Integrating ACT components in CBT training: Trainee appetite and supervisor preparedness

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This study examined interest and skills in Acceptance and Commitment Therapy in students undertaking a post- graduate cognitive behaviour therapy course and their supervisors, and considered whether it would be appropriate to include an ACT component to the training. Results from two Qualtrics surveys suggest that there is considerable interest in ACT amongst CBT students and their supervisors mostly consider themselves able to supervise if an ACT component is added to the training. We discuss how this could be done in a coherent way.

Keywords: *Psychotherapy Training; ACT; Cognitive Behavioural Therapy; Māori*

Introduction

Clinicians face an array of therapeutic modalities they can use to assist people. One approach is to choose a single empirically supported approach and practice it exclusively, but this could exclude useful techniques. Another approach is to be 'eclectic', choosing techniques from a range of (preferably empirically supported) therapies. However, this can be problematic as this can mean there is no coherent guiding theory and there is a risk of using techniques in a disorganised or incoherent fashion, with a loss of fidelity for a specific therapeutic model (Ciarrochi & Bailey, 2008). Therapeutic modalities are not just a set of techniques: the process of therapy and the use of the underlying model in shared formulations is all part of the therapeutic modality.

This raises important issues for psychotherapy training providers. While there are several evidence-based cognitive behavioural therapies available, the challenge for training courses is to teach these in a coherent way that is consistent with the research evidence, which makes sense to students and is likely to benefit clients. An eclectic approach may lack coherence and interfere with competence development.

Cognitive behaviour therapy (CBT) has its origins in Behaviour Therapy, which many consider the 'first wave' of scientifically based psychotherapy. Behaviour therapy was developed in the 1950's as an alternative therapy to psychoanalysis. The second wave was Cognitive Therapy developed in the 1970's by Aaron Beck with its first application to depression and later to anxiety and ultimately to a wide range of psychological disorders. In the late 1980's there was a merge between behaviour therapy and cognitive therapy into what is called CBT (Alford & Beck, 1997). Cognitive Behaviour Therapy is based on the idea that our cognitions about situations affect our emotions and behaviours. It uses a guided discovery process to help clients learn skills to notice their cognitions and consider alternative interpretations of situations and to experiment with changing behaviour as a way of testing the validity of their cognitions. This occurs in the context of a collaborative relationship with the therapist. Cognitive Behaviour Therapy has the largest evidence base of any form of psychotherapy (Roth & Fonagy, 2005) and is widely taught and practiced both internationally and in New Zealand (NZ) (Mathieson, Bennett, Cargo, & Froggatt, 2021).

More recently, the so-called 'third wave' of cognitive therapies have emerged. These include Acceptance and Commitment Therapy (ACT)(Hayes, Strosahl, & Wilson, 1999), Dialectical Behaviour Therapy (DBT) developed for the treatment of borderline personality disorder (Linehan, 1993), Mindfulness-Based Cognitive Therapy (Segal, Williams, & Teasdale, 2001), Compassion-Focussed Therapy (Gilbert, 2009), and meta-cognitive therapy (MCT) (A. Wells, 2000). More recently, 'process-based therapy' has been proposed as a way forward, i.e. an evidence-based search for powerful and coherent change processes that may occur across a range of therapies (Hayes & Hofmann, 2017).

Acceptance and Commitment Therapy is a 'third wave' therapy that is gaining momentum both in terms of its' evidence base and popularity. There is a growing body of research to support the use of ACT to treat a range of psychiatric and psychological problems and populations (Graham, Gouick, Krahe, & Gillanders, 2016; Hayes, 2020). There are similarities between ACT and CBT (Harley, 2015; Hofmann & Asmundson, 2017b). Both target changes in thinking and behaviour, albeit in different ways (Menin, Ellard, Fresco, & Gross, 2013) and both approaches can be placed in the larger context of the emotion regulation, encouraging adaptive regulation strategies (Hofmann & Asmundson, 2017a). There are, however, significant theoretical differences, with ACT proposing that suffering is driven by fusion with distressing thoughts and experiential avoidance, rather than accepting discomfort in the service of a rich and meaningful life in line with one's values (Hayes et al., 1999). Traditional CBT theory, on the other hand, posits that there are specific beliefs associated with different mental health problems (such as seeing oneself as helpless or vulnerable in anxiety disorders). Traditional CBT also takes the approach that rather than learning to defuse from

thoughts, the evidence for thoughts and beliefs can be usefully evaluated, including experiments with changing behavioural strategies, so as to reach more helpful perspectives and behaviours (Ciarrochi & Bailey, 2008).

Components of ACT have been introduced into traditional CBT. For example mindfulness (a key part of ACT), is encouraged in a well-known CBT self-help book (Greenberger & Padesky, 2015). Some authors regard it as possible to integrate CBT and ACT in a coherent and effective way, noting that there is nothing in ACT or its underlying model that suggests that cognition cannot change, nor that cognitive change cannot be helpful (Ciarrochi & Bailey, 2008; Harley, 2015). Experts in ACT also recognise the similarities (as well as the differences) between ACT and CBT (Hayes & Hofmann, 2017).

The term 'third wave' could be interpreted to imply that what came before has been superseded. Instead, CBT is evolving to include ACT approaches, while remaining unified by a core premise about the role of cognitions. Newer approaches can arguably be viewed as the next generation of CBT, which emphasise some new facets, rather than being part of a separate 3rd wave (Harley, 2015). More broadly, cognitive behavioural approaches, including ACT are being viewed under the umbrella of 'process-based' therapies, which is the idea of building on concepts of known clinical utility and organising them into coherent theoretical models and targeting core mediators and moderators in order to achieve change (Hayes & Hofmann, 2017; Hayes, Hofmann, & Ciarrochi, 2020; Hofmann & Hayes, 2019).

Can elements of the CBT and ACT be integrated? This is an important question for therapists with a background in standard CBT and an interest in ACT. While Hayes et al (2013) originally argued against adding 'a dash of mindfulness here and a dollop of values there' (p.915), recently Hayes and Hofmann (2017) have elaborated on the idea of both ACT and traditional CBT being process-based therapies. Russ Harris (ACT trainer) notes in his workshops that you can "dip your toe in the water" (integrate ACT into your existing therapy modality) or you can "jump right in" (full use of the ACT model) when starting out with ACT. Despite what could be seen as a tension between the agenda of change and the agenda of acceptance, there may be some contexts in which a hybrid approach may be helpful (Ciarrochi & Bailey, 2008; Harley, 2015). For example, mindfulness practices can assist people to engage with cognitive restructuring through fostering the ability to observe one's thinking and defusing from it. In the traditional CBT treatment of generalised anxiety disorder, once the client has learnt that worry is neither dangerous nor helpful, being able to defuse from worry and let it go mindfully, rather than engaging with it is desirable (Adrian Wells, 2013). Similarly, there is strong evidence supporting the addition of mindfulness skills to prevent relapse of depression, after traditional CBT for depression (Segal et al., 2001). Further, some individual clients may find a combination of cognitive defusion and cognitive restructuring skills is beneficial in a given situation depending on personal preference or thinking style. A recent meta-analysis on the effect of psychological intervention on the fear of cancer recurrence supports this approach. Traditional (Beckian) CBT (10 studies) was compared to contemporary CBT (including ACT, 9 studies). Post-treatment the effect size for contemporary CBT was significantly larger than for traditional CBT (Tauber et al., 2019).

In NZ, the efficacy and relatively brevity of CBT has meant that demand for CBT in clinical settings is high. Due to a scarcity of clinical psychologists, the past twenty years has seen the development of post- graduate CBT training courses for other mental health professionals (such as nurses, occupational therapists and social workers), as a way of increasing access to CBT. This is in line with international trends, such as the widespread CBT training provided as part of the 'Increasing Access to Psychological Therapies' programme in the United Kingdom (Liness et al., 2019).

Since the late 1990's, the University of Otago, Wellington has offered postgraduate certificate-level training in CBT. A post-graduate diploma level CBT course (advanced course) has been running since 2011. These academic-year-long courses are taught in line with best practice CBT training (Sudak et al., 2016). Each course has approximately 21 students who work at least 0.6 FTEs in a variety of public mental health settings. Students attend three, weeklong block courses (usually face to face, but delivered by Zoom during Covid lockdowns). They have on-site supervision in their workplaces, provided by clinical psychologists and their competence is assessed in multiple ways, including ratings of video-recorded CBT sessions with clients (Barnfield, Mathieson, & Beaumont, 2007).

While, in the past, traditional CBT has been the predominant model taught in the Otago CBT courses, the course has continued to develop since it commenced in 1999, to include evidence-based advances in CBT, such as mindfulness-based cognitive therapy for the prevention of relapse in depression (Segal et al., 2001). In recent years, the course lecturers observed that students on the courses were bringing up ACT-related concepts in class discussions, but tended to see ACT as completely unrelated to CBT. Anecdotally we had also noticed increasing enthusiasm expressed by clinical psychologist colleagues for ACT.

It was unclear to University of Otago CBT teaching staff what therapeutic modalities were used at the 'coal face' of mental health services in NZ and, to what extent ACT was being used. Perhaps, in line with 'third wave' process-based approaches, it would be beneficial to bring ACT components into advanced (diploma level) CBT training so that students become aware how it relates to and complements traditional CBT. This could assist students to use CBT and ACT concepts in a maximally coherent, integrated way with their clients. This would ensure that the courses would be current and relevant, and informed by the latest research. It would also ensure that the introduction of ACT components occur with due consideration given to how these are integrated with the core ingredients of CBT and with consideration of cognitive behavioural theory.

If introductory ACT concepts and techniques are introduced in the post- graduate CBT course, it will be essential that on-site clinical psychologist supervisors have adequate knowledge and experience of ACT to support the students' learning. It is unclear whether this is

the case. It is also unclear to what extent ACT components are culturally compatible in the NZ context, where the indigenous population are Māori and the Treaty of Waitangi enshrines the principle of equal access to resources.

Aims

The primary aim was to find out whether the CBT diploma course should and could include training in ACT by assessing the following:

1. The level of interest and expertise in the ACT model of therapy of previous and present students.
2. The level of skills, knowledge and practice of ACT among the clinical supervisors (all senior clinical psychologists), to determine whether they are adequately trained to provide include ACT as part of CBT supervision.
3. What therapy modalities are currently being used in NZ mental health services.
4. The opinions of trainees and supervisors regarding the cultural appropriateness of ACT with Māori (indigenous New Zealanders).
5. Discuss the training implications of the findings in relation to the theoretical similarities and differences between CBT and ACT.

The findings will guide the future content of our post-graduate CBT training, potentially leading to us introducing ACT at the postgraduate diploma level.

METHODS

Participants

Students: Participants for Survey 1 were past and present students of our post graduate certificate and post graduate diploma in CBT (dating back five years). The rationale for this was that as mental health professionals working in clinical settings across NZ, hence would have knowledge of what therapies were being used. Participants were recruited by identifying them in our database and 87 students were emailed an invitation to take part in a Qualtrics e-survey (September 2019 Version of Qualtrics)

Supervisors: Eighty-one past and present supervisors from the last 5 years were emailed invitations to take part in Survey 2 also via Qualtrics.

The majority of participants, both student and supervisor were of NZ European ethnicity, with a small number of Māori, Pasifika, Indian and 'other', which is roughly in proportion to the overall ethnic mix of students attending the course. Of the student sample the most common profession was psychiatric nurse (43%), with the next largest groups being occupational therapists (19%) and social workers (18%). Seventy-six percent of students and 86% of supervisors had been working for six or more years in their occupation. Adult community mental health was the most common workplace for both students (28%) and supervisors (47%). In the student sample, there was also a large "other group" (24%) for workplace and these were students working as counsellors at Primary Health Organisations. Details are shown in Table 1.

Survey

Surveys 1 and 2 were bespoke surveys developed for this study. Survey 1 had 19 questions including demographics; Survey 2 had 18 questions including demographic questions. These may be found in the Appendices.

Procedure

Surveys were emailed to potential participants. Both surveys took about five minutes to compete. The information sheet and participant consent were embedded into the survey itself. Qualtrics software was used to analyse the data. Descriptive statistics are used to describe the results.

RESULTS

82% of students responded to survey 1 and 48% of supervisors responded to survey 2.

Knowledge, Training and Experience in ACT

Forty three percent of students who responded reported some prior training in ACT. Fifty percent reported they had no training in ACT but were considering it. Of the students who had no ACT training, 25% reported this was due to not knowing where to get training from, 25% reported they did not have the funding for training in ACT and 16% reported that time was the reason for not having training. Forty-nine percent of students described their knowledge of ACT as fair/good and 51% rated it as very poor/poor. None rated their knowledge as excellent (Table 2).

Table 1. Characteristics of Students and Supervisors.

	Students (%)	Supervisors (%)
Participants	**N = 72**	**N = 39**
Gender		
Male	24	21
Female	76	79
Ethnicity		
NZ European	71	73
Māori	5	5
Pasifika	4	0
Indian	3	3
Chinese	0	3
Other	17	16
Occupation		
Psychologist	6	100
Nurse	43	0
Occupational therapist	19	0
Social worker	18	0
Psychiatric registrar	0	0
A& D counsellor	6	0
Other	8	0
Years working in Occupation		
6 or more years	76	85
Work Setting		
DHB inpatient	3	6
DHB Community Adult	28	47
DHB Community Child	13	9
A and D	10	6
DHB specialist service	21	6
Other	24	27
CBT Training Status		
Completed Certificate in CBT	96	0
Completed Diploma in CBT	37	0

Table 2. Students and Supervisor ACT Knowledge, Training and Experience.

	Student %	Supervisors %
Previous Training in ACT		
Yes	43	89
No, but considering it	50	3
No, and no interest	7	8
Knowledge of ACT		
Very poor/poor	51	6
Fair/good	49	92
Excellent	0	3
Expertise in ACT		
Very poor/poor	75	5
Fair/good	25	73
Excellent	0	3
Use of ACT		
Never	32	11
Rarely/sometimes	56	54
Often/always	12	34
Estimate of my colleagues' interest in ACT		
None at all	0	
A moderate amount/a little	62	
A lot/ A great deal	38	
Percentage of colleagues in my workplace that use ACT to at least some degree	Mean = 40% (*SD* = 27.31)	Mean = 36%

Seventy three percent of supervisors rated their expertise in ACT therapy as "fair"/"good". Thirty-four percent reported using ACT often or always when doing therapy, and 54% percent reported rarely or sometimes using ACT. Ninety-two percent reported they had a fair/good knowledge of the ACT model, with 89% of supervisors reporting some (formal or self-directed) training in ACT. Eight percent said they had no training in ACT and were not considering any training (see Table 2).

Perceptions of colleague's interest in ACT

Results suggest that both students and supervisors report that ACT is being talked about and used in the workplace, with perceptions that 36% (according to supervisors) or 40% (according to students) of colleagues using it (Detail in Table 2).

Supervisor Experience and Ability to Support ACT Training.

Thirty one percent of supervisors reported they would feel confident to supervise students in ACT currently and an additional, 40% reported they would possibly feel confident to supervise ACT within a year or two. The supervisor survey was completed in 2018 and over 70% of the supervisors responses suggested that they would possibly be confident to supervise ACT by 2021, while 30% indicated that they do not feel confident to supervise ACT. Nineteen percent of supervisors reported that ACT is the predominant model they use in their practice (Table 3).

Table 3. Clinical Psychology Supervisors' Confidence and Use of Models

Question	%
I feel confident to supervise ACT:	
Yes	31
No, but possibly in a year or two	40
No	29
CBT is the predominant model currently used	67
Second most predominant model used	
ACT	19
DBT	28
EMDR	24
Family therapy	10
Other (compassion focussed, interpersonal therapy, schema therapy)	20

Training in ACT

The largest group of supervisors had taught themselves ACT through independent reading and learning (16%). Sixteen percent had attended Russ Harris workshops (which could be in NZ, Australia or online) and 17% had attended other NZ workshops. Twenty-seven percent of students reported they had taught themselves ACT through independent reading and learning, Twelve percent had attended a Russ Harris workshop and nine percent had attended other NZ workshops (Table 4).

Cultural Appropriateness of ACT

Seventy-six percent of students considered ACT to be appropriate to use with Māori clients, 22% reported they did not know if it was appropriate or not, one student thought it likely would be and three students reported they did not think ACT was appropriate with Māori clients. Fourteen students (20%) elaborated on their views. Student elaborations regarding appropriateness with Māori are in Table 5.

Table 4. Training in ACT

Type of training in ACT	Student %	Supervisor %
Independent learning through books with no workshops attended.	27	16
Russ Harris Workshop (Part 1)	12	16
1-2-day workshops run by NZ presenter	9	17
Reasons for not training in ACT		
Other things more of a priority	32	-
I don't know where to get training in ACT	25	-
Lack of time for training	16	-
Lack of money for training.	25	-

Table 5. Students views on appropriateness of ACT for Māori

Question	Ethnicity
Māori have hauora/mauri ora and values based models available. Example: Powhiri Poutama 7 key features that help ground and centre whanau	M
ACT could work within any culture, one just needs to be respectful of beliefs, etc.	NM
I think with understanding of Māori cultural aspects it can be applied	NM
I think values work is appropriate with any culture	NM
I work in a Māori organisation and I believe there is a place for ACT.	M
Very useful especially explaining meaning by use of metaphors	NM
As always, provide clear rationale and psychoeducation, ask the client if they are willing to try it. Be careful to be holistic in approach, for example include spirituality. Understand basic concepts of culture and how not to be offensive	NM
Absolutely appropriate as a values based modality with strong emphasis on action	NM
The values and compassion component are very appropriate for cultural input. Also using the choice point eliminates pass or fail. ACT works with the language of the person using kindness and acceptance. Focusing on self-context can help with including culture.	NM
Needs more research but likely can be helpful.	NM

Note: Māori/ part- Māori (M); Non- Māori (NM)

Supervisors

Seventy-nine percent of supervisors (n=39) considered ACT to be suitable to use with Māori clients. None of the supervisors thought ACT was inappropriate for Māori and 21% said they did not know. Ten supervisors elaborated on their views of using ACT with Māori clients. Of the nine positive comments, four supervisors said they had used ACT with Māori clients. The elaborations made by supervisors are in Table 6.

DISCUSSION

While CBT and ACT can be viewed as two different therapies, many ACT concepts have been incorporated into traditional CBT in the last 10 years. It is useful for student therapists to understand the theoretical background of ACT, and the differences and similarities to CBT, which need to be reconciled by a primarily CBT therapist. The results of this study support anecdotal observations that there is an appetite for ACT components within the CBT training courses offered by the University of Otago. Most of the post-graduate CBT students and supervisors were interested in ACT as a therapy modality. However, while the students were interested in the ACT model, the majority (75%) of them rated their expertise as very poor/poor, with none of the students rating their expertise as excellent. The results also show that the majority of the clinical supervisors (all senior clinical psychologists) have (or are developing) ACT knowledge and skills to feel confident to supervise students in relation to ACT as a component of a CBT course.

The majority of participants (both students and supervisors) who expressed a view on cultural appropriateness were of the view that it would be appropriate to use ACT when working with Māori clients.

Limitations of this study were that it was based on self-report and only 48% of supervisors responded, meaning this may not accurately reflect the knowledge and skills of the supervisors. Perceptions by students and supervisors that ACT is used by around 40% of workplace colleagues may be over- or under-estimations. Very few participants in this study were Maori (or Pasifika), so it is not possible to draw conclusions in relation to their responses.

It is worth noting that ACT workshops typically do not assess competence development or require supervised practice. They tend to rely on participants having solid pre-existing therapy skills. By comparison, the current CBT course is a comprehensive full academic-year course and includes supervised CBT practice and assessment of competence prior to achieving the post-graduate qualification. The CBT course is funded by the NZ Ministry of Health and students are given time off work to complete the block courses and the examination, thus removing cost and accessibility barriers.

Based on these results, we will cautiously incorporate introductory ACT concepts into our current CBT diploma course, using a five-hour workshop by an ACT trainer who is part of the CBT course teaching staff. This will be taught at the diploma level, so that students will already have a solid grasp of the traditional CBT approach taught

Table 6. Supervisors views on appropriateness of ACT for Māori

Question	Ethnicity
As with any individualised therapy needs, if the approach taken is culturally sensitive and matched to the client's needs (and not in conflict with cultural beliefs and values), Act has the potential to be beneficial with Māori clients it would be important to have a clear assessment with the individual first and then determine the appropriateness	NM
I don't know. There should be a consultation process and then an evaluation before use. I imagine it could be adapted to be culturally appropriate but it should be assumed that it is	NM
Very Appropriate	NM
Unsure about the effectiveness of ACT with Māori clients, may be potentially useful	NM
I think ACT can be applied within a Tikanga Māori context, in the same way that other behavioural therapies can be	NM
Individual variation , creative collaborative adjustments	NM
I've used ACT with Māori clients. It seems to fit well given the focus on values and flexibility inherent in the implementation of the theory	NM
I think the values based living activities would be very suitable for Māori clients; there are interventions developed for exactly this and they seem very appropriate	NM
I think the values based living activities would be very suitable for Māori clients; there are interventions developed for exactly this and they seem very appropriate.	M
Much of ACT is about acceptance of who you are currently and what life values you have. This would fit with a Māori world view	NM
Use frequently, easily integrated with Māori concepts	M
My Māori clients have responded particularly well to this approach	M
I've used it effectively with Māori who have found it really helpful	NM

Note: Māori/ part- Māori (M); Non- Māori (NM)

at certificate level (the certificate course is a prerequisite for the diploma course). It will focus on how ACT and CBT fit together, demystify ACT, and cover some basic act techniques. Learning about ACT in a way that makes sense to students will involve ensuring that the students understand that both ACT and CBT sit under the umbrella of cognitive behavioural therapies, and that both CBT and ACT are process-based therapies with similarities and differences, particularly the significant differences between ACT's 'relational frame theory' and CBT 'cognitive specificity' theory. Students will be encouraged to consider in what ways ACT can complement traditional CBT. As with CBT, we do not want ACT to be viewed as just a bunch of "techniques", but to have at least a basic understanding of what theoretical processes these techniques are targeting when including ACT concepts and techniques in formulations and treatment plans. Acceptance and Commitment Therapy concepts, such as values (which is one of the six main principles) fit well theoretically with CBT and can strengthen commitment to behavioural change (which is both an ACT and a CBT goal). Within a CBT formulation, students who do further ACT training can learn to draw on ACT techniques as appropriate. For example, within a CBT vicious flower formulation (Moorey, 2010), where rumination is identified as a maintaining factor in depression, students can teach mindfulness and defusion techniques to clients.

Third wave CBT therapies are the next generation of cognitive-behavioural therapies. Like a good CBT formulation that evolves with new information, they build on the solid empirical foundation that traditional CBT provides. This study suggests that (in NZ at least) there is a desire to include ACT within CBT training and that the majority of clinical supervisors report they are largely in a position to support this learning. What seems critical is that therapists maintain fidelity to an evidence-based intervention, and have flexibility to meet the needs of the individual client. Supervisors will have an essential role in ensuring that ACT components are only brought in where it fits with the CBT formulation and that they are integrated in a coherent way. As this survey was conducted in 2018 and there were a number of supervisors with no/minimal formal ACT training we will run the supervisor survey again before the next diploma level course, to check whether sufficient numbers of supervisors are adequately position to supervise the ACT components of the course. We will also support supervisors by providing the training materials and discussing them at regular supervisor audio-conferences.

Adding an introductory ACT component to the course will enable students to cater to a broader spectrum of presentations and personalities using a process-based approach while remaining faithful to the theory of the evidence based therapies. Thus, in addition to broadening the range of clinicians who are competent to deliver evidence-based therapy in NZ, the course will broaden their skill set beyond traditional CBT.

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NOTICE OF CORRECTION:

This is a corrected version of the article published in December, 2021. The author order in the original version was incorrect, and missed during the proofing process. This version (published May 3rd, 2022) presents the correct author information.

APPENDIX 1

Student Survey

1. Have you done any training or learning in Acceptance and Commitment Therapy (ACT)? (Yes/No but considering it/ No and have no plans to do so)
2. Which of the following have you done? (Reading books- independent learning/ Russ Harris 2 day workshop-beginners/ Russ Harris 2 day workshop- advanced/ Russ Harris Boot Camp/ 1-2 day workshop-NZ presenter/ 1-2 Day workshop-International presenter/ International ACT conference
3. If you have not done any formal training in ACT, what is the reason for this? Choose as many as relate to you (Not Interested in ACT training/ There are other things that are a higher priority for me/ I don't know where to get training in ACT/ Lack of time
4. How would you rate your knowledge in ACT (Very Poor/ Poor/ Fair/ Good/ Excellent)
5. How would you rate your expertise in ACT? (Very Poor/ Poor/ Fair/ Good/ Excellent)
6. To what extent do you use ACT in your clinical work currently? (Never/ Rarely/ Sometimes/ Often/ Always)
7. Do you see ACT as suitable with clients from a range of different cultures? (Yes/ No/ Don't Know)
8. We are interested in your thoughts about the use of ACT with Māori clients. Please elaborate if you have any views about the appropriateness or not of ACT with Māori (or you can leave this blank)
9. When thinking about your colleagues (of any discipline) who do therapy, how much interest would you estimate they have in ACT? (None at all/ A Little/ A Moderate Amount/ A Lot/ A great Deal)
10. When thinking about your workplace what percentage of your colleagues do you think use ACT at least to some degree in their clinical work (0-100 Slider)
11. Gender (Male/ Female/ Other)
12. What ethnic group(s) do you belong to? Mark the space or spaces that belong to you (NZ European/ Māori / Pasifika/ Chinese/ Indian/ Other (please specify))
13. My professional occupation is (Nurse/ Occupational Therapist/ Social Worker/ Psychiatrist or Psychiatric Registrar/ Clinical Psychologist/ Counselling Psychologist/ AOD Counsellor/ Other (please specify)
14. How long have you been working in this occupation? (less than 3 years/ 3-6 years/ 6-10 years/ 10+ years)
15. My work setting is (DHB General Hospital/ DHB Inpatient/ DHB Adult Community Mental Health Service/ DHB Community Based Child and Adolescent Service/ Alcohol and Drug Service/ DHB Specialist Service (please specify)/ Private Practice/ Other (please specify)
16. I have completed the certificate in CBT (COBE401) through Otago University (Yes/ No)
17. I completed the certificate in CBT in: (year) (2013/ 2014/ 2016/ 2017)
18. I have completed or am enrolled in the diploma in CBT (COBE404) through Otago University (Yes/ No)
19. I completed or am enrolled in the Diploma in CBT in: (year) (2011/ 2015/ 2018)

Supervisor Questionnaire

1. Have you done any training or learning in Acceptance and Commitment Therapy (ACT)? (Yes/ No but considering it/No and have plans to do so)
2. Which of the following have you done? (Independent learning (please specify)/ Russ Harris two day workshop beginners/ Russ Harris 2 day workshop advanced/ Russ Harris Boot camp/ 1-2 day workshop by NZ presenter/ 1-2 day workshop or conference outside NZ/ Member of ACT interest group/ Attended ACBS conference/ other (please comment).
3. If you have not done any formal training in ACT, what is the reason for this? Choose as many as relate to you (Not interested in learning ACT/There are other things that have a higher priority for me/ I do not know where to get training in ACT/ Lack of time for training/ Lack of money for training).
4. How would you rate your knowledge in ACT? (Very Poor/ Poor/Fair/ Good/ Excellent)
5. How would you rate your expertise in ACT? (Very Poor/ Poor/ Fair/ Good/ Excellent)
6. To what extent do you use ACT in your clinical work currently? (Never/ Rarely/ Sometimes/ Often/ Always)
7. Would you currently feel confident to supervise a student who was in the beginning stages of training in ACT? (Yes/ Not currently, but I could potentially see myself doing this in a year or two)/ No)
8. Do you see ACT as suitable with clients from a range of different cultures? (Yes/ No/ Don't Know)
9. We are interested in your thoughts about the use of ACT with Māori clients. Please elaborate if you have any views about the appropriateness or not of ACT with Māori (or you can leave this blank)
10. When thinking about your colleagues (of any discipline) who do therapy, how much interest would you estimate they have in ACT? (None at all/ A little/ A moderate amount/ A lot/ A great deal)
11. When thinking about your workplace what percentage of your colleagues do you think use ACT at least to some degree in their clinical work? (Response on 0-100 Sliding scale)
12. Gender (Male/ Female/ Other)

13. What ethnic group(s) do you belong to? Mark the space or spaces that belong to you (NZ European/ Māori / Pasifika/ Chinese/ Indian/ Other (please specify)
14. I am a clinical psychologist (Y/N)
15. How long have you been working in this occupation? (Less than 3 years/ 3-6 years/ 6-10 years/ 10+ years)
16. The setting I do most of my clinical work is: (DHB general hospital/ DHB inpatient/ DHB community-Adult/ DHB community- Child & Adolescent/ AOD service/ DHB specialist service (please specify)/ Private Practice/ Other (please specify)
17. Is CBT the predominant model that you use in your clinical work currently? (Yes/ No)
18. What is the second most frequent model you use in your clinical work? ACT/ Family Therapy/ EMDR/ DBT/ Compassion-Focused Therapy/ Interpersonal Therapy/ Schema Therapy/ Solution-Focused Therapy/ Other (please specify).