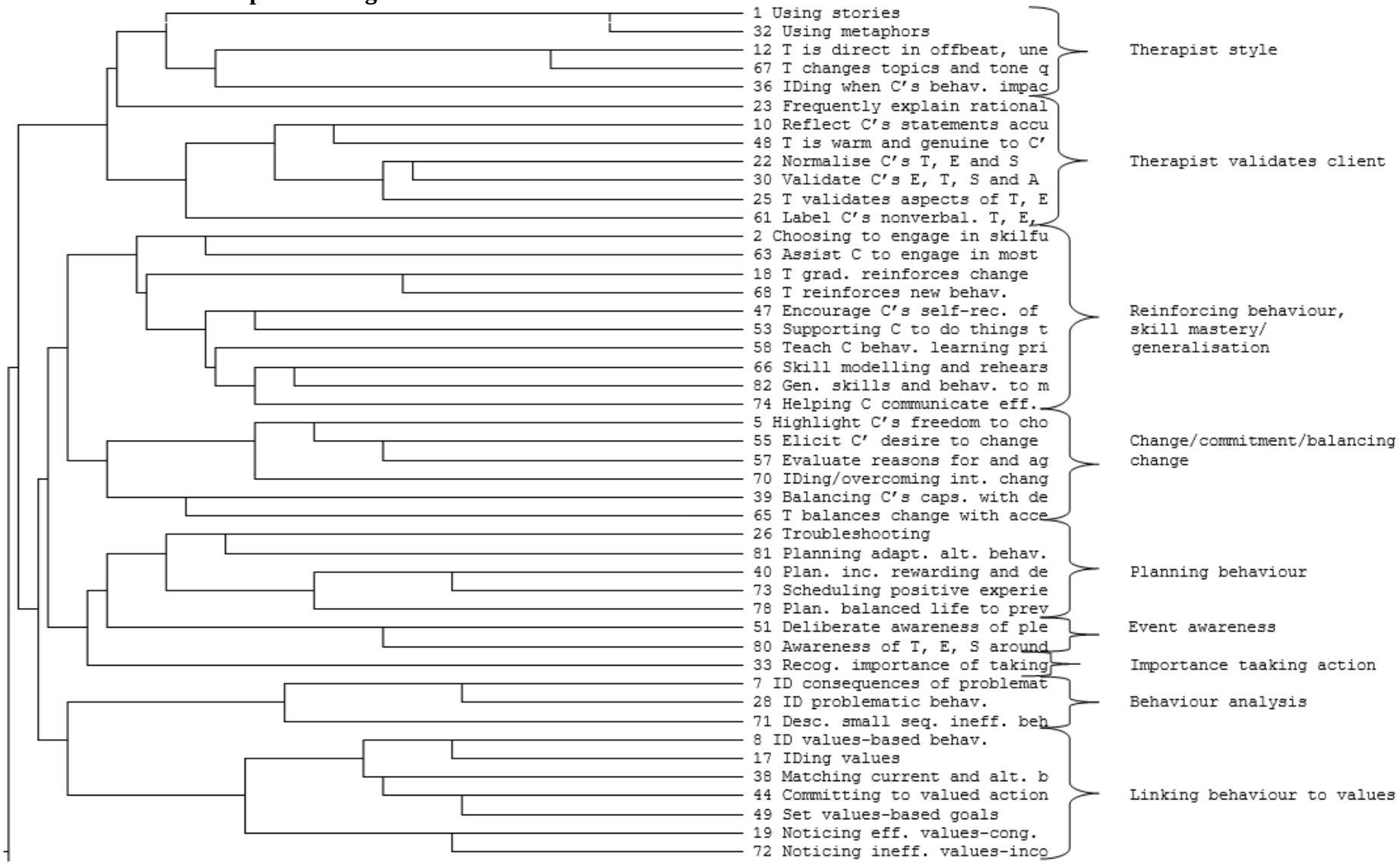
Appendix K: Lay Sample Dendrogram



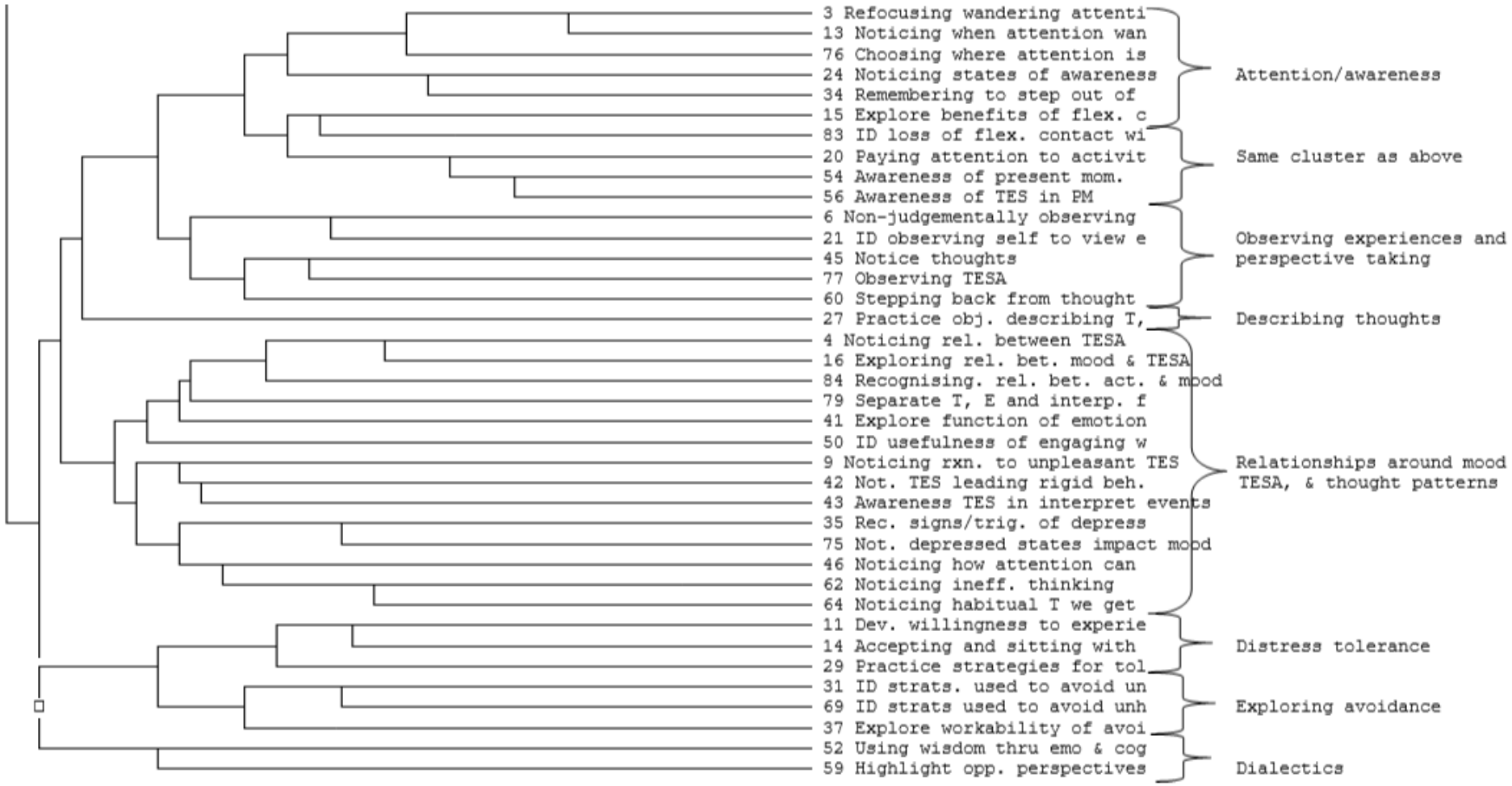
Appendices


3 Refocusing wandering att.
13 Noticing when attention wan
76 Choosing where attention is
24 Noticing states of awareness
34 Remembering to step out of
15 Explore benefits of flex. c
20 Paying att. to acts in PM
54 Awareness of present mom.
56 Awareness of TES in PM
83 ID loss of flex. contact wi
Attention/awareness
43 Awareness T, E and S in int
51 Deliberate awareness of pleas
80 Awareness of T, E, S around
Events Awareness
6 Non-judgementally observing
21 ID observing self to view e
Observing
4 Noticing rel. between TESA
16 Explr. rel. bet. mood & TESA
77 Observing E, T, S and A
9 Noticing rxn. to unpleasant
41 Explore function of emotion
Relationships, reactions, observations
45 Notice thoughts
50 ID usefulness eng. thoughts
60 Stepping back from thought
Thoughts
35 Rec. signs/trig. of depress
75 Not. depress. states imp. mood
42 Noticing T, E and S leading
46 Noticing how attention can
62 Noticing ineff. thinking
64 Noticing habitual T we get
33 Recog. importance of taking
84 Recognising. rel. between A-M
Relationship around TESA/ mood & thought patterns
11 Dev. willing. to exper. TES
27 Practice obj. describing T,
52 Using wisdom through balanc
59 Hghlght. opp. perspectives
79 Separate T, E and interp. f
Willingness/dialectics/ perspective taking
14 Accepting and sitting with
29 Practice strategies for tol.
Distress tolerance
31 ID strats. used to avoid un
37 Explore workability of avoid
69 ID strats used to avoid unh
Exploring Avoidance

Appendix L: Combined Sample Dendrogram



Appendices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76 Choosing where attention is
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16 Exploring rel. bet. mood & TESA
84 Recognising. rel. bet. act. & mood
79 Separate T, E and interp. f
41 Explore function of emotion
50 ID usefulness of engaging w
9 Noticing rxn. to unpleasant TES
42 Not. TES leading rigid beh.
43 Awareness TES in interpret events
35 Rec. signs/trig. of depress
75 Not. depressed states impact mood
46 Noticing how attention can
62 Noticing ineff. thinking
64 Noticing habitual T we get
11 Dev. willingness to experie
14 Accepting and sitting with
29 Practice strategies for tol
31 ID strats. used to avoid un
69 ID strats used to avoid unh
37 Explore workability of avoi
52 Using wisdom thru emo & cog
59 Highlight opp. perspectives
Attention/awareness
Same cluster as above
Observing experiences and perspective taking
Describing thoughts
Relationships around mood TESA, & thought patterns
Distress tolerance
Exploring avoidance
Dialectics