Multi-Disciplinary Clinicians Experiences of an Acceptance and Commitment Therapy Intervention

University of Southampton Doctoral Programme in Clinical Psychology

Small Scale Research Project

Word Count: 4970

5th September 2014

Abstract

Healthcare staff report high levels of stress, which can have a negative impact on staff-wellbeing, patient care and healthcare costs. Stress management interventions for NHS staff are therefore crucial. Previous research suggests that acceptance and commitment therapy (ACT) is efficacious in reducing stress and enhancing wellbeing in healthcare clinicians. This study sought to explore these findings further by exploring NHS MDT clinician's perceptions of the impact of an ACT-informed wellbeing workshop on stress and wellbeing, the mechanisms of impact and the acceptability and feasibility of offering the workshop in a highly pressurised NHS service. Participants considered the workshop to be acceptable and accessible and described a reduction in stress levels and an enhancement in wellbeing following the workshop despite continuing to experience workplace stressors. Participants attributed this improvement to the utilisation of mindfulness, cognitive defusion and values-based living in their clinical and professional practice. Participants felt that these skills enabled them to develop self-awareness of inner experiences, non-judgmental acceptance of these inner experiences and provided a choice regarding their responses. This promoted feelings of relaxation, wellbeing and a sense of control. The findings suggest that ACT is a plausible wellbeing intervention for NHS MDTs.

Introduction

In comparison with other sectors, it is reported that healthcare staff experience higher levels of illness due to stress, depression and anxiety (Health and Safety Executive [HSE], 2007). Aside from the negative impact on staff general wellbeing, stress can lead to burnout (Hutton and Pyne, 2013; Beck, 2013), presenting wider implications for patients and the healthcare system. Stress and burnout can be costly in terms of recruitment and retention of staff (Bennett, Plint and Clifford, 2005), with additional training needs and reduced clinical time increasing costs. Increased turnover can result in interrupted and diminished service delivery (Boyer and Bond, 1999) and lead to suboptimal functioning in the workplace (Taris, 2006). Naturally the impact of this can undermine the quality of care patients receive, with evidence suggesting that staff satisfaction is directly related to subsequent patient satisfaction (Beck, 2013) and poorer outcomes (Gowdy, Carlson and Rapp, 2003).

The literature suggests that both job characteristics and individual characteristics contribute to reported levels of stress in the workplace. Change, role conflict, team conflict, lack of reward, lack of control and demand overload are all identified stressful job characteristics (HSE, 2001), whilst cognitive models are drawn upon to explain individual variations of stress levels. Cognitive models of stress and wellbeing state that ones cognitive appraisal of an experience determines subsequent affective and behavioural responses (Beck, 1963; Lazarus, 1966). Thus ones cognitive appraisal of a situation, rather than the situation itself, determines whether the situation is perceived as stressful and the actions a person will take in response.

The evidence regarding stress and wellbeing interventions for healthcare staff favours individual interventions over organisational and environmental interventions (McVicar, 2003; Mimura and Griffiths, 2003). It suggests that individual-focused interventions should be driven by theory, specifically cognitive-behavioural theory,

incorporating relaxation and maladaptive cognition modification components (Galbraith and Brown, 2011; Marine, Ruotsalainen, Serra and Verbeek, 2006).

Cognitive behaviour therapy (CBT) (Beck, 1963) was developed as a collaborative psychological therapy that teaches tools and techniques to modify maladaptive cognitions that are hypothesised to contribute to and maintain distress through active in-session and homework tasks. CBT can be delivered with individuals, groups and in self-help format; therefore is considered cost-effective and accessible. In more recent years traditional CBT approaches have evolved into the now defined 'third-wave CBT' approaches. The focus has shifted from modifying maladaptive cognition to modifying ones relationship to such cognitions and other inner psychological events e.g. emotions and physical sensations (Biglan, Hayes and Pistorello, 2008). This approach draws from functional contextualism, which is sensitive to the context and functional utility of thoughts, feelings and behaviours, rather than their content or form (Hayes, Strosahl and Wilson, 2003).

Acceptance and Commitment Therapy (ACT) is one such third-wave CBT. Based on relational frame theory, ACT argues that language enables humans to essentially time travel through their thoughts. Inner language (e.g. thoughts) enables humans to derive and combine verbal relations, enabling one to predict the future and learn from the past. ACT suggests that whilst this is useful in terms of human progress, this ability is also unhelpful in terms of creating and exacerbating human suffering as humans increasingly live inside the world of language and move away from directly experiencing the world (Harris, 2008). As a result, humans relate to their thoughts as if they are accurate, truthful representations of life itself, rather than mental processes attempting to construct the world (Hayes et al., 2003; Harris, 2008).

ACT aims to reduce the harmful functionality and context of unpleasant inner psychological events (such as thoughts and feelings) by teaching clients to connect with present moment experience, therefore reducing experiential avoidance, and fostering

psychological flexibility towards such experience. Psychological flexibility is developed through six core processes; present moment awareness (increasing contact with here-and-now experience), acceptance (full awareness and openness to all inner experiences), defusion (gaining distance from inner experience; viewing thoughts as just thoughts), self-as-context (observing and noticing experiences as separate from the essence of self), connection to values (meaningful life aims) and committed action (taking effective action in line with values) (Hayes et al., 2003; Harris, 2008).

These processes are developed through the use of metaphors and brief mindfulness practices that promote present-moment contact and non-judgemental acceptance of ones experiences. Mindfulness practices also promote awareness of the self-as-context, enabling one to differentiate between internal events such as cognitions, affect and physical sensations and the 'observing self' (the self that notices these internal experiences). Cognitive defusion exercises build on mindfulness practices, facilitating a distanced awareness of inner experiences such as thoughts, enabling one to view them as just mental events, not accurate representations of reality. ACT also encourages clarification of ones life-values and committed action and behaviours in accordance with these values (Harris, 2008, 2009).

Previous studies have explored the utilisation of ACT as a stress and wellbeing intervention for same-discipline clinical staff groups with encouraging results. Research has demonstrated reductions in distress (Bethay, Wilson, Schnetzer, Nassar and Bordieri, 2013), lowered stress levels and burnout, improvement in overall wellbeing, (Brinkbor, Michanek, Hesser, Berglund, 2011) and improvements in clinician qualities such as therapy skills, compassion and therapeutic relationships (Stafford-Brown and Pakenham, 2012). Evidence also indicates that ACT prevents future ill-health (Biglan et al., 2008).

Whilst the value of ACT as a wellbeing intervention for same-discipline clinical staff groups is evident, there is limited research exploring the impact of ACT within NHS multi-disciplinary teams (MDTs), teams of various healthcare workers such as physicians, nurses, occupational therapists, physiotherapists and psychologists. NHS MDTs are potentially at increased risk of the prevalence of stressful job characteristics including inter-discipline conflict due to competing models of aetiology and treatment, recruitment and pay freezes with simultaneous increases in clinical demand and wide scale reorganisation following austerity measures.

Also absent in much of the literature is the clinician's voice. There is limited research exploring healthcare clinicians experiences and perceptions of utilising ACT techniques, including an exploration of the active components of the intervention in clinical practice. One would expect, based on the cognitive model of distress, that intervention components targeting the functionality and context of cognitions would be most effective. This theory appears to be supported by recent research (Bethay et al., 2012). Further, there is limited research exploring the perceived acceptability and feasibility of the intervention, which is crucial to staff participation and engagement, as well as commissioning of services.

Present Study

There is a timely need for stress and wellbeing management programmes within the NHS that are cost-effective, feasible and acceptable within the workplace. The present study aims to explore MDT clinician's perceptions of the impact of an ACT-informed wellbeing workshop on stress and wellbeing. This study also aims to look beyond the impact of the workshop to understand the active components of the intervention in participant's daily clinical (e.g. client engagement) and professional practice (e.g.

colleague engagement) and to understand how these active components translate into outcomes. Further, this study sought to explore the acceptability and feasibility of delivering the workshop within a routine NHS clinical service.

Method

Design

Participants were asked to complete open-ended questionnaires exploring their subjective experiences of an ACT-informed wellbeing workshop. Inductive thematic analysis was utilised to explore participant's responses and to analyse themes noted in the textual data.

Participants

Using a criterion sampling approach, participants were recruited from attendees of an ACT-informed wellbeing workshop facilitated within a local community neuropsychological rehabilitation MDT service. The service is located in an urban area of South England, serving a population of approximately 84,250. Participants (n=4) were clinical members of the MDT consisting of occupational therapists, psychologists, nurses and physiotherapists. 50% of the sample was female (n=2).

Measures

Participants completed two open-ended questionnaires to explore their subjective experiences of the wellbeing workshop. The questions were designed to encourage reflective answers, probe for further information and ask for specific examples. Participants were encouraged to give careful consideration to their responses and answer questions as fully as possible. At the end of each questionnaire a space was provided to

share any further perceptions and experiences that participants felt were relevant to share and that were not addressed by the questions asked.

Acceptability and feasibility. Immediately on completion of the workshop, participants were asked to complete an open-ended questionnaire exploring their perceptions of the acceptability, accessibility and feasibility of the ACT-informed wellbeing workshop and the techniques presented for their personal use as a clinician within their clinical and professional practice.

Impact on stress, wellbeing; active components. One-month post workshop, participants were asked to complete a further questionnaire consisting of a series of broad open questions exploring their perceptions of the ACT-informed wellbeing workshop and their experiences of utilising ACT techniques in clinical and professional practice. This questionnaire sought to explore the techniques utilised, if any, how participants utilised the techniques and the impact of utilising the techniques. Participants were guided to areas such as the effect of the intervention on stress levels and general wellbeing in the workplace, the impact of the intervention on engagement with patients and colleagues and the usefulness of the techniques in clinical practice.

Procedure

Attendees of an ACT-informed wellbeing workshop were invited to participate in an evaluation of the workshop as part of the study. Invitations to participate were sent via email along with an information sheet regarding the research project and a consent form. Participants were asked to read, sign and return the consent form if they agreed to take part in the research project.

The one and a half hour workshop, facilitated by the psychology department at the community team base, was a condensed version of the ACT intervention described by

Harris (2008). It consisted of psychoeducation regarding the six core processes of ACT, teaching mindfulness and thought defusion techniques and a reflective space to consider personal values and aligned committed action that can be taken daily in clinical and professional practice. Participants were given a handout summarising information covered during the workshop.

Participants were sent the first questionnaire immediately following the workshop and the second questionnaire one-month post workshop. The questionnaires were sent via email along with instructions emphasising careful consideration and elaboration of responses. Participants were instructed to return the questionnaires in an envelope marked confidential and addressed to the author via internal trust mail within one week of receipt.

Analysis

The data was analysed by the author. Inductive thematic analysis was employed due to its flexibility and ability to provide rich, detailed and complex accounts of the text (Braun and Clarke, 2006), therefore possessing the ability to explore participants experiences and the meanings given to them. In this respect themes were grounded in the data.

Analysis involved recursive movement through the phases of thematic analysis proposed by Braun and Clarke (2006). Initially the questionnaires were read and reread repeatedly to familiarise the author with the data, and to immerse the author in the participant's perspectives and experiences (phase one). During this active reading process, meanings and patterns were explored, with any salient information and reflections recorded in the margins of the questionnaire. To facilitate the organisation of data into meaningful groups open semantic coding was employed. Codes were identified at the word and sentence level by working systematically through the data corpus, capturing the

essence of the text (phase two). As coding progressed, a coding manual was developed. Codes were entered into the manual with descriptions attached. Where possible, codes were labelled drawing on participant's language and own words.

Hard copies of codes were produced on paper, allowing for exploration of common and salient themes (phase three). Overarching themes and subordinate categories were recorded in the coding book, accompanied by descriptions and examples from the text. For validity purposes, themes were reviewed for accurate representation of the data and its meanings and refined if necessary (phase four). To enhance reliability, the themes were reviewed by the project supervisor. Once themes were established, they were defined and named, again using in-vivo naming where possible (phase five).

The analysis involved an iterative, dynamic process of moving between the data corpus and themes, constantly comparing the text and descriptions of themes to ensure that themes were applied consistently and sensitively to the raw data (Dennison, Yardley, Devereux and Moss-Morris, 2010). Throughout this process the author endeavoured to acknowledge and take ownership of their position and perspective, maintaining a reflective diary to assist with bracketing, reflexive practice and a reliable analysis of the data. This encouraged adherence to Elliot's quality criteria (Elliot, Fischer, Rennie, 1999).

Consent / Ethics

All participants were invited to give signed consent to take part in the project, following an email attaching a written information sheet that detailed the project, its aims, participants expected role and data collection and storage methods. Participants were also given a handout detailing available sources of wellbeing support.

Results

The inductive thematic analysis resulted in the establishment of sixteen themes regarding MDT clinician's experiences of the ACT-informed wellbeing workshop. Following a review these themes were modified further resulting in twelve final themes, which were then organized into three super-ordinate categories (table 1).

Super-ordinate Category	Themes
Reflections on the Workshop	**Acceptability of the Workshop**
Staff perceptions on the feasibility,	**Accessibility of the Workshop**
relevance and practicalities of the	**Delivery Style of the Workshop**
workshop	**Identified Needs**
Application of the	**Present Moment Self-Awareness**
ACT Techniques Utilised	**Nonjudgmental Towards Self**
How ACT techniques were applied in	**Observing Thoughts**
clinical practice	**Values-Based Actions**
	Distinguishing Primary-Secondary Suffering
Impact of Techniques Utilised	**Management of Own Wellbeing**
The impact of the techniques	**Enhancement of Clinician Qualities**
on clinical and professional	**Added to Clinical Skills**
practice and wellbeing	

Table 1.1. Themes identified from the thematic analysis.

Two out of four (50%) participants had prior experience of ACT, each possessing varying levels of experience and knowledge. Whilst the remaining participants had no experience of ACT, they did possess basic knowledge of traditional CBT approaches.

Reflections on the Workshop

Acceptability. All of the participants reported finding the workshop a highly acceptable use of clinical time in terms of relevance and feasibility. Participant's views reflected the suitability of the workshop in providing timely and valuable stress and

wellbeing management skills. Practically, the length of the workshop was deemed sufficient and easily accommodated within busy routine clinical practice.

> *So worth investing time in, excellent concept and tool (EC, psychologist)*
> *It was an acceptable and practical use of clinical time. One and a half hours is manageable! (JC, occupational therapist)*
> *Understanding how I cope or ways of helping me cope (with the demands and constraints) can only be a good thing (DC, nurse)*

Accessibility. Despite varying levels of experience and knowledge of ACT, all of the participants found the workshop accessible. Those with limited or no experience reported that they were able to follow the workshop with ease. Those that had significant experience of ACT found that the clarity and simple format of the workshop clarified aspects of ACT for them and enabled them to build on their already developed skills. Many (75%) reported that the metaphors and examples utilised by ACT were helpful in aiding the learning process and consolidating their knowledge and understanding.

Workshop clarified the approach for me and made it more accessible (EC, psychologist)

Identified Needs. However, those that had limited or no prior knowledge of ACT felt that they would have benefited from future workshops to extend, consolidate and refresh their knowledge of the ACT techniques presented. Whilst the techniques were grasped during the workshop, a lack of confidence in applying the techniques resulted in them not being utilised following the workshop. Participants attributed this to a lack of knowledge and confidence in applying the techniques and felt that further training or a booster session would be useful.

I don't know (the techniques) off the top of my head so when there was situation where they would be useful I just didn't think to use them. One session was probably not enough for me (DC, nurse)

Delivery. All participants commented on the delivery style of the facilitator and the format of the workshop. Participants appreciated the clarity and presentation of the delivery of the session material in aiding their understanding of the ACT techniques taught during the workshop. Participants also appreciated the interactive and participatory engagement style of the workshop and felt that the small group size further facilitated this, enabling fruitful discussions to take place.

Clarity was superb, held my attention (NC, psychologist)
Very well presented- lots of useful information given in an accessible way (JM, occupational therapist)

Application of ACT Techniques in Clinical and Professional Practice

Three out of four participants (75%) stated that they had utilised ACT techniques in their clinical and professional practice. These participants shared that they had utilised mindfulness, cognitive defusion, connecting with values and committing to values-based action and in doing so had drawn from all six ACT core processes.

Present Moment Self-Awareness. All of the participants who utilised ACT techniques reported practicing mindfulness in their clinical and professional practice. Participants felt that mindfulness enabled them to develop or enhance self-awareness, enabling them to become more aware of inner processes such as thoughts and feelings as they emerged in the present moment. This awareness enabled them to be connected to the here and now, enabling them to take control and make choices that were helpful to them in the moment.

Self-awareness and insight allows us to take control of our thoughts and therefore the decisions we make (DC, nurse)

Non-Judgmental Towards Self. Practicing mindfulness also enabled participants to begin to change their relationship towards these experiences, becoming more accepting and less judgemental of their internal experiences once they were aware of them. Participants had begun to approach their inner worlds with compassion, warmth and an understanding of inner processes.

Observing Thoughts. A common theme amongst participants was that of thought defusion. Participants reported that they had begun to see their thoughts from an observer perspective, seeing them from a defused rather than a fused position. In the process they had begun to relate to their thoughts more mindfully, *'seeing thoughts as only thoughts'*. This had helped participants in situations where their thoughts had been deemed more unhelpful and resulted in misinterpretations of situations. Defusing from thoughts enabled them to step back from their thoughts in situations, gain perspective and not react to the situation based on such thoughts.

Values-Based Actions. Participants reported significant benefits in reconnecting with their values, particularly in the context of providing direction for actions in the workplace. Once participants had reconnected with their values, the skills of mindfulness and committed action enabled them to move towards their values by taking values-based actions.

Relook at (my) values and made adjustments to the direction I was travelling (NC, psychologist)

Distinguishing Primary from Secondary Suffering. Participants reported that distinguishing between primary and secondary suffering was very powerful. This helped

participants to keep perspective within situations and enabled them to explore ways in which their reactions to situations could worsen the outcome.

> *The primary and secondary suffering circles was a useful explanation of how destructive thoughts can snowball creating an even bigger problem (JM, occupational therapist)*

An awareness of primary and secondary suffering also enabled participants to feel empowered in situations where they had previously felt powerless and helpless. Participants reported 'gaining perspective' and responding to stressful situations through making choices that could improve that moment and therefore their quality of life.

Impact of ACT Techniques Utilised

Management of Own Wellbeing. All of the participants that had utilised ACT techniques in their clinical and professional practice felt that the techniques had either enhanced or maintained their wellbeing and lowered stress. Participants reported finding the techniques useful for coping with stress and anxiety, thus improving their quality of life. In comparison to stress and wellbeing levels before the workshop, two out of the three participants who had utilised ACT techniques reported that their stress levels had lowered and they were feeling calmer within themselves one-month post workshop.

Participants did not feel that their sources of stress (workplace stressors such as IT problems, service constraints, staff conflict) had necessarily changed during the month. Participants attributed their change in stress and wellbeing levels to the ACT skills they had learned, specifically mindfulness, thought defusion and values-based living, which had enabled them to regain perspective, enhance present moment awareness and, as a result, make helpful choices aligned to their values in difficult moments. Participant's felt that they had begun to take more ownership of their feelings and reported enhanced feelings

choice and control. Participants reported significant benefits in reconnecting with their values and felt that reducing the gap between their values and their actions helped to enhance a sense of wellbeing.

> *Refocusing to bring our values closer to us helped to alleviate stress (JM, occupational therapist).*

The participant who reported consistency in their wellbeing levels following the workshop, reported themselves to be mostly happy and content in their professional role despite the presence of numerous workplace stressors. This participant felt that ACT served as a protective factor, maintaining wellbeing and preventing the development of stress despite the presence of multiple stressors.

> *I have been using the techniques for years. In my role I am faced with many stresses, but I am mostly content and happy, not particularly experiencing high stress levels. As I have been using (ACT techniques) for a while I think they maintain my wellbeing (EC, psychologist)*

Enhancement of Clinician Qualities. The techniques helped to develop and enhance self-awareness, empathy and non-judgement of others. Mindfulness helped participants to develop more of an understanding of their patients and their struggles in daily life. This helped to generate an understanding of the universality of suffering and distress, with participants viewing internal processes as universal to being human. Participants saw patients and staff as not quantitatively different in anyway. This was reflected implicitly in the use of universal language such as ‘we’ and ‘us’ and explicit statements.

> *There is much in ACT to benefit everyone (NC, psychologist)*

Participants acknowledged the value of managing their own emotional wellbeing in order to support the emotional wellbeing of patients. They also felt that as a result of enhanced self-awareness and emotional self-management skills that they were better able to serve as 'role models' when engaging with patients, modelling their own self-management to patients.

Enhancement of Clinical Skills and Tools. Whilst teaching clinical tools and skills to use with clients was not the direct aim of the workshop, many participants shared experiences and examples of drawing on the techniques in their clinical therapeutic work with patients. Participants described utilising and introducing ACT techniques during therapy sessions with patients, which enhanced the outcome of therapy and rehabilitation efforts.

(I am) aware of (the clients) values to improve rehabilitation (NC, psychologist)

Discussion

Participants experienced an ACT-informed wellbeing workshop as an 'acceptable', 'accessible' and effective tool for lowering stress and enhancing and maintaining wellbeing. Interestingly, the presence of perceived workplace stressors did not change during the follow-up period, suggesting that organisational factors were not responsible for improved wellbeing and reduced stress levels. Indeed, participants attributed their improved or maintained wellbeing levels to the acquisition of ACT techniques, specifically mindfulness, cognitive defusion, connection with values and taking values-based actions.

Mindfulness practices appeared to facilitate connection to present-moment experience, enabling participants to 'enhance self-awareness' of inner experiences. Further, this self-awareness was of a non-judgemental nature, enabling clients to notice and observe but not evaluate these experiences. This appeared to reduce the struggle with unavoidable unpleasant inner experiences (Hayes et al., 2003; Williams, Teasdale, Segal

and Kabat-Zinn, 2007), enhancing feelings of wellbeing and relaxation. This also enhanced participant's sense of 'choice and control', an important findings considering lack of perceived control in the workplace is an identified stressor (HSE, 2007).

Cognitive defusion techniques appeared to further enhance the development of the 'observing self', enabling participants to become more aware of the process of thinking and the function of thoughts in their life, reflecting the previous findings of Hayes et al. (2003) and Bethay et al. (2012). Through 'observing thoughts', participants appeared to relate more mindfully to them, thus relating to thoughts as 'simply thoughts', not accurate reflections of reality. In doing so participants felt that they were able to 'regain perspective'. Participants did not automatically believe the content of their thoughts, thus, aligned to cognitive-behavioural theory, their influence on behaviours, wellbeing and stress reactions was lessened. This enabled participants to respond more effectively to environmental demands (Hayes et al., 2003), further enhancing feelings of wellbeing.

The utilisation of techniques in clinical and professional practice appeared to enhance clinician qualities, supporting the previous findings of Stafford-Brown and Pakenham (2012). Such a mindful and defused approach appeared to enhance self-awareness in practice, enabling participants to break habitual patterns of reacting to experience and to choose actions aligned to their values (Williams et al., 2007). This was identified to be very powerful and suggests that acting in ways consistent to workplace values potentially strengthened clinician qualities, further enhancing wellbeing through creating a sense of life meaning and direction (Hayes et al., 2003). Further, such an approach appeared to enhance empathy and increase participant's recognition of the universality of human suffering. This was important for intensifying of the therapeutic relationship (Hayes et al., 2003), which is an important predictor of therapeutic outcomes (Lambert and Barley, 2001; Leahy, 2008).

These findings are aligned to the ACT approach described by Harris (2008) and Hayes et al. (2003) and support prior research suggesting that a more accepting and defused stance towards inner and external experiences, a connection with values and committed behaviours aligned to values can enhance wellbeing and reduce stress levels.

That the workshop was deemed highly acceptable and accessible is encouraging considering the varying levels of experience and knowledge of attendees. The delivery and facilitation style of the workshop and facilitator were highly rated and potentially enhanced these findings, thus future workshops should consider suitability trained facilitators and a participatory style of delivery reflecting adult learning styles. It is worth noting that those with no prior experience of ACT lacked the knowledge and confidence to apply the techniques in clinical practice, potentially indicating the need for further booster sessions or an ongoing series of workshops. However care would need to be taken to ensure this does not compromise acceptability and feasibility. A potential solution is to train clinical supervisors to offer ACT-informed supervision to support the ongoing development and application of skills. Further research is required to explore the feasibility and efficacy of such adaptations.

Limitations

The findings of the study should be considered in light of its limitations. The voluntary nature of the sample may reflect more motivated participants who share an enthusiasm for ACT and thus may have been motivated to present ACT in a positive light. The purposive nature of the sample aimed to enhance transferability of the findings, seeking participants who are representative of standard NHS MDT services, although the small and specific sample does hinder wider generalisations from being made. However, the findings do reflect and support previous research.

It is possible that previous knowledge and personal beliefs of the author may have influenced the interpretation of responses, however the author made every effort to bracket

their own views and beliefs to avoid biasing the results and sought to utilise participant's own words where possible.

The questionnaire design of the study, whilst seeking to maximise openness, consideration and reflection of answers, hindered further exploration of participant's responses. Triangulation of data collection measures including follow-up interviews could have been useful to probe participant's responses further, for example exploring participant's definitions of enhanced quality of life and wellbeing.

Whilst the aim of the study was to explore perceptions of the impact of the workshop on wellbeing and the mechanisms through which the workshop affected wellbeing, the study could have been strengthened by a mixed methods design, undertaking quantitative evaluations of stress and wellbeing. However the small sample size would limit statistical power, thus larger trials are required to extend and replicate these results.

Clinical Implications

The findings support and extended previous research, suggesting that ACT has potential value as an effective stress and wellbeing intervention for MDT healthcare staff within routine NHS services. That participants reported a preventative quality supports the work of Biglan et al. (2008) and suggests that teaching ACT techniques during the training of healthcare staff may be a useful and cost-effective additive to training programmes. This potentially has beneficial downstream effects for patient care and healthcare costs.

Whilst the value of individual-targeted interventions is evident, it is also important to note that organisational factors play a critical role in wellbeing in the workplace and these factors should not be neglected. It is important that wider organisational issues are

also addressed to avoid locating organisational problems in individual staff and therefore 'blaming' them for their distress.

Conclusion

NHS MDT clinicians experienced an ACT intervention as an acceptable and accessible tool for lowering stress and enhancing and maintaining wellbeing. Specifically, mindfulness, cognitive defusion and values-based living appeared to enable clinicians to develop self-awareness of, and a non-judgemental and defused stance towards, their internal experience, promoting choice in their responses. This appeared to enhance feelings of control and foster a sense of wellbeing in clinicians, resulting in lowered stress and enhanced clinician qualities. A larger trial, perhaps drawing on a mixed-method design, is required to enhance the transferability and generalizability of these findings.

References

Beck, A. (1963). Thinking and depression: Idiosyncractic content and cognitive distortions. *Archives of General Psychiatry, 9,* 324-333.

Beck, A. (1963). Thinking and depression: theory and therapy. *Archives of General Psychiatry, 10,* 561-571.

Beck, A. (2013). Compassionate care post Francis: How relevant is staff experience? *Clinical Psychology Forum, 249,* 10-12.

Bennett, S., Plint, A., and Clifford, T. J. (2005). Burnout, psychological morbidity, job satisfaction, and stress: a survey of Canadian hospital based child protection professionals. *Archives of Disease in Childhood, 90,* 1112-1116.

Bethay, J. S., Wilson, K. G., Schnetzer, L. W., Nassar, S. L., and Bordieri, M. (2013). A controlled pilot evaluation of acceptance and commitment therapy for intellectual disability staff. *Mindfulness, 4*(2), 113-121.

Biglan,A., Hayes, S., and Pistorello, J. (2008). Acceptance and commitment: Implications for prevention science. *Prevention Science, 9*(3), 139-152.

Boyer, S. L. and Bond, G. R. (1999). Does assertive community treatment reduce burnout? A comparison with traditional case management. *Mental Health Services Research, 1*(1), 31–45.

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

Brinkbor, H., Michanek, J., Hesser, H., and Berglund, G. (2011). Acceptance and commitment therapy for the treatment of stress among social workers: A randomized controlled trial. *Behaviour Research and Therapy, 49,* 389-398.

Dennison, L., Yardley, L., Devereux, A., and Moss-Morris, R. (2010). Experiences of adjusting to early stage MS; the patient's perspective. *Journal of Health Psychology, 16*(2), 478-488.

Elliot, R., Fischer, C. T., and Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229.

Galbraith, N. D. and Brown, K. E. (2011). Assessing intervention effectiveness for reducing stress in student nurses: quantitative systematic review. *Journal of Advanced Nursing, 67*(4), 709–721.

Gowdy, E. A., Carlson, L. S. and Rapp, C. A. (2003). Practices differentiating high-performing from low-performing supported employment programs. *Psychiatric Rehabilitation Journal, 26*, 232–239.

Guest, G., Bunce, A., and Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82.

Harris, R. (2008). *The happiness trap*. London: Robinson.

Harris, R. (2009). *ACT made simple*. Oakland, CA: New Harbinger.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (2003). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press.

Health and Safety Executive (2001). *Health and Safety Executive, Tackling Work-Related Stress: A Manager's Guide to Improving and Maintaining Employee Health and Well-being*. London, UK: HSE Books.

Health and safety Executive (2007*). Self-reported Work-related Illness and Workplace Injuries in 2005/2006*. London, England: Health and Safety Executive.

Hutton, J., and Pyne, D. (2013). The benefits of delivering a mindfulness-based cognitive therapy course to trainee clinical psychologists. *Clinical Psychology Forum, 251,* 32-36.

Lambert, M.J. and Barley, D.E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357-361.

Lazarus, R. S. (1974). Psychological stress and coping in adaptation and illness. *International Journal of Psychiatry in Medicine, 5,* 321–333.

Leahy, R. (2008). The therapeutic relationship in cognitive behavioural therapy. *Behavioural and Cognitive Psychotherapy, 36*(06), 769-77 doi: http://dx.doi.org/10.1017/S1352465808004852

Marine, A., Ruotsalainen, J. H., Serra, C., and Verbeek, J. H. (2006). Preventing occupational stress in healthcare workers. *Cochrane Database of Systematic Reviews, 4*.

McVicar, A. (2003). Workplace stress in nursing: a literature review. *Journal of Advanced Nursing, 44*(6), 633-642.

Mimura, C. and Griffiths, P. (2003). The effectiveness of current approaches to workplace stress management in the nursing profession: an evidence based literature review. *Journal of Occupational and Environmental Medicine, 60*, 10–15.

Stafford-Brown, J. and Pakenham, K. I. (2012). The Effectiveness of an ACT Informed Intervention for Managing Stress and Improving Therapist Qualities in Clinical Psychology Trainees. *Journal of clinical Psychology, 68*(6), 592–613.

Taris, T. W. (2006). Is there a relationship between burnout and objective performance? A critical review of 16 studies. *Work and Stress*, *20*(4), 316 – 334.

Williams, M., Teasdale, J., Segal, Z. & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guildford Press.

Appendix A

Code Book Version 1

Category Theme	Code Sub Theme?	Definition	Example Quote	Distinguishing Features
Evaluation	Acceptability	Attendees opinions of the acceptability of the wellbeing workshop e.g. appropriate material, relevance, length, timing, topic,	One and a half hours was manageable Interesting and informative Worth investing time in Whole session was very useful Definitely an approach I can utilise therapeutically and personally Timing- not stressed… Valuable clinical tool Useful to know about and good to have a better understanding Excellent concept and tool for everyday living The amount of material was just right for the length of time of the session Helpful and highly informative Very helpful both personally and professionally Very useful and well presented Clinically and personally relevant I strongly feel this could be a good intervention, I very much like and believe in principles of self-awareness and the benefits this brings	Whether the workshop was deemed an acceptable use of clinical time, suitable for attendees and their needs (relevance and feasibility)
	Accessibility (of ACT?)	Attendees opinions of the ease of understanding of material covered and the ease of use of the techniques shared	An easy tool to use (P1, L3) Very easy to follow I valued the small group size Made ACT more accessible Timing- not stressed… Easy tool… Gave a good introduction to ACT It was simple and brought back to basics… which is invaluable Visual representations will probably help me Workshop clarified the approach for me and made it more accessible It put the approach into context Lots of useful information given in an accessible way Different clinicians present with varying degrees of ACT knowledge – presentation was accessible to all Metaphors and examples were useful	How easy the workshop was to follow and how easy the techniques were to put into practice
	Delivery	Attendees opinions of the presentation, delivery, format and engagement style	Clarity was superb Held my attention Very well presented to all levels I valued the small group size There was time afterwards to ask questions as the group was small Sensible and informed view point The facilitator made the session interesting and informative… she was brilliant Invited participation Answered questions with knowledge and authority The delivery and presentation of the workshop was interesting and very easy to follow Very well presented – lots of useful information given in an accessible way Lots of examples Very good explanation of the approach	Opinions of the presentation style

Code Book v1.0.

Application of ACT in Clinical and Professional Practice	Self-Awareness		Awareness of my mood and how best to control it Encourages self-awareness Self awareness and insight allows us to take control of the thoughts and the decisions we make	
	Impact Divide into impact on self, impact on clinical/professional work		For coping with stress and anxiety Improve Q.O.L. when I am anxious or stressed Allows me to be more empathic with patients I tried to hear how (the patient) does and found it overwhelming. Less judgmental Ownership for wellbeing I feel that I have choices and control in my life Useful personally Being mindful and using mindful breathing helps to regain perspective Some anxiety, frustration and usefulness before the workshop and feelings calmer after the workshop Will use information with clients and self To reduce stress, improve mood and enhance relaxation Very helpful both personally and professionally Have been using techniques for years… faced with may stresses, mostly content and happy, not particularly high stress levels. As I have been using them a while I think they maintain my wellbeing (EC) The techniques certainly reduce stress and enhance pleasure in day to day moments,	
	Application of techniques in own clinical practice – e.g. therapy techniques		Helping the person to adjust to their new situation Be aware of (the clients) values to improve rehab I use the techniques with client and myself Helped to highlight how to describe ACT to clients Using mindfulness with clients	
Techniques Drawn Upon	Mindfulness		If I can make changes in my own life because of being mindful… Being mindful will allow me to be more empathic with patients and less judgemental Self-awareness and insight allows us to take control of our thoughts and therefore the decisions we make Mindful approaches in clinical and professional practice Bringing things back to the here and now Being mindful helps to regain perspective I have used mindful breathing, walking eating	
	Thought Defusion		Address unhelpful thought processes Learning about fusion and defusion Observing thoughts in clinical and professional practice Recognising thoughts are only thoughts, especially in more difficult	

Code Book v1.0.