

# Guided Respiration Mindfulness Therapy: Development and Evaluation of a Brief Therapist Training Program

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Published online: 30 November 2015  
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**Abstract** The present paper describes the development and evaluation of a standardized multi-component therapist training program in guided respiration mindfulness therapy (GRMT). GRMT is a manual-based, experimental clinical intervention involving concentrated focus on sustained self-regulation of breathing, application of mindfulness to emergent somatic experience and relaxation. Therapists ( $n = 61$ ) new to the approach attended a 2-day experiential workshop and were evaluated pre-post workshop for change in intervention knowledge, as well as change in mindfulness. These trainees also participated in post-workshop focus group sessions to explore perception of the intervention. A subset of 40 therapists participated in a second training component, and 14 of these were rated for competent delivery of the intervention during participation in a clinical trial. During training, therapists personally received the treatment giving the opportunity to assess treatment session ( $n = 283$ ) impact on sense of wellbeing. Results indicated a brief focused training program can equip therapists with basic knowledge and skills required

to deliver the standardized manual-based treatment. Qualitative analysis of focus group sessions showed that therapists endorsed the intervention for clinical use and found it personally beneficial. This research provides a foundation for further evaluation of clinical effectiveness of the intervention.

**Keywords** Breathwork · Brief psychotherapy · Mindfulness · Psychotherapy training · Respiration · Self-regulation · Treatment development

## Introduction

The implementation of new and novel therapies requires a range of processes before they can be translated into clinical practice. The first process involves training therapists in the implementation of the approach. The effectiveness of such training remains a relatively unexplored field (Herschell et al. 2010). More specifically there is no current literature on the training of practitioners in guided respiration mindfulness therapy (GRMT). GRMT is a manual-based experimental approach to psychotherapy based on a process that synthesizes three core components which are sustained over the course of a session: (1) the self-regulation of respiration utilizing an uninterrupted rhythmic breathing pattern aimed at removing breathing inhibition and increasing contact with somatic experience, (2) application of mindfulness with a specific somatic focus on physical sensations as they emerge moment-to-moment, and (3) the progressive relaxation of tension at increasingly subtle levels. The approach draws on the lead authors experience with breathwork (e.g., Minett 2004), classical Buddhist respiration-mindfulness concentration practice (e.g., Nāṇamoli 1964), and the respiration research literature

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(e.g., Bolton et al. 2004; Bradley 2002). A previous report (Lalande et al. 2012) proposing this three-component model, presented a theoretical rationale and qualified support for the potential utility of GRMT as a treatment for anxiety and depression. Empirical research was identified supporting the proposition that habitual breathing inhibition can develop in response to stressful environments. Also identified were interventions with comparable components to GRMT which have demonstrated effective in the treatment of depression and anxiety. GRMT is comparable to mindfulness-based stress reduction (MBSR; Kabat-Zinn 1990) and mindfulness-based cognitive therapy (MBCT; Segal et al. 2002) in that it is based on a formal meditative process. A meta-analytic review examining the effectiveness of these approaches in 39 studies with a total clinical sample of 1140 participants (Hofmann et al. 2010) found robust effect sizes (Hedge's  $g$ ) for anxiety (0.97) and depression (0.95) symptoms. Both MBSR and MBCT involve passive observation of breathing and physical sensations. GRMT is distinct from mindfulness training taught in MBSR and MBCT in that practice involves sustained concentration on self-regulation of breathing. Self-regulation of breathing has been suggested as a possible primary treatment for anxiety (Jerath et al. 2015) as it can promote an ANS shift from sympathetic dominant state (e.g., anxiety) to a parasympathetic dominant state. GRMT is also comparable to Jacobson's (1924) original conceptualization of progressive relaxation training in its aim for clients to learn to localize tensions and relax them at increasingly subtle levels, however GRMT is distinct in that no muscle contractions are used and relaxation is learnt through self-regulation of breathing and mindfulness. Unlike mantra based meditation which uses controlled thinking in the form of silent repetition of a word or phrase (Ospina et al. 2007), GRMT practice actively discourages engagement with thinking.

Case examples using the GRMT approach provided by the lead author gave an initial indication of positive depression and anxiety symptom response measured on the Depression Anxiety Stress Scale (DASS; Lovibond and Lovibond 1995) and suggested investigation of therapeutic effects is warranted. In an open, uncontrolled clinical trial evaluation of GRMT associated with the evaluation of therapist training reported in this current paper, a community sample of 42 participants with a DSM-IV diagnosis of anxiety and/or depression received up to 10 sessions of the manualized GRMT intervention. Results showed statistically significant improvement ( $p < .001$ ) in depression and anxiety symptoms (DASS) over the course of treatment with 83 % of participants also experiencing clinically significant improvement (Lalande et al. 2016).

The current paper reports on the development and evaluation of a therapist training program designed to

achieve a standardised approach to treatment and benchmarks for therapist competence. Our broad aim being to lay a foundation for systematic research which could evaluate the clinical utility of this intervention in a meaningful way.

### Description of the GRMT Intervention

To practice GRMT, therapists learn to guide clients in applying the three core components: respiratory regulation, mindfulness, and relaxation. The intervention can be completed in 50–60 min during which time the client is in a lying position with eyes closed and hands at their side. Therapists learn to sensitively administer a range of standardized intervention statements tailored to encourage client compliance to each component of the method. Respiratory regulation involves adopting and maintaining a breathing pattern characterised by unbroken rhythmicity, mobilization of the diaphragm and upper chest with depth of inhalation dependent on session dynamics, and complete release of all respiratory and peripheral muscles on exhalation. Relaxation of respiratory muscle control during exhalation serves as a centre point from which progressive awareness of tension and its release encompasses the whole body. Mindfulness in GRMT is somatically focused with particular attention given to establishing contact with the most salient sensation at any given moment. Relaxation involves gaining skill in recognizing the presence of tension at increasingly subtle levels and learning to release it throughout the therapy session.

We suggest it is rare for people to intentionally develop a level of somatically focused mindfulness concentration at which point insight spontaneously arises. The concept of making and sustaining 'contact' with the body through attention and concentration is seen as the basis of feeling in Buddhist psychology (Hanh 1998) and is the starting point of therapy in GRMT. Attention and concentration are deployed by having the client engage in the volitional regulation of their respiration. Since the therapist is monitoring this engagement on a moment-to-moment, breath-by-breath basis, there is little opportunity for the client to disengage cognitively or behaviourally from attending to the respiratory regulation process and contact with their body. Contact with somatic experience is deepened with the targeted application of mindfulness, and engagement in the process of relaxation of tension. The therapist learns to address any disengagement or deviation from protocol with an intervention aimed at helping the client reengage. Psychotherapy in GRMT is characterised by insight and integration, which takes place at the union of sustained concentration on regulation of breathing, establishment of mindfulness of sensations, and the relaxation of physical tension employed as a defense against contact with uncomfortable inner experience. Clients gain competence

in approaching, tolerating and accepting their inner experience, which will often be related to deep personal meaning. The therapy experience can in part be characterised as exposure, and therapist training involves learning to guide the process in a way that maintains client engagement. The therapy is experienced as non-cathartic (e.g., meditative), safe and as comfortable as possible.

### Development of Therapist Training

The first step in therapist training is manualization of the intervention. Guidelines suggested by the stage model of treatment development (e.g., Carroll and Nuro 2002; Rounsaville et al. 2001) were adopted to produce a treatment manual that aimed to (1) provide a cohesive framework to guide therapists delivery, (2) encourage intervention protocol adherence and promote competence, (3) inform therapist training and supervision and (4) guide development of tools for evaluating the effectiveness of training.

The quantity of training ranges widely, however the general format suggested by Weissman et al. (1982) is instructive and widely accepted (Miller and Binder 2002; Moncher and Prinz 1991; Perepletchikova and Kazdin 2005). This consists of a treatment manual, an intensive didactic seminar, experiential role-play practice plus subsequent supervised practice and feedback. Although research into the effectiveness of therapist training has been neglected (Fairburn and Cooper 2011) and evidence for effectiveness remains tentative (for a recent review, see Beidas and Kendall 2010), this model seems to have the most empirical support (Herschell et al. 2010). Training effectiveness may be enhanced with increased emphasis given to a number of key training components. Active learning, which involves behavioral rehearsal, modeling, coaching and feedback is considered to be critical to effective training (Beidas and Kendall 2010; Perepletchikova and Kazdin 2005), and has been found to differentiate the training outcomes of different trainers even when the training is standardized, manual-based, and trainers are highly experienced (Henry et al. 1993).

Supervision seems to increase adherence (Anderson et al. 2012) but when explicitly focused on increasing manual adherence may further enhance training effectiveness. Feedback in this case should be based on actual practice behaviour observed in recorded sessions and evaluated against treatment specific adherence and competence measures (Perepletchikova and Kazdin 2005). This approach is more likely to improve adherence than reliance on therapists self-descriptions of practice, especially in a new and novel treatment, because therapists may not recognise and therefore cannot report those areas of clinical

practice where competence needs to be acquired, maintained and improved (Miller and Mount 2001).

An important ethical issue in providing training in experiential practices is the amount of personal exposure needed for competent practice. An instructive example that applies to GRMT is offered by Segal et al. (2002, pp. 53–55) who found competence in mindfulness training, as taught in Mindfulness Based Stress Reduction (MBST; Kabat-Zinn 1990), requires therapists have themselves been in the position of client and gained experiential knowledge of, and comfort with, emergent experiences elicited by the intervention across multiple sessions. Segal et al. (2002) point out that this deeper understanding of what takes place equips therapists to provide a supportive and safe therapeutic environment for clients that fosters acceptance and engagement with the intervention, especially when encountering challenging inner experiences. In this current study some therapists, after satisfactorily completing the first two stages of training, would continue their involvement under supervision in a clinical trial designed to evaluate competence in delivering GRMT and the therapeutic effects of GRMT practice on depression and anxiety symptoms. Therefore therapists need to be sufficiently familiar with the psychosomatic dynamics of GRMT and the therapeutic process that unfolds across sessions. It is therefore of great importance to give therapists sufficient personal experience of the treatment they would deliver.

The current study involves development and testing of a standardized therapist training program. Our primary aim is to determine whether a brief training process is sufficient to develop therapist knowledge and competence in GRMT practice. Secondly, we aim to assess therapist acceptance of a new therapeutic methodology. A novel component of the training program comprises therapist participation in the GRMT therapy. This experiential component allows preliminary evaluation of the impact GRMT practice on therapist well-being and mindfulness.

## Method

### Design

The primary focus of the study had two key elements, (1) repeated measures evaluation of the impact of a two-day experiential workshop on change in intervention knowledge, and post-workshop focused discussions to explore therapist experience of training, and (2) evaluation of the outcome of extended training on therapist competence in delivering the intervention in a clinical context. A secondary focus involved repeated measures evaluation of the

impact of (a) the 2-day workshop on therapist mindfulness, and (b) the impact of receiving the intervention on therapists wellbeing.

### Ethical Review

The study received ethical clearance from the Queensland University of Technology Office of Research Ethics and Integrity, and was classified as ‘low risk’.

### Therapists

Participating therapists responded to study information sent out by email through university and hospital mental health networks in Brisbane, Australia. All therapists went through a consent process and were informed of: details of the content and aims of the study; the experimental status of the intervention; and the experiential nature of the training process and the possibility of physical or psychological discomfort as a result of receiving the intervention during training. Participants were required to have a minimum of 1 year counselling experience or be currently enrolled in a graduate clinical psychology or counselling program. Sixty-one therapists (male: 13 %, female: 87 %) completed the initial 2-day workshop. Participants identified themselves as being a practicing psychologist ( $n = 17$ , 27.8 %), probationary psychologist currently undertaking graduate clinical training ( $n = 18$ , 29.5 %), practicing counsellor ( $n = 14$ , 22.9 %), currently undertaking graduate counselling training ( $n = 5$ , 8.1 %), social worker ( $n = 4$ , 6.5 %), nurse ( $n = 2$ , 3.2 %), and occupational therapist ( $n = 1$ , 1.6 %). Four therapists had completed doctoral level studies. The majority ( $n = 40$ ) of these therapists volunteered to participate in the second component of training, and 14 (male: 21.5 %, female: 78.5 %) of these who elected to participate in the trial stage of the broader study were evaluated for competence in delivering the intervention. All participants had a self-identified interest in holistic or somatically focused approaches to treating depression and anxiety.

### Training Process

The training process required therapists to be familiar with the client treatment manual (Lalande 2007). This manual comprised two sections to guide therapists in delivering the intervention. Section one provided intervention characteristics, a rationale for use with the targeted diagnostic syndromes of depression and anxiety, indications and contraindications, and guidance on managing clinical

challenges. Section two was practice focused. It provided detailed narrative guidance therapists could use to orient clients to the use of respiratory regulation, mindfulness and relaxation components of treatment. Guidance for actual GRMT facilitation included a lift-out table which spelt out intervention statements matched to observed client respiratory cues. Instructions aimed to provide clear, succinct expressions of the behaviour the therapist wished to encourage in clients to remain on protocol. Guidelines for sensitively facilitating session completion and markers for characteristics of effective delivery were also provided.

### Training Components

The training program comprised three components. The first component was a standardized 2-day (14-h) training workshop. This was first piloted with two therapists in order to establish feasibility and timing of content and prompted a number of minor modifications. The workshop was then offered on seven occasions between late 2008 and 2012 with 61 therapists attending. Workshop content extended the treatment manual and provided a theoretical and technical understanding of foundational skills and an experiential understanding of the therapeutic process. The format included slide presentations, role-play demonstrations and discussion of specific skills and procedures. Each day also gave therapists practice in delivering one live GRMT treatment session under close supervision followed by debriefing and feedback.

The second component was 6 additional 3-h training sessions. These involved therapists meeting in pairs on a weekly basis and employing their training by administering GRMT to each other in a live session. It's important to note that these sessions were not role-plays. Sessions were video record with recordings used to guide supervision aimed at encouraging manual adherence. Therapists received a minimum of two supervision sessions either individually or in pairs, as well as attending at least one group supervision meeting. Therapists were encouraged to request additional supervision if needed either in person or by phone. On completion of these two training components therapists had administered eight sessions of the intervention and had personally received the treatment equivalent of what someone with a clinical condition would receive.

The third component was participation in a clinical trial evaluation of the intervention. Therapists were given the opportunity to treat one or more clients for up to 10 sessions. Therapists could receive supervision as often as they requested or after every second session. The first author conducted training and supervision.

## Measures

### *Guided Respiration Mindfulness Therapy Knowledge Questionnaire (GRMT-KQ)*

We developed a new 7-item measure, the GRMT-KQ, to assess therapists acquisition of foundational knowledge. Items were constructed using a short answer format with clinical vignettes requiring specific responses. Knowledge was ranked on 5-levels: high (5), medium (4), minimum acceptable (3), somewhat less than satisfactory (2), or not at all satisfactory (1). These levels were then collapsed into a dichotomous rating of either less than satisfactory knowledge (levels 1 and 2), or satisfactory knowledge (levels 3, 4, and 5), representing what in the lead author's opinion was necessary for adequate delivery of the intervention. Areas assessed related to: treatment rationale, respiratory regulation, mindfulness, managing client comfort, and intervention specific meaning of integration. An example item being, "Before giving a client their first GRMT session, it is necessary to give clear instructions in how to apply mindfulness. What instructions would you give your client regarding this component of the approach?" This short answer format was well suited to assessing basic knowledge as answers cannot be guessed, they must be supplied. The GRMT-KQ was completed before and after completion of the 2-day workshop. Pre- and post-workshop knowledge of GRMT was independently assessed by two raters. The intra-class correlation coefficient (two-way random effect model for absolute agreement) was .928 (CI .970–.989) pre-workshop and .822 (CI .703–.893) post workshop. This indicated that the GRMT-KQ had acceptable inter-rater reliability. An estimate measure of internal consistency was calculated by averaging ratings from the two judges (Cronbach's  $\alpha = .81$ ) as suggested by Hayes and Krippendorff (2007).

*GRMT-KQ Rating Manual* To foster rating reliability we rated GRMT-KQ responses with a manual specifically developed for this study. A draft manual was developed by the first author, who acted as the first rater. This was then reviewed for clarity and adequacy of guidance by a second rater previously trained in the GRMT intervention. Both raters then independently rated 2 questionnaires. Discrepancies in judgements were discussed leading to further refinement of rating guidance. Raters then independently rated test responses from 20 therapists. This last process was repeated twice before satisfactory agreement between raters was achieved. The resulting 5-page rating manual contained context and aims of knowledge assessment, and scoring system including a standardised rubric and narrative guidance for interpreting alternative or ambiguous

responses. The two raters independently rated all questionnaires.

### *Guided Respiration Mindfulness Therapy Competence Scale (GRMT-CS)*

In order to evaluate therapist competence in facilitating the core GRMT intervention, we developed the GRMT-CS based on the client treatment manual. The general structure of the widely used Cognitive Therapy Scale (Young and Beck 1980) was used as a model. The GRMT-CS consisted of 13 items rated on a 7-point scale from 0 (very poor) to 6 (excellent). A score of  $\geq 3$  was considered satisfactory competence, while a score of  $\leq 2$  was considered unsatisfactory. The scale had two parts. Part A (10 items) assessed the use of key intervention statements in guiding the client in the application of respiratory regulation, mindfulness and relaxation, as well as general support. For example, guidance provide for inhalation was graded from a score of 0 corresponding to "Therapist failed to coach client in the regulation of inhalation" to a score of 6 which corresponded to "Therapist consistently worked with client throughout the session to ensure appropriate depth and speed of inhalation to ensure engagement with therapy process and manage client comfort." Part B contained 3 additional items rating, (1) the degree interventions were provided when needed, (2) correctness of interventions chosen for target behaviour, and (3) therapist flexibility in delivering interventions. Item 1 of part B was rated slightly differently to other scale items in that it used a continuum ranging from, too little (-0, -1, -2), adequate but less than ideal (-3, -4), high correspondence (-5, 6, +5), adequate but more than ideal (+4, +3), and too much (+2, +1, +0). Fourteen therapists provided at least one GRMT treatment and submitted recordings of at least one full session (session 3 or later). All sessions were rated by the lead author who also provided 5 additional sessions (exemplars of competent practice), which were rated and used as a reference point. Cronbach's alpha coefficients demonstrated the GRMT-CS (with item 1 of part B removed due to modified scoring) to have excellent internal consistency ( $\alpha = .96$ ).

### *Toronto Mindfulness Scale (TMS)*

To determine if therapists state-mindfulness changed from pre- to post workshop we used the Toronto Mindfulness Scale (Lau et al. 2006). The TMS is a 13-item measure using a 5-point Likert scale with a range of 0 (not at all) to 4 (very much). The scale comprises two subscales: 'curiosity' reflecting an attitude of interest in connecting with ones experience, and 'decenteredness' reflecting the capacity for observing thoughts without over identification

with them. The TMS has demonstrated good internal consistency ( $\alpha = .84-.88$ ) across a number of studies (Lau et al. 2006). Cronbach's  $\alpha$  coefficients in the present study showed good internal consistency pre-workshop ( $\alpha = 0.79$ ) and post-workshop ( $\alpha = 0.88$ ).

### *Therapist Perception of Treatment*

In order to explore therapists perception of the intervention semi-structured focus groups were conducted at the end of each 2-day workshop. Discussion centred around three areas, (1) implementation of the GRMT intervention in therapists own clinical contexts, (2) experience of training from a professional perspective, and (3) therapists personal experience of receiving the intervention. Audio recordings of group discussions were transcribed verbatim resulting in a 16,000-word transcript. This was then analysed following Braun and Clarke's (2006) guidelines to identify the major themes and subthemes in therapists experience.

### *Guided Respiration Mindfulness Therapy Impact Measure (GRMT-IM)*

The GRMT-IM is a 5-item self-report measure developed for this study to obtain preliminary data on the impact of GRMT sessions on therapist wellbeing. Items were rated from very little (1) to very much (10), and assessed change in level of relaxation (How relaxed would you say you are at the moment?), anxiety (How would you describe the level of anxiety you are experiencing right now?), worry (What level of worry are you experiencing about your life at the moment?), enthusiasm (How enthusiastic would you say you feel about your life at this moment?), and openness to experiencing (At this moment, how receptive would you say you are to observing unpleasant thoughts and feelings without trying to control or change them?). Therapists completed the scale immediately before and shortly after receiving the GRMT intervention during training. Cronbach's  $\alpha$  coefficients in the present study showed good internal consistency ( $\alpha = .79$ ).

## **Results**

### **Training Effectiveness**

#### *Therapists Acquisition of Knowledge*

GRMT knowledge increased significantly ( $t(60) = 24.52$ ,  $p < .001$ ) from pre to post-workshop. The mean post-workshop knowledge score was 3.7 ( $SD = .67$ ) out of a possible score of 5, compared to 1.5 ( $SD = .55$ ) pre-workshop with a very large effect size (Cohen's  $d$ ) of 3.58.

Using the cut-off scores for acceptable knowledge, outlined in the method section above, by post-workshop 43 (70 %) therapists demonstrated acceptable knowledge on 6 or more assessment items, with twenty three (37.7 %) rated as demonstrating acceptable knowledge on all seven items.

#### *Therapist Acquisition of Competence*

Competent delivery of the intervention was evaluated. Session recordings were provided by a subset of therapists during their participation in a clinical trial associated with a broader program of research. Recordings were also provided by the first author for rating as a 'gold standard' comparison. All recordings were evaluated for competence using part A and B of the GRMT-CS.

On part A of the GRMT-CS therapists achieved an overall mean competence score of 3.77 ( $SD = 1.47$ ). Ten therapists (71.5 %) demonstrated a satisfactory level of competence (mean score of  $\geq 3$ ) with ratings ranging through excellent ( $n = 2$ ), very good ( $n = 5$ ), and good ( $n = 3$ ). Three therapists were judged as delivering borderline adequate delivery, while one was judged less than adequate. By way of comparison, the 5 recordings from the lead author had an overall mean of 5.26 ( $SD = 0.65$ ). After recordings from the four therapists who failed to demonstrate adequate delivery were removed from the data the remaining therapists mean competence score ( $M = 4.43$ ,  $SD = 0.78$ ) was not significantly different from the mean competence score of the researcher ( $t = 1.94$ ,  $df = 22$ ,  $p = .065$ ), although the effect size ( $d = 1.05$ ) was large.

Part B of the GRMT-CS evaluated the timing, correctness and flexibility of delivery of interventions. Therapists achieved an overall mean score of 3.96 ( $SD = 1.58$ ). Ten therapists (71.5 %) were ranked as providing intervention statements when needed (timing) with a rating of high ( $n = 6$ ), or adequate ( $n = 4$ ) timing. The same therapists ( $n = 4$ ) ranked as less than competent on part A of the GRMT-CS were also rated as demonstrating less than adequate level of timing with the majority ( $n = 3$ ) falling into the too little range, while one demonstrated over-use of interventions. Eleven therapists (78.5 %) were ranked as competently providing correct interventions for observed client behaviour, and flexibility in providing interventions, with ratings of high ( $n = 6$ ), or adequate ( $n = 5$ ). Three therapists ranked as less than adequate on both these items. No treatment model non-compliant therapeutic techniques were evident in any of the recorded sessions.

The relationship between therapist competence (as measured by the GRMT-CS) and knowledge acquisition (as measured by GRMT-KQ score post-workshop) was investigated through Pearson correlation. This indicated a

moderate association, which was not significant because of the small sample size ( $r = .411$ ,  $n = 14$ ,  $p = .144$ ).

### Impact of the 2-Day Workshop on Therapist Mindfulness

Therapists ( $n = 61$ ) mindfulness increased significantly from pre-workshop to post-workshop as measured with the TMS (paired sample  $t$  test,  $t$  ( $df=60$ ) = 5.292,  $p < 0.01$ ). The pre-workshop mean of 31.93 ( $SD = 6.46$ ) increased to 36.48 ( $SD = 8.31$ ), with a medium effect size ( $d = 0.61$ ). However, the TMS curiosity subscale scores did not change significantly from pre-workshop ( $m = 18.02$ ,  $SD = 3.87$ ) to post-workshop ( $m = 18.59$ ,  $SD = 4.32$ ,  $t$  ( $df=60$ ) = 1.237,  $p = 0.221$ ) with an effect size of  $d = 0.13$ . The TMS decenteredness subscale scores did change significantly ( $t$  ( $df=60$ ) = 6.714,  $p < .001$ ), with a pre-workshop mean of 13.92 ( $SD = 4.14$ ) which increased to 17.86 ( $SD = 5.11$ ) post-workshop with an effect size of  $d = 0.84$ .

### Therapists Perception of the GRMT Intervention

Therapist ( $n = 61$ ) perceptions of the GRMT intervention were evaluated through thematic analysis of the transcript of post-workshop focus group sessions. A range of clear sub-themes were identified under three themes: treatment implementation, training, and personal experience of the intervention.

#### Therapist Perception of Treatment Implementation

There was consensus across sessions that the intervention was useful, easy for clients to pick up, and worked quickly. It was seen as a good fit with current trends in psychotherapy with one therapist stating, “*I see similarities with some of the facets of things like ACT and mindfulness which are very popular and people are accepting very widely now.*” There was overall endorsement and enthusiasm for its implementation with broad (but not universal) applicability. Therapists across sessions also felt it would be useful in the treatment of trauma, and generally beneficial for clients who have difficulty regulating emotions, avoid inner experience, or have difficulty verbally articulating issues. One therapist stated, “*Some people really struggle to put their thoughts and their feelings into words, and this ... you just go through the process and it completes itself and very little verbal interaction is required.*”

#### Therapist Perception of Training

Therapists found the client treatment manual useful and engaged with it, for example, one therapist stated, “*I*

*thought I would experiment with some of those things in the back of the manual today, and I wasn't sure if I was saying too much, but afterwards [the “client”] said no, she thought they were really appropriate.*” Therapists across multiple focus group sessions indicated they felt they had acquired some basic confidence after 2 days of training. For example, one therapist referring to the second day of training stated, “*I found I had a bit more confidence today in speaking up and keeping [the client] on track. I felt like I was more able to attend to what was happening with [the client].*” There was general agreement across sessions that more training was needed to become competent in the good timing of interventions and in managing unusual client reactions. A number of therapists reported experiencing powerful, unambiguously intervention linked therapeutic effects during the two sessions experience during the workshop. These included regressed states which, while experienced as positive, were identified as indicating the need for adequate therapist training to ensure clients can work through this material in a mindful and integrative way.

#### Therapists Personal Experience of the Intervention

Therapists discussed themes of somatic effects, psychological effects, and therapeutic experiences. Somatic effects were captured in one therapist's statement that, “*I became a little bit anxious then that seemed to pass. Then my right arm felt very painful and jerking about ... Then after that I seemed to experience very pleasant, extremely pleasant, very regular, smooth breathing and that continued for the rest of the session.*” Other somatic effects discussed were increased feelings of energy and arousal which was not reported as distressing, just notable transient experiences. The psychological experience of wellbeing and sense of spiritual connection was also discussed in multiple focus group sessions. For example, one therapist described, “*This great sense of love and loving and being loved came over me, and then ... a big feeling of spiritual connection and that was just wonderful.*” Therapists expressed surprise and excitement about gaining insight into previously unconscious psychological material and experiencing what felt like its integration. For example, a number of therapists mentioned integration of grief experiences, “*...for me it was like going through a grief process ... my father died in November ... I was right back there ... I reconnected to it with the breathing, and it changed at the end.*” Another therapist stated, “*I liked it because you process grief, you recognise it and you process it, and it's safe to do it.*” A number of therapists described regression type experiences, for example, one therapist stated, “*I saw myself when I was very little, and an experience ... I found intolerable as a child ... and I was almost back in that experience and I got an emotional release around that ... and that was when I*

*understood what this process was about.*” Therapists across sessions also reported that with repeated practice they were able to engage more fully with the therapeutic process and that the intervention was personally useful and highly engaging.

### **Impact of the GRMT Intervention on Therapists Wellbeing**

Sixty-one therapists personally received up to 8 sessions of the GRMT intervention during the training process. Change in therapists sense of wellbeing after receiving a session, as measured with the GRMT-IM, was evaluated for a total of 283 sessions. The GRMT-IM mean score increased significantly from pre-intervention ( $m = 6.27$ ,  $SD = 1.29$ ) to post-intervention ( $m = 7.99$ ,  $SD = 1.296$ ) ( $t(df=282) = 22.428$ ,  $p < 0.01$ ) with an effect size of  $d = 1.32$ . All 5 items on the GRMT-IM showed significant change from pre- to post session in the expected direction with large effect sizes for relaxation ( $d = 1.42$ ), anxiety ( $d = 1.04$ ), and worry ( $d = 0.94$ ), and medium effect sizes for enthusiasm ( $d = 0.65$ ), and openness to experience ( $d = 0.61$ ).

### **Discussion**

This study evaluates the implementation of a therapist training program which aims to disseminate GRMT. GRMT is a novel, experimental clinical intervention based on sustained self-regulation of respiration, somatically focused mindfulness and relaxation.

#### **Training Effectiveness**

The results show an experiential 2-day training workshop that utilised known elements of effective training can equip therapists with foundational knowledge in this unfamiliar intervention. The majority of therapists (71.5 %) assessed for competence were able to deliver the core GRMT intervention at a satisfactory or better level, intervene appropriately and in a timely manner in response to client cues and use interventions relatively flexibly. By way of comparison, Sholomskas et al. (2005) found a 3-day CBT training plus supervision resulted in 54 % of therapists achieving adequate levels of adherence and skill in videotaped role plays as assessed using the Yale Adherence Competence Scale (YACS; Carroll et al. 2000). The YACS is comparable to the scale developed in this study in that it uses a 7-point, Likert-type scale and rates the degree to which therapists adhere to treatment protocols and competently deliver the intervention. Although no direct comparison was possible due to the use of different measures, this suggests that therapists can acquire a working

knowledge of, and basic competence in, GRMT that is comparable to that achieved in CBT.

#### **Training Recommendations**

We are mindful that knowledge acquisition after completing the 2-day workshop can be improved, and that nearly 30 % of therapists assessed for competence failed to acquire a satisfactory level in performing the GRMT intervention. This group were resistant to using a standardised manual, which suggests further training alone is unlikely to establish competence. It is important to bear in mind that GRMT is a novel approach to therapy and training introduces a fundamentally new set of technical intervention skills, practice awareness and theoretical assumptions. This was reinforced by therapists perception of the need for further training expressed in the post-workshop focus group sessions. While we are aware that the experiential nature of GRMT may not suit some therapists, we believe that for the majority of therapists competence will improve with continued practice. Specifically with increased skill in accurately interpreting client respiratory behaviour, successfully administering the manualized interventions, and increased comfort with the experiential nature of the intervention. Consequently, we recommend foundation level training be strengthened by providing a second 2-days of training that focuses more intensely on these practice components; increasing the number of supervised training practice sessions from 6 to 10; and strengthening the coaching aspects of supervision. Additionally, we recommend introducing clear competence assessment that is ongoing to identify training non-responders early and some form of examination and certification system as a necessity.

#### **Therapist Intervention Acceptance**

An important finding in this study was that most therapists appeared to accept the treatment manual and engaged with it when administering the intervention. Therapists also expressed strong endorsement for the clinical implementation of GRMT and specifically identified potential benefit for clients who have difficulty regulating emotions, avoid inner experience, or have difficulty verbally articulating their problems. Therapists were comfortable with the experiential nature of the intervention, generally did not find it overly challenging or difficult to facilitate, and perceived it as personally beneficial. Therapists also experienced the intervention as fast acting and relatively easy to pick up. This is important as innovations that are perceived by therapists and other stakeholders as relatively simple to learn and use will be more readily adopted (Greenhalgh et al. 2005).

## Therapeutic Impact on Therapists Receiving GRMT During Training

Results suggest that GRMT can produce therapeutic effects. There has been little attention given to the evaluation of training effects on therapists personal experience in the research literature. One study which has (Montagno et al. 2011) examined the impact of a 3-day experiential training in emotion-focused therapy on therapists intervention competence and personal lives through both quantitative and qualitative methods. Their results showed experiential training increased therapists ability to process emotions and levels of self-compassion consistent with the treatment model. We evaluated the impact of GRMT sessions on therapist well being (subjective experience of relaxation, anxiety, worry, enthusiasm and openness to experience) using the GRMT-IM and qualitative analysis. The fact that there was a large effect size for the GRMT-IM pre-post sessions suggests the intervention has an effect, particularly in increasing relaxation and reducing anxiety. This conclusion is strengthened by support from the qualitative data, which showed therapists experienced a range of meaningful and unexpected therapeutic effects. This also suggests the approach may offer therapists themselves a useful option for engaging in their own therapy and self-care that does not require extensive dialogue, external interpretation and other elements commonly associated with psychotherapy.

### *Mindfulness Effects*

The results suggest training in GRMT may increase some aspects of mindfulness in therapists. The significant change on the TMS decentred subscale score pre/post workshop may indicate GRMT increases the capacity for a decentred perspective on one's inner experience. This increase was consistent with the significant change observed on item 5 (openness to experience) of the GRMT-IM, which is conceptually similar to decenteredness in the TMS. The non-significant change on the TMS curiosity subscale in this study may reflect the high pre-workshop mean for this therapist group compared to what might be expected in non-therapist populations (Altmeyer and Maloney 2007). We could expect therapists to be relatively curious about their own functioning, reflecting a personality characteristic related to the profession.

### **Limitations**

A lack of trained trainers meant all training, including supervision was delivered by a single trainer. While results are based on a standardized training program with content

and delivery remaining constant over multiple trainings, it remains to be seen if a comparable outcome would result if the same training program was delivered by a different trainer. Secondly, given time restraints, the same issue meant a lack of suitably experience raters to rate session competence. Consequently, all clinical session recordings were rated with the GRMT-CS by one rater introducing the possibility of rater bias with no assurance that the competency scale was used consistently across all therapists. Future work is needed to establish interrater reliability of this scale.

The development of tools that make it possible to assess therapist acquisition of knowledge and competence in the approach was an important feature of this study. In addition to further work needed to establish the interrater reliability of the GRMT-CS, there is scope for further development of the GRMT-KQ. However, good internal consistency suggests each item measures the same core construct and that it is reasonable to make inferences about knowledge of GRMT from scores on this questionnaire.

This study used a new self-report measure (GRMT-IM) to assess wellbeing effects of the intervention. We wanted an instrument that was quick to administer, didn't create a burden for therapists, and was sensitive to the main areas we expected GRMT to have an impact on. As it turned out the 5-items yielded a scale that had acceptable reliability, but we acknowledge it is a new instrument and we have no knowledge of its reliability and validity outside of this study.

While the use of focus groups to assess therapist perception of treatment proved valuable, it did not provide precise numbers of how many therapists felt the same way. Future research could include forced choice questions on a Likert-type scale to get a more precise understanding in this area. Furthermore, while results indicated therapist endorsement for GRMT, therapists self-selected to be involved in the study and had a pre-existing bias toward holistic treatments. It is unknown if GRMT would receive the same level of endorsement among therapists more broadly.

### **Conclusion**

Findings indicate a brief, focused training program is effective in establishing a foundational level of knowledge and skill in the use of manual-based GRMT for therapists with no prior experience of the intervention. Therapists found the intervention personally useful and also endorsed its clinical use. This study provides a foundation for systematic research aimed at evaluating the clinical utility of this intervention.

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