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Master of Science

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Knowledge, Attitudes, and Beliefs Towards the Therapeutic use of
Mindfulness Amongst Psychotherapists in New Zealand

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Abstract

Mindfulness has infiltrated psychology in the last two decades, and clinical efficacy in utilising mindfulness is increasing worldwide. Very little research has explored what mental health professionals know about mindfulness, and their attitudes towards its therapeutic use. Understanding practitioners' knowledge and attitudes towards clinical tools is essential in future integration within therapy. The current study explored knowledge, attitudes, and beliefs surrounding various aspects of mindfulness among New Zealand psychotherapists, to identify whether knowledge of mindfulness was related to attitudes towards its use. A total of 53 psychotherapists completed a questionnaire that elicited quantitative responses about personal mindfulness, attitudes towards alternative therapies, and beliefs surrounding perceived competencies with use of mindfulness clinically. Psychotherapists are in agreement with proposed competencies, have positive attitudes towards its use, and are personally highly mindful. ANOVA revealed attitudes and competencies towards the use of mindfulness are related to religious affiliation and professional specialisation. Most had previous mindfulness education and believed it benefits their daily life, but suggested they would consider clinical use if their knowledge was greater. Psychotherapists' personal mindfulness was not associated with attitudes towards, or competencies with its use. Despite a number of limitations, possible implications of the findings suggest future clinical utilisation of mindfulness within New Zealand, is reliant on understanding its current location within the minds of mental health professionals. A lack of education about mindfulness may be the reason for low utilisation, and this research may provide insight into areas of deficiencies. Knowledge in therapeutic mindfulness is pertinent in the improvement of future utilisation and infiltration within mental health professions, in turn accomplishing its clinical potential.

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Introduction

There has been an increasing interest in mindfulness among Western societies in recent years. Mindfulness, described as deliberate and non-judgemental attention of moment-to-moment experiences, was originally labelled by Buddhist religion as an ancient wellness technique (Johanson & DAPA, 2006; Lang, 2013; Majumdar, Grossman, Dietz-Waschkowski, Kersig, & Walach, 2002; McKenzie, Hased, & Gear, 2012). Over the past 30 years, the interface between meditation and Western organisations has developed, spanning across many disciplines; from exercise classrooms as a way of connectedness or enjoyment, to hospitals as a remedy for numerous physical and mental health problems (Lang, 2013; McMahan, 2012). Furthermore, individual engagement is boundless with no restrictions to specific nationalities or cultures (Charters, 2013). As a result, mindfulness has developed into a practice which is both accessible and easily accomplished by users, significantly improving its appeal as a panacea world-wide (Lang, 2013). Subsequently, mindfulness has infiltrated psychology in an optimistic way, and expanded its application through the development of measures and therapeutic tools enabling incorporation into therapy.

The benefits of mindfulness use in clinical applications have flourished throughout expanding literature, including practitioner studies, patient outcome studies, and refinement of various mindfulness related measures. Strong empirical support is testament to the vast applications of mindfulness within a psychological context, to improve personal well-being, professional relationships with clients, and as an adjunct to traditional psychotherapy (Majumdar et al., 2002; Stauffer & Pehrsson, 2012). Because the majority utilise student samples, there is still very little known about knowledge and attitudes surrounding the clinical use of mindfulness among psychotherapists and mental health professionals (McKenzie et al., 2012). This lack of focus within the literature stimulates the need to further explore what is known about mindfulness among the Western professional population. Understanding the way mental health professionals react and respond to emerging trends in therapies, is an area which will be immensely rewarding (Wilson, White, & Obst, 2011). It is vital that knowledge and attitudes surrounding the clinical use of such therapies are explored from the psychotherapists perspective, in order to enrich patient outcomes. Underutilisation of therapies has been linked with a lack of knowledge and poor

understanding surrounding integration, and subsequent negative attitudes towards their use (Hipol & Deacon, 2013; McKenzie, et al., 2012). Thus, it is pertinent to explore how psychotherapists are reacting to alternative therapies.

Insight into the levels of practitioner mindfulness, their attitudes towards alternative therapies, and knowledge about perceived competencies relating to clinical use, are central areas of interest. The current research explores the location of mindfulness within psychotherapies, and psychotherapists' attitudes towards the integration of these techniques within practice. Personal mindfulness and the relationship between demographic factors are also significant in informing possible reasons for the current implementation among New Zealand practitioners. Insight into the present understanding of perceptions surrounding therapeutic integration holds promise for finding reasons for clinical utilisation. This study aims to determine New Zealand psychotherapist's knowledge, attitudes, and beliefs towards mindfulness, and its use within clinical practices.

Chapter one will discuss the origins of mindfulness within Buddhism and its expansion into the Western world, including the development of a working definition. The cultivation of mindfulness practice is described, and ways by which it is quantified. Chapter two discusses where mindfulness is situated within the discipline of psychology, types of mindfulness therapies and their use within psychology, as well as the overall effectiveness of these within therapy. Chapter three discusses the therapeutic context of mindfulness use and previous research surrounding knowledge, attitudes, and competencies. It provides an overview of current practitioner and professional sample studies, and the current level of theoretical knowledge surrounding mindfulness in therapies is discussed. Finally, previous studies of mindfulness within practice, including knowledge, attitudes, and competencies are discussed. Chapter four gives an overview of the current study and its intentions. Chapter five covers participant demographics and procedures, and chapter six states the results from multiple analyses. Chapter seven discusses these results with assumptions and implications from the present study's findings, as well as limitations and conclusions.

Chapter 1

Overview of Mindfulness

The subject of mindfulness has gained a noticeable amount of focus and attention in recent years, particularly within the psychological community. This chapter overviews mindfulness origins within Buddhism, and explains its location within the Eastern world-view. A working definition of mindfulness is addressed, with reference to context and perspectives. Finally, mindfulness and real world involvements are discussed, as well as ways by which it can be measured.

1.1 *Origins in Buddhism*

Rooted in a Buddhist philosophy dating back more than 2500 years, mindfulness has been deliberately practiced in an attempt to alleviate human suffering (Cigolla & Brown, 2011; Germer, Siegel, & Fulton, 2005). Mindfulness has developed from wisdom traditions, and is a crucial part of Buddhist meditation practices, known as *satipaṭṭhāna* (McMahan, 2012; Singh, Lancioni, Wahler, Winton, & Singh, 2008). In Buddhist language, the Pali word *Sati* translates to mean mindfulness, and *sampajañña* meaning clear comprehension (Mapel, 2012; Williams & Kabat-Zinn, 2013). Defined as an essential ingredient to living life without emotional or mental suffering, its origin is situated deep within existing Buddhist philosophies (Brown, Ryan, & Creswell, 2007; Thera, 2005; Mapel & Simpson, 2011). With mindfulness as the vehicle, Buddhism teaches fundamental principles unfamiliar to Western society, including concepts such as the ultimate non-existence of the self (McMahan, 2012).

Mindfulness only became a part of the Western world in more recent times (Cigolla & Brown, 2011; Germer, et al., 2005; “Melbourne Academic Mindfulness Interest Group,” 2006). Through integration with modern traditions and definitions, McMahan states “Buddhist mindfulness provides a resource for the contemporary Western demand for therapeutic practices, and Western clinical and scientific sites in turn offer a significant locale for Buddhist tradition to instantiate itself within Western society” (p. 280). This description relocates mindfulness from its assumptions as a distant religious component, to a practice located within the 21st Century; equally beneficial within a Western contextual existence.

Although mindfulness therapies do not strive for Buddhist goals during meditative practices, it does not make the practice anti-Buddhism, but rather reinvents mindfulness practice in a Western way (McMahan, 2012). Mindfulness retains historical religious beginnings, however, one does not need to be, nor is expected to be Buddhist, in order to understand or employ mindfulness in their life (Johanson & DAPA, 2006; Majumdar et al., 2002). This integration between religion, beliefs, and Western traditions allows for a wide range of applications, and incorporates a broad range of individuals who are not restricted in the use of mindfulness due to their own historical backgrounds. Thus, making mindfulness an appropriate construct to research and utilise in a psychological context.

1.2 Defining Mindfulness

Definitions of mindfulness differ depending on context, whether clinical, spiritual, or social; and whether from a researcher, practitioner, or clinician's perspective of mindfulness (Singh et al., 2008). Because of this, consensus on a clear definition of mindfulness for empirical purposes is yet to be made. Common descriptions indicate it is the deliberate and non-judgemental attention being placed on the present sensations, emotions, perceptions, and mental activity, with a calm and clear mind of that moment-to-moment experience, whilst lacking any expectation (Horst, Newsome, & Stith, 2013; Lang, 2013; Majumdar et al., 2002; Singh et al., 2007; Stanley, et al., 2006).

Shapiro, Brown, and Astin (2008) defined mindfulness using Kabat-Zinn's (1990) definition as "looking deeply into oneself in the spirit of self-inquiry and self-understanding" (p. 12). Mindfulness in lay terms, is neither pursuing an experience nor pushing it away, but rather having acceptance of being in that moment, without over-identifying with it (Singh et al., 2007; Williams & Kabat-Zinn, 2013). Williams and Kabat-Zinn (2013, p.43) stated mindfulness is the "de-automatization of habitual judgement tendencies", with a goal of taking each moment as it comes, rather than focussing on the past or future expectations. They advocate it provides:

“-a way to disengage from the habitual patterns of discursive and affective reactivity so as to allow for more reflective response to the difficult

circumstances of one's life rather than remain prisoner of one's own habits and compulsions" (p. 43)

Various studies exploring mindfulness and its clinical application have followed closely to this definition, which incorporates the theoretical construct of mindfulness, the practice of mindfulness, and the psychological process of being mindful (Germer et al., 2005); while also highlighting the significance of the 'non-judgment' and 'awareness' components (Cigolla & Brown, 2011; Felder, Dimidjian, & Segal, 2012; Horst et al., 2013; Kabat-Zinn et al., 1992; Lang, 2013; Singh et al., 2007; Stanley et al., 2006; Stauffer & Pehrsson, 2012).

The present research will adopt this definition of mindfulness: 'mindfulness' is the deliberate attention being placed on present bodily sensations, emotions, perceptions, and mental activity, with a calm and clear mind of that moment-to-moment experience, whilst lacking any expectation or judgment (Kabat-Zinn, 2001).

1.3 Being Mindful

A variety of forms of mindfulness apply to mental health, but all follow two distinct components, 'present-being' and 'non-evaluation'. Mindfulness exercises typically include three steps; stop, observe, and return, to create a deeper awareness of the self, focussing not only on what is being done (attention/awareness), but also how it is being done (Horst et al., 2013). There is a central focus on an attitude that is friendly, curious, interested, and accepted, whilst refraining from self-criticism; tuning in to attentions, thoughts, and sensations associated with being in that precise moment (Horst et al., 2013).

Mindfulness enables clients to shift between modes of mental functioning, and differentiate between 'doing' and 'being' in the moment (Childs, 2007; Weick, 2006). Remarkably, the average adult spends nearly 50% of his or her waking life mind wandering, and not paying any attention to what he or she is actually doing (Powietryznska, Tobin, & Alexakos, 2014). Changing objects of attention and creating moment-to-moment responsiveness, allows the cultivation of greater relaxation and concentration (Kabat-Zinn et al., 1992). An individual is able to develop the ability to divert attention or redirect it, in a bid to be more mindful in the present moment (Singh et al., 2007). In doing so,

mindfulness meditation enhances an individual's ability to observe the mind, subsequently leading to a more realistic appreciation for both positive and negative experiences (Childs, 2007; Majumdar et al., 2002). The more mindful people become, the more observant they are of thoughts as they arise into conscious awareness (Cameron, 2003; Shapiro et al., 2008).

An example of being mindful might be sitting at the bus stop concentrating on one's breathing, whilst paying particular attention to the nostrils and feeling the inhalation and exhalation of the breath. Mindfulness practice can be both 'formal' and 'informal' (Cigolla & Brown, 2011). 'Formal' mindfulness is a practice of structured meditation; such as participating in a yoga class and practicing 'body scanning', where an individual pays attention to sensations in each part of the body sequentially, moving from the tip of the skull to the bottom of the feet (Cigolla & Brown). 'Informal' mindfulness incorporates mindfulness processes into everyday activities such as walking, eating, and showering (Cigolla & Brown). An example might be to sit and notice the sounds of the birds singing whilst waiting for a bus ride (Stauffer & Pehrsson, 2012).

1.3.1 Evaluating Mindfulness

A variety of self-report instruments have been developed to quantify mindfulness by measuring aspects such as everyday mindfulness, mindfulness skills, experience of mindfulness, and individual differences in a tendency to be mindful (Singh et al., 2008). Singh et al. effectively commented on the limitations of mindfulness measures, detailing their primitive stages in development, notably: construct validity, the defining of mindfulness, external validity, samples of convenience such as student populations, and criterion validity, the absence of objective measures to compare against. Previously, concerns have been raised over the ability to quantify mindfulness as it is a concept that is difficult to define, questioning the feasibility and reliability of its elusive nature (Cigolla & Brown, 2011). However, these limits are to be expected in emerging fields of research, and must be considered in further utilisation of the measures. Although many measures include some aspect of mindfulness, a focus has been placed on those measures assessing 'mindfulness' as a construct and psychological process. These include the Mindfulness Attention Awareness Scale (MAAS) and The Five Facet Mindfulness Questionnaire (FFMQ), including its short form (FFMQ-SF).

Brown and Ryan (2003) developed a theoretical and empirical examination of mindfulness, and its role in psychological well-being. Due to individual differences in frequency and the way individuals deploy attention and awareness, variations in mindfulness must exist (Brown & Ryan, 2003). To investigate these differences they developed the MAAS. The scale assessed differences in individual states of mindfulness, focussing on 'attention' and 'awareness' aspects occurring in the present moment. Although the MAAS was utilised successfully in preliminary studies, it moved away from exploring attributes such as acceptance, trust, and empathy, which are highly pertinent to encapsulate mindfulness (Brown & Ryan, 2003). It was viewed by Brown and Ryan, that present-centeredness of attention-awareness is the sole foundation to mindfulness, expressed by its emphasis in the design of their measure. Further research was indicative of multiple facets which became evident in mindfulness studies, deeming the MAAS not as comprehensive for measuring mindfulness as the FFMQ.

The FFMQ was initially developed by Baer, Smith, Hopkins, Krietemeyer and Toney (2006), who were the first to assess and acknowledge different aspects of mindfulness. By combining different items from existing mindfulness questionnaires and running an exploratory factor analysis, the five facets were revealed and subsequently included in the design of their measure. These include: observing- how one notices or attends to both internal and external experiences; describing- how one labels internal and external experiences with their words; acting- attending to ones activities in the moment with awareness, rather than being on automatic pilot; non-judging- placing no judgment on inner experiences, such as thoughts or feelings whilst also being non-evaluative; and finally non-reactivity- having the ability to allow inner experience such as thoughts and feelings, to flow in and out of the mind without allowing them to control you (Baer et al., 2006; Bohlmeijer, ten Klooster, Fledderus, Veehof, & Baer, 2011). The exploration of these facets is invaluable for understanding the very nature of mindfulness itself in relation to other variables, including clinical patients, the general population, and practitioners. Furthermore, this measure embraces Kabat-Zinn's (2001) definition of mindfulness, chosen for this study, as it goes further than the MASS to encompass aspects previously overlooked in the designing of mindfulness measures.

Carmody and Baer (2008) used the FFMQ long-form to measure changes in mindfulness, associated with the participation in a mindfulness-based stress reduction (MBSR) program. This study validated the utilisation of the FFMQ with practitioners and mindfulness. Participants with long-term experience in meditation practices had 'superior' levels of knowledge about mindfulness, and significantly higher 'personal' levels of mindfulness. The FFMQ showed good internal consistency and correlations with expected variables relating to mindfulness, such as experiential avoidance, suppression of thoughts, openness to experience, and emotional intelligence (Baer et al., 2006; Carmody & Baer, 2008). Di Benedetto and Swadling's (2014) study was one of few to utilise the full version of the FFMQ, when testing psychologists' burnout in their work. Although the findings gave positive insights into the use of this tool as a mindfulness measure, Bohlmeijer et al. (2011) developed a comprehensible short-form of the FFMQ.

Developed to measure a sample of depressed individuals, the short form (FFMQ-SF) had similar content validity and psychometric properties pertinent to the full version (Bohlmeijer et al., 2011). Findings indicated strong Pearson's correlations between the FFMQ-SF and FFMQ-full on each facet: observing $r = .89$; describing $r = .98$; acting with awareness $r = .92$; non-judging $r = .96$; and non-reactivity $r = .95$ (Bohlmeijer et al., 2011). This tool is indicative of the level of mindfulness individuals have with regards to everyday living. This shortened version was deemed more appropriate for use with a professional sample as time constraints for professional engagement could be restricted. Previously, the FFMQ-SF has been limited to use with clinical samples only, and has yet to be assessed in alternative samples. The exploration of mindfulness facets is a useful tool in understanding the very nature of mindfulness as a theoretical construct, in relation to other variables including clinical patients, the general population, and practitioners. These aspects are important to consider when exploring the understanding individuals have surrounding the use of mindfulness, and gaining insight into their level of knowledge and attitudes towards mindfulness; highlighting the suitability for its inclusion in the current study, and those which seek to measure a level of mindfulness within individuals.

1.4 *Summary*

Although mindfulness in origin is Buddhist, it is evident that definitions and use of mindfulness varies greatly between disciplines and practices. Mindfulness is an endeavour to reach a state of inner compassion and understanding through deliberate attention, in attempt to be engaged in moment-to-moment experiences. Whether it be 'formal' or 'informal', being mindful is achievable for everyone and relatively accessible. Throughout the literature, a number of definitions mean the practice of mindfulness and the focus of research studies vary somewhat. These variations have led to the development of multiple methods designed to measure various aspects of mindfulness, which span across multiple populations and professions. Mindfulness has been used not only in practice, but also as a clinical tool to help alleviate human anguish. The uses of mindfulness within a psychological discipline are vast, therefore the following chapter will endeavour to discuss some of these areas.

Chapter 2

Mindfulness in Psychology

Introduced to Western psychotherapy by John Kabat-Zinn in the 1970s, mindfulness fits into a broad spectrum of psychological areas including: positive psychology, psychodynamic psychotherapy, humanistic psychology, CBT, brain science, and health psychology to name only a few (Germer et al., 2005). Germer et al. (2005, p. 27) stated “the grand tradition of contemplative psychology in the East and the powerful scientific model of the West are finally meeting”. As such, mindfulness approaches have been described throughout the psychological literature as the third wave of behavioural therapies (Mapel & Simpson, 2011), emphasising the profound changes which are occurring with the introduction of integrated psychotherapies. This chapter will address clinical mindfulness in general; discuss various mindfulness methods, and how they have been utilised throughout psychology.

2.1 *Mindfulness in Clinical Psychology*

Clinically, mindfulness has added a new dimension to traditional cognitive therapies by expanding them (Baer, 2003; Singh et al., 2007). According to Williams and Kabat-Zinn (2013, p. 19) “the application of mindfulness in clinical settings has spread beyond stress reduction to psychotherapy” aiding in the treatment of both chronic physical and psychological disorders (Majumdar et al., 2002; Stauffer & Pehrsson, 2012). Additionally, the terms ‘mindfulness techniques’ and ‘mindfulness therapies’ are used interchangeably as they equally encompass a range of mindfulness interventions.

Enabling insight into the nature of the mind and the self in an endeavour to reach enlightenment¹ (Claessens, 2009; Singh et al., 2008), patients learn techniques for self-care and self-control of maladaptive behaviours, aiding in greater personal empowerment and

¹ Enlightenment is a term used to describe the ease and understanding of the nature of life; the foundation for perfect mental health (Kabat-Zinn & Davidson, 2012). In Buddhism, it is said that by “accepting the impermanence of life, relationships, and desirable things and learning to let go of them that one finds enlightenment” (Leming & Dickinson, 2011, p. 139), and thus ends the cycle of death and rebirth (Williams & Kabat-Zinn, 2013). Enlightenment in mindfulness has been described as “true knowledge and liberation”; a state an individual can reach through “direct contemplation of the body, feelings, mind, and experiential phenomena” (Williams & Kabat-Zinn, 2013, p. 24).

engagement with their own well-being (Adkins, Singh, Winton, McKeegan & Singh, 2010; Rybak, 2012; Singh et al., 2007).

Utilised clinically as a supplement for existing treatments, models, and techniques (Horst et al., 2013; Majumdar et al., 2002; Stauffer & Pehrsson, 2012), two types of psychotherapy with a mindfulness orientation have been identified:

- (1) Mindfulness-informed psychotherapy
- (2) Mindfulness-based psychotherapy.

2.1.1 Mindfulness-informed Psychotherapy

According to Stauffer and Pehrsson (2012) mindfulness-informed psychotherapy is a conjunction of Buddhist and Western psychology. Germer et al. (2005) suggest that therapists theoretically teach patients mindfulness skills based on a frame of reference, without explicitly teaching patients how to practice. Two examples of this type of psychotherapy include Acceptance and Commitment Therapy (ACT) and Dialectical Behavioural Therapy (DBT); both of which are described in more detail below.

ACT is a synthesis of mindfulness and cognitive behavioural change strategies, and works to increase tolerance toward unwanted internal experiences, as treatment for a range of physical and mental conditions (Lang, 2013). ACT is a manual-based treatment that has been referred to as a hybrid, combining value-based behavioural change strategies with the experience of mindfulness (Lang, 2013). Ultimately aiming to encourage psychological flexibility and symptom reduction, ACT improves the 'quality of life' of patients burdened with moderate to severe anxiety and depression (Lang, 2013). Following the core function of mindfulness, ACT emphasises a non-judgemental acceptance of all experiences (Mapel & Simpson, 2011). A study by Mapel and Simpson (2011) describes ACT as incorporating 'defusion skills', which allow the individual to step back and see the phenomenon experienced as separate from the individual experiencing them.

Combining mindfulness and behavioural therapies, DBT is most commonly used to treat borderline personality disorder (BPD), eating disorders, self-mutilation, para-suicide, and complex post-traumatic stress disorders (Horst et al., 2013; Lang, 2013). DBT incorporates mindfulness by encouraging the individual to apply skills learned in everyday

life (Mapel & Simpson, 2011). Therapy is aimed at reducing psychological distress and increasing acceptance of thoughts, whilst simultaneously decreasing reactivity (Horst et al., 2013; Lang, 2013). Specifically developed for treating suicidal clients suffering from BPD, DBT targets the suicidality components of the illness (Mapel & Simpson, 2011). Mapel and Simpson described it as an intensive approach, which aims to utilise mindfulness as a core skill, promoting greater self-acceptance, whilst also acknowledging that acceptance is a form of change. These include problem-solving skills, emotion regulation, distress tolerance self-management skills, and interpersonal effectiveness (Mapel & Simpson, 2011). DBT has been a choice of treatment extensively validated across the literature for its benefits and positive patient outcomes, predominantly in medical fields (Andión et al., 2012; Lenz, Taylor, Fleming, & Serman, 2014; Ritschel, 2012).

2.1.2 Mindfulness-based Psychotherapy

Alternatively, mindfulness-based psychotherapy is an integration of mindfulness with traditional cognitive behavioural therapies, which aim to alter an individual's cognitive patterns or thoughts to promote changes in behaviour (Horst et al., 2013). Emphasis is placed on mindfulness skills in practice (e.g., mindful eating and breathing with awareness), not just through therapy, but also daily living (Germer et al., 2005). Examples of this type of therapy include mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR), which are described in more detail below.

MBCT is theory driven, designed to reduce relapse through psychological intervention (Hayes & Shenk, 2004). An integration of MBSR and CBT elements has shaped the emergence of MBCT. Where CBT has a focus on changing thought contents, the mindful side is more focused on changing 'awareness of' and 'relationships to' thoughts (Hayes & Shenk, 2004). Derived from a model of cognitive vulnerability, it is assumed to be associated with relapse in depressed patients due to maladaptive ruminations (Lang, 2013; Ma & Teasdale, 2004). MBCT moves clients towards decentering from those ruminations, encouraging an "accepting and non-judgemental stance towards thoughts, emotions, and sensations" (Felder, et al., 2012, p. 179). MBCT incorporates formal meditation practices such as breathing-focussed meditation or body-focussed meditation, to help foster awareness into the present-mind (Felder et al., 2012). Additionally, it reduces ruminative tendencies in those suffering from depression and anxiety when used as an adjunct to

pharmacotherapy (Felder et al., 2012; Lang, 2013). Although mostly positive results are publicised, some suggest there may be relapse related psychopathologies not successfully resolved with the use of MBCT (Ma & Teasdale, 2004). A greater knowledge of the success of MBCT could lead to more fitting treatments for some clients, outside of the 'usual' treatment processes.

MBSR helps to teach patients to apply mindfulness practice into everyday life as a coping resource, to use in treating physical symptoms and psychological distress (Carmody & Baer, 2008; Lang, 2013; Mapel & Simpson, 2011; Miller, Fletcher, & Kabat-Zinn, 1995). These techniques include body scanning, yoga, and sitting meditation, which each encourage mindful movements and acknowledgement of sensations experienced (Carmody & Baer, 2008). Additionally, MBSR programs encourage informal mindfulness practices, improving awareness of the external and internal environment during daily events (Carmody & Baer, 2008). Outcomes associated with MBSR are decreases in ruminations, as the ability to sustain attention is developed and strengthened. Because anxiety and depressive disorders are associated with ruminations and negative thought processes, MBSR studies imply that therapy helps to interrupt the thought-pattern cycle, training individuals to return to their conscious awareness in the present moment (McKenzie et al., 2012). Levels of mindfulness have been found to increase through the use of MBSR techniques, ultimately improving psychological symptoms and perceived stress experienced (Carmody & Baer, 2008).

New Zealand psychotherapists' confidence in utilising alternative therapy types may be enhanced through a greater knowledge surrounding the successful applications of mindfulness techniques, and alternative ways to incorporate them within specific diagnoses. This type of therapy also illustrates the multifaceted application of mindfulness techniques, which can be adjusted to fit a range of individuals and diagnoses.

2.1.3 Effectiveness of Mindfulness in Therapy

A wide range of literature focusses on patient outcomes through the use of mindfulness-based therapies. Much of this is based in the United States of America, European countries, Australia, and few from New Zealand. Worldwide research has

suggested the advantages of using mindfulness therapies outweigh any disadvantages for its use, supporting its clinical application in psychological care (McKenzie et al., 2012).

Several MBSR studies explored program effectiveness and patient outcomes (Kabat-Zinn et al., 1992; Majumdar et al., 2002; Mapel & Simpson, 2011), by assessing how mindfulness based approaches interact with current levels of anxiety, depression, and psychosomatic symptoms such as chronic pain (Kabat-Zinn et al., 1992; Lang, 2013; Majumdar et al., 2002; Mapel & Simpson, 2011; Miller et al., 1995; Grossman, Niemann, Schmidt, & Walach, 2004). Other studies have adapted mindfulness approaches to fit intellectually disabled patients with anger management and aggression problems, as an adjunct to already strict psychopharmacological treatments (Adkins et al., 2010; Singh et al., 2007). Lang (2013) argues that mindfulness alone is enough to strengthen the capacity to choose the focus of a clients' attention, to improve both anxiety and depression. One study in particular was designed to treat depression relapse, finding more than half of the treatment group had success, when compared to the control group (Ma & Teasdale, 2004). However, limitations include difficulties in controlling experiences that send clients into relapse, making individual outcomes highly variable (Ma & Teasdale, 2004).

Another MBSR study examined the frequency of mindfulness practice, and found more practice led to greater mindfulness, and subsequently a reduction in psychological distress and improvement in well-being (Carmody & Baer, 2008). There has been some recent criticism to mindfulness studies and suggestion that mindfulness is not a panacea to mental health concerns (e.g., Farias & Wikholm, 2015). However, the studies above largely support the usefulness of mindfulness techniques in reducing and improving a variety of physical and psychological issues experienced by patients. Furthermore, Mindfulness-based therapies are relatively cost effective for the patient. Following the initial training, ongoing treatment relies solely on self-practice with a mere cost of personal time, supporting a magnitude of benefits which outweigh the sole risks of producing only slight improvements (Lang, 2013; Miller et al., 1995). Clinicians using mindfulness strive to examine efficacy and the effectiveness of interventions using rigorous research methodologies. However, mindfulness is a clinical tool still in early stages of development, in both research and practice (Singh et al., 2008).

2.2 *Summary*

The effectiveness of mindfulness therapies is evident. However, there is still little known about *how* psychology as a discipline is responding to changes in clinical practices, and the emergence of new therapy types (Wilson, et al., 2011). Without further investigation into knowledge and attitudes surrounding mindfulness, it is difficult to establish where mindfulness is lacking, and whether these areas could be the reason for underutilisation. This may determine the feasibility of its application here in New Zealand. The following chapter will explore current psychological perspectives on the use of mindfulness therapies, and how this may influence future use.

Chapter 3

Mindfulness and the Clinician

Literature indicates the benefits for both the client and practitioner of mindfulness oriented therapies. Given the apparent trend to employ mindfulness in a therapeutic context (as described in chapter 2), understanding factors influencing practitioners, particularly psychologists' and psychotherapists', and their willingness to utilise and incorporate alternative therapies into their psychological practices, is pertinent. This chapter discusses potential reasons for the implementation or not of mindfulness into clinical therapeutic practice.

3.1 *Mindfulness Knowledge, Attitudes, and Competencies*

Dimidjian and Segal (2015) researched the current evidence surrounding mindfulness based interventions up to 2013, with 308 articles included in the analysis. Of those selected, only 15 articles had a healthcare clinician or student sample, highlighting the dearth of literature investigating practitioner experiences in relation to mindfulness outcomes. Even less have focussed on reasons why mindfulness might or might not be integrated into a therapeutic context from a practitioner's perspective. Various studies have addressed related areas such as levels of practitioner mindfulness and the impact this has on therapy and patient outcome (Stanley et al., 2006). Others have looked at the effects that mindfulness has on the clinical relationship between the patient and the practitioner (Brito, 2013; Hopkins & Proeve, 2013; Horst et al., 2013). Others have explored mindfulness programs, and their use with a sample of training professionals and psychotherapists, with an attempt to improve self-care (Aggs & Bambling, 2010; Christopher et al., 2011; Hemanth & Fisher, 2014; Hopkins & Proeve, 2013). From the current research available, despite its lack of specificity in investigating factors influencing implementation of mindfulness, it appears some specific concerns are evident. These include inexperience with mindfulness, levels of theoretical knowledge, and the unknown cost to patients, which may be impacting the uptake of mindfulness in a clinical framework (Wilson et al., 2011).

3.2 *Inexperience with Mindfulness*

Therapists are expected to have some history of personal practice in meditation, and formal training in the procedures of mindfulness (Singh et al., 2008). Singh et al. (2008, p. 663) stated, “Mindfulness is a multifaceted practice and without personal engagement in meditation, the therapist is unable to fully relate to the experiences of the participants and to provide individualised feedback”. Indeed, therapists have been encouraged to engage in their own mindfulness practice, as this ensures the response to participants can be driven both intellectually and from within (Felder et al., 2012). This allows the therapist to embody an attitude of compassion and support; both invaluable in effective practice. Singh et al. (2008, p. 663) found “the meditation practice of therapists is a critical variable in the training of participants and delivery of mindfulness interventions, and consequently the outcomes for the participants”.

In a sample of 52 (23 females and 29 males) highly experienced psychotherapists who had previously encountered mindfulness, Stauffer and Pehrsson (2012) explored agreement towards a set of competencies, relating to the use of mindfulness methods and training clients in its use. Drawing from more than 162 studies published from 1987 to 2007 and specifically focussed on mindfulness-based therapies, the authors grouped competency statements into four distinct areas: (1) integrated and engaged practice; (2) cultural competencies and mindfulness use; (3) competency limits and continuing education; and (4) clinical considerations. Findings revealed practitioners competencies in mindfulness methods, their effectiveness, and practice, prior to using with clients, were considered important to the competent implementation of mindfulness in a therapeutic context.

Although participants felt it was important to have prior training and practice before administering mindfulness to others, the duration of recommended training time varied somewhat. Interestingly, findings also revealed continued education, being aware of personal limits, and having a willingness to seek further training were important. This suggests while experiential knowledge may be implicated in therapeutic mindfulness use, theoretical knowledge may also be important.

3.3 *Levels of Theoretical Knowledge*

Only one study has investigated the theoretical knowledge individuals have towards mindfulness specifically, and how this might impact attitudes towards its use. McKenzie et al. (2012) investigated medical and psychology students' perspectives. Participants in this sample included 'exposed' medical students who had encountered mindfulness within their curriculum; 'non-exposed' medical students; and 'non-exposed' psychology students. The self-designed questionnaire included both qualitative and quantitative items, to assess a range of aspects of mindfulness and its usage. Strong positive associations were found between knowledge components, and likelihood to administer or recommend mindfulness therapies in their future practice. Medical students with exposure to mindfulness through their course work were the most likely to recommend or administer mindfulness therapies (98%), compared to 'non-exposed' medical students (25%). However, most interestingly, 'non-exposed' psychology students were more likely to report a recommendation for, or administration of, mindfulness in future careers (60%). These findings could be indicative of an entrenched acceptance for mindfulness therapies among psychology students. Further findings proposed theoretical knowledge of and/or education about mindfulness, even in the absence of personal practice, may be an important influencer in shaping attitudes toward the implementation of mindfulness techniques.

Indeed, other studies have suggested brief training following a short mindfulness course has the ability to provide acceptable knowledge and skills to aid in therapeutic practice, and increase positive attitudes towards use (Aggs & Bambling, 2010; Hopkins & Proeve, 2013). However, additional studies are required to support these assumptions within a professional population.

3.4 *Unknown or Perceived Risk to Patients*

In broader definitions, mindfulness practices have been referred to under the heading of Complementary and Alternative Therapies (CAT). CAT refers to a wide range of therapies and medicines, and can include ingestible medicines, naturopathy, herbal medicines, yoga, aromatherapy, and acupuncture as either an adjunct or alternative to traditional therapies (Wilson & White, 2007). The use of CAT has risen over the past decade in both medical and psychological services (Wilson & White, 2007). Given mindfulness is

sometimes categorised as CAT, research on attitudes towards CAT, although primarily centred on medical practitioners, may provide useful insight.

Wilson et al. (2011) investigated attitudes and level of knowledge toward CAT usage in clinical settings in the previous year, in a sample of 122 clinical psychologists, using a quantitative questionnaire (PATCAT). Mean scores for 'knowledge' aspects indicated participants considered it to be of some importance to have an understanding of CAT. Such a finding is very much cognisant with findings mentioned previously regarding the importance of knowledge about mindfulness to implementation. Mean scores for 'integration' aspects indicated an overall positive attitude towards CAT usage in clinical settings. Mean scores for 'perceived risk' revealed a moderate perceived risk towards professional utilisation, and thus a diminished attitude towards its use. Combined, such findings suggest in the absence of adequate knowledge about mindfulness, 'perceived risk' of mindfulness may impact 'attitudes' towards its use in clinical situations.

3.5 *Summary*

This chapter provides insight into the current state of mindfulness and CAT utilisation within a therapeutic context. Although these studies are scarce, extending them to include professional psychological populations could give insight into how these aspects may impact future practice, and the current understanding of mindfulness perspectives. Consistent with previous findings, deficient theoretical 'knowledge' leads to a reduction in personal engagement with health practices. Furthermore, competencies required when utilising mindfulness vary somewhat. Thus, professional willingness to incorporate mindfulness into practice may be reliant on the quality and extent of mindfulness knowledge and interpretation of risks, pivotal in determining one's attitude. Accordingly, insight into this area may improve understanding around professional utilisation of mindfulness.

Chapter 4

Overview of the Current Study

It is unclear whether, and to what extent, psychotherapists' knowledge and attitudes of mindfulness practice and interventions may influence clinical utilisation, despite substantial empirical support for its effectiveness (Lang, 2013; Majumdar et al., 2002; "Melbourne Academic Mindfulness Interest Group", 2006; McKenzie et al., 2012). Few studies have explored the attitudes psychologists have towards therapy types within a mental health framework, as the majority focus their interests on patient and practitioner benefits. Of the few studies in New Zealand, the majority are patient outcome oriented, or concerned with educational use of mindfulness (Mapel, 2012; Mapel & Simpson, 2011). These areas, although important, do not give any indication on the location of mindfulness within the context of psychotherapy. However, one in particular contributes a reflective insight of her personal integration of mindfulness from a cognitive psychologist's perspective (Buttle, 2013). This article heads in the direction of interpreting attitudes towards the use of mindfulness in practice.

Most benefits for mindfulness are known, however, psychotherapists' knowledge and attitudes surrounding its application in a therapeutic sense, are yet to be unveiled. This research intends to interpret some of the attitudes and beliefs surrounding mindfulness in New Zealand. Furthermore, pertinent insight into factors of importance or significance when using mindfulness among psychotherapists may be discovered. Currently, there are no studies looking at personal levels of mindfulness or its therapeutic use among New Zealand psychotherapists. One of the first steps to improving dissemination and utilisation of any mental health therapy is to understand practitioners' understandings and perceptions of them as a whole, and their beliefs surrounding its use as a clinical tool (Wilson et al., 2011). For this reason, this study aims to expose practitioners' personal mindfulness, competencies relating to its use, and attitudes towards alternative therapies in general. This may provide the insight required to determine the current status of mindfulness application within psychology, and ways of effectively improving integration of this therapeutic tool, as well as how it is currently being viewed in New Zealand.

4.1 *Research Aim and Objective*

The objective of this study is to explore the knowledge, attitudes, and beliefs that New Zealand psychotherapists have towards mindfulness and its use within clinical practices, with or without previous exposure to mindfulness in their training. The current research will set out to ascertain the following:

- (1) The relationship between FFMQ-SF scores, MCQ and PATCAT scores.
- (2) The relationship between age and number of practicing years, and FFMQ-SF, PATCAT and MCQ scores.
- (3) Whether those who have learnt about mindfulness previously, will have higher FFMQ-SF scores, MCQ, and PATCAT scores.
- (4) How participant's profession, religious affiliation, place of practice, traditional therapy choice, and practice group, relate to the PATCAT, MCQ, FFMQ-SF and Mindfulness Knowledge scores.

Chapter 5

Methodology

This section will address the rationale for the study's design, the participants included, and the measures developed and used in this study. An outline of the statistical analysis will follow, and an explanation for the scoring which has been applied. Finally, a discussion of the research design and the procedures is given.

5.1 *Procedure*

Data was collected through an online survey. Letters were sent to the New Zealand Association of Counsellors (NZAC) (see Appendix A), New Zealand Psychological Board (NZPB) (see Appendix B), New Zealand Association of Psychotherapists (NZAP) and NZPS (see Appendix C). Letters explained the project, gave access to the web survey, and asked if each association would email an invitation, supplied by senior researchers of the college (Dr Karan Frewin and Dr Natasha Tassell-Matamua), to members to participate in the survey. Requests for email invitation with a copy of the survey link were sent to each associations' email database. NZAP agreed to forward the link to their members, NZAC declined but approved an advertisement in their monthly newsletter, as did NZAP, and NZPS and NZPB declined access. Advertisements were drawn up and sent to NZAC and NZPA (see Appendix D).

The questionnaire was distributed with an information sheet about the purpose of the study, who was conducting the research, and its location embedded within a wider questionnaire as part of a research team at Massey University (see Appendix E for information sheet). The participants were informed about who was eligible to take part, as well as the estimated time it would take to complete the survey in its entirety. Withdrawal was possible at any stage during the questionnaire, with no detriment or penalty to the participant. Full confidentiality and anonymity was assured, and no individual was identified through the use of data provided. Additional information about the research could be obtained by contacting the researchers through information provided. An option was given to request a summary of the findings following the completion of the research.

As the questionnaire administration was entirely web-based, participants had the convenience of participating in the research at a location and time which best suited them. The participants were not age restricted, however current registration in New Zealand was necessary. As the researchers were English speaking, the questionnaire was written and answered in English. Ineligible candidates were those who did not consent for collection of their data.

5.2 *Participants*

A total of 53 participants took part in the research. The majority (72%) were female. All were over 36 years of age at questionnaire completion, with over half (66%) being 55 years or older, whilst nearly one quarter (23%) were between 36 to 45 years old. The majority (51%) of reported 'professions' were Counsellors, whilst over a third (36%) were Psychologists or Psychotherapists; the remaining (13%) were Clinical Psychologists, with two participants declining to answer. Over three quarters of those who participated (85%) held postgraduate qualifications as their highest level of study, including Masters and Doctorate degrees; less than one quarter (13%) reported undergraduate degrees, and only one participant (2%) selected 'other'. Participant 'length of practice' varied from one to forty-four years; over half (53%) had practiced between eleven to twenty-five years, whilst nearly a quarter (24%) reported practicing between one to ten years. Nearly a quarter of those who responded (19%) had practiced for twenty-six years or more.

Nearly half of the participants (41%) were religiously affiliated with Christian beliefs, nearly a quarter (19%) reported 'Other', over a third (36%) reported no religious affiliation at all, and the fewest (4%) reported Buddhist affiliations. The majority of participants (68%) reported their ethnicity as 'NZ/Pākehā', less than one quarter (13%) reported 'European' and 'other' (13%), whilst 'Māori/Pacific' participants made up (8%) of the respondents. Over half (59%) reported their marital status as 'Married', whilst almost one fifth (19%) were 'Single', less than one fifth respectively (13%, 8%) were 'Divorced' or reported 'De-facto' statuses. Finally, one participant (2%) reported being a 'Widow/er'.

5.3 Assessments and Measures

5.3.1 Mindfulness Knowledge

McKenzie et al. (2012) explored knowledge and attitudes among medical and psychology students, through a series of questions developed to understand their orientation towards the clinical use of mindfulness techniques. It was deemed appropriate to utilise aspects of these questions, as very few studies have explored knowledge and attitudes surrounding mindfulness use.

Section one consisted of six questions adopted from McKenzie et al.'s (2012) study and developed by the researcher, to assess participant's knowledge and attitudes towards mindfulness in a general, spiritual, and clinical capacity. Items include: "What is the extent of your knowledge on Mindfulness?" (General knowledge), "To what degree do you believe mindfulness therapies may improve the therapeutic relationship between you and your patient?" (Clinical knowledge), and "To what degree do you believe religious understanding is required in mindfulness therapies?" (Spiritual knowledge) (see Appendix F for a full list of items). Responses were given using a five point Likert scale ranging from 1 (*non-existent or not-at-all*) to 5 (*extensive or extensively*). Participants responded according to their level of knowledge and/or attitude associated with the questions. A higher score was indicative of a greater level of agreement and thus a positive attitude and greater knowledge towards mindfulness.

Section two included a mixture of five dichotomous and short answer items, (see Appendix F for a full list of items), developed specifically for this study, to give insight into how and where participants had learnt about mindfulness previously. One question asked "Have you ever learnt about mindfulness therapies?" giving the option to respond with 'yes' or 'no', then the possibility to include the source, for example: University, Professional Development Workshop, Colleagues, Self-Interest, or other. The second question was developed for this study to assess the participants' personal attitude towards mindfulness in daily life, not specific to a clinical setting which included: "Do you believe being mindful can improve your daily life outside of your professional environment?". The final three questions were developed based on McKenzie et al.'s (2012) study to assess attitudes towards clinical application of mindfulness, and insight into current therapy choices that

may substitute for a mindfulness approach, which included: “If your knowledge of mindfulness therapies was greater, would you consider using it in your clinical application?”, and “What therapy type do you use most commonly when treating anxiety?” allowing the participant to briefly comment on their therapy of choice. These questions were not scored, but rather developed to give insight into what attitudes currently surround clinical use of mindfulness.

5.3.2 *Five Facet Mindfulness Questionnaire- Short Form (FFMQ-SF)*

A shortened version, the FFMQ-SF, was developed by Bohlmeijer et al. (2011) containing 24 items, from the original 64 item FFMQ developed by Baer et al. (2006). The FFMQ-SF is an instrument used for assessing all five facets of mindfulness. Examples of items for each of the five facet subscales include: “I pay attention to physical experiences, such as the wind in my hair or sun on my face” (observe), “I am good at finding words to describe my feelings” (describe), “It seems I am ‘running on automatic pilot’ without much awareness of what I’m doing” (acting with awareness), “I tell myself I shouldn’t be feeling the way I’m feeling” (non-judgement), and “I watch my feelings without getting carried away by them” (non-reacting) (see Appendix G for a full list of items).

Participants were asked to select the option that best suited their agreement with each statement, using the six point Likert scale ranging from: 1 (*never or very rarely true*) to 5 (*very often or always true*). Responses to each item on the measure were summed to give an overall score ranging from 24 to 120, with higher scores being indicative of higher levels of personal mindfulness. The FFMQ-SF was reported to be equivalent with the FFMQ-full version through a series of Pearson’s correlation tests. High correlations with each of the original facets were demonstrated as follows: for observing $r = .89$; describing $r = .98$; acting with awareness $r = .92$; non-judging $r = .96$; and non-reactivity $r = .95$ (Bohlmeijer et al., 2011).

5.3.3 *Mindfulness Competency Questionnaire (MCQ)*

Stauffer and Pehrsson (2012) developed a 16 item questionnaire, relating to mindfulness competencies in the area of counselling and psychotherapy. The questions designed by the authors capture the clinicians’ perspective on mindfulness and potentially

emphasise their personal attitude towards practicing with mindfulness methods and techniques.

In the current study, Stauffer and Pehrsson's (2012) competencies were used in the questionnaire as a set, using the following stem phrase for each item, "Counsellors and psychotherapists who train in the use of mindfulness methods...". The items fit into four sub-categories with the following example items. An example for 'integrated and engaged practice' includes: "Practice mindfulness methods on a regular basis, especially when training others in these methods", an example item for 'cultural competency and mindfulness use' includes: "I respect clients' culture, including religious and/or spiritual beliefs and values that relate to physical and mental functioning", an example item for 'competency limits and continuing education' includes: "have knowledge of the various types and methods of meditation and mindfulness", and an example item for the sub-category 'clinical considerations' includes: "have knowledge of which types of mindfulness methods are effective, ineffective, and potentially harmful for use in treating specific types of mental health disorders" (see Appendix H for a full list of items).

Participants were asked to respond to the statement using a five point Likert scale ranging from: 1 (*strongly agree*) to 5 (*strongly disagree*), according to their level of agreement. The scores were summed for each statement with totals ranging from 16 to 80, and after reversing the scores, a higher score demonstrating stronger agreement with the statement, thus indicating attitudes towards different aspects of mindfulness competencies. A Cronbach alpha was used to test the median reliability for the competency statements, which found excellent internal consistency of .93 (Stauffer & Pehrsson, 2012). This alpha level was supported as significant from the expectation that reliabilities of .70 or more are sufficient (Nunnally, 1978; Stauffer & Pehrsson, 2012).

5.3.4 Psychologists Attitudes towards Complementary and Alternative Therapy (PATCAT)

Wilson et al. (2011) developed an 11-item PATCAT questionnaire to measure a professional sample of practicing psychologists. Designed to capture three sub-scales: (1) perceived importance of knowledge about available therapies; (2) attitudes towards integration with psychological practice; and (3) concerns about associated risk of use in

clinical settings, it was an appropriate measure to explore current attitudes towards clinical utilisation of mindfulness based therapies.

In the current study, 10 items were selected and included in the questionnaire with a range from each sub-section: “Practicing therapy professionals (psychologists, counsellors, psychotherapists) should be able to advise their clients about commonly used complementary therapy methods” (Importance of knowledge); “Clinical care should integrate the best of conventional and complementary practices” (Attitudes towards integration); and “Complementary medicine represents a confused and ill-defined approach” (Perceived risks) (see Appendix I for a full list of items). These were answered using a seven-point Likert scale ranging from: 1 (*strongly disagree*) to 7 (*strongly agree*).

The scores were summed for each statement with totals ranging from 7 to 70, with a higher score demonstrating stronger agreement with the proposed competencies required when utilising complementary therapies in practice. Findings from the initial design of the measure supported the reliability of the refined 11-item scale, and a reported Cronbach alpha = 0.89, sufficient for use in further studies such as the current research.

5.4 *Data Analysis*

5.4.1 *Quantitative Analysis*

The Statistical Package for the Social Sciences (SPSS) was used to analyse the quantitative data. Before the data was analysed, the raw data scores were manipulated for two of the measures. MCQ scores were reversed to ensure a higher score represented a stronger agreement. Twelve of the FFMQ-SF scores and four of the PATCAT scores required reversing before the scores could be summed. Reverse scoring was completed for questions FFMQ-7, FFMQ-8, FFMQ-10, FFMQ-11, FFMQ-12, FFMQ-13, FFMQ-14, FFMQ-15, FFMQ-16, FFMQ-17, FFMQ-18, and FFMQ-19. Reverse scoring for PATCAT questions, CAT-7, CAT-8, CAT-9, CAT-10 (perceived risk sub-scale). Following this, the sum for each participant was totalled giving an indication of level of personal mindfulness. The total scores for ‘Mindfulness Knowledge’ and MCQ were also totalled for each participant then used for further analyses.

Data for 'length of practice' in their profession was transformed into categorical data to fit the requirements for ANOVA testing. Categories were generated as follows: 1=1-5 years, 2=6-10 years, 3=11-15 years, 4=16-20 years, 5=21-25 years, 6=26-30 years, 7= >31 years practicing. Challenges with questionnaire design meant that 'Place of Practice', 'Practice Group', and 'Traditional Therapy Choice' were grouped into meta-categories to reduce the significant variability in responses. Those which were closely related to one another were grouped together.

Several statistical analyses were used to determine whether any correlations or differences occurred between the measures and demographic statistics (See Appendix J).

Chapter 6

Results

This chapter presents the results of the study. First descriptive statistics are presented, followed by a breakdown of each mindfulness measure (including subscales). Subsequently, demographic and client practice variables are broken down with correlations or relationships for each measure.

Descriptive Statistics

6.1 *Dichotic Questions ‘Mindfulness Knowledge’*

The ‘Mindfulness Knowledge’ questionnaire contained three dichotic questions with the choice to elaborate ‘Have you ever learnt about mindfulness therapies?’ (Mi7a), ‘Do you believe being mindful can improve your daily life outside of your professional environment?’ (Mi8a), and ‘If your knowledge on mindfulness therapies was greater, would you consider using it in your clinical application?’ (Mi9a) (refer to Appendix C).

Table 1a provides the descriptive statistics. As shown, nearly all (93%) had learnt about mindfulness therapies before, while Table 1b provides the descriptive statistics for where their knowledge was acquired. All of the participants who answered (100%) believe that mindfulness has the ability to improve daily life outside of their professional environment, and over three quarters (91%) of those who answered would consider using mindfulness in clinical applications if their knowledge was greater.

Table 1a

Descriptive statistics for 'Mindfulness Knowledge' dichotic questions Mi7a, Mi8a, and Mi9a.

Question	Response	Frequency	Percent	Valid Percent
Mi7a	Yes	49	92.5	92.5
	No	4	7.5	7.5
Mi8a	Yes	51	96.2	100.0
	No	0	.	.
Mi9a	Yes	42	79.2	91.3
	No	4	7.5	8.7

Table 1b

Descriptive statistics for 'Mindfulness Knowledge' questions Mi7b.

Source	Frequency	Valid Percentage
University	3	6.3
Professional Development Workshop	22	45.8
Colleagues	5	10.4
Self Interest	13	27.1
Other	5	10.4

6.2 Mindfulness Measures

Table 2 provides an overview of the means, standard deviations, range, and number of participants for each of the mindfulness measures. As shown in the table, participants scored moderately in the mindfulness knowledge questions, indicated specifically by the mean score. Overall high mean scores were shown for 'Mindfulness Knowledge', FFMQ-SF, PATCAT, and the MCQ.

Table 2

Means, Standard Deviations, Score Range, and number of Participants Data of Research Variables

Measure	Scale (Score Range)	Mean	SD	Participants (N)	Cronbach's alpha
Mindfulness Knowledge	Mindfulness Questionnaire (min=12, max=25)	18.9	2.60	N=53	.261
Mindfulness (FFMQ-SF)	Personal Mindfulness (min=73, max=112)	94.9	9.34	N=50	.861
Competencies (MCQ)	Mindfulness Competency Measure (min=41, max=80)	59.6	9.89	N=45	.953
Attitudes (PATCAT)	Attitude towards Complementary and Alternative Therapy (min=23, max=68)	49.2	9.75	N=47	.921

6.2.1 PATCAT Sub-scales

Descriptive statistics were obtained for each of the three sub-categories within the PATCAT questionnaire. Table 3 shows the minimum and maximum scores for sub-category, the mean, and standard deviations. The mean score for perceived importance of 'knowledge' was 4.97 ($SD= 1.22$). The mean score for attitudes towards 'integration' was 5.46 ($SD= .96$), and the mean score for perceived 'risks' was 4.48 ($SD= 1.08$).

Table 3

Means, Standard Deviations, Score Range, and number of Participants Data for PATCAT sub-scale variables

	N	Minimum	Maximum	Mean	Std. Deviation
PATCAT 'Knowledge'	49	2.00	7.00	4.97	1.22
PATCAT 'Integration'	48	2.67	7.00	5.46	.996
PATCAT 'Risk'	48	1.50	7.00	4.48	1.09

6.3 Mindfulness, Knowledge, Attitude, and Competency Variables

To assess the linear relationship between each of the four measures, (PATCAT, MCQ, FFMQ-SF, and ‘Mindfulness Knowledge’) a bivariate Pearson’s correlation coefficient (r) was calculated. Prior to calculating r , the assumptions of normality, linearity and homoscedasticity were assessed, and found to be supported for all four of the measures. Pearson’s correlation data for each of the measures shown in Table 4 indicated both negative and positive relationships, but the strength of each relationship was weak and non-significant.

Table 4

Results showing a Pearson’s r correlations between the FFMQ-SF, PATCAT, MCQ, and Mindfulness Knowledge.

Measure		Mindfulness (FFMQ-SF)	Competencies (MCQ)	Attitudes (PATCAT)	Mindfulness Knowledge
Mindfulness (FFMQ-SF)	Sig. (2-tailed)	.	.804	.922	.571
Competencies (MCQ)	Sig. (2-tailed)	.	.	.413	.159
Attitudes (PATCAT)	Sig. (2-tailed)491

To assess the linear relationship between Participant Age and the PATCAT, MCQ, Mindfulness Knowledge, and FFMQ-SF, a Kendall’s Tau-B was used. Prior to calculating r , the assumptions of normality, linearity and homoscedasticity were assessed, and normality was violated for all four of the measures against age. Thus, a Kendall’s Tau-B for non-parametric data was better fitted to analyse the measures. As shown in Table 5, Kendall’s tau-b for FFMQ-SF, MCQ, PATCAT, and Mindfulness Knowledge indicated both negative and positive correlations, and the strength of each relationship was weak and non-significant.

Table 5

Results showing a Kendall's Tau-B correlation between Participant Age and each measure.

Test	Participant Age	Mindfulness (FFMQ-SF)	Competencies (MCQ)	Attitudes (PATCAT)	Mindfulness Knowledge
Kendall's tau-b	Correlation Coefficient	.050	.189	-.096	-.059
Participant Age	Sig. (2-tailed)	.645	.101	.395	.586

Normality assumptions were not violated, so an independent sample *t* test was used to compare average scores of males and females for FFMQ-SF, PATCAT, MCQ, and Mindfulness Knowledge. Table 6 shows the results, which indicated no significant differences on any of the measures.

Table 6

Results of an Independent sample t-test on each measure according to Gender.

Measure	Gender	N	Mean	<i>t</i>	df	Sig. (2-tailed)	Cohen's <i>d</i>
Mindfulness (FFMQ-SF)	Male	14	92.2857	-1.242	48	.220	1.99
	Female	36	95.9167				
Competencies (MCQ)	Male	13	56.2308	-1.497	43	.142	.21
	Female	32	61.0313				
Attitudes (PATCAT)	Male	13	48.0769	-.508	45	.614	.87
	Female	34	49.7059				
Mindfulness Knowledge	Male	15	19.6000	1.226	51	.226	1.92
	Female	38	18.6316				

Normality assumptions were not violated, so an independent samples *t* test was performed to compare average scores for FFMQ-SF, PATCAT, MCQ, according to whether participants had learnt about mindfulness therapies previously or not.

The results presented in table 7 indicate participants who had previously practiced mindfulness ($M = 93.9, SD = 8.90$) scored significantly lower than those who had not previously practiced ($M = 106.0, SD = 5.48$), $t(48) = -2.62, p < .012$, two-tailed, $d = 0.158$. The *t* test for PATCAT and MCQ comparing the difference between mean scores and previous practice in mindfulness or not, were found to be non-significant.

Table 7

Results of an independent t-test on each measure according to previous mindfulness education.

Measure	Gender	N	Mean	<i>t</i>	df	Sig. (2-tailed)	Cohen's <i>d</i>
Mindfulness (FFMQ-SF)	Yes	46	93.9348	-2.624	48	.012*	1.38
	No	4	106.0000				
Competencies (MCQ)	Yes	41	59.8049	.345	43	.732	.97
	No	4	58.0000				
Attitudes (PATCAT)	Yes	43	49.0000	-.585	45	.562	1.70
	No	4	52.0000				

* $p < 0.05$

Normality assumptions were not violated, so a one-way between group analysis of variance (ANOVA) was used to investigate whether there were any significant differences according to Profession on all four mindfulness measures (FFMQ-SF, MCQ, PATCAT, Mindfulness Knowledge).

Table 8

Results of a one-way ANOVA on each measure according to Profession.

Measure	F	df	Sig. (2-tailed)	Cohen's d (η^2)
Mindfulness (FFMQ-SF)	1.396	49	.256	.20
Competencies (MCQ)	4.874	43	.006*	.27
Attitudes (PATCAT)	3.548	46	.022*	.20
Mindfulness Knowledge	.957	50	.421	.06

* $p < 0.05$

Table 8 provides the results of the ANOVA. As shown, there were no significant differences according to profession on the Mindfulness Knowledge or FFMQ-SF measures. However, there were significant differences on the MCQ, $F = (3, 40) = 4.87$, $p = .006$, $\eta^2 = .27$ (27% of the variability), and for PATCAT, $F = (3, 43) = 3.55$, $p = .022$, $\eta^2 = .20$ (20% of the variability), indicating scores were influenced by profession.

Normality assumptions were not violated, so an ANOVA was used to investigate whether there were any significant differences according to MCQ, PATCAT, Mindfulness Knowledge and 'Religious Affiliation'. The homogeneity of variance was violated for the FFMQ-SF measure, and thus a post-hoc test was performed with the Gabriel's procedure.

Table 9 provides the results for the ANOVA. As shown, there were non-significant differences according to religious affiliation on the Mindfulness Knowledge, FFMQ-SF, and MCQ measures. However, there was a significant difference on the PATCAT measure, $F = (3, 43) = 7.02$, $p = .001$, $\eta^2 = .33$ (33% of variability), indicating scores were influenced by religious affiliation.

Table 9

Results of a one-way ANOVA on each measure according to Religious Affiliation.

Measure	F	df	Sig. (2-tailed)	Cohen's d (η^2)
Mindfulness (FFMQ-SF)	2.267	49	.093	.129
Competencies (MCQ)	.152	44	.928	.011
Attitudes (PATCAT)	7.024	46	.001*	.329
Mindfulness Knowledge	1.709	52	.177	.095

* $p < 0.05$

Normality assumptions were not violated, so an ANOVA was used to investigate whether there were any significant differences according to FFMQ-SF, MCQ, PATCAT, Mindfulness Knowledge and 'Place of Practice'. Table 10 provides the results for the ANOVA. As shown, there were no significant differences according to place of practice on each of the measures.

Table 10

Results of a one-way ANOVA on each measure according to Place of Practice.

Measure	F	df	Sig. (2-tailed)	Cohen's d (η^2)
Mindfulness (FFMQ-SF)	1.350	49	.266	.107
Attitudes (PATCAT)	1.184	46	.332	.101
Mindfulness Knowledge	.781	51	.543	.062
Competencies (MCQ)	1.061	44	.388	.096

Normality assumptions were not violated, so an ANOVA was used to investigate whether there were any significant differences according to FFMQ-SF, MCQ, PATCAT, Mindfulness Knowledge and 'Length of Practice'. Table 11 provides the results for the ANOVA. As shown, there were no significant differences according to length of practice on each of the measures.

Table 11

Results of a one-way ANOVA on each measure according to Length of Practice.

Measure	F	df	Sig. (2-tailed)	Cohen's d (η^2)
Mindfulness (FFMQ-SF)	.519	48	.790	.069
Competencies (MCQ)	.293	43	.936	.045
Attitudes (PATCAT)	.623	45	.710	.088
Mindfulness Knowledge	.341	50	.911	.044

Normality assumptions were not violated, so an ANOVA was used to investigate whether there were any significant differences according to FFMQ-SF, PATCAT, Mindfulness Knowledge and 'Practice Group'. The homogeneity of variance was violated for the MCQ measure, and thus a post-hoc test was performed with the Gabriel's procedure. Table 12 provides the results for the ANOVA. As shown, there were no significant differences according to practice group on each of the measures.

Table 12

Results of a one-way ANOVA on each measure according to Practice Group.

Measure	F	df	Sig. (2-tailed)	Cohen's d (η^2)
Mindfulness (FFMQ-SF)	.604	.49	.616	.375
Competencies (MCQ)	.172	44	.915	.012
Attitudes (PATCAT)	.458	46	.713	.031
Mindfulness Knowledge	.647	51	.589	.039

Normality assumptions were not violated, so an ANOVA was used to investigate whether there were any significant differences according to FFMQ-SF, MCQ, PATCAT, Mindfulness Knowledge and 'Traditional Therapy Choice' when working with clients.

Table 13a

Results of a one-way ANOVA on each measure according to 'Traditional Therapy Choice'.

Measure	F	df	Sig. (2-tailed)	Cohen's d (η^2)
Mindfulness (FFMQ-SF)	.177	49	.970	.020
Competencies (MCQ)	5.471	44	.001*	.412
Attitudes (PATCAT)	.572	46	.721	.065
Mindfulness Knowledge	.525	51	.756	0.54

* $p < 0.05$

Table 13a provides the results for the ANOVA. As shown, there were no significant differences according to traditional therapy choice on the Mindfulness Knowledge, FFMQ-

SF, and PACAT measures. However, there was a significant difference on the MCQ measure, $F(5, 41) = 5.47, p = .001, \eta^2 = .41$ (41% of the variability), indicating scores were influenced by traditional therapy choice. Table 13b provides the descriptive statistics for MCQ scores according to traditional therapy choice.

Table 13b

Descriptive statistics showing MCQ mean scores according to 'Traditional Therapy Choice'.

Therapy Choice	N	Mean	SD
Primarily Psychodynamic	10	52.80	9.14
Primarily CBT	8	64.38	7.98
Eclectic Approach/ Mixed	11	57.45	8.61
Narrative	5	60.60	7.23
Includes Mindfulness	6	72.17	4.79
Other	5	54.60	8.14

Chapter 7

Discussion

7.1 Findings and Implications

Although the present research has a number of limitations [to be discussed in subsequent sections], a number of tentative assumptions can be drawn from the findings. This chapter will describe these by giving an overview of the findings relating to each measure; a comparison between each of the measures; and comparisons between each of the measures with various variables relating to practitioners personally, for example length of practice and profession. Limitations and future implications will follow, closing with concluding interpretations.

7.1.1 Mindfulness Measures

With respect to the first research goal, the knowledge and attitudes of mindfulness and its usage among a New Zealand psychotherapist population was revealed. Findings gave insight into the existing location of New Zealand psychotherapists' mindfulness, aligned with previous studies worldwide. Contrary to initial predictions, the sample was relatively knowledgeable about several aspects of mindfulness. It was presumed the lack of research incorporating mindfulness in New Zealand, was a reflection of a lack of theoretical knowledge and practical utilisation among practitioners. However, this may not be the case given the apparent knowledge-base of the present sample.

Overall, the sample had a tendency to be mindful in daily living. A higher score in the FFMQ indicates a stronger background in meditation practices, and thus level of personal mindfulness (Baer et al., 2006). Mindfulness has been described by Keane (2014) as a means of self-attunement, and enables the ability for individuals to attune to others. As this is vastly important among psychotherapists, it may be reason for the current samples level of mindfulness. When comparing scores with previous research using the same measure (in patients with fibromyalgia), the current psychotherapist population were significantly more mindful, further consistent with expected outcomes (Baer et al., 2006). These findings suggest New Zealand psychotherapists are in fact more open to mindfulness in general daily living, and accordingly more likely to apply these beliefs within their

practices. These assumptions insinuate that the sample were familiar with mindfulness practices and in line with hypotheses, should be somewhat knowledgeable about its applications.

Findings for proposed mindfulness competencies among New Zealand psychotherapists suggest a moderate to high level of agreement. These findings were comparable with Stauffer and Pehrsson's (2012) study using 'expert' professionals in the clinical use of mindfulness. These comparisons indicate New Zealand psychotherapists are similarly knowledgeable about utilising mindfulness within practice, as their 'expert' counterparts. Therefore, findings suggest that although mindfulness may not be readily incorporated into practitioners' daily practice, they feel competency standards must be met at a high level to appropriately use mindfulness. Additionally, recent research suggests that clients are seeking knowledge and guidance regarding various treatment options, encouraging the need for psychotherapists to be competent in many approaches in order to meet patients' needs (Wilson et al., 2011). These findings uncover current levels of knowledge surrounding mindfulness practice among New Zealand psychotherapists. Furthermore, they indicate that the therapeutic use of mindfulness is held in high regard, and must be incorporated whilst upholding a strict set of practice standards. Further investigation into specific areas relevant to New Zealand psychotherapists is of importance, and may be advantageous to explore.

Mindfulness was reportedly utilised by almost all participants, contrary to previous research expectations. Tasca et al. (2015) reported that clinicians do not always rely on research to inform their practices, or to determine their interventions. Interestingly, this may be the case for the current study as 93% of participants had learnt about mindfulness previously. The vast majority of respondents reported their knowledge was acquired through professional development workshops or self-interest, as opposed to University or alternative means. Findings suggest evidence of some deficiencies in university input about mindfulness. This gap may reduce the knowledge surrounding mindfulness until further education, such as workshops, are available to training psychotherapists. Previously, McKenzie et al. (2012) found medical students who received mindfulness education within their University curriculum, advocated mindfulness integration and utilisation within treatment, significantly more so than those who had no previous education. Further

research is required to determine whether shortfalls in mindfulness knowledge are due to deficits in tertiary education, or a lack of interest from the psychotherapist. Nevertheless, if mindfulness is integrated into the psychological university curriculum, it may improve dissemination and strengthen attitudes towards its use therapeutically. Additionally, participation bias may have skewed the current findings. Rosmarin, Green, Pirutinsky and McKay (2013) stated those who view therapies through an empirical lens tend to leave religion out of their scope, and thus see spirituality and/or religious beliefs as incompatible with their knowledge. Thus, those who had previously engaged with alternative and spiritual therapies, including mindfulness, may have been drawn to answering the questionnaire, meanwhile those who lacked interest failed to partake in the survey. However, these assumptions are tentative and require further investigation to be validated.

All of those who participated in the questionnaire believed mindfulness had the ability to improve daily life outside of their professional environment. This insight aligns with previous literature suggesting a deeper knowledge of mindfulness corresponds with more optimistic attitudes towards its use in daily living, and the ultimate improvement of personal well-being (Carmody & Baer, 2008). In accordance with predictions, nearly all of the psychotherapists reported they would consider using mindfulness in clinical applications if their knowledge were greater. This implies the current level of knowledge held was insufficient to some extent, and could be reason for underutilisation. Others have supported ideas that a lack of knowledge can lead to underutilisation among practitioners (e.g., Hipol & Deacon, 2013; McKenzie, et al., 2012). Consequently, it is fair to conclude that a greater dissemination of knowledge of mindfulness clinically, has the potential to increase application both personally and therapeutically.

Attitudes towards CAT and mindfulness were positive overall and higher than anticipated. Findings were also similar to those in Wilson et al.'s (2011) professional sample. Mindfulness studies have infiltrated Australian literature, suggesting their interests and attitudes towards CAT and mindfulness are more developed. Wilson et al. (2011) proposed an increase in utilisation of alternative medicines and therapies among the Australian public, could be motivation for the positive attitudes held towards CAT. Because of this, the current sample was expected to have poorer attitudes due to reduced access.

This was not the case. It has been further argued that mindfulness is the embodiment of the characteristics and attitudes effective therapists embrace, providing a possible rationale for the findings in the present study (Keane, 2014). Recommendation and use of mindfulness therapies, as an option for treatment, is reliant on the attitudes health professionals hold (McKenzie et al., 2012), further supporting the idea that theoretical and practical knowledge are significant predictors of attitudes mental health professionals hold. It appears New Zealand psychotherapists share similar attitudes towards CAT with Australian mental health professionals. Therefore, it would be of benefit to explore psychotherapists' attitudes towards CAT further, and compare Australian and New Zealand psychotherapists' interests of mindfulness integration within research and practice.

Findings for PATCAT subcategories were comparable with Wilson et al.'s (2011) study. Perceived importance for theoretical 'knowledge' about CAT and 'integration' within practice were held in high regard and stronger than those in Wilson et al.'s (2011) Australian study. Although these findings are supportive of a greater positivity towards CAT use, these attitudes towards its use are not reflected within New Zealand literature. Attitudes may be only one factor in determining clinical use, placing a greater significance on levels of knowledge surrounding utilisation of mindfulness practices. Psychotherapists strongly agreed with 'integration' aspects specifically, such as "a number of CAT approaches hold promise for the treatment of psychological conditions" (see Appendix C), demonstrating a promising outlook for the use of CAT within a mental health context in New Zealand. Little research has focussed specifically on integration of mindfulness into therapeutic practice (Dimijian & Segal, 2015). Thus, the current findings insinuate attitudes and beliefs surrounding its implication are strong, and tentatively support optimistic outlooks towards clinical integration of CAT. However, the lack of integration in reality could be a reflection of additional deficiencies within mindfulness practices that require further investigation in order to improve utilisation.

Potential 'risk' associated with the use of CAT was low, supporting strong positive attitudes towards clinical use. Mental health professionals place emphasis on the use of evidence based approaches, which may not encompass mindfulness (Wilson et al. 2011). Boudette (2011, p. 109) reflected on therapy sessions with alternative therapy use describing client's views, "...many are turned off by the word 'mindfulness'". For this reason

it was expected that psychotherapists would consider the use of alternative therapies to come with a level of professional risk. Contrary to initial ideas, the findings were not indicative of this. Risks associated with mindfulness use were viewed as relatively inconsequential. It is likely New Zealand psychotherapists' believe risks associated with CAT use are minimal, and are more likely to incorporate mindfulness within therapy. Further research is required to determine what extent risks may be associated with underutilisation.

In summary, the aim of this study was to explore New Zealand psychotherapist's knowledge, attitudes, and beliefs towards mindfulness using various measures. High levels of personal mindfulness, positive attitudes towards CAT, as well as strong levels of agreement with proposed mindfulness competencies. These findings provided promising insight towards mindfulness use among New Zealand psychotherapists. Interestingly, perceived mindfulness competencies were comparable to international studies, suggesting some overlap in practicing standards and expectations involving mindfulness worldwide. It could be of interest to explore variations between psychotherapists internationally, to determine whether there is a set standard of practice in the therapeutic use of alternative therapies. Contrary to initial assumptions, CAT is viewed with an encouraging standing among New Zealand psychotherapists providing a unique perspective on the current outlook of mindfulness therapeutically. Positive attitudes and beliefs are suggestive of alternative factors influencing the underutilisation of mindfulness therapeutically, and possibilities of a greater significance in theoretical knowledge. These initial findings give promising insight into the status of mindfulness and its use psychologically in New Zealand.

7.1.2 Mindfulness Measure Comparisons

Interestingly, there were no significant relationships between any of the measures. Interactions were anticipated between psychologist's attitudes towards CAT, mindfulness levels or perceived competencies. Personal mindfulness experienced by New Zealand practitioners appears to be independent of their open-mindedness towards alternative therapies, and their expectations surrounding mindfulness competencies in clinical applications. Inexperience with mindfulness therapeutically may indicate their attitudes towards its use and expectations for competencies are hindered, as suggested by Wilson et al. (2011). Thus, utilisation may in fact be associated with experiential knowledge or

alternative factors more aligned with clinical practice. Some of these factors are explored and discussed in the following sections.

Age did not influence mindfulness knowledge or attitudes. It was thought that older psychotherapists would have poorer attitudes towards the use of CAT or mindfulness, resulting from stronger beliefs towards traditional therapies. For instance, the number of years before 'expected' retirement may impact decisions relating to therapy choice. Alternatively, the perceived time required to learn mindfulness to incorporate it into therapy effectively, may also influence decisions relating to mindfulness application. Although Lang (2013) and Miller et al. (1995) identified the cost effectiveness and ease associated with learning mindfulness for patients, complexities in learning mindfulness increase when intending to teach and practice it therapeutically (Singh et al., 2008). Furthermore, a standardised teaching manual for psychotherapists is yet to be identified in the literature (Singh et al., 2008). Most of the participants were aged between 56 years and 65 years old and were likely to have engaged with mindfulness previously, indicating a possible sample bias. However, tentative speculations could suggest age has no considerable influence on quality of knowledge and personal attitudes towards mindfulness, or beliefs surrounding competencies. It may be of interest to investigate variations between ages when mindfulness knowledge was first acquired, and the differences surrounding expectations of therapeutic mindfulness applications.

It was initially thought that women could be more perceptive of their thoughts and be more attentive to moment-to-moment experiences, reflected by their personal mindfulness levels. However, gender was not found to influence any of the mindfulness measures. Participation within previous mindfulness studies report significant gender disparities (Mapel, 2012; McKenzie et al., 2012; Wilson et al., 2012; Wilson & White, 2007). Thus, the overall high levels of mindfulness experienced may only be reflective of a female dominant sample, and must be considered when interpreting findings. The current findings concur with McKenzie et al. (2012), who found gender was not significant when investigating knowledge of mindfulness. The current findings suggest psychotherapists in general (both male and female) were equally mindful. Furthermore, gender did not influence proposed competencies, supporting assumptions that educational or professional backgrounds are more likely to determine expectations within clinical

practice. Mental health professionals are assumed to have been trained similarly with no inequality relating to gender, therefore, comparisons with other groups (for example, medical practitioners) may be more significant to explore. Further inclusion of men within mindfulness studies may be useful in extending generalisability of the findings more accurately. However, it is fair to assume that in this case, gender does not predict knowledge of or attitudes toward mindfulness or how it should be applied clinically.

Previous education in mindfulness had an influence on practitioners' mindfulness in daily life. However, contrary to initial predictions, those with no previous education had greater personal mindfulness. Findings by Carmody and Baer (2008), McKenzie et al. (2012), and Singh et al. (2008), found mindfulness experience was related to mindfulness use in daily life. Thus, it was assumed that those who practiced or engaged in it previously would have higher levels of mindfulness. However, this was not the case. Interestingly, Kholocci (as cited in Keane, 2013) reported that experience with mindfulness did not influence personal levels of mindfulness. Furthermore, it was reported that differences in intensity, diversity, and quality of previous mindfulness practice is not reflected by the duration of one's practice (Keane, 2013). This suggests that although participants reported 'previous education', uncertainty lies within the ability to accurately quantify what this means in terms of theoretical and experiential knowledge. Further research has stated that the FFMQ may not be sensitive to more complex conceptualisations of mindfulness (Keane, 2013). It is possible those same reasons apply to the findings in the present study. Further research is required to make reasonable assumptions about previous mindfulness education, and how it relates to knowledge and attitudes of mindfulness use therapeutically.

Additionally, these unexpected outcomes may be due to inexperience with mindfulness. An individual who had no education of mindfulness, and thus never practiced it personally, may not truly understand the experiences associated with being mindful on a daily basis. For example, "I find it difficult to stay focussed in the present moment" (see Appendix D), may prove challenging to answer without previous attempts to achieve mindfulness. Consequently, those who had no education in mindfulness may have inflated their experiences of mindfulness, and thus their response with what they would prefer to experience, rather than what is experienced in reality. Several methodological limitations

may also be reason for the findings, such as significant disparities with the number of participants previously educated in mindfulness. Responses may have also been conflicted due to the subjective interpretation of the questions within the measure. Furthermore, those experienced in mindfulness had most likely encountered the measure previously, whereas others would have been blind to the measures intentions. Finally, the extent of 'learning' was not clearly defined, meaning interpretations of the question itself may have varied between participants.

In summary, there was no interaction between each of the mindfulness measures, or with gender or age. Previous mindfulness education was found to influence levels of personal mindfulness with results opposing predictions. Although these findings were not expected, several assumptions could be drawn as reasons for the current outcomes. A number of limitations within the design of the study may have led to inequalities within the sample, and an inability to accurately capture the anticipated outcomes for each variable. Findings suggest alternative variables are more influential in providing insight into how knowledge and attitudes towards clinical mindfulness are formed in New Zealand. However cautious, the current findings show promise for upcoming research and give reason for future studies.

7.1.3 Measures and Practitioner Variations

Several ANOVAs were used to investigate the impact various demographic factors had on each measure; including profession, length of practice, religious affiliation, ethnicity, place of practice, practice group, and traditional therapy choice.

In agreement with initial hypotheses, 'profession' had an impact on perceived mindfulness competencies in clinical settings, and attitudes towards CAT. Various professions are indicative of differing educational pathways and levels of 'formal' education. Pelling (2007) stated that expectations in competencies or areas of importance when practicing vary by profession choice. This may also be the case for differing specialisations within psychotherapy fields, such as those within the current study. Furthermore, expectations surrounding professional development may vary between occupations, creating distinctions between source and quality of mindfulness knowledge. Alternatively, variations may reflect hesitation among professionals to increasing their

workload by undertaking additional training and professional development (Wilson et al., 2011). These findings support the assumption that attitudes towards CAT could be shaped by differing expectations within mental health professions. The extent of these variations need to be explored further.

Religious affiliation influenced attitudes towards CAT, but not perceived competencies and knowledge. It was of little surprise that religious affiliation had a link with attitudes towards the spiritually-based CAT, as Curlin et al. (2009) stated spirituality and religion are closely aligned. Mindfulness has been found to be culturally compatible with every nationality and culture, thus supporting its links with religion (Charters, 2013). Furthermore, Curlin et al. found physicians' willingness to incorporate CAT was affected by religious and spiritual characteristics. Another study has found CAT usage is more prevalent in areas where religious observance is higher, suggesting a greater use of CAT linking to positive attitudes towards its use (Hughes, 2006). In addition, Rosmarin et al. (2013) stated those who view spirituality and religion as personally important, may better recognise the domain of mindfulness. These studies are supportive of the current findings, suggesting those who are affiliated with a religion may feel more in tune with a spiritual side, and thus more open to using CAT therapeutically. Therefore, the practice of mindfulness clinically may in fact be viewed more openly by those of particular religious orientations. However tentative these assumptions may be, the findings are certainly indicative of religious affiliation having some influence on attitudes towards CAT. Further research is required to explore how these findings specifically relate to New Zealand, especially given it is a relatively secular society, and how applicable they are to the use of mindfulness in clinical practice.

Place, type of practice, and number of years practicing were not significantly related to mindfulness. Thus, where you practice, how long for, and the dominant clientele group do not influence personal knowledge, attitudes towards, or the proposed competencies surrounding mindfulness and its clinical application. Hipol and Deacon (2013) found choice of treatment was determined by the level of knowledge held by psychotherapists. It was thought psychotherapists in private practice may follow a set of guidelines and hold attitudes toward alternative therapies that differed from psychotherapists working in government run organisations, due to differences in their scope of practice. However, the

current findings suggest variability in work place and clientele does not necessarily influence the way one chooses to treat a client, nor their competencies surrounding therapeutic applications. Additionally, there was no evidence to suggest the number of years one had practiced influenced knowledge and attitudes towards mindfulness, or their expectations of practicing competencies. It was expected generational differences would contribute to some noteworthy differences, due to a more informed perspective in modern generations (Wilson et al., 2011). Keane (2013) and Hemanth and Fisher (2014) suggested mindfulness practice may provide a useful and important resource in the continued professional development of therapists, as well as an adjunct to psychotherapy training. The current findings indicate psychological professionals do keep up with new and emerging fields and practices, irrelevant of the number of years practicing, suggesting knowledge of mindfulness is stronger than anticipated. Tasca et al. (2015) stated psychotherapists are interested in research that speaks to them personally or their therapeutic relationships, but also show interest in what their clients may bring to therapy (Tasca et al., 2015). This could suggest interactions between practitioners and patients influence mindfulness knowledge, an area requiring further investigation. Continued education is important within all professional fields throughout the duration of occupation, and may be reason for the current findings. It tentatively implies that psychotherapists are keeping up with advances in the literature, reducing disparities in attitudes and knowledge surrounding psychotherapies, and in this case mindfulness.

‘Traditional Therapy Choice’ was found to influence competencies surrounding mindfulness use. Findings indicated those who currently include mindfulness within their therapy showed stronger support for proposed competencies, more so than participants with alternative therapy choices. Stauffer and Pehrsson (2012) stated an understanding in how to integrate mindfulness methods into everyday life and practice is highly important. Thus, if mental health professionals did not appropriately train in mindfulness use themselves, they will inevitably and unknowingly leave out elements essential to mindfulness practice (Stauffer & Pehrsson, 2012). Accordingly, it was of little revelation that those who readily incorporate mindfulness into their therapy, strongly advocated a comprehensive understanding of proposed competencies in clinical practice. The current findings speak to the aims of this study, supporting the impression that those who are

knowledgeable about mindfulness, and in this case readily incorporate it therapeutically, are more likely to have stronger agreement with 'expert' proposed mindfulness competencies. This in turn, solidifies the assumption a lack of knowledge among non-mindfulness users can unknowingly lead to reduced or improper use of mindfulness clinically.

In summary, knowledge and attitudes towards the use of mindfulness therapeutically, and agreement with proposed competencies was influenced by various factors. Significantly, profession, religious affiliation, and traditional therapy choice were found to influence psychotherapists' attitudes toward alternative therapies, as well as agreement with expertly proposed competencies of mindfulness use clinically. However, alternative findings suggest there could be some impairment surrounding levels of knowledge as those who were engaging with mindfulness or followed certain religions, were most positive and open about incorporation and use of mindfulness. This implicates continued education and quality of both experiential and theoretical knowledge as important factors in the ongoing incorporation of mindfulness therapeutically.

7.2 Limitations

7.2.1 Procedural Limitations

Firstly, difficulties with recruitment lead to small sample size (N= 53), and significant gender disparities contributed to issues regarding generalisability of the findings. Recruitment was mainly from online survey advertisements (discussed previously) within another research study, possibly leading to reduced participation. Direct engagement with individuals, such as sending the questionnaire via personal emails, could improve future dissemination and response rates. This would benefit future studies in accessing a wider range of participants throughout New Zealand. By exploring a wider range of practicing psychotherapists, there was hope both those who are regular practitioners of mindfulness, as well as those who are not knowledgeable about mindfulness, take part in the study. The limited number of participants may explain some of the non-significant findings from the majority of analyses. For example, very few participants reported 'no' previous engagement with mindfulness. However, as an initial exploratory study, the sample size was sufficient.

Secondly, it may be of some benefit to include the 'number of years practicing mindfulness' in future research questionnaires. The present study explored the number of years practicing, but not mindfulness specifically. Including this option may provide a clearer insight surrounding the quality of mindfulness knowledge and how this interacts with attitudes towards its use clinically, and professional competencies. Furthermore, future research could be extended to include a broader range of professions and levels of professional development. These include both psychological and medical students, as well as alternative professions which utilise mindfulness therapeutically, such as midwives and nurses. These additions may give insight into the scope of mindfulness use in practice within New Zealand, and attitudes towards its application throughout a range of therapeutic contexts.

Thirdly, difficulties occurred during data analysis when categorising some variables from qualitative responses to numerical scales. Meta-categories formed for 'practice group' and 'area of work' proved challenging as the majority of participants specified more than one dominant group or area. Significant variations in responses led to the formation of generalised categories that may not have accurately captured each individual's intended response. In future, it would be beneficial to restrict participants with a pre-arranged set of responses that allows for a more succinct representation of their work, improving the accuracy of statistical analyses. Alternatively, including a quantitative aspect may give a deeper understanding of psychotherapist's responses and experiences with mindfulness.

7.2.2 Variable Limitations

Each measure used in this study was recently developed and is yet to be extensively validated by further research. Construct validity is reliant on definitions of mindfulness used (Singh et al., 2008). Thus, it is important to ensure the definition for each mindfulness measure is consistent, ensuring reliable participant interpretations.

As Stauffer and Perhsson (2012) stated, the MCQ is a proposed set of competencies designed in America and not a set standard. Although this measure was considerably useful, a refined set of standards within a realm of competencies applicable to New Zealand must be crafted. A focus on ethical considerations and practices unique to New Zealand may be more appropriate when researching the current sample. Thus, extensions of the

MCQ could incorporate a broader and more applicable measure of perceived competencies within New Zealand.

Very little research has explored attitudes towards CAT, and is restricted to studies within Australia. The development of the PATCAT effectively utilised a sample of health professionals facing increases in the use of CAT within their practice. However, the measure has limits noted in previous research, which subsequently requires further validation. For example, the definition of CAT has proven problematic throughout the literature, particularly with classifications encompassing a varying range of treatments and therapies (Wilson & White, 2007). Creating a measure that is standardised with stringent definition guidelines from previous research may improve the measure's specificity.

7.3 Conclusion

The present research offers an insight into psychotherapists' knowledge, attitudes, and beliefs surrounding mindfulness and its use in New Zealand. Mindfulness offers important clinical advantages, which are wellness-based and subsequently non-invasive to the patient, with non-compliance stated as its greatest risk (Lang, 2013; McKenzie, 2012). Thus, it is significantly important to investigate how mindfulness is being received among New Zealand psychotherapists, and whether a lack in knowledge may be reason for underutilisation of this immensely beneficial tool.

Benefits from mindfulness use extend from patient outcomes, to improvements in therapeutic relationships, as well as improvements in clinician well-being. The present study found mindfulness is actually viewed as considerably beneficial in both personal and professional practice. These promising findings support highly positive attitudes towards CAT, and interest in alternative therapies within the New Zealand psychological context. Furthermore, the exceptionally high levels of personal mindfulness experienced by the current sample of psychotherapists were encouraging, as well as associations between demographics and mindfulness measures.

It was initially assumed that a lack of literature in New Zealand meant mindfulness was viewed undesirably and consequently underutilised in therapeutic practice. However, it seems a lack of theoretical and experiential knowledge surrounding mindfulness may be cause for reduced application, suggesting deficits in educational curriculums. Previous

research provides evidence to support the idea that increased application of mindfulness within University curriculums significantly improves the depth of mindfulness knowledge (McKenzie et al., 2012). Furthermore, attitudes towards its future application were enhanced significantly. This insight demands a need to expand New Zealand university curriculums to include mindfulness, improving access and dissemination of knowledge that can be used therapeutically. Psychotherapists in New Zealand have a positive attitude towards the use of mindfulness within their personal and professional lives. What are lacking are the tools to improve experiential and theoretical knowledge. Differences between knowledge, attitudes, and beliefs will always exist, but improvements in dissemination of therapeutic mindfulness will rapidly increase use in research and practice within New Zealand.

This research is intended to be used by researchers, clinicians, and education providers who wish to gain further insight into the knowledge and attitudes New Zealand psychotherapists have towards mindfulness. The findings provide direction for understanding how mindfulness is situated within a professional population, and factors which may contribute to knowledge, attitudes, and applications. Although not immediately applicable to clinical practice, it was intended these findings spark interest in those uncertain about the use of mindfulness therapeutically, and provide some level of curiosity to encourage clinicians to seek experience and further knowledge in mindfulness.

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Appendix A: NZAC Access Request

Antony McFelin
New Zealand Association of Counsellors
PO Box 25154
Wellington 6146

Dear Mr McFelin

We, Dr Karen Frewin² and Dr Natasha Tassell-Matamua are currently undertaking an ethically approved research project concerned with spirituality in psychology, psychotherapy and counselling. Through an on-line survey we wish to investigate knowledge, attitudes and beliefs towards spirituality amongst health practitioners in New Zealand (Ethical Approval Southern A, Application15/40).

Research shows that many people endorse spirituality as personally important, and indicate they have had at least one 'spiritual experience' in their life. These experiences often lead to a variety of life changes and psychological shifts in those who have them. Current literature illustrates that practitioners often feel ill-prepared to address client presentations of a spiritual nature, and that discussion of spiritual issues is largely absent in most therapy and psychological training programmes.

There is limited research into the attitudes and practices of professional psychologists, psychotherapists and counsellors, toward spiritual aspects of their client's lives, even though there are calls for distinct spirituality training for these helping professions. Our project seeks to examine the local meaning of spirituality, the role of spirituality in practitioner/client interactions, and concerned directly with spirituality, the present needs of practitioners in educational training programmes. Findings will not only illuminate the current practices of a body of health practitioners, but will also contribute to the development of 'spiritual competency' guidelines for

² Dr Frewin is a registered psychologist and a senior lecturer in counselling and guidance with Massey University Institute of Education. Dr Tassell-Matamua is a lecturer with Massey University School of Psychology, and has researched different forms of spiritually transformative experiences over the past few years.

health practitioners in New Zealand, alongside directly informing the teaching of practitioners through Massey University's professional psychology and counselling programmes.

We wish to invite practicing registered psychologists, and practicing psychotherapists and counsellors, who are also current members of a recognised professional body, to take part in this research, via our online survey.

In this regard, we are writing to request permission to access your email database so that members can access the survey. We would like to send you an email with an accompanying link to the survey, and ask that you send the email to your practicing members. We wish to send the research email as soon as possible, giving members approximately two to three weeks to respond, so that results are available to us during November 2015. Depending on response rates, we may ask you to send a follow up reminder email shortly before the closing date of the survey.

If you would like to have a look at the survey before considering our request, please click on the link here:

[Spirituality in Psychology, Psychotherapy, and Counselling.](#)

It will be very helpful if you would let us know as soon as possible if you can accommodate our request.

Many thanks

Yours sincerely

Karen Frewin, PhD
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Appendix B: NZPB Access Request

Anne Goodhead
New Zealand Psychologists Board
PO Box 10-626
Wellington 6143

Dear Ms Goodhead

We, Dr Karen Frewin³ and Dr Natasha Tassell-Matamua are currently undertaking an ethically approved research project concerned with spirituality in psychology, psychotherapy and counselling. Through an on-line survey we wish to investigate knowledge, attitudes and beliefs towards spirituality amongst health practitioners in New Zealand (Ethical Approval Southern A, Application15/40).

Research shows that many people endorse spirituality as personally important, and indicate they have had at least one 'spiritual experience' in their life. These experiences often lead to a variety of life changes and psychological shifts in those who have them. Current literature illustrates that practitioners often feel ill-prepared to address client presentations of a spiritual nature, and that discussion of spiritual issues is largely absent in most therapy and psychological training programmes.

There is limited research into the attitudes and practices of professional psychologists, psychotherapists and counsellors, toward spiritual aspects of their client's lives, even though there are calls for distinct spirituality training for these helping professions. Our project seeks to examine the local meaning of spirituality, the role of spirituality in practitioner/client interactions, and concerned directly with spirituality, the present needs of practitioners in educational training programmes. Findings will not only illuminate the current practices of a body of health practitioners, but will also contribute to the development of 'spiritual competency' guidelines for health practitioners in New Zealand, alongside directly informing the teaching of practitioners through Massey University's professional psychology and counselling programmes.

³ Dr Frewin is a registered psychologist and a senior lecturer in counselling and guidance with Massey University Institute of Education. Dr Tassell-Matamua is a lecturer with Massey University School of Psychology, and has researched different forms of spiritually transformative experiences over the past few years.

We wish to invite practicing registered psychologists, and practicing psychotherapists and counsellors, who are also current members of a recognised professional body, to take part in this research, via our online survey.

In this regard, we are writing to request permission to access your email database so that members can access the survey. We would like to send you an email with an accompanying link to the survey, and ask that you send the email to your practicing members. We wish to send the research email as soon as possible, giving members approximately two to three weeks to respond, so that results are available to us during November 2015. Depending on response rates, we may ask you to send a follow up reminder email shortly before the closing date of the survey.

If you would like to have a look at the survey before considering our request, please click on the link here:

[Spirituality in Psychology, Psychotherapy, and Counselling.](#)

It will be very helpful if you would let us know as soon as possible if you can accommodate our request.

Many thanks

Yours sincerely

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Appendix C: NZAP Access Request

Nikky Winchester
New Zealand Association of Psychotherapists
PO Box 57025 Mana
Porirua 5247

Dear Ms Winchester

We, Dr Karen Frewin⁴ and Dr Natasha Tassell-Matamua are currently undertaking an ethically approved research project concerned with spirituality in psychology, psychotherapy and counselling. Through an on-line survey we wish to investigate knowledge, attitudes and beliefs towards spirituality amongst health practitioners in New Zealand (Ethical Approval Southern A, Application15/40).

Research shows that many people endorse spirituality as personally important, and indicate they have had at least one 'spiritual experience' in their life. These experiences often lead to a variety of life changes and psychological shifts in those who have them. Current literature illustrates that practitioners often feel ill-prepared to address client presentations of a spiritual nature, and that discussion of spiritual issues is largely absent in most therapy and psychological training programmes.

There is limited research into the attitudes and practices of professional psychologists, psychotherapists and counsellors, toward spiritual aspects of their client's lives, even though there are calls for distinct spirituality training for these helping professions. Our project seeks to examine the local meaning of spirituality, the role of spirituality in practitioner/client interactions, and concerned directly with spirituality, the present needs of practitioners in educational training programmes. Findings will not only illuminate the current practices of a body of health practitioners, but will also contribute to the development of 'spiritual competency' guidelines for health practitioners in New Zealand, alongside directly informing the teaching of practitioners through Massey University's professional psychology and counselling programmes.

⁴ Dr Frewin is a registered psychologist and a senior lecturer in counselling and guidance with Massey University Institute of Education. Dr Tassell-Matamua is a lecturer with Massey University School of Psychology, and has researched different forms of spiritually transformative experiences over the past few years.

We wish to invite practicing registered psychologists, and practicing psychotherapists and counsellors, who are also current members of a recognised professional body, to take part in this research, via our online survey.

In this regard, we are writing to request permission to access your email database so that members can access the survey. We would like to send you an email with an accompanying link to the survey, and ask that you send the email to your practicing members. We wish to send the research email as soon as possible, giving members approximately two to three weeks to respond, so that results are available to us during November 2015. Depending on response rates, we may ask you to send a follow up reminder email shortly before the closing date of the survey.

If you would like to have a look at the survey before considering our request, please click on the link here:

[Spirituality in Psychology, Psychotherapy, and Counselling.](#)

It will be very helpful if you would let us know as soon as possible if you can accommodate our request.

Many thanks

Yours sincerely

Karen Frewin, PhD	Natasha Tassell-Matamua, PhD
Institute of Education	School of Psychology
Private Bag 11222	Private Bag 11222
Massey University	Massey University
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Appendix D: NZAC and NZPA Newsletter Advertisement

RESEARCH PROJECT SEEKS YOUR SUPPORT

Dr Karen Frewin and Dr Natasha Tassell-Matamua would like to invite registered psychologists to participate in a national survey concerned with “Spirituality in Psychology, Psychotherapy and Counselling: Investigating Knowledge, Attitudes and Beliefs Towards Spirituality Amongst Health Practitioners in New Zealand”. The research is being conducted through Massey University. Karen is a registered psychologist and a senior lecturer in counselling and guidance with the Institute of Education. In her counselling and supervision practice, she has talked with many clients about spiritual experiences and/or the difficulties some clients and practitioners face when wanting to talk about spiritual beliefs. Natasha is a lecturer with the School of Psychology, and over the past few years has researched different forms of spiritually transformative experiences. This research project will extend that work, by developing a broader profile of practitioner’s understandings of spirituality, and furthering awareness of the types of knowledge health practitioners are seeking in order to address matters of spirituality.

The link below will take you to an online information sheet. After reading this you can decide whether or not you would like to continue with the survey questionnaire. Karen and Natasha would like to hear from as many practising psychologists as possible and very much look forward to your response.

Follow the link HERE: <http://tinyurl.com/q5odl88>

CLOSING DATE OF SURVEY: 20 November 2015

Appendix E: Information Cover Sheet



Spirituality in Psychology, Psychotherapy and Counselling: Investigating Knowledge, Attitudes and Beliefs Towards Spirituality Amongst Health Practitioners in New Zealand

INFORMATION SHEET

Who is doing this research?

The research is being conducted through Massey University by Dr Karen Frewin and Dr Natasha Tassell-Matamua. Karen is a registered psychologist and a senior lecturer in counselling and guidance with the Institute of Education. In her counselling and supervision practice, she has talked with many clients about spiritual experiences and/or the difficulties some clients and practitioners face when wanting to talk about spiritual beliefs. Natasha is a lecturer with the School of Psychology, and has researched different forms of spiritually transformative experiences over the past few years. This research will extend that work, by developing a broader profile of practitioner's understandings of spirituality, and furthering awareness of the types of knowledge health practitioners are seeking in order to address matters of spirituality.

What is this research about?

We are interested in exploring the knowledge, attitudes, and beliefs of practicing psychologists, psychotherapists, and counsellors, about spirituality. Research shows many people endorse spirituality as personally important, and indicate they have had at least one 'spiritual experience' in their life. These experiences often lead to a variety of life changes and psychological shifts in those who have them. Current literature illustrates that practitioners often feel ill-prepared to address client presentations of a spiritual nature, and acknowledge that discussion of spiritual issues is avoided in therapy training programmes, with a general neglect of this area in psychological trainings and practice. There is limited research into the attitudes and practices of professional psychologists, psychotherapists and counsellors, toward spiritual aspects of their client's lives, and there are calls for distinct spirituality training for these helping professions. This project seeks to hear from New Zealand practitioners about the concept of spirituality. We want to know what spirituality means to you, the role of spirituality in practitioner/client interactions, and your thoughts concerning the current absence of training and conversations about spirituality in educational training programmes for helping professionals.

Who can take part in this research?

If you are a practicing registered psychologist, or a practicing psychotherapist or counsellor who is also a current member of a recognised professional body, then we would like to invite you to take part in this research.

What will I be asked to do?

You will be asked to fill out an anonymous questionnaire relating to knowledge, attitudes, and beliefs about the concept of spirituality, the role of spirituality in practitioner/client interactions, and your thoughts concerning spirituality and educational training programmes for helping professionals. Questions include a scenario, some questions about NDEs (Near-Death Experiences), and the association of mindfulness with spiritual practice. The questionnaire should take about 35-55 minutes.

If you wish to receive a summary of the results of the research once it is completed, you will have the option of providing your contact details so the summary can be emailed or posted to you. This information will be separate from the questionnaire responses you submit, so we won't be able to link your details with your responses.

What are my rights as a participant?

If you decide to take part in the questionnaire you can choose to skip or not respond to any of the questions asked, ask any questions about the study, and withdraw from the study at any time. We promise to store any information we obtain from you in a secure and confidential fashion, and only use it for the purposes of this research. We understand that issues of spirituality can be very personal and may raise certain emotions. If at any time you feel participation in this study raises any concerns for you that you would like to discuss further, you can contact Karen or Natasha who will be able to provide you with assistance.

What do I do now?

If you feel you would like to participate in this research, you can click on the >>Next button below, to take you to an online version of the research questionnaire.

Who can I contact about the research?

If you have any further queries or would like to know a little bit more about the study before you participate, please contact either Karen or Natasha via the contact details below.

Many thanks,

Karen and Natasha

Contact Information

Researchers	
Dr Karen Frewin Institute of Education Massey University Palmerston North New Zealand +64 6 3569-099 ext 84381 K.E.Frewin@massey.ac.nz	Dr Natasha Tassell-Matamua School of Psychology Massey University Palmerston North New Zealand +64 6 3569-099 ext 85080 N.A.Tassell-Matamua@massey.ac.nz
Te Kunenga ki Pūrchuroa	Massey University School of Psychology & Institute of Education Palmerston North, New Zealand T +64 6 3569-099 ext 85071 : W psychology.massey.ac.nz
<p><i>This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 15/40.</i></p> <p><i>If you have any concerns about the conduct of the research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email humanethicsoutha@massey.ac.nz.</i></p>	

Appendix F: Mindfulness Knowledge

Following are some questions concerned with the practice of mindfulness. Over the last three decades or so mindfulness has developed as a popular Western psychological intervention, and is currently growing in popularity as a practice in daily life. Originating through Eastern esoteric beliefs, and having roots in spiritual teachings, Western practices of mindfulness have been widely adapted as non-secular ways of paying attention. Western mindfulness is consistently used in Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness Based Stress Reduction (MBSR), and incorporated into other therapeutic practices, for example, CBT and pluralistic practices. Because of its historical association with spiritual practice we would like to ask you some questions about mindfulness.

The following series of questions will evaluate your knowledge and attitude towards mindfulness in a general, spiritual, and clinical nature. Please choose the option which best fits your answer to each question using the following five point scales:

Mi1. What is the extent of your knowledge on Mindfulness?

1- Non-existent 2- Brief 3- Adequate
4- Good 5- Extensive

Mi2. How suited do you believe mindfulness therapies are as a treatment for a range of psychological conditions?

1- Non-existent 2- Brief 3- Adequate
4- Good 5- Extensive

Mi3. To what extent do you believe that the use of mindfulness therapies, implies a therapist's spiritual orientation?

1- Not at all 2- Subtly 3- Moderately
4- Strongly 5- Extensively

Mi4. To what degree do you believe religious understanding is required when using mindfulness in therapies?

1- Not at all 2- Subtly 3- Moderately
4- Strongly 5- Extensively

Mi5. To what degree do you believe mindfulness therapies may improve the therapeutic relationship between you and your patient?

1- Not at all 2- Subtly 3- Moderately
4- Strongly 5- Extensively

Mi6. To what extent do you believe mindfulness therapies alone, can bring about patient change towards the desired patient outcome?

1- Not at all 2- Subtly 3- Moderately
4- Strongly 5- Extensively

Please answer the following questions by selecting 'Yes' or 'No', and if you can elaborate on your choice, please do so in the box provided.

Mi7a. Have you ever learnt about mindfulness therapies?

Mi7b. If 'Yes' where did you learn: University; Professional Development Workshop; Colleagues; Self Interest; Other

Mi8a. Do you believe being mindful can improve your daily life outside of your professional environment?

Mi8b. Please elaborate.

Mi9a. If your knowledge on mindfulness therapies was greater, would you consider using it in your clinical application?

Mi9b. Please elaborate.

Mi10a. What behavioural therapy type do you use most commonly when treating clients with Anxiety?

Mi11a. What behavioural therapy type do you use most commonly when treating clients with Depression?

Appendix G: FFMQ-SF

The following series of questions form the Five Facet Mindfulness Questionnaire- Short Form (FFMQ-SF). These will evaluate your attention and awareness of everyday experiences, to give an indication on your level of mindfulness. Please choose the option which best fits your answer to each question using the following scale:

1- Never or Very Rarely True 2- Somewhat Infrequently 3- Somewhat Frequently

4- Very Frequently 5- Very Often or Always True

1. I pay attention to physical experiences, such as the wind in my hair or sun on my face.
2. Generally, I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
3. I notice the smells and aromas of things.
4. I notice visual elements in art or nature, such as colours, shapes, textures, or patterns of light and shadow.
5. I'm good at finding words to describe my feelings.
6. I can easily put my beliefs, opinions, and expectations into words.
7. It's hard for me to find the words to describe what I'm thinking.
8. When I feel something in my body, it's hard for me to find the right words to describe it.
9. Even when I'm feeling terribly upset, I can find a way to put it into words.
10. I find it difficult to stay focused on what's happening in the present moment.
11. It seems I am "running on automatic" without much awareness of what I'm doing.
12. I rush through activities without being really attentive to them.
13. I do jobs or tasks automatically without being aware of what I'm doing.
14. I find myself doing things without paying attention.
15. I tell myself I shouldn't be feeling the way I'm feeling.
16. I make judgments about whether my thoughts are good or bad.
17. I tell myself that I shouldn't be thinking the way I'm thinking.
18. I think some of my emotions are bad or inappropriate and I shouldn't feel them.
19. I disapprove of myself when I have illogical ideas.
20. I watch my feelings without getting carried away by them.
21. When I have distressing thoughts or images, I don't let myself be carried away by them.
22. When I have distressing thoughts or images, I feel calm soon after.

23. Usually when I have distressing thoughts or images I can just notice them without reacting.

24. When I have distressing thoughts or images, I just notice them and let them go.

Appendix H: MCQ

The following competency statements reflect mindfulness competencies in a clinical setting. Please choose the option which best fits your answer to each question using the following five point scale:

1- Strongly Agree 2- Agree 3- Neutral 4- Disagree 5- Strongly Disagree

Statement stem phrase: *Counsellors and psychotherapists who train in the use of mindfulness methods...*

1. ... understand how to integrate mindfulness methods and skills into everyday tasks and behaviours.
2. ... seek continuing education opportunities on mindfulness and mindfulness-related topics.
3. ... are able to recognize the limits of their own professional competence when training clients in mindfulness methods.
4. ... respect clients' culture, including religious and/or spiritual beliefs and values that relate to physical and mental functioning.
5. ... practice mindfulness methods on a regular basis, especially when training others in these methods.
6. ... engage in the process of metacognitive examination by way of mindfulness practices.
7. ... are able to distinguish between psychological processes related to mindfulness and other mental processes critical to clinical practice (examples include compulsion, obsession, hypervigilance, mindlessness, psychotic features, dissociation, and thought blocking).
8. ... have knowledge of the various types and methods of meditation and mindfulness
9. ... have a fundamental knowledge and remain current in both the professional literature and the popular literature related to mindfulness.
10. ... have knowledge of which types of mindfulness methods are effective, ineffective, and potentially harmful for use in treating specific types of mental health disorders.
11. ... practice each specific mindfulness technique prior to using that technique with clients.
12. ... consult and seek training when integrating mindfulness methods with other psychotherapeutic techniques.
13. ... know of available resources for continued practice of mindfulness, including audio/visual, local meditation/mindfulness teachers, and online resources.

14. ... personally practice mindfulness methods for a sufficient length of time prior to training others in mindfulness methods.
 15. ... seek opportunities for mindfulness-based retreats to explore, understand, and increase mastery of mindfulness methods.
 16. ... are aware of cross-cultural/multicultural competencies relevant to applying mindfulness-based interventions and training.
-

Appendix I: PATCAT

The following questions will examine your viewpoint towards Complementary and Alternative Therapies (CAT). Please choose the option which best fits your answer to each question using the following seven point scale:

1- Strongly Disagree 2- Disagree 3- Disagree Somewhat

4- Neither Agree nor Disagree

5- Agree Somewhat 6- Agree 7- Strongly Agree

Note: *CAT and Complementary and Alternative Medicine (CAM) are terms used interchangeably. For the purpose of this research please use the following definition:*

CAM is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional health care. While some scientific evidence exists regarding some complementary and alternative medicine therapies, for most there are key questions that are yet to be answered through well-designed scientific studies – questions such as whether these therapies are safe and whether they work for the diseases or medical conditions for which they are used (NCCAM, 2006).

1. Psychology professionals should be able to advise their clients about commonly used complementary therapy methods.
2. Information about complementary therapy practices should be/should have been included in my psychology degree curriculum.
3. Knowledge about complementary therapies is important to me as a practising clinical psychologist/
4. Clinical care should integrate the best of conventional and complementary practices.
5. Complementary therapies include ideas and methods from which conventional psychotherapy could benefit.
6. A number of complementary and alternative approaches hold promise for the treatment of psychological conditions.
7. Complementary therapies should be subject to more scientific testing before they can be accepted by psychologists.

8. Complementary therapies can be dangerous in that they may prevent people getting proper treatment.
 9. Complementary therapy represents a confused and ill-defined approach.
 10. Complementary medicine is a threat to public health.
-

Appendix J: Questionnaire

Respondent Consent

Thank you for participating in this questionnaire.

Your participation implies consent.

You have the right to decline to answer any particular question.

I have read and understood the information sheet for this study and consent to collection of my responses. (Please click on the 'Yes' choice if you wish to proceed).

- Yes
- No

Demographics

What is your gender?

- Male
- Female
- Other (Please specify)

How old are you?

- 18-25 years
- 26-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- 66-75 years
- 76-85 years

What is your marital status?

- Single
- De-facto
- Married
- Divorced
- Widow/er
- Civil union

How many children do you have?

- 0
- 1
- 2
- 3
- 4
- 5+

What is your ethnicity?

(If your answer includes more than one ethnic group, please indicate which one you consider to be your primary ethnicity).

- Māori
- NZ/Pākehā
- European
- Samoan
- Cook Island Māori
- Tongan
- Niuean
- Chinese
- Indian
- Other (Please specify)

What is your religious affiliation?

- Christian
- Buddhist
- Muslim
- Hindu
- None
- Other

What is your highest qualification?

- High school
- Undergraduate
- Postgraduate
- Other (Please specify)

Client Practice

(Please specify in the box provided)

What is your profession?

Where do you primarily practice?

(eg. Private practice, DHB, specialised clinic, NGO)

How many years have you been engaged in practice?

How would you identify your client group/s?

(eg. Children exposed to domestic violence, adolescents with anger issues, mental-health, adults experiencing anxiety and depression, gender re-assignment, elderly, ACC)

How would you describe your traditional way of working with clients?

(eg. Primarily CBT, psychodynamic, pluralistic, ACT, DBT, eclectic approach utilising....., systems approach, action-methods such as....., Hakomi)