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Client Perceptions of the Utilization of Mindfulness Activities in Therapy

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CLIENT PERCEPTIONS OF THE UTILIZATION OF MINDFULNESS ACTIVITIES
IN THERAPY

A Dissertation
Presented to
The Faculty of the Department of Psychology
Western Kentucky University
Bowling Green, Kentucky

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Psychology

By
Anissa S. Pugh

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CLIENT PERCEPTIONS OF THE UTILIZATION OF MINDFULNESS ACTIVITIES
IN THERAPY

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CLIENT PERCEPTIONS OF THE UTILIZATION OF MINDFULNESS ACTIVITIES IN THERAPY

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The aim of the current study was to examine client perceptions of the use of mindfulness activities in the therapeutic process. For this current study, 21 participants completed a seven-item demographic questionnaire, a 39-item Five-Facet Mindfulness Questionnaire (FFMQ), and a 10-item Mindfulness Experience Questionnaire. The present study investigated three research questions. Research Question 1 looked at how clients perceived the effectiveness of the use of mindfulness activities in therapy. The next research question examined how clients viewed the addition of mindfulness activities to be an acceptable treatment approach based on personal values and beliefs. The third research question for this study examined which facet(s) of mindfulness from the therapeutic process clients use the most in their lives. Results from this study showed the clients perceived the mindfulness activities as being effective for treating the presenting problem that brought them to therapy. Additionally, results from this study showed participants perceived the activities as being an acceptable form of treatment based on their individual values and beliefs. Participants from this study preferred therapy sessions that included mindfulness activities and would prefer more mindfulness activities in future sessions. Furthermore, participants indicated that mindfulness activities allowed them to form a relationship and share an experience with their therapists. Finally, based on the FFMQ, participants most frequently used the Observing facet over the other four facets and least utilized the Acting with Awareness facet.

Chapter One: introduction

In the last 35 years, the topic of mindfulness techniques in therapy has increased in both the frequency of use by clinicians and in research studies. In this time frame, research publications have risen from 0 in 1980 to over 700 in the year 2014 (American Mindfulness Research Association, n.d.). Research studies have shown mindfulness activities to be an empirically supported therapy intervention that can be used with a variety of client populations and presenting problems.

Over the years, there have been several mindfulness-based therapy approaches developed to treat a variety of medical and psychological problems. The first mindfulness-based therapy approach was developed by Jon Kabat-Zinn (1990) as a form of treatment for individuals who suffer from chronic pain. The Mindfulness-Based Stress Reduction program is an eight-week group therapy program in which individuals learn a variety of mindfulness activities that can be used in their daily lives. In this approach to mindfulness, the activities are learned in therapy sessions and clients are encouraged to practice the interventions for at least 45 minutes per day outside of the group therapy sessions. After the initial development of Mindfulness-Based Stress Reduction, newer generation therapies, such as Dialectical Behavior Therapy (DBT; Linehan, 1993) and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) were developed and included mindfulness activities into individual therapy sessions.

Acceptance and Commitment Therapy uses mindfulness-based activities along with other interventions to encourage clients to focus on the present-moment experience rather than focusing on past or future events that cause psychological suffering (Harris, 2009a). In Dialectical Behavior Therapy, mindfulness activities are similar to those in Mindfulness-

Based Stress Reduction in that the activities promote nonjudgmental thoughts of both internal and external aspects of a person's environment.

Even with the extensive research on the effectiveness of mindfulness-based therapeutic approaches, there is little research on the effectiveness of newer approaches, such as Dialectical Behavior Therapy, that incorporate mindfulness activities into therapy. Many of the research studies focus solely on Mindfulness-Based Stress Reduction and few examine the other mindfulness-based approaches available. In addition, there is little knowledge about how clients perceive the inclusion of mindfulness-based therapy approaches and which facets of the construct they believe to be the most beneficial to their therapeutic process and overall outcome.

The purpose of the current study was to assess clients' perceptions of the use of mindfulness activities in their overall therapeutic process. Additionally, the study examined which facet(s) of mindfulness is most commonly used by participants based on the Five-Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006).

What is Mindfulness?

The practice of mindfulness has been around for over 2,500 years and can be traced back to early Buddhism and other religious traditions (Kabat-Zinn, 2003). One religious practice that views mindfulness as the core technique is Buddhism (Turner, 2009). However, even though the therapy activities resemble practices from Buddhism, when these skills are taught in therapy sessions, they are often used independently of the religious and cultural Buddhist traditions and beliefs.

In the traditional Buddhist mindfulness-training regimen, the goal is to lessen personal suffering (Turner, 2009). This is similar to the aim of the American Psychological Association (APA) Ethics Code Principle A, which states that psychologists work to benefit those with whom they work and do no harm (American Psychological Association, 2010). In traditional Buddhist training focused attention is fostered in the individual by practicing two forms of meditation practices: mindfulness meditation and concentrative meditation (Turner, 2009). The traditional form known as mindfulness meditation teaches the individual to focus and notice all the moment-to-moment experiences occurring, whether they are thoughts, emotions, or sensations. By contrast, the concentrative meditation form has the individual focus on a single item that can be either internal or external (Turner, 2009). Current mindfulness training helps clients to increase their ability to sustain attention in a variety of settings.

Present day mindfulness-based therapeutic techniques most closely resemble those of the Eastern meditation practices. There are two primary forms of Buddhist meditation practices that are currently used in mindfulness therapy activities. The first form of meditation is the open awareness practice. In open awareness practice, the individual focuses on the complete experience that he or she is currently feeling without modifying the moment in any way (Parkin, Jarman, & Vallacher, 2015).. This technique can be seen in the Acceptance and Commitment Therapy “Notice Five Things” activity, which involves noticing five things in the environment with each of the five senses (Harris, 2009a). The other form of meditation is the focused attention practice, which requires the individual to focus all of his or her attention on a specific meditation object

(breathing, mental image, or a tangible object in the environment) and bring back his or her attention when attention drifts from that object (Parkin, Jarman, & Vallacher, 2015).

Definition of Mindfulness

Over the years there has been several definitions used to explain the term mindfulness. The most commonly used clinical definition of mindfulness is an awareness that occurs by paying attention on purpose, in the present moment, and non-judgmentally to the unfolding experience in a moment by moment way (Kabat-Zinn, 1990). Bishop and colleagues (2004) developed a two-part operational definition of mindfulness that focuses on (1) attention and (2) acceptance. The first aspect of mindfulness is regulating attention in the present moment between the changing thoughts and emotions that an individual is currently experiencing (Bishop et al., 2004). The second aspect of the operational definition of mindfulness is the orientation an individual has to the present experience (Bishop et al., 2004). For this orientation, an individual has to be open to being curious about where the mind wanders and the different items that are present in the environment. An individual has to observe all of the thoughts, sensations, and emotions that are initially seen without creating a state of relaxation or changing the emotions (Bishop et al., 2004). This creates a sense of acceptance of the moment and this is an ongoing process for every experience a person has in a lifetime.

There are three distinct assumptions about mindfulness. First, it is a process of being aware of the experience and not getting lost in one's thoughts. Next, it requires an individual to be open and nonjudgmental to an experience. Finally, it requires the flexibility to focus attention on different aspects of an environment (Harris, 2009b). Clinicians work on two core skills when discussing mindfulness with clients, including

the regulation of attention to increase awareness of the present moment and to relate to the environment based on the present experience in a non-judgmental way. For instance, therapy activities would incorporate these skills by having the client observe what is happening in the present environment and then work on not focusing on any one aspect of the environment.

Facets of Mindfulness

There have been several measurement instruments created to assess the construct of mindfulness. A few psychometric measures that assess the tendency of the individual to use mindfulness in daily life include the Freiburg Mindfulness Inventory (FMI; Buchheld, Grossman, & Walach, 2006), the Mindful Attention Awareness Scale (MAAS; Brown & Ryan, 2003), the Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004), and the Mindfulness Questionnaire (MQ; Chadwick, Hember, Mead, Lilley, & Dagnan, 2008). Each of these questionnaires are self-report forms in which the individual rates his or her experiences with varying aspects of mindfulness, such as being present in daily life, being non-judgmental of experiences, and accepting current experiences.

To understand what makes mindfulness approaches effective, researchers first need to understand the mechanisms underlying these mindfulness approaches. There are questions about whether the construct of mindfulness should be conceptualized as either a single factor or a multi-factor construct. The MAAS seems to be a single factor instrument that looks at the tendency to be attentive and aware of present moments in daily life (Brown & Ryan, 2003). In contrast, the KIMS and the MQ appear to measure multiple facets with each questionnaire identifying four separate facets (Baer et al.,

2006). An initial study conducted by Baer, Smith, Hopkins, Krietemeyer, and Toney (2006) on five different measures of mindfulness showed a possible five-facet model for this construct. The five questionnaires used were the Mindful Attention Awareness Scale (MAAS), the Freiburg Mindfulness Inventory (FMI), the Kentucky Inventory of Mindfulness Skills (KIMS), and the Mindfulness Questionnaire (MQ). All of the established mindfulness questionnaires studied were chosen based on them having good internal consistency. Items for these five instruments were combined to create a 112-item questionnaire. The study indicated mindfulness has a five-facet solution (Baer et al., 2006). The final part of the study was to look at the replicability of the five-facet structure found and in this final step the five-facet structure was replicated. Facets that emerged were named Observing, Describing, Acting with Awareness, Nonjudging of Inner Experience, and Nonreactivity to Inner Experience (Baer et al., 2008). The first facet of *Observing* refers to the noticing and attendance to both internal and external experiences and includes such things as thoughts, emotions, sensations, sounds, smells and visual stimuli. The facet of *Describing* shows how the individual uses words to explain internal experiences. *Acting with Awareness* includes awareness to the present moment and not behaving as if the individual is on autopilot (Baer et al., 2008). Next, is the *Nonjudging of Inner Experiences* facet, which refers to having a non-judgmental view of thoughts and emotions. The last facet of *Nonreactivity to Inner Experiences* allows the individual to let thoughts and feelings to occur with an acceptance and to not get caught up with the inner experiences of a moment.

These five facets of mindfulness were then used to create the 39-item Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006). This scale was created by using

items that loaded most highly with each of the five facets of mindfulness. Four of the found facets (Observing, Describing, Acting with Awareness, and Nonjudging of Inner Experiences) each have eight items on the questionnaire, while the Nonreactivity to Inner Experiences facet has seven items. This questionnaire asks individuals to rate the degree to which the statement is true for them (Bohleider, ten Klooster, Fledderus, Veehof & Baer, 2011). It utilizes a five-point Likert scale with scores ranging from 1 (*never or very rarely true*) to 5 (*very often or always true*). Higher scores on each subscale indicate a higher degree of mindfulness.

However, even with the creation of the FFMQ, there were still concerns about the Observing facet due to its potential to be sensitive to changes with regular meditation practice. Baer and colleagues (2008) suggested this sensitivity might change the relationship of the Observing facet with the other facets in the model. To investigate the construct validity of the FFMQ, Baer and colleagues (2008) constructed a study with individuals who had a history of meditative practices, which was defined as regular practice (at least one or twice per week) and those who had no prior experience with meditative practice. Along with the construct validity of the measurement, the study looked at the relationship between meditation experience, FFMQ, and the psychological well being of the participant. The study found that all facets except for Acting with Awareness were highly correlated with meditation experience (Baer et al., 2008). The study also found that the Observing facet had varying relationships across the different levels of meditation experience. For example, those who scored higher on the Observing facet had higher levels of psychological adjustment when they used meditation techniques (Baer et al., 2008). Baer and colleagues (2008) suggested that mindfulness

approaches teach skills to individuals that allow them to be nonjudgmental of all stimuli in the environment and this allows the individual to not focus on the unpleasant or pleasant stimuli

Mindfulness in Therapy

Mindfulness activities in therapy are not used to change clients, but are used to teach clients to be aware of what is currently happening in both the inner and exterior world surrounding them. There are a variety of conditions that are treated using mindfulness approaches, including pain management, stress relief, anxiety, depression, and weight loss (Harrington & Dunne, 2015). Studies on clients with chronic pain have found that those who used mindfulness-based activities had significant improvements in the level of pain and other medical symptoms not associated with the pain (Davis & Hayes, 2011).

There are a variety of mindfulness approaches and each approach uses a variety of techniques, but they all contain a meditative component. Kabat-Zinn (2003) proposed two forms of meditation practice. The first form of meditation is known as formal meditation, which is the first portion of the meditation process and can be thought of as providing the structure for a mindful way of living. Formal meditation requires the individual to be in a sitting or lying position while noticing his or her breathing (Kabat-Zinn, 2003). This form of mindfulness can be seen in some of the most basic mindfulness techniques such as simply observing one's own breath. The next form of meditation is informal meditation, which occurs spontaneously in daily activities and in therapy (Kabat-Zinn, 2003). This form requires the individual to make conscious decisions to be nonjudgmentally aware of all experiences in life no matter how simple or

complex these experiences are. An example of this type is seen in the ACT activity known as “Leaves on a Stream.” In this activity, individuals are asked to place all thoughts and emotions on a imaginary leaf in their mind and send the thought down the stream without becoming fixated on any one thought or emotion (Harris, 2009a).

One of the first aspects of mindfulness that is taught to clients in therapy is to become aware of all aspects of the present experience that they are experiencing, including shifting thoughts, emotions, and sensations. For example, in Dialectical Behavior Therapy, clients may be asked to sit for a pre-determined period of time and allow all thoughts and emotions to pass through their mind without judging or becoming fixated on any one thing. After this activity is over, the client and therapist will then have time to discuss what the client experienced. Activities such as these also give the client the opportunity to notice if one specific thought, feeling, or sensation becomes the center of focus when working towards being non-judgmental of the experience. In this processing of the experience, clients will learn to have an attitude of curiosity about what the experience entails and how the mind shifts to varying thoughts and stimuli (Bishop et al., 2004).

Both traditional cognitive behavioral and mindfulness-based approaches agree that thoughts contribute to the difficulties from which a client is suffering (Montgomery et al., 2013). However, unlike traditional cognitive behavioral approaches, which place an emphasis on changing those thoughts, mindfulness approaches look to alter the relationship between the individual and the thoughts (Greco & Hayes, 2008). When working on this aspect of mindfulness, an individual will strive to just observe the thoughts and experience rather than to create or change his or her emotions to something

else. This requires the individual to be accepting of the experiences, thoughts and emotions that arise in the moment.

Mindfulness Based Therapy Approaches

For most people, being mindful is not a natural behavior and requires practice and the intention of being mindful. In contrast to being mindful, individuals will often act in a mindless way, which is described as having no awareness about what is happening in the present moment and focusing on the past and future events (Greason & Welfare, 2013). Mindfulness based approaches in therapy are not used as simply a relaxation tool to manage an individual's mood. Rather, these approaches are used to manage the observed effects of an individual's mood and behaviors (Kabat-Zinn, 1990). In therapy, the use of mindfulness techniques does not require individuals to change their thoughts and feelings to stop rumination, but rather the individual will learn to observe those thoughts and feelings without allowing them to control their actions and behaviors.

Clients are able to achieve a state of mindfulness with similar activities from each of the differing mindfulness-based approaches. For instance, clients can reach a state of mindfulness when they sit in an upright position and spend time focusing on their breathing. When using this technique, the individual places an emphasis on simply acknowledging what the mind wanders to without judging the object that catches his or her attention (Bishop et al., 2004). For this state of mindfulness, clients' thoughts and emotions are witnessed by the mind without having an automatic reaction or creating a habitual reaction to the event (Bishop et al., 2004). It is believed this allows clients to respond in a reflective manner instead of a reflexive manner.

The four most commonly used mindfulness-based approaches are Mindfulness-Based Stress Reduction, Mindfulness-Based Cognitive Therapy, Acceptance and Commitment Therapy, and Dialectical Behavior Therapy. Within these four therapeutic approaches there are similarities and differences in how mindfulness is approached and taught by the therapist.

Mindfulness-Based Stress Reduction. This approach was developed by Jon Kabat-Zinn to treat those with severe chronic pain problems (Kabat-Zinn, 1990). Mindfulness-Based Stress Reduction was the first approach to bring mindfulness activities into psychotherapy (Kabat-Zinn, 1990). Mindfulness-Based Stress Reduction was initially created for those attending an outpatient stress reduction clinic as a training channel to relieve suffering and to serve as a model for other hospitals (Kabat-Zinn, 2003). In this approach, clients attend group sessions over the course of 8 to 10 weeks for approximately two and a half hours a week. Individuals who attend these courses are asked to practice the skills learned for a minimum of 45 minutes a day outside of the group sessions. There are several activities that individuals learn over the course of the program; however, all of the exercises instruct individuals to focus all of their attention on the target stimuli (breathing, sitting, etc.). Other activities learned within Mindfulness-Based Stress Reduction are sitting and walking meditation, yoga, and body awareness (Morales Knight, n.d.).

Mindfulness-Based Cognitive Therapy. After the initial development of Mindfulness-Based Stress Reduction, a new approach was developed as a combination of Mindfulness-Based Stress Reduction and Cognitive Behavioral Therapy known as Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002). This

approach was developed to prevent and treat recurring depression in adults. A previous study showed that Mindfulness-Based Cognitive Therapy is an effective prevention intervention for individuals who have had three or more episodes of depression and was found to be equivalent to maintenance antidepressants for symptom reduction (Segal et al., 2010). Mindfulness-Based Cognitive Therapy has the treatment goal of allowing clients to develop an awareness of negative thinking patterns and then learning to respond in a more effective manner to those patterns by accepting those negative thought patterns (Ma & Teasdale, 2004). Similar to other Cognitive Behavioral Therapy programs, Mindfulness-Based Cognitive Therapy gives clients the skills to move away from responding to negative events in an automatic fashion.

Mindfulness-Based Cognitive Therapy is an eight-week intervention program where individuals attend weekly group sessions that last for approximately two to two and half hours. In these sessions, participants learn mindfulness skills and then are encouraged to use these skills at home. The program begins with clients identifying the automatic negative thought patterns that they experience and then adding mindfulness exercises that promote acceptance of the experience (Herbert & Forman, 2011). One of the most widely used Mindfulness-Based Cognitive Therapy techniques is known as the “three-minute breathing space” and gives the client a very brief insight into what mindfulness entails (Segal et al., 2002).

Recently developed evidence-based behavioral therapies include mindfulness as a key intervention used within therapy sessions. Two of these newer approaches are Acceptance and Commitment Therapy and Dialectical Behavior Therapy.

Acceptance and Commitment Therapy. In contrast to Mindfulness-Based Stress Reduction, both Acceptance and Commitment Therapy and Dialectical Behavior Therapy use shorter activities that do not require the client to engage in formal meditation (Baer et al., 2006). Acceptance and Commitment Therapy was developed by Steve Hayes (Hayes, Strosahl, & Wilson, 1999) with the aim of developing clients' psychology flexibility. Psychological flexibility is described as the ability to be in the present moment with full awareness of the experience and to then take action that is based on one's personal values (Harris, 2009). Acceptance and Commitment Therapy allows clients to have a better understanding of how thoughts and cognitive processing influence emotional pain (Chapman, 2006).

Unlike other mindfulness-based approaches, Acceptance and Commitment Therapy provides hundreds of activities to encourage clients to develop the necessary skills to be mindful in life and to increase their own psychological flexibility. Acceptance and Commitment Therapy assumes that language and cognitive processing infers with clients direct experience with environmental stimuli and thus creates inflexible behaviors (Harris, 2009b). Acceptance and Commitment Therapy defines mindfulness as being conscious of the surrounding experience instead of being lost in our thoughts (Harris, 2009b). When developing mindfulness skills in Acceptance and Commitment Therapy sessions, clients will learn to be flexible in paying attention to both the external world and the internal psychological world. The aim of Acceptance and Commitment Therapy mindfulness is to accurately notice what is happening in the environment while gathering important information about how to behave (Harris, 2009b). In Acceptance and Commitment Therapy, the mindfulness component is broken down

into four distinct skills: defusion, acceptance, spacious awareness, and present moment awareness. The defusion skill allows individuals to distance themselves from unhelpful thoughts and the acceptance skill allows them to let painful experiences to come and go without creating a struggle (Harris, 2009b). The spacious awareness skill involves noticing thoughts and feelings but not using them as a way to identify oneself. Finally, the present moment awareness skill encourages clients to engage in the here-and-now experience while having a non-judgmental attitude (Harris, 2009b). Acceptance and Commitment Therapy adds the additional component of how thinking and cognition influence individuals' struggles in life. With this additional component, mindfulness activities allow clients to learn to discriminate between noticing that thoughts are occurring and allowing those thoughts to control their lives (Harris, 2009). Mindfulness activities are used in therapy sessions when clients are exceedingly concerned with past or future events and are not connected with the here and now experience.

Dialectical Behavior Therapy. Marsha Linehan developed Dialectical Behavioral Therapy (Linehan, 1993) for a specific population of clients who had suicidal thoughts (Chapman, 2006). Many of the clients who Dr. Linehan treated were women who were diagnosed with Borderline Personality Disorder. While treating the clients, Dr. Linehan observed that many clients dropped out of treatment when therapy focused only on behavioral and cognitive changes (Linehan, 1993). Dr. Linehan then combined parts of other therapeutic approaches such as mindfulness and acceptance-based techniques to create Dialectical Behavioral Therapy. Dialectical Behavioral Therapy uses the idea of dialectical philosophy that is characterized by balancing the two opposing forces of acceptance and change in therapy (Linehan, 1993). These forces can cause tension in

therapy when a therapist encourages change in the client and the client wishes to just be accepted. For this reason, the therapist is constantly balancing the two forces in session in order to help clients reach their treatment goals (Linehan, 1993).

In Dialectical Behavioral Therapy, there are specific stages that clients will work through when receiving therapy and working on their treatment goals. In Stage 1, the focus of therapy is to stabilize the client and allow the client to achieve behavioral control (Dimeff & Linehan, 2001). This is the first stage because Dialectical Behavioral Therapy was developed to treat Borderline Personality Disorder and one of the traits of the disorder is that the person engages in self-injurious behaviors; thus behavioral stabilization has to be the first/primary goal of therapy. Other goals of this stage are to create stability in the client's attendance to therapy. Stage 2 works on the non-traumatic emotional experiences that a client is undergoing. The following stage (Stage 3) works toward the goal of achieving a higher level of "ordinary" happiness by reducing ongoing problems associated with the disorder (Dimeff & Linehan, 2001). Additionally, the final stage is for the clients to achieve a sense of joy and completeness in their life.

In Dialectical Behavioral Therapy, once a client is stable, the next step is for the client to learn the core skills, which include the use of mindfulness. Mindfulness is the "core skill" in Dialectical Behavioral Therapy that allows change to occur in an individual's life by increasing his or her ability to focus on one thing in a moment without judgment (Turner, 2009). Dialectical Behavioral Therapy has the principle that a clients can mindfully accept themselves while also striving to make change in their own life (Montgomery et al., 2013). Clients who attend therapy with a Dialectical Behavioral

Therapy approach attend both individual and group sessions in which mindfulness skills are taught.

Mindfulness in Dialectical Behavioral Therapy is taught with the idea of syncing acceptance and change in the client's life. Dialectical Behavioral Therapy mindfulness activities are similar to MBSR skills in that they promote nonjudgmental views of thoughts, environmental objects, and emotions. Dialectical Behavioral Therapy mindfulness skills are aimed at reducing the confusion about the self. However, Dialectical Behavioral Therapy approaches the learning of these skills in a different manner (Baer, 2003). In Dialectical Behavioral Therapy, mindfulness is defined by six skills from two different categories. The first category, "what" skills, is based on what an individual is doing and includes the ideas of observing, describing, and participating. The second category is known as the "how" skills and includes being nonjudgmental, being one-mindful, and being effective. Another difference between Dialectical Behavioral Therapy and Mindfulness-Based Stress Reduction is the amount of time clients attend therapy. Instead of attending group therapy sessions for eight weeks as seen in Mindfulness-Based Stress Reduction, clients in Dialectical Behavioral Therapy have no specific time frame for which they will attend sessions, but rather, clients set a goal for the duration of usage such as one year of treatment (Baer, 2003).

Dialectical Behavioral Therapy has been found to be effective in treating individuals diagnosed with Borderline Personality Disorder. Following a normal Dialectical Behavioral Therapy protocol, Stepp, Epler, Jahng, and Trull (2008) investigated the effect of Dialectical Behavioral Therapy skills on different features of Borderline Personality Disorder. Over a 12-month period, participants were provided

with each of the four modes of Dialectical Behavioral Therapy, including (1) individual therapy, (2) weekly skills group, (3) phone consultation, and (4) therapist consultation team meetings. Over the 12-month period, clients incorporated mindfulness skills into each weekly group session along with two extensive group modules of mindfulness to allow for a better understanding of the topic. Each week, participants were given a Dialectical Behavioral Therapy diary card by their individual therapists to track behaviors and the incorporation of learned skills, including mindfulness, into daily life. Based on the diary cards, participants used on average 7.1 skills per week and indicated they used the Mindfulness skill more often than the other Dialectical Behavioral Therapy skills. Stepp and colleagues (2008) found that clients used the Mindfulness skill 44% of the time followed by Distress Tolerance (29%), Emotion regulation (18%), and Interpersonal Effectiveness (9%).

Vujanovic, Bonn-Miller, Bernstein, McKee, and Zvolensky (2010) studied the impact of mindfulness skills on multiple facets of emotion dysregulation. Emotion dysregulation in an individual is characterized by limited understanding of one's emotions, increased emotional states, maladaptive coping skills for these increased emotional states, and reactivity to varying emotional states (Vujanovic et al., 2010). The study examined the six facets of emotion dysregulation using the Difficulties Regulating Emotions Scale (DERS; Gratz & Roemer, 2004). The six facets included in the DERS are Lack of Emotional Clarity, Nonacceptance of Emotional Responses, Limited Access to Emotion Regulation Strategies, Lack of Emotional Awareness, Difficulties Engaging in Goal-Directed Behavior, and Impulse Control (Gratz & Roemer, 2004). The study

found that higher levels of the mindfulness facet accepting without judgment were associated with lower levels of difficulties with emotion regulation.

Client Perception of Mindfulness

Horst, Newsom, and Stith (2013) studied the perception of using mindfulness in therapy for both therapists and clinicians using it for the first time. Several themes were identified about therapeutic processes that incorporate mindfulness approaches. These themes can be organized into two categories: the experience of using mindfulness activities and suggestions on how the activities can be successfully utilized in therapy (Horst et al., 2013). In the first category, clients reported that it was helpful to use the activities in response to the presenting problem and to help with transitions in session. One benefit of the activities described by both therapists and clients was the conversations that occurred due to both individuals completing the activity together in session. In the second category, themes of being a shared experience, continued practice, flexibility, and the overall processing experience appeared.

Research has begun to look at how a client's use of mindfulness activities can have a positive impact on not only the outcome for the client, and also on how the client perceives the therapeutic process as a whole. However, few studies have looked at how a therapist's personal use of mindfulness can impact the therapeutic process. Greason and Welfare (2013) examined how therapists mindfulness practice can have a positive impact on common therapeutic factors that have been shown to lead to more positive client outcomes in therapy. Greason and Welfare (2013) measured three factors of therapy that have been shown to have a positive influence on the client's outcome: empathy, congruence, and the therapeutic working alliance. Results of the study indicated that

therapists who use mindfulness were better able to attend to various stimuli during the session. This attention was positively correlated to the client's perception of the common factors of the therapeutic process (Greason & Welfare, 2013).

Limitations in Current Literature

While there is extensive literature on the effectiveness of mindfulness based therapy approaches to treat a variety of psychological disorders, there is limited research on the effectiveness of newer generations of mindfulness approaches such as Dialectical Behavior Therapy and Acceptance and Commitment Therapy. Furthermore, although there is research on what facets are considered to be part of the construct of mindfulness there is no research on which facets clients use most frequently. Finally, there is limited research on what parts of mindfulness activities clients find to be the most beneficial for their overall treatment outcome.

Current Study

The purpose of the current study is to assess client perceptions of the utilization of mindfulness activities in his or her overall therapeutic process. Additionally, the study explores which facets of mindfulness that clients utilize most in their lives. For the purpose of this study, the Kabat-Zinn (1990) definition of mindfulness will be used when discussing the construct. Thus, mindfulness in the context of the present study is defined as an awareness that occurs by paying attention on purpose, in the present moment, and being non-judgmental to the unfolding experience in a moment-by-moment fashion (Kabat-Zinn, 1990). The present study investigated three research questions. Research Question 1 examined how clients perceive the effectiveness of the use of mindfulness activities in therapy for their presenting problem. The second research question looked at

how clients view the addition of mindfulness activities to be an acceptable treatment approach based on personal values and beliefs. Finally, the third research question for this study examined which facet(s) of mindfulness from the therapeutic process clients use the most in their lives.

Chapter Two: Methods

Participants and Design

The sample consisted of 21 therapy clients who received therapeutic services from a Southern private practice. The sample consisted of 6 men and 15 women. Participants ranged in age from 19 years old to 61 years old with a mean age of 42.67 ($SD = 12.36$). The sample consisted of 18 Caucasian participants and 3 African American participants. The modal frequency of education level was 12 years. The sample was composed of 11 participants who graduated from high school, 2 participants who indicated they had some college experience, 3 participants who had an associate's degree, 4 participants who had a bachelor's degree, and 1 participant who indicated he or she had a master's or professional degree. The number of therapy sessions attended by clients where mindfulness activities were utilized ranged from 3 sessions to 60 sessions with a mean of 19 ($SD = 17.71$). The demographics characteristics of the participants are presented in Table 1.

Table 1. Participant Demographics Compared to 2010 US Census Data

	Study	US Census
Gender (% Male/% Female)	71.41/28.59	50.80/49.20
Ethnicity (% Caucasian/ % African American)	85.71/14.29	75.67/213.40
Age (SD)	42.67 (12.36)	37.70
Level of Education in Years (SD)	13.19 (1.57)	
Number of Therapy Sessions with Mindfulness Activities (SD)	19.00 (17.71)	

Notes: For age, highest level of education, and number of therapy sessions using mindfulness activities the mean is reported with standard deviation in parenthesis. US Census data based on 2010 Census information.

Recruitment Center

All participants from this study were clients at a Southern private practice that closed in 2017. The private practice specialized in Dialectical Behavior Therapy and used the four modes of therapy including (1) weekly skills group therapy, (1) individual therapy, (3) therapist consultation meetings, and (4) skills coaching over the phone (Linehan, 1993). The typical diagnoses seen at the private practice were personality disorders, mood disorders, and anxiety disorders. All therapy sessions included one mindfulness activity. Participants began learning mindfulness activities on the second session, which followed an initial evaluation session. All participants saw the same therapist who was also the data collector for this study.

Measures

Demographics. A demographic questionnaire with seven questions was given to the participants. The first five questions assessed age, gender, ethnicity, highest level of education, and previous therapy attendance. These questions were formatted as multiple-choice items. The sixth and seventh items focused on the extent to which participants found therapy effective and past use of mindfulness activities in therapy. These questions were formatted as Likert Scale items ranging from 1 (*Not Effective*) to 9 (*Effective*). See Appendix A.

Five-Facet Mindfulness Questionnaire. The Five-Facet Mindfulness Questionnaire (FFMQ; Bear et al., 2006) was developed through factor analysis of five previously accessible self-report mindfulness questionnaires including the Freiburg Mindfulness Inventory (Buchheld et al., 2006), the Mindfulness Questionnaire (Chadwick et al., 2008), the Kentucky Inventory of Mindfulness Skills (Baer et al., 2004), the Cognitive and Affective Mindfulness Scale (Feldman, Hayes, Kumar,

Greeson, & Laurenceau, 2007), and the Mindful Attention and Awareness Scale (Brown & Ryan, 2003). The FFMQ was created to measure five facets of mindfulness: *Observing, Acting with Awareness, Describing, Nonreactivity to Inner Experiences, and Nonjudging of Inner Experience*. The FFMQ consists of 39 questions using a five-point Likert scale that asks participants to choose the option that best describes “your own opinion of what is generally true for you (Baer et al., 2006).” Scores range from 1 (*Never or rarely true*) to 5 (*Almost or always true*). An example question from the FFMQ is “When I am walking, I deliberately notice the sensations of my body moving.” A high score means that the individual experienced the statement more frequently. Eighteen items for this scale use reverse scoring (3 Describing, 7 Acting with Awareness, and 7 Nonjudging of Inner Experiences). The five factors show good internal consistency, with Cronbach’s alpha ranging from .72 to .92 (Baer et al., 2008). See Appendix B.

Mindfulness Experience Questionnaire. The Mindfulness Experience Questionnaire consists of 10 items using themes from Horst, Newman, and Stith (2013) study. Interview questions were formatted to allow for closed-ended responses that were based off responses from participants in the Horst, Newman, and Stith (2013) study. The questionnaire assessed how participants perceive mindfulness activities in individual therapy sessions. The first questions looked at how many therapy sessions the participants used mindfulness activities and the second question assessed whether participants would want more or fewer mindfulness activities in future therapy sessions. The next three questions looked at whether participants viewed the mindfulness activities as being acceptable and effective at meeting their presenting problems in therapy. These questions are Likert Scale items ranging from 1 (*Unacceptable*) to 9 (*Acceptable*). The

final four questions assessed what time during individual therapy session was most beneficial to use mindfulness activities (beginning, middle, or end), which mindfulness activities were the most beneficial, and which aspects of the mindfulness activities were the least beneficial. Questions 7 through 9 are rank-order items and question 10 had participants pick two of the five options. See Appendix C.

Procedures

Before beginning the study, the owner of the private practice was contacted to discuss the purpose of the present study. After the researcher obtained permission from the private practice owner (See Appendix D) and approval was obtained from the Western Kentucky University Institutional Review Board (See Appendix E), data collection began by a licensed psychological associate who was trained in integrating mindfulness activities into therapy sessions.

After an individual therapy session, the licensed psychological associate, who was also the data collector, provided therapy clients with an explanation of the nature of the study by reviewing the informed consent document with them. Then, participants were asked if they were willing to participate in the study. Those willing to complete the questionnaires were given an informed consent to sign. See Appendix F. Participants were given the demographic portion of the questionnaire packet to assess their age, gender, ethnicity, and previous therapy history. After completing the demographic portion, participants were asked to complete the 39-item Five-Facet of Mindfulness Questionnaire. Finally, participants were asked to complete the 10-item Mindfulness Experience Questionnaire.

When all portions of the questionnaire were completed, the researcher provided the participants with a debriefing statement and thanked them for their involvement. The study materials took approximately 20 minutes for the participants to complete.

Chapter Three: Results

Preliminary Analyses

Prior to examining the three research questions, it was determined that there was no missing data. First, items from each of the five facets of the FFMQ were averaged to create indices of facet utilization. The *Observing, Describing, Acting with Awareness*, and *Nonjudging of Inner Experiences* index scores were created using the eight items that make up those facets. The *Nonreactivity to Inner Experiences* facet had seven items averaged to create single index score. Cronbach's alpha was computed for each of facets of mindfulness from the FFMQ and were found to have acceptable internal consistency. This data is presented in Table 2

Table 2. Cronbach's Alpha by Facet

Facet	Cronbach's alpha
Observing	.66
Describing	.62
Acting with Awareness	.71
Nonjudging of Inner Experiences	.82
Nonreactivity to Inner Experiences	.72

Research Question One

The first research question for this study looked how clients perceive the effectiveness of the use of mindfulness activities in therapy for their presenting problem. To evaluate this research question, descriptive statistics of the participants' belief that the use mindfulness activities was effecting in treating their presenting problem were created.

The mean level of perceived effectiveness for the mindfulness activities was 8.00 with a standard deviation of 1.41.

Research Question Two

The second research question looked at how clients view the addition of mindfulness activities to be an acceptable treatment approach based on their personal values and beliefs. Similar to research question one, descriptive statistics of the participants' belief that the use mindfulness activities was acceptable treatment intervention were created. The mean level of treatment acceptability for this study was 7.95 with a standard deviation of 1.43. Table 3 shows the means and standard deviations from questions three, four, and five on the Mindfulness Experience Questionnaire that targeted participants' perceptions on how the mindfulness activities impacted therapy.

Table 3: Mean Scores and Standard Deviations for Effectiveness and Acceptability of Mindfulness Activities on Treatment Outcome For the Utilization of Mindfulness Activities

Question 3: Treatment Acceptability Based on Personal Values, Likes, and Needs	7.95 (1.43)
Question 4: Beneficial for Overall Therapy Process	8.14 (1.49)
Question 5: Effectiveness of Mindfulness Activities as An Intervention for Presenting Concerns	8.00 (1.41)

Note: Standard deviations appear in parenthesis next to each mean. Scores range from 1 (*Unacceptable*) to 9 (*Acceptable*)

Research Question Three

The third research question for this study looked at which facet(s) of mindfulness from the therapeutic process clients use the most in their lives. To evaluate the research

question on which facets of mindfulness clients used the most in their lives the means of the five facet single index scores were computed and compared. Means and standard deviations for the five facets from the FFMQ appear in Table 4.

Table 4. Means and Standard Deviations for the Facets of Mindfulness

Observation	3.95 (0.87)
Describing	3.07 (0.94)
Acting with Awareness	2.79 (0.88)
Nonjudging of Inner Experiences	3.31 (0.97)
Nonreactivity to Inner Experiences	2.88 (0.91)

Note: Standard deviations appear in parenthesis next to each mean. Scores range from 1 (*Never or rarely true*) to 5 (*Almost or always true*).

Additionally Findings

The remaining questions from the Mindfulness Experience questionnaire were examined using visual models to assess perceptions of the utilization of mindfulness activities in therapy sessions. The results are reported with the use of graphs. Question two on the Mindfulness Experience Questionnaire examined if clients would prefer more or less time spent on mindfulness activities in future therapy sessions. Results found that 61.9% of clients preferred more mindfulness activities, 23.8 preferred the same amount of mindfulness activities (1 activity in session), and 14.3% preferred less mindfulness activities in future therapy sessions. This suggests that clients would prefer more mindfulness activities in future therapy sessions. Figure 1 shows participant preference for the amount of mindfulness activities incorporated into future therapy sessions.

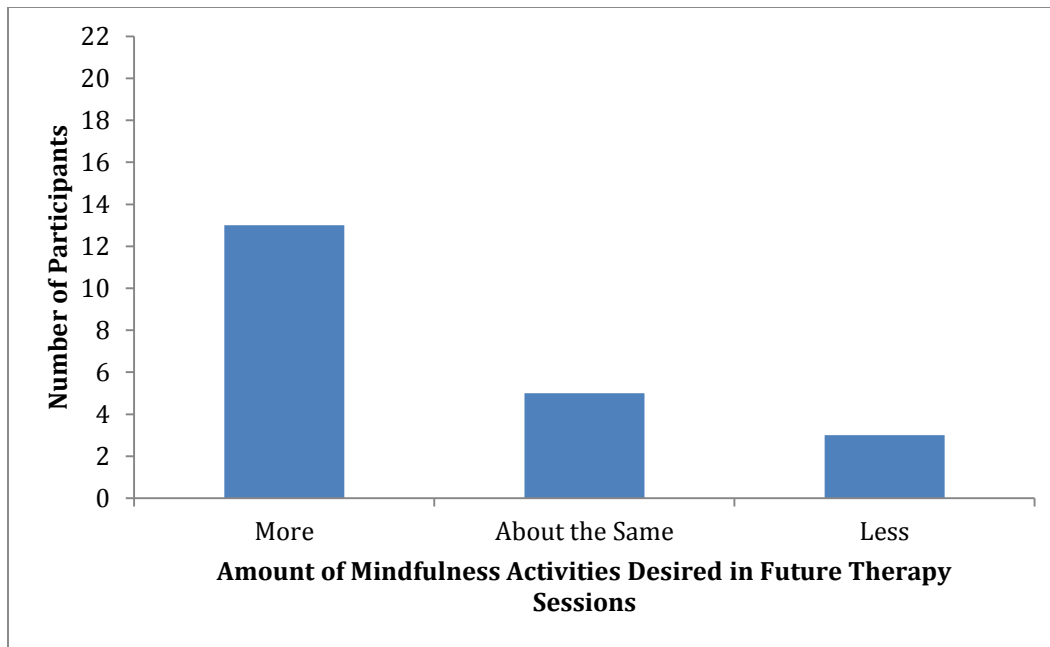


Figure 1: Amount of Mindfulness Activities Desired in Future Therapy Sessions

Question six on the Mindfulness Experience Questionnaire looked at client preference for the inclusion of mindfulness activities in future therapy sessions based on past usage of mindfulness activities. For this study, 85.7 % clients indicated they would prefer mindfulness activities in future sessions and 14.3% indicated they would prefer future therapy sessions without mindfulness activities.

Item seven on the Mindfulness Experience Questionnaire looked at what part of the therapy session clients found mindfulness activities to be most desirable. Participants ranked the time periods from the most beneficial (1) to least beneficial (3). Results indicated that 47% of participants preferred mindfulness activities at the beginning of the therapy session, 19% of participants preferred mindfulness activities in the middle of the session, and 34% of participants preferred mindfulness activities to be at the end of the session. Figure 2 shows what time period (beginning, middle, or end) of the therapy session participants found the mindfulness activities to be most beneficial

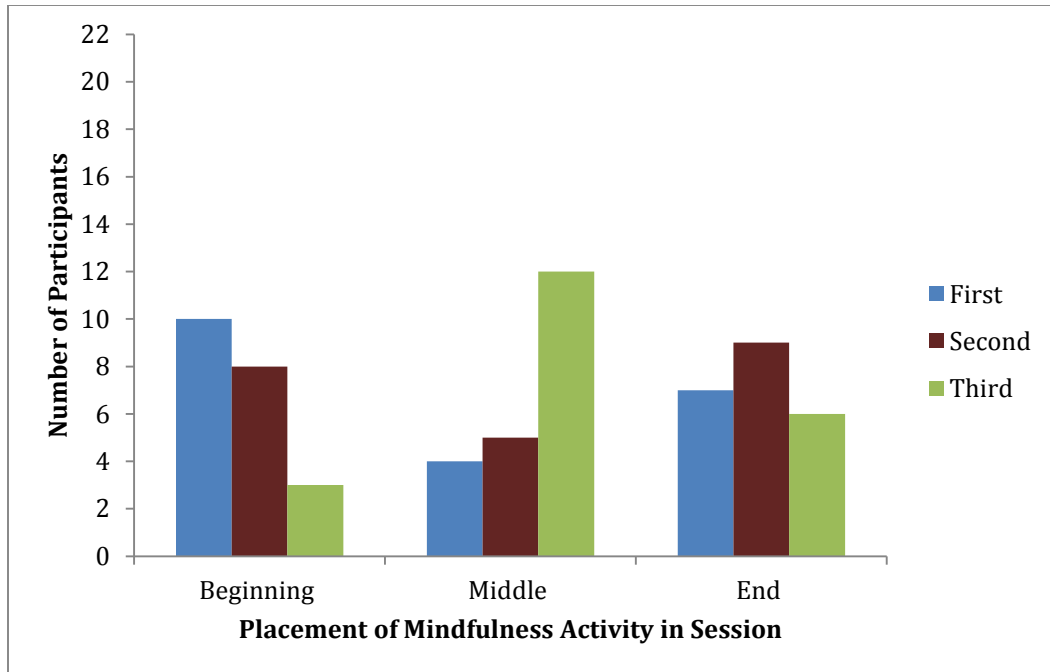


Figure 2: Rank Placement for Mindfulness Activities in the Therapy Session

Question eight on the Mindfulness Experience Questionnaire asked participants to rank five mindfulness activities used in therapy from most to least helpful. Results from this study indicated that 52% of participants reported the mindfulness of breath to be the most helpful, 24% reported the mindfulness of observation to be the most helpful, 14% indicated the mindfulness of thought activities were the most helpful, and 5% reported the mindfulness of participation or mindfulness of body movements to be the most helpful. Figure 3 shows which specific mindfulness activities participants preferred in therapy sessions and shows how participants ranked each activity from most helpful (1) to least helpful (5).

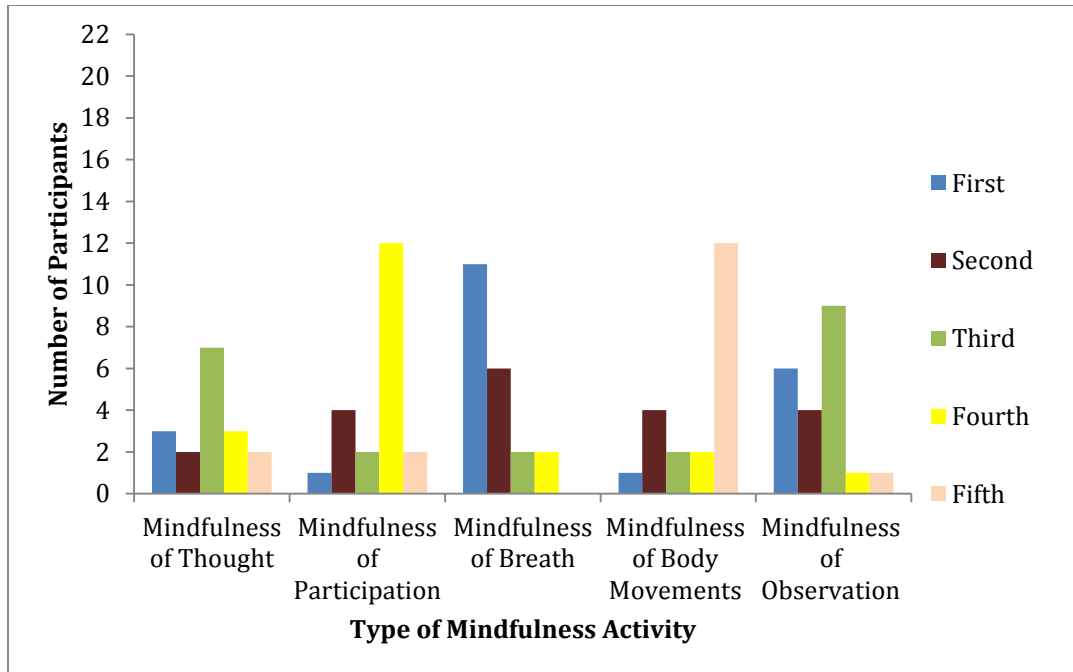


Figure 3: Rank Order of Most Helpful to Least Helpful Mindfulness Activities

Question nine on the Mindfulness Experience Questionnaire asked participants to rank the helpfulness of the facet of mindfulness from most to least helpful. Participants ranked the different facets from most helpful (1) to least helpful (3). Results from this study indicated that 57% of clients reported the focus on breathing facet to be helpful, 29% reported the most helpful facet was removing focus from thoughts and emotions, and 14% reported that noticing their environment was the most helpful facet of mindfulness. Figure 4 shows which specific facet of mindfulness participants from this study found to be the most beneficial from the different mindfulness activities.

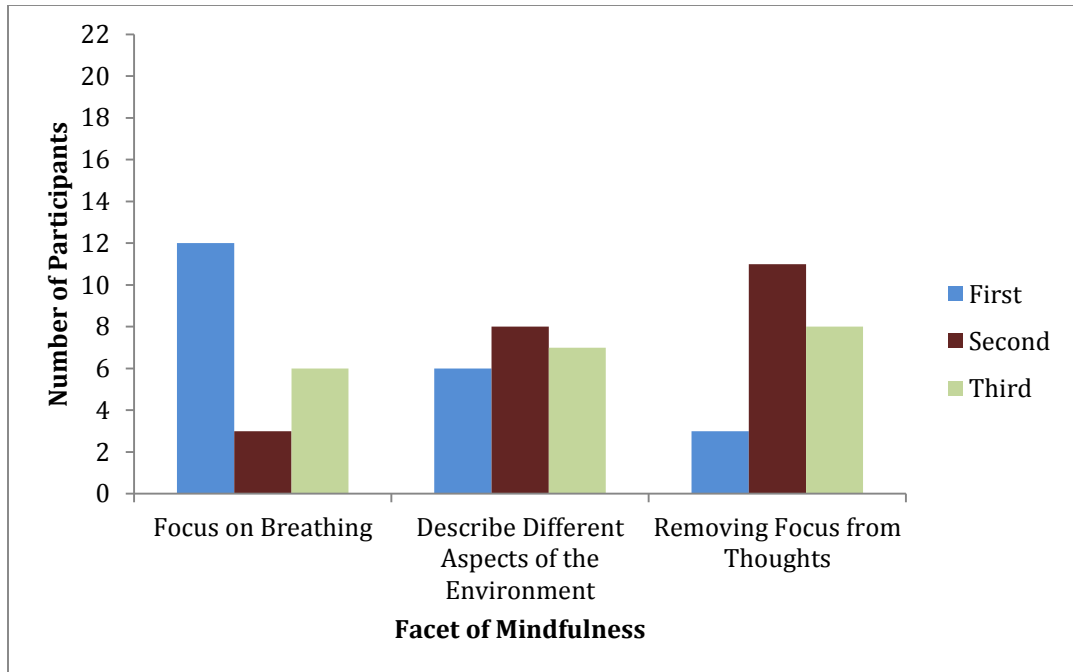


Figure 4: Rank Order for Most Helpful to Least Helpful Facet of Mindfulness

Item 10 on the Mindfulness Experience Questionnaire asked clients to pick two of the five options on how mindfulness activities impacted the therapy session. Participants provided their top two ways that mindfulness activities enhanced the therapeutic process from the list of five potential factors. Results indicated that participants chose mindfulness activities allowed the therapeutic relationship between client and therapist to form, allowed the client and therapist to share an experience, and provided transitions within the therapy sessions. Figure 5 suggests how the use of mindfulness activities enhanced the overall therapeutic process.

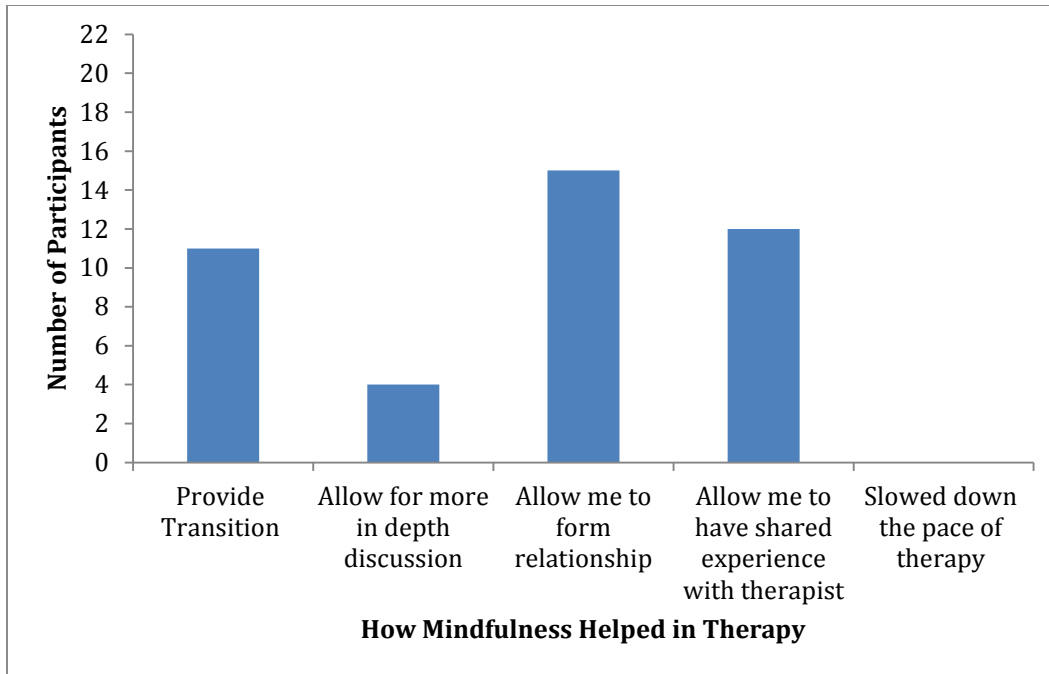


Figure 5: Areas Where Mindfulness Activities Impacted the Overall Therapeutic Process

Chapter Four: Discussion

The current study was designed to examine client perceptions of the use of mindfulness activities within the therapeutic process. Past research has found that mindfulness activities are beneficial in treating a variety of presenting problems such as depression and anxiety (Harrington & Dunne, 2015). However, there has been little research on which facets of mindfulness clients use most in their lives. The study also aimed to understand how clients viewed the mindfulness activities within the therapy session.

The current study had three research questions. The first research question examined how clients perceive the effectiveness of the use of mindfulness activities in therapy to treat their presenting problem. The second research question looked at how clients view the addition of mindfulness activities to be an acceptable treatment approach based on their personal values and beliefs. The last research question examined which facet(s) of mindfulness from the therapeutic process clients use in therapy.

The first research question for this study looked at how clients perceived the effectiveness of the use of mindfulness activities in therapy sessions to treat their presenting problem. The mean level of perceived effectiveness for the mindfulness activities as an intervention for treating their presenting problem was 8.00 on a 9-point Likert scale, which suggests high levels of effectiveness for this sample group. This is similar to the findings from Harrington & Dunne (2015), which showed that therapists use mindfulness activities to treat an assortment of symptoms, including anxiety, depression, pain management, and stress relief. Additionally, the results from this study suggest that mindfulness activities can be a recurring therapeutic activity that can be

utilized as the client progresses through the therapeutic process. This relates to previous research, which found that mindfulness activities help patients to increase relaxation, improve mood, increase self-awareness and self-worth, and decrease problems with sleep disturbances (Finucane & Mercer, 2006).

The second research question examined how clients view the addition of mindfulness activities to be an acceptable treatment approach to treat their presenting problem. The mean value for mindfulness being an acceptable treatment approach was 7.95 on a 9-point Likert Scale, suggesting high levels of perceived treatment acceptability for this sample. These findings might indicate, if replicated by other studies, that mindfulness activities are not solely for clients who have one particular set of beliefs or values, but, rather, can be used for any client seeking therapy.

The third research question for this study looked at which facet(s) of mindfulness from the therapeutic process clients use the most in therapy. This study found the most commonly used facet of mindfulness for this sample was the Observing facet. As shown in Table 4, clients from this study used the Observing facet most frequently followed by the Nonjudging of Inner Experiences facet. This suggests that clients in this sample prefer to notice and attend to their internal experiences as well as their external experiences. This also suggests that clients in this sample spend time noticing their thoughts and emotions along with the sounds, smells, and visual stimuli in the environment around them. The Observing facet may also be the most utilized mindfulness facet due to it also being one of the most frequently taught mindfulness skills in many of the therapeutic approaches.

Interestingly, results from this study found that the least commonly used facets for this sample are the Acting with Awareness and Nonreactivity to Inner Experiences. This indicates that clients from this sample did not spend as much time focusing on being in the present moment or not getting caught up in their inner experiences such as focusing on thoughts or emotional experiences. These findings show that, while clients from this sample were still attending and being nonjudgmental of the different aspects of the experience both internally and externally, they are still getting caught up in those experiences after they occur. This insinuates that clients from this study are having difficulties letting go of the moment and, thus, they have the potential to miss out on other aspects of the environment because their minds are fixated on other stimuli. Gu and colleagues (2016) proposed that practicing mindfulness activities over time can alter the quality of observations that a person experiences. It was suggested that mindfulness practice allows for a stronger relationship between the Observation facet and the Acting with Awareness facet to be developed. Additionally, Gu and colleagues (2016) proposed that, as individuals use more mindfulness in life, they are better able to focus their attention back to the present moment rather than being on autopilot, which would increase the Acting with Awareness usage in daily life.

Furthermore, the results of this study indicate that clients in this sample believe mindfulness activities are beneficial for the overall therapeutic process. The mean level for mindfulness activities perceived as being beneficial was an 8.14 on a 9-point Likert scale, which shows that clients from this sample group see mindfulness activities as being highly beneficial overall. This is similar to findings from Shapiro, Brown, and Biegel (2007) who found that increases in mindfulness within therapy provided overall

beneficial effects on mental health. Specifically, Shapiro and colleagues (2007) found that increases in mindful awareness and mindful attention within therapy were associated with perceived lower levels of rumination and anxiety. Results from this study indicate that not only are mindfulness activities effective for clients alleviating the pain associated with their presenting problem, but they are also beneficial for other aspects of the therapeutic process, such as enhancing the therapeutic relationship and allowing for practice within the therapy session to occur.

Strengths and Limitations

The current study has several strengths. As more therapeutic approaches begin to incorporate mindfulness activities into treatment, it is important to not only understand if these activities are effective, but to also understand how clients utilize mindfulness activities in their lives outside of therapy. This study contributed to the research findings from Horst and colleagues (2013) in that it provided a more detailed understanding on what specific aspects of mindfulness activities a few clients utilize. Additionally, this study looked at which specific facets of mindfulness clients utilize in therapy, which has not been previously studied. This knowledge may help therapists to better tailor mindfulness activities to a client's specific facet preference or to work on increasing usage of other facets. Finally, this study utilized clients with a variety of diagnoses and presenting problems, which supported previous research findings, in that mindfulness activities can be used to treat a variety of presenting problems (Harrington & Dunne, 2015).

There are limitations to the current study. One significant limitation of the study was using all self-report questionnaires. Self-report questionnaires rely on the

assumption that participants are answering all items truthfully and accurately rather than in a random or socially desirable style (Schwarz, 1999). Another significant limitation of this study was the small sample size. Additionally, all data was collected from therapy clients who received therapeutic services from the same private practice. This decreases the overall representativeness of the target population and only allows for responses from clients at one organization. For example in this study, 71.41% of the participants were female and this is higher than 2010 U.S. Census data, which showed 50.80% of the population are female (U.S. Census Bureau Public Information Office, n.d.). Clients were all from the same region of the county and there may be different perceptions of the utilization of mindfulness activities of clients from other areas, which potentially limits generalizability. Additionally, the same therapist who utilized Dialectical Behavior Therapy approaches saw all clients in this study. This decreases the ability to generalize findings to other therapeutic approaches that incorporate mindfulness into their techniques. Finally, this study did not counterbalance the questionnaires, which may have impacted participants' views on mindfulness.

Implications

Participants in this study reported liking mindfulness activities for these reasons: it allowed for the participants to have a shared experience with their therapist and allowed for the therapeutic alliance to develop. This is similar to a mixed-methods study conducted by Finucane and Mercer (2006) in which participants described the therapists as empathic listeners because the therapists were able to relate mindfulness activities back to their own experiences. Therapist and clients from Horst and colleagues (2013) believed mindfulness activities were successful because they allowed the therapeutic

alliance to develop by practicing the exercises together and allowing the client to become comfortable with the therapist.

The reasons that participants in this study reported liking mindfulness activities appear to be related to the common factors in therapy and not specifically to the mindfulness interventions. Common factors in therapy are a core group of elements that are shared by all forms of psychotherapy regardless of the specific interventions used within those therapeutic approaches (Miller, Seidel, & Hubble, 2015). One of the most studied common factors in therapy is the therapeutic alliance, which includes (a) the bond between therapist and client, (b) the agreement on therapy goals, and (c) the agreement on specific therapy tasks to be completed (Wampold, 2015).

Recommendations for Therapists

Understanding client perceptions of the utilization of mindfulness activities within the therapeutic process could allow therapists to tailor future therapy sessions to meet the needs of their clients based on client views. Clients in this sample indicated that they preferred mindfulness activities to be used either at the beginning or the end of the therapy session rather than in the middle of the session. This suggests that, if therapists are going to start using mindfulness activities in therapy, they should include the activities at the beginning of the session to allow clients to get into the present moment with therapeutic expectations that the client will continue being in the present moment during the rest of the session. These findings relate to those from Horst and colleagues (2013), where both therapist and client participants indicated that mindfulness activities allowed them to refocus on the current therapy session rather than being caught up in what was occurring before the session. Additionally, similar to Horst and colleagues

(2013) participants from this study indicated that mindfulness activities provided transitions within the therapy session from one activity to the next.

Clients in this sample indicated they view mindfulness activities that focus on observing both internal and external experiences as helpful in treating their presenting problem. Results from this study indicated that clients found activities that allowed them to focus on breathing to be the most beneficial for treating their presenting problem. These findings are similar to Finucane and Mercer (2006) who found that the most used mindfulness activity three months post therapy by participants was a three-minute breathing activity. Additionally, Finucane and Mercer (2006) found that participants use breathing activities for two reasons: (1) to recognize and disengage from worrisome thinking, and (2) to cope with the physiological symptoms associated with their anxiety.

Future Research

Future research should focus on determining whether similar perceptions exist for clients receiving other therapeutic approaches that utilize mindfulness activities. For instance, research could look at Acceptance and Commitment Therapy, which is considered to be a third-wave behavioral approach like Dialectical Behavior Therapy. By looking at other therapeutic approaches, additional perceptions of mindfulness could be studied to further enhance the therapeutic process for clients. Another area for future research to expand on is understanding the specific parts of mindfulness that clients find to be effective in treating their presenting problem, such as how those parts are used within and outside of the therapy sessions. Next, research should focus on understanding which facets of mindfulness clients most frequently utilize in their daily lives. Finally, future research that focuses on the mindfulness techniques from Dialectical Behavior

Therapy could measure mindfulness using the Kentucky Inventory of Mindfulness Scale (Baer et al., 2004). The Kentucky Inventory of Mindfulness Scale was created using topics for Dialectical Behavior Therapy mindfulness and may provide more detailed information regarding specific techniques from this therapeutic approach. A future study may use an experimental design by randomly placing participants in either an experimental group that incorporates mindfulness activities and a control group that does not have mindfulness activities incorporated to see how clients perceive different aspects of the therapeutic experience.

Conclusion

The results of the current study found that clients view the inclusion of mindfulness activities into the therapeutic process as being both an effective and acceptable treatment intervention. Clients from this study indicated that including mindfulness activities added to the overall therapeutic process in that it allowed them to form a relationship with their therapists, allowed for shared experiences to be created, and provided transitions within the therapy session. Results of this study showed how clients utilize the five facets of mindfulness in their lives. For instance, clients more frequently utilize the Observing facet over the Acting with Awareness facet. Results of this study provided new knowledge on how therapists can better utilize mindfulness for clients in therapy sessions based on client perceptions. In future sessions, it may be beneficial to begin therapy sessions with these activities. Furthermore, clients enjoy engaging in mindfulness activities that allow them to use the Observing facet, such as noticing their breathing or noticing different aspects of the moment.

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Appendix A: Demographic Questionnaire

For each question please provide the answer that best describes you and your previous therapy experience. There are no right or wrong answers.

- 1.) What is your age?

- 2.) What is your gender?
Male
Female
Other _____

- 3.) What is your ethnicity?
Caucasian
Hispanic or Latino
African American
Native American or
American Indian
Asian/ Pacific Islander
Other _____

- 4.) What is the highest degree or level of school you have completed?
Some high school
High school graduate
Some college, no degree
Associate degree
Bachelor's degree
Master's degree
Professional degree
Doctorate degree

- 5.) Have you ever been in counseling or therapy before?
 Yes
 No

6.) To what extent do you think the therapy was effective?

1 2 3 4 5 6 7 8 9
Not effective Effective

7.) Have you ever used mindfulness activities in therapy before? Mindfulness activities are those that allow you to come into contact with the present moment and to be apart of this moment without judging the experience.

0 2 3 4 5 6 7 8 9
Never All the time

Appendix B: Five-Facet Mindfulness Questionnaire

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1	2	3	4	5
Never or very rarely true	Rarely true	Sometimes true	Often true	Very often or always true

- _____ 1. When I'm walking, I deliberately notice the sensations of my body moving.
- _____ 2. I'm good at finding words to describe my feelings.
- _____ 3. I criticize myself for having irrational or inappropriate emotions.
- _____ 4. I perceive my feelings and emotions without having to react to them.
- _____ 5. When I do things, my mind wanders off and I'm easily distracted.
- _____ 6. When I take a shower or bath, I stay alert to the sensations of the water on my body.
- _____ 7. I can easily put my beliefs, opinions, and expectations into words.
- _____ 8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
- _____ 9. I watch my feelings without getting lost in them.
- _____ 10. I tell myself I shouldn't be feeling the way I'm feeling.
- _____ 11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
- _____ 12. It's hard for me to find the words to describe what I'm thinking.
- _____ 13. I am easily distracted.
- _____ 14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
- _____ 15. I pay attention to sensations, such as the wind in my hair or sun on my face.
- _____ 16. I have trouble thinking of the right words to express how I feel about things.

1	2	3	4	5
Never or very rarely true	Rarely true	Sometimes true	Often true	Very often or always true

- _____ 17. I make judgments about whether my thoughts are good or bad.
- _____ 18. I find it difficult to stay focused on what’s happening in the present.
- _____ 19. When I have distressing thoughts or images, I “step back” and am aware of the thought or image without getting taken over by it.
- _____ 20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
- _____ 21. In difficult situations, I can pause without immediately reacting.
- _____ 22. When I have a sensation in my body, it’s difficult for me to describe it because I can’t find the right words.
- _____ 23. It seems I am “running on automatic” without much awareness of what I’m doing.
- _____ 24. When I have distressing thoughts or images, I feel calm soon after.
- _____ 25. I tell myself that I shouldn’t be thinking the way I’m thinking.
- _____ 26. I notice the smells and aromas of things.
- _____ 27. Even when I’m feeling terribly upset, I can find a way to put it into words.
- _____ 28. I rush through activities without being really attentive to them.
- _____ 29. When I have distressing thoughts or images I am able to just notice them without reacting.
- _____ 30. I think some of my emotions are bad or inappropriate and I shouldn’t feel them.
- _____ 31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

1	2	3	4	5
Never or very rarely true	Rarely true	Sometimes true	Often true	Very often or always true

_____32. My natural tendency is to put my experiences into words.

_____33. When I have distressing thoughts or images, I just notice them and let them go.

_____34. I do jobs or tasks automatically without being aware of what I'm doing.

_____35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

_____36. I pay attention to how my emotions affect my thoughts and behaviors.

_____37. I can usually describe how I feel at the moment in considerable detail.

_____38. I find myself doing things without paying attention.

_____39. I disapprove of myself when I have irrational ideas.

7.) When during an individual therapy session did you find it most desirable to do mindfulness activities? Please choose only **ONE** choice.

- _____ Beginning
- _____ Middle
- _____ End

8.) Rank the mindfulness activities from most (1) to least (5) beneficial.

- _____ Mindfulness of Thought (Noticing Thoughts)
- _____ Mindfulness of Participation (One Word Story)
- _____ Mindfulness of Breath (Deep Breathing)
- _____ Mindfulness of the Body Movements (Paired Muscle Relaxation)
- _____ Mindfulness of Observation (Observing with Different Senses)

9.) Rank the aspects of the mindfulness activities from (1) most to (3) least helpful.

- _____ Focusing on my breathing
- _____ Noticing different aspects of my environment
- _____ Removing focus from any one thought or emotion

10.) How did the mindfulness activities impact the therapy session? Please circle only TWO that apply

- Provided transition
- Allowed for more in depth discussions
- Allowed me to form a relationship with my therapist
- Allowed me to share an experience with my therapist
- Slowed down the pace of the therapy session

Appendix D. Recruitment Center Approval Letter



DBT Center of Western Kentucky
1300 Andrea St Suite 205
Bowling Green, KY 42104
Phone: (270) 904-2260
Fax: (270) 781-9680

To Whom It May Concern:

After meeting with Anissa Pugh to discuss her dissertation project on client perceptions of mindfulness activities in therapy, we have agreed to allow her to conduct her study at our office located in Bowling Green, Kentucky. We understand the project is a voluntary process for participants and that participants are free to withdraw at any time. If you have any questions, please feel free to contact me at 270-904-2260.

Thanks.

Mandy Logsdon

Office Manager

DBT Center of Western Kentucky

Appendix E: IRB Approval Letter



INSTITUTIONAL REVIEW BOARD
OFFICE OF RESEARCH INTEGRITY

DATE: March 27, 2017

TO: Anissa Pugh
FROM: Western Kentucky University (WKU) IRB

PROJECT TITLE: [1047880-1] Client Perception of the Utilization of Mindfulness Activities in Therapy
REFERENCE #: IRB 17-348
SUBMISSION TYPE: New Project

ACTION: APPROVED
APPROVAL DATE: March 27, 2017
EXPIRATION DATE: March 1, 2018
REVIEW TYPE: Expedited Review

Thank you for your submission of New Project materials for this project. The Western Kentucky University (WKU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a *signed* consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of March 1, 2018.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Paul Mooney at (270) 745-2129 or irb@wku.edu. Please include your project title and reference number in all correspondence with this committee.

Appendix F: Informed Consent

Project Title: Client Perception of the Utilization of Mindfulness Activities in Therapy

Investigator: Anissa Pugh, MA, LPA

Faculty Supervisor: Rick Grieve, PhD, Department of Psychology, GRH 3018
Western Kentucky University Phone: (270) 745-4527

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give your signed agreement to participate in this project.

You must be 18 years old or older to participate in this research study.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have.

If you then decide to participate in the project, please sign this form in the presence of the person who explained the project to you. You should be given a copy of this form to keep.

1. Nature and Purpose of the Project: The purpose of the project is to investigate how clients perceive the addition of mindfulness activities into the individual therapy process. Additionally, the study will look at what parts of the mindfulness activities that clients find to be the most beneficial.

2. Explanation of Procedures:

Here are the study procedures that you will be asked to complete:

- 1) A demographics questionnaire: these are questions about you and your past therapy history.
- 2) Five-Facet Mindfulness Questionnaire: these questions assess the measure the five facets of mindfulness.
- 3) Mindfulness Experience Questionnaire: these questions assess the perception of the addition of mindfulness activities into therapy.

The study should take between 10 to 20 minutes to complete.

3. Discomfort and Risks: No anticipated discomfort or risks are associated with adding mindfulness activities to therapy sessions, although some participants may not enjoy using the activities. There is minimal to no anticipated discomfort while completing the questionnaires; however, you may become bored or tired when responding to the information.

4. Benefits: If you participate in this study, you will be given new skills to use in daily life to help treat the presenting problem that brought you to therapy. The results of this study will potentially allow researchers to understand client perceptions on the use of mindfulness activities on the therapeutic process.

5. Confidentiality: Your data will be numerically coded for confidentiality and stored securely. Any data collected will be kept in a password-protected document on a password-protected computer. Any data collected and recorded on hard copy will also be locked and stored securely. The data will be kept secure for a minimum of three years after project completion. Please be aware that the research team may discuss the group results in general terms in a public forum, and you may request a copy of this report. Specific individual information will never be revealed.

6. Refusal/Withdrawal: Refusal to participate in this study will have no effect on any future services you may be entitled to from the DBT Center of Western Kentucky or the university. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

Signature of Participant

Date

Witness

Date

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD
Paul Mooney, Human Protections Administrator
TELEPHONE: (270) 745-2129