# RUNNING ACCEPTANCE AND COMMITMENT THERAPY GROUPS FOR PSYCHOSIS IN COMMUNITY SETTINGS

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ABSTRACT

In this paper, we discuss the practice implications of our group Acceptance and Commitment Therapy for psychosis (ACTp) evaluations, in terms of the adaptations required to ACT interventions for group implementation in routine services for people with psychosis. ACTp shows promise as a brief individual intervention for people with psychosis to improve recovery, reduce future relapse, and reduce healthcare costs. Outcomes for group ACT interventions for non-psychotic severe mental illnesses support the potential for further cost-savings, through group delivery, and two recent trials suggest that adapting group ACT interventions to suit people with psychosis is both feasible and clinically effective. Trials were run from 2010-2014, and included people with psychosis and caregivers. Qualitative feedback was collected from group participants and service user co-facilitators. Based on this experience, we recommend psychosis-specific content for group interventions, and highlight process considerations to accommodate the particular needs of people with psychosis and their caregivers. With these adaptations, group ACTp can be feasible, acceptable, and effective as a routine frontline intervention in services for people with psychosis, however; this work is in the preliminary stages and further research is needed to consolidate the evidence base.

## Introduction

Psychosis is considered a burdensome condition, in terms of its personal impact on sufferers, the impact on family and significant others, and the broader societal costs of care (Andrew et al., 2012; Whiteford et al., 2013). Medication is the first line treatment and is helpful, but many report that distressing psychotic symptoms persist despite adhering to a recommended regime, and others prefer not to take medication (National Institute for Health and Care Excellence, 2014; Burns et al., 2014; Morrison et al., 2014). Cognitive behavioural therapy adapted for people with psychosis (CBTp), is internationally recommended as an adjunct to medication (Gaebel, Riesbeck, & Wobrock, 2011), but its availability is severely limited (The Schizophrenia Commission, 2012; Haddock et al., 2014). Obstacles to increasing delivery include the high cost of training the workforce in the range of CBT competences required for effective delivery (Roth and Pilling, 2013; Shafran et al.,1993). Despite strong evidence for cost-effectiveness, service priorities also limit delivery: sixteen or more hours of individual therapy continues to be viewed as a “luxury‟ that is not be prioritised for funding (MIND, 2010, 2013). Brief and group CBTp interventions have the potential to improve both dissemination and access, but the evidence base remains limited, with a modular focus on particular symptom presentations, requiring serial treatments, rather than psychosis more broadly, restricting their applicability outside the research setting (NICE, 2014; Waller et al., 2013a,b; Freeman et al., 2015; Moritz et al., 2014).

Contemporary, contextual cognitive behavioural therapies, such as Acceptance and Commitment Therapy (ACT), have an emerging evidence base as an individual therapy to promote recovery from psychosis (Ost, 2014; Bach & Hayes, 2002; Farhall et al., 2013; Gaudiano & Herbert, 2006; Shawyer et al., 2012; White et al., 2011). The evidence base suggests both equivalent clinical effects and cost effectiveness for ACT interventions based on shorter protocols compared to traditional CBTp, with broad, and often transdiagnostic inclusion criteria that fit them well to frontline implementation (Bach et al., 2012; Ost, 2014).

ACT aims to promote effective management of psychological distress as a transdiagnostic phenomenon, by increasing psychological flexibility, in order to facilitate meaningful steps towards chosen life values (Morris, Johns & Oliver, 2013). Psychologically flexible responses are characterised by acceptance, mindful awareness, defusion, and values-based behavioural activation, in contrast to less helpful approaches to managing distress, such as suppression of distressing experiences and behavioural and emotional avoidance (Morris et al., 2013).

In ACT for psychosis, treatment is focused on managing the distress and disability associated with the condition, usually persisting psychotic symptoms. Importantly, given the heterogeneity of presentations within clinical psychosis, experimental studies demonstrate a clear relationship between greater impact of psychotic symptoms and psychologically inflexible responding (Udachina et al,

2009; Oliver et al., 2011; Vilardaga et al., 2013; Morris et al., 2014). Moreover, ACTp has been shown to achieve change specifically by increasing psychological flexibility (White et al., 2011; Gaudiano, Herbert, & Hayes, 2010; Bach, Gaudiano, Hayes & Herbert, 2013; Bacon, Farhall & Fossey, 2013). This means that the key psychological processes targeted in therapy, and the main strategies for therapists to learn, can be clearly and succinctly specified, and yet still have wide applicability in routine care. Hence, therapy, and therapist training, can be briefer, compared to both traditional, generic CBTp approaches, and the required range of modular, symptom-specific innovations.

The transdiagnostic model of ACT lends itself well to application in a group format (Walser & Pistorello, 2004), and group ACT interventions have been trialled in the workplace (Flaxman & Bond, 2010); in physical healthcare / medical settings (Dahl, Wilson, & Nilsson, 2004); and in community mental health services for people with serious (non-psychotic) mental illness (Clarke, Kingston, James, Bolderston & Remington, 2014). For people with psychosis, group interventions can be particularly valuable, affording opportunities for normalising experiences, for gaining peer support, and for the facilitation of perspective-taking skills, to augment specific therapeutic strategies (Ruddle et al., 2011; Abba et al., 2008; Dannahy et al., 2011; Jacobsen et al., 2011).

Our research group has recently completed two evaluations of the effectiveness of ACT as a group intervention for psychosis. The first, the ‘ACT for Life’ study (Johns, et al., 2015), was a feasibility study of a group ACTp intervention. A total

of 89 participants were recruited and outcomes demonstrated significant increases in mood and functioning from baseline to follow up. The second evaluation built on the 'ACT for Life' study, employing a randomised controlled design to test the effectiveness of the same intervention for both service users and caregivers (Jolley, Johns et al., submitted; ISRCTN: 68540929). A total of 51 service users and 52 caregivers were recruited to this study, with significant improvements for both groups on the main trial outcome of wellbeing. The purpose of this paper is to detail the adaptations firstly to individual ACTp to suit a group setting, and secondly to group ACT interventions to suit the context of psychosis services, in order to inform future dissemination, workforce development and implementation initiatives.

## ACT for Psychosis Groups: Aims, Content and Structure

### *Aims*

Group ACTp aims to help people with psychosis to pursue activities with personal meaning and purpose, in line with recovery principles, and to more effectively manage the impact of distressing symptoms, rather than trying to reduce or eliminate them. By de-emphasising approaches that engender struggle or avoidance, strategies are developed that work to increase values- based actions. Key to this is normalising psychotic symptoms as part of the range of human experiences and highlighting that the response to these experiences can influence their impact on functioning. As a starting point, mindfulness skills are introduced to help participants notice their internal experiences (thoughts,

emotions, bodily sensations, voices and other anomalous perceptual experiences) and to notice their habitual, automatic responses to these experiences. Particular emphasis is then placed on exploring the workability of responses that tend to narrow or restrict opportunities for values-based action.

Skills promoting openness to internal experiences are introduced as alternatives to the potentially unworkable strategies of avoidance, resistance, judgement and struggle. These skills of defusion, willingness (acceptance) and mindfulness are introduced as additional strategies that participants can employ alongside or in tandem to strategies they already use.

From the outset, values are introduced and participants are gently invited to consider what constitutes, for them as an individual, a life filled with richness, vitality and meaning. Values are positioned as a helpful and broad guide for action, in contrast to action motivated primarily by the desire to avoid unwanted experiences. Step by step, progressive plans are developed to assist participants to engage in valued actions, which are reviewed regularly within the group. Acceptance and willingness choices, together with the practice of defusion and mindfulness skills, are used to encourage and facilitate persistence with valued goals.

Given these aims for the group, we were interested in measuring both a range of outcomes, such as wellbeing, as captured by the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al. 2007); and processes, such as experiential avoidance, using the Acceptance and Action Questionnaire (AAQ-II,

Bond et al., 2011).

*Structure of Sessions*

Our group ACTp interventions consisted of four, two-hour weekly group sessions. Before the groups commenced, we ran a "taster" session, introducing participants to key ACT constructs and exercises, emphasising mindfulness exercises and values-based living. Participants were then asked if they would like to "opt in" to the intervention, which we found helped retention rates for subsequent sessions. When recruiting for and promoting the groups, we would recommend highlighting the workshop-style as this prepares participants for the interactive nature of the sessions that emphasise skills development.

Additionally we ran two "booster" sessions, held eight weeks after the group programme ended. The booster sessions did not introduce any new material and aimed to provide a refresher of skills taught in the main groups as well as a space for participants to reflect on any progress or difficulties encountered since the groups ended.

Workshops were facilitated by a lead therapist, competent in ACTp (EO'D, EM, JO, or LJ) accompanied by one or two co-facilitators, who were either mental health practitioners experienced in working with people with psychosis, or service user consultants. All co- facilitators attended an ACT training event designed for the study. Each group comprised between six and eight participants, with two or three facilitators. This ratio allowed close support during smaller group discussions and exercises, and one-to-one support if required. Sessions included

a half-way break with refreshments, and a clear message that participants could take an additional break whenever they wished.

The groups followed a similar format:

1. Warm-up exercise 2. Two noticing (mindfulness) exercises 3. Discussion of the committed action/out-of session activity from the previous week 4. Group discussion / activity (including role playing and experiential exercises) 5. Planning committed action/out-of-session activity for the coming week. An overview of the group session content can be viewed in Table 1.

[INSERT TABLE 1 HERE]

The groups were complemented by power point slides; video (a role play of a person struggling with their distressing experiences); an animation[1] of the "Passengers on the Bus" metaphor; audio recordings of mindfulness exercises; worksheets; and between-session homework materials. The ACT for Life manual (Oliver, Morris, Johns & Byrne, 2011) can be downloaded from the Association for Contextual Behavioral Science website [1](http://tinyurl.com/ACT-for-Life). The manual provides detailed guidance on the materials and equipment required for each session.

*Central Organising Metaphor*

[1] The animation can be downloaded here: http://tinyurl.com/PoB-Download

Our group ACTp interventions are based principally on the “Passengers on the Bus‟ Metaphor (Hayes et al. 2009), which is reiterated throughout the four sessions. This metaphor describes being on a “bus of life”, where the bus driver makes choices in terms of the direction the bus heads that represent moves away or towards chosen values. On the bus are various passengers that represent thoughts, feelings or memories, and the metaphor highlights the ways in which the driver interacts with their passengers and how this can function to limit or increase movement towards chosen values.

This metaphor was introduced as a way of assisting participants to identify their values (the direction they want their bus to travel in) and to notice what movement in a valued direction (their passengers). Using this overarching metaphor allows for key concepts such as valued direction, mindfulness, defusion and willingness to be threaded together in a memorable and coherent narrative arc.

## ACT for Psychosis Groups: Participants and Selection

### *Participants*

Participants for both evaluations were recruited from specialist, secondary care, adult community psychosis services in a single inner-city borough of a large mental health trust, catering for both early and established psychosis. Participants were identified by community mental health team staff, from their current caseloads and, having consented to participate, were assessed using questionnaire measures. Leaflets and posters providing brief descriptions of the

groups were also provided to interested participants. Over the two studies from which these observations are based, we ran 33 separate groups and in total, 120 participants received a group ACTp intervention.

*Inclusion/Exclusion Criteria*

To maximise the frontline clinical utility of the intervention, inclusion criteria for both studies were kept broad. The only inclusion criterion was being a client of the associated service. The only exclusion criteria were speaking insufficient English to understand the assessment and therapy materials, and a clinical presentation that precluded participating in a moderately demanding group activity for a two-hour period.

**Considerations and Adaptations for ACT Groups for People with Psychosis**

*Prior to the group:* We offered brief assessment meetings prior to the start of the group to establish the person's interest in the group; confirm that they met inclusion criteria; and give them the opportunity to find out what the groups would entail. These assessments typically lasted between 20-30 minutes. We talked briefly about the aims and content of the group, and addressed any concerns or questions. Participants often expressed reservations about meeting others and sharing their experiences. In response, we emphasised the focus on moving forward, looking at personal goals and values, and highlighted that there was no pressure to discuss personal experiences. We fed back that previous workshops have shown particular benefit for participants feeling "stuck" in their lives, or not knowing how to move forward. For our second study, we offered a further 45-

minute “taster” or introductory session for potential participants to experience what the group would involve, and to meet other potential group participants. Our experience has been that these “taster” sessions have increased participants‟ preferences for subsequently participating in the groups.

*Setting the scene:* We have found that warm-up exercises help participants to feel comfortable and encourage group interaction, talking and sharing. An example of a warm- up exercise would be to share with a fellow participant three really important things they would want with them if they were stuck on a desert island. We then use the outcomes from these discussions in the wider group to begin to introduce the notion of values. The first session aims to be a gentle introduction – providing a taste of what is to come and outlining the general structure of the sessions. We emphasise that the aim of the sessions is to have some fun as well as work on identifying values/goals and learning new skills. It is important to allow participants to join in at their own pace – we make it clear that we are inviting people to take part in exercises, and it is fine to sit back and observe if that is preferred. The normalising aspect of the groups, having facilitators join in and discuss their own struggles and experiences, has been found to be a powerful part of the group process.

*Mindfulness exercises:* Several adaptations are necessary when using mindfulness with people with psychosis to take into consideration experiences related to unpleasant voices, images or paranoid thoughts (Chadwick, Newman-Taylor & Abba, 2005). As with mindfulness based stress reduction (MBSR)

protocols, we started with breath and body awareness, using the breath as a central focal point. Broadly, in our mindfulness practices, we invited participants to cultivate an on-going awareness of psychosis experiences and the thoughts and feelings that can follow them. The practices carefully limited states of deep concentration, which have been linked to onset of auditory hallucinations (Chadwick, 2006).

All mindfulness exercises lasted no more than 10 minutes in length, so as not to be overwhelming to participants who may find silence difficult if they are experiencing distressing symptoms. Frequent instruction was given, with pauses of no longer than 10 seconds in the initial exercises to reduce the likelihood that participants would become lost in responses to psychosis. With exercises in later sessions, pauses were extended to 20-30 seconds.

As with any mindfulness exercise, the debrief enquiry is often the trickiest stage. This was particularly the case with this participant group who are very focused on developing further methods to control their experiences, and in our experience would be quick to notice the immediate benefits such as relaxation. As such, we aimed to balance the need to reinforce the range of experiences that participants noticed, those that are perceived as both positive and negative, with any response that highlighted ACT consistent processes. We would gently emphasise these to the rest of the group.

We also provided a recording of mindfulness exercises used in the group to support participants with home practice. We encouraged home practice but took

an accepting stance to non-completion.

Below are some of the common questions that participants with psychosis have made during debriefing, along with some ACT consistent therapist responses.

*Participant* – "I felt like my voices got worse"

*Facilitator* – "Sometimes that can happen as we start to quieten down and turn inwards. It's a common experience, although perhaps not always pleasant. Also, keep in mind, it's OK to take things gently and slowly, and pause and refocus outwards during the exercise if you need to take a break.

*Participant* – "I found it really weird to do that. I'm not sure I like it"

*Facilitator* – "That sounds like some great noticing of your experiences and what your mind was saying about them. When we slow down we can notice all sorts of experiences and judgements... experiences we like and welcome, experiences we are neutral or unsure about, and ones that we don't like or judge negatively. We are going to encourage you to share your experience of the variety of exercises we do, and the effect that practising these skills has in your day to day life."

*Participant* – "I couldn't do it, my mind was too busy"

*Facilitator* – "So you noticed that it was difficult to focus on the present moment. We find that mindfulness can be tricky and it is very normal for

> your mind to wander – this happens to everyone. Were you able to notice where your mind went? Next time we practice, I wonder whether you would be willing to try and notice where your mind takes you and see if you can gently bring it back to the exercise. We'll try some other mindfulness exercises as well, so you can see what you prefer."

*Using an over-arching metaphor - The Passengers on the Bus:* Using the "Passengers on the Bus" as the central metaphor was particularly beneficial as all six of the ACT processes are represented within the metaphor. This metaphor was revisited during each session, and was used as a memory aid, which was particularly helpful for participants who might otherwise struggle to recall the key elements. Additionally we played an animation of the passengers on the bus metaphor to provide a visual representation.

We have found that participants occasionally take the metaphor literally or miss the notion that "passengers" represent internal experiences. However, with gentle correction and repetition over the weeks, virtually all participants are able to engage usefully with the metaphor.

A common issue that arises in relation to auditory hallucinations is whether the "voice" should act as a passenger. Because most participants identify the voice as an external experience to them coming from an outside source, over which they have little control, we tend to encourage participants to label their thoughts about the voice hearing experience as the passenger. For example, a thought could be "I can't do this activity because my voices are telling me I'm a failure".

Finally, in the second session we use an exercise in which we act out the metaphor "in vivo" so that participants can experiment in session with how to relate differently to distressing content (for a full description and video demonstration of this is available here: http://tinyurl.com/PoB-demo). This exercise is crucial for this client group, for whom the control agenda is so strong. Psychotic symptoms are often scary or, alternatively, absorbing, and acting out the metaphor allows for an embodiment of what a willing response to move in a valued direction looks and feels like.

*Scaffolding*: Key to the groups is the use of scaffolding – through facilitators modelling and giving examples, thus allowing clients to build up to applying the exercises themselves. The central narrative based around the "Passengers on the Bus" metaphor increases how memorable the key concepts are, and also reduces confusion. The first session of the group introduces the concepts by using a 5-minute video of an actor describing recent life challenges associated with psychosis. Doing this, allows participants to gradually approach discussion of the experience of psychosis at their own pace in the first session. This case example forms the basis for discussion of unworkable coping strategies, personal values and links with the over-arching metaphor. In later sessions, we then invite discussion these issues in relation to participants' own personal experience.

*Everyone is doing "what works"... help by addition rather than subtraction:* The ACT emphasis on learning by addition (rather than replacement) is key for this client group, who often remain attached to coping strategies that are very

effective in modulating extremely distressing experiences in the short term. In the groups, it is useful to understand what strategies participants use to get things done in their lives, and to respectfully introduce the idea of willingness as an addition “to the toolkit”. Experiential learning is encouraged, that it is about “trying willingness out” to see if this approach does result in more valued actions. In this way we respectfully acknowledge the expertise that participants have in their own lived experience, while providing support for an expansion of ways of coping that will work within their lives.

*Facilitator self-disclosure and participation:* an important component of the groups is the facilitators‟ own self-disclosures about the ways that they struggle, and the commitments that they will engage in for homework. We have found that modelling this engages group participants and encourages a sense of universality, as well as perspective taking. We consider the level of self-disclosure (not too emotionally evocative, but not trivial commitments either); group participants have informed us that witnessing the facilitators participate in this way has increased connection with the group and reduced personal stigma.

*Values and goals:* We noticed in the workshops that the distinction between a goal and a value can be difficult and we would recommend that time is taken to clarify this. Values are introduced in the first session and are referred to throughout the workshops, particularly in the committed action/out-of-session planning activities (see below). Self-disclosure from facilitators is also helpful in modelling the difference between values and goals. We particularly highlight the

importance of working towards personal values, acknowledging the pressure that societal values can have on everybody.

In our experience, values work with service users with psychosis can be a very sensitive area due to the significant loss and hopelessness often associated with psychosis. We proceed slowly, often emphasising that steps towards values need not represent large or significant life changes.

*Committed action/out-of-session planning:* Committed action is an integral part of the sessions. We encouraged clients set values-based goals by starting small and identifying something in line with their values that can be completed over the week in between sessions. We emphasise that completing the action is not the only aim of the committed action, rather the ability to notice thoughts, emotions and sensations that may show up along the way.

When deciding on the committed action, we found find it was helpful to split into smaller groups, which enabled more focused and detailed work. We would also recommend mixing up the smaller groups over the course of the workshops to allow facilitators and participants to work with everyone in the group, and to enable all the facilitators have a good understanding of what each participant was working towards.

We asked permission to telephone each participant during the week, which we found to be important as a way of reviewing progress towards their committed action they had made in the previous. These calls were brief, lasting between five to ten minutes. In the calls we asked participants about their committed action

and, rather than emphasising successful completion as the critical outcome, we focused in discussing what "passengers" or difficult thoughts and feelings they may have noticed in considering moving towards the committed action. We also used the telephone calls to encourage attendance to the next session. Feedback from participants has indicated that the mid-week phone calls were greatly appreciated.

*Ending the groups:* We have noticed that the final session can be emotive. We make sure to thank participants for attending, recognising that they invested their time for this and express our hope that this time contributed to them moving towards their chosen valued directions. We also ask for feedback after the group, with a particular focus on what was helpful and what was not so helpful about the sessions, and their most memorable experience. Feedback is extremely helpful and has led to the on-going development of the group protocol.

We have found it helpful for facilitators to make a follow-up phone call to clients a few weeks after the group has concluded. We also ask clients if they are willing for facilitators to share information discussed in the group with a carer/team member, to help maintain and generalise the client's gains.

**Conclusions**

Research on ACT interventions for psychosis have to date, all focused on one-to-one interventions. However, there are several indications that a group format may be useful in this context, particularly for reducing self-stigmatisation that can be a prominent feature alongside the experience of psychosis. Although group

ACT interventions are widely reported in the literature our experience has been that while this is a format that is useful, adaptations are required when working with people with psychosis, in terms of both the content and also delivery.

Our experience through running a large number of these groups has allowed us to make several recommendations. One of the key to these adaptations included efforts to promote and maintain engagement. In our experience, for a range of reasons, participants struggled to attend multiple sessions and it was necessary to include adaptations such as taster sessions, between session reminders and scheduling sessions at suitable times. We also found it necessary to work hard to make the content understandable, accessible and memorable. This included the use of a key central metaphor (the Passengers on the Bus) that was repeated each week and acted-out to enhance participant engagement with the material. We also used different modes of presentation of the materials and employed memory aides through the use of handouts.

We also adapted the delivery exercises and techniques. For example, we used short, “talky” mindfulness exercises and avoided long, eyes shut exercises. We tended to avoid the use of the word acceptance, and emphasises “willingness” as an active alternative to struggle. We tended to emphasise learning by addition, so that participants were encouraged to try out new skills in addition to old skills, rather than completely dropping previously learned coping repertoires.

Finally, we worked hard to embed the processes into daily life. For the outset, we introduced the concept of values and worked towards clarifying goals that could

be achieved in the service of those values. We encouraged participants to take steps towards goals outside of sessions and feedback progress to care givers and the care team in order that they could continue to facilitate gains made.

Overall, our experience leads us to conclude that, with appropriate adaptations, ACT groups for psychosis are both feasible and acceptable as an intervention delivered in routine care for people with psychosis and their caregivers. Additionally, data from our two trials support this conclusion; suggesting that this is an effective intervention for increasing well-being and helping participants negotiate life obstacles more effectively in order to be able to choose to take values-based actions. Although early signs are positive, it is important to note that this work is in the preliminary stages and further research is needed to consolidate the evidence base.

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Table 1. Group Session Overview

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|---|---|
| Taster Session | • Introductions and group set up<br>• Introducing Values and obstacles to value based actions<br>• Introduction to Passengers on the Bus Metaphor<br>• Mindfulness of Body and Breath exercise<br>• Summary of group |
| Session 1 | • Introductions and group set up<br>• Icebreaker exercise<br>• Mindfulness of Body and Breath exercise<br>• Introducing Values<br>• Introduction to Passengers on the Bus Metaphor and watch animation<br>• Mindfulness of Body Stretch Exercise<br>• Out of Session Planning Activity exercise – values based action plus mindfulness practice |
| Session 2 | • Warm up exercise<br>• Mindful eating exercise<br>• Passengers on the Bus review<br>• Review of Out of Session Activity exercise<br>• Video vignette exercise<br>• Acting out the Passengers on the Bus metaphor<br>• Mindfulness Breathing Space exercise<br>• Out of Session Planning Activity exercise – values based action plus mindfulness practice |
| Session 3 | • Warm up exercise<br>• Leaves on the Stream mindfulness/ defusion exercise<br>• Review of Out of Session Activity exercise<br>• Sticky Labels Defusion exercise<br>• Lemon, Lemon, Lemon Defusion Repetition exercise<br>• Acting out the Passengers on the Bus metaphor<br>• Three Minute Breathing Space exercise<br>• Out of Session Planning Activity exercise – values based action plus mindfulness practice |

| | |
|---|---|
| Session 4 | • Warm up exercise<br>• Mindful Walking Exercise<br>• Review of Out of Session Activity exercise<br>• Noticing Others' Values Perspective Taking Exercise<br>• Review of Group Key Messages<br>• Revisit Passengers on the Bus Metaphor<br>• Review of Learning and Progress exercise<br>• Clouds in the Sky mindfulness/ defusion exercise<br>• Out of Session Planning Activity exercise – values based action plus mindfulness practice<br>• Wrapping Up exercise |
| Booster Session 1 | • Warm up exercise<br>• Mindfulness of Body and Breath exercise<br>• Revisit Passengers on the Bus Metaphor<br>• Review of Learning and Progress exercise<br>• Refresher of Skills Exercise<br>• Out of Session Planning Activity exercise – values based action plus mindfulness practice |
| Booster Session 2 | • Warm up exercise<br>• Clouds in the Sky mindfulness/ defusion exercise<br>• Review of Learning and Progress exercise<br>• Refresher of Skills Exercise<br>• Out of Session Planning Activity exercise – values based action plus mindfulness practice |