Getting Off the Couch:

Psychotherapists Who Have Incorporated Therapeutic Lifestyle Changes Into Their Practice

By

Kellsey D. Calhoon

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Abstract

Twenty percent of Canadians are affected by mental illness (Mental Health Commission of Canada, 2011). Mental illness can be positively impacted by Therapeutic Lifestyle Changes (TLCs). TLCs include such things as exercise, diet, recreation, sleep, sunlight exposure, interpersonal relationships, spiritual involvement, and stress management (Ilardi, 2009; Walsh, 2011). TLCs offer greater accessibility and affordability, fewer side effects, and less social stigma than traditional methods of mental healthcare (Walsh, 2011). However, despite the positive research, TLCs are underutilized by psychologists (Walsh, 2011). Five psychologists who use TLCs in their practices answered semi-structured interview questions such as, "What inspired you to begin using TLCs in your practice?", "How did you learn to effectively use TLCs with clients?" and "What challenges have you faced incorporating TLCs?" Interpretative Phenomenological Analysis (Smith, Flowers, & Larkin, 2009) was used to identify intra-individual and inter-individual themes. Themes identified related to therapist congruency, developing competency and recognizing limits, finding what fits for the client, drawing on therapist skills, looking at the whole picture, and addressing and removing barriers. These findings help explain how psychologists are able to incorporate TLC into existing therapies, and how other psychologists can obtain the knowledge and skills necessary to use TLCs.

Preface

This thesis is an original work by Kellsey Calhoon. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name “How Psychotherapists Incorporate Therapeutic Lifestyle Changes into Practice”, No. 40379, July 15, 2013.

Dedication

Mom,

It was you who first taught me about TLCs by simply allowing me to be a witness to your strength, balance and wisdom.

Lighting the path with passion and vision. Setting fire with hard work and devotion.

Warm. Unyielding. Incandescent. Your *eternal flame* forever guides me.

I love you.

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In our society, the diseases leading to the highest rates of morbidity and mortality are strongly determined by lifestyle. Non-Communicable Diseases (NCDs), such as cardiovascular disease, cancer, diabetes, and obesity, are often avoidable yet they make up 68% of global deaths (World Health Organization, 2010). These statistics are comparable in Canada, with cancer, heart disease, and stroke responsible for 56% of all deaths (Statistics Canada, 2009).

According to the World Health Organization (2010), a large number of the NCDs are caused by behavioural risk factors such as insufficient physical activity, misuse of alcohol, unhealthy diet, and tobacco use. DeVol and Bedrosian (2007) similarly point out that 70% of mortality and morbidity are related to what we eat, how much we eat, alcohol use, smoking and exercise – and that is before considering other lifestyle choices such as relationship habits, sleep patterns, sexual behaviours, and drug use.

These preventable risk factors may be countered by healthy behaviours and choices, referred to as Therapeutic Lifestyle Changes (TLCs). TLCs include exercise, diet and nutrition, recreation, service to others, time in nature, religious or spiritual involvement, interpersonal relationships, sleep, exposure to sunlight, relaxation, and stress management (Ilardi, 2009; Walsh, 2011).

The benefits of TLCs also extend to mental health, with empirical research demonstrating improvement in many areas of mental health resulting from healthy behaviours (e.g., Borgonovi, 2009; Dowd et al., 2004; Gómez-Pinilla, 2008; Khaw et al., 2008; Ornish et al., 2008; Sidhu, Vandala & Balon, 2009; Walsh, 2011; WHO, 2010). With 20% of Canada's population being affected by mental illness (Mental Health Commission of Canada, 2011), TLCs are a promising

intervention, possessing less social stigma, fewer side effects and fewer complications than traditional methods of mental healthcare (Walsh, 2011). Compared with psychotherapy and psychopharmacological treatment, TLCs are at least as effective if not more so (Ilardi, 2009; Walsh, 2011). In addition to their effectiveness, TLCs are both accessible and affordable – an important factor considering Canada is conservatively estimated to spend $50 billion on mental health care each year (Mental Health Commission of Canada, 2011). Overall, TLCs have a role in "primary prevention, for secondary intervention, and to empower patients' self-management of their own health" (Walsh, 2011, p. 579).

Psychotherapists have the potential to play a key role in TLC promotion due to their time spent one-on-one with clients and their inherent behaviour change skills. Despite the positive research on TLCs as interventions, however, TLCs are an underutilized intervention by psychotherapists (e.g., Callahan, 2004; Faulkner & Biddle, 2001; McEntee & Halgin, 1996; Pollock, 2001; Royak-Schaler & Feldmen, 1984; Walsh, 2011).

The purpose of this study was to gain a deeper understanding of how psychotherapists incorporate TLCs into their practice by speaking to those who do use TLCs in their work. It is hoped that the findings from this study will help to bridge the gap between research and practice by providing a clearer depiction of how TLCs are incorporated into existing therapies so that more therapists might also do so.

Literature Review

The group that bears one of the largest inequalities in health is individuals with mental illness (Roberts & Bailey, 2013; World Health Organization, 2005). These individuals suffer a higher morbidity and mortality rate than those without mental illness, dying an average of 25 years earlier (Brown, Barraclough, & Inskip, 2000; Harris & Barraclough, 1998; Parks,

Svendsen, Singer & Foti, 2006; Scott & Happell, 2011).

Individuals with mental illness tend to have a more sedentary lifestyle and make poorer dietary choices than people without mental illness (Baker et al., 2011; Brown, Birtwistle, Roe, & Thompson, 1999; Osborne, Nazareth, & King, 2007; Scott & Happell, 2011). Specifically, schizophrenia, attention-deficit/hyperactivity disorder, mood disorders, and trauma have been associated with obesity and obesity-related comorbidities (Taylor et al., 2012). Furthermore, cardiovascular disease is the leading cause of death amongst individuals with severe mental illness (Baker et al., 2011). This high rate of cardiovascular disease could be related in part to the fact that smoking and alcohol consumption behaviours are also high amongst these individuals, thereby increasing their risk for cardiovascular diseases (Baker et al., 2011).

Side effects from the medications that those with mental illness are prescribed are another reason that these individuals generally suffer a higher morbidity and mortality rate than those without a mental illness. Some side effects that can accompany psychiatric medications include changes in weight, changes in appetite, drowsiness and fatigue, insomnia, nausea, headaches, emotional numbing, mood changes, sexual dysfunction and suicidality (National Institute of Mental Health, 2010; Turjanski & Lloyd, 2005). Another side effect of many medications is an increased risk of cardiovascular diseases (Chiverton, Lindley, Tortoretti, & Plum, 2007; Roberts & Bailey, 2013; Verhaeghe, Maeseener, Maes, Heeringen, & Annemans, 2011).

Many of these physical and mental illnesses, and the side effects of their treatment, are influenced by modifiable lifestyle behaviours. Choices such as smoking, alcohol consumption, inactivity or poor nutrition have been found to cause, contribute to and perpetuate a variety of illnesses and ailments (World Health Organization, 2010). While avoiding these unhealthy behaviours is not a panacea for all morbidity and mortality, countering them with positive

lifestyle choices has been shown to improve mental and physical health. These healthy behavioural choices are commonly referred to in the literature as Therapeutic Lifestyle Changes, or TLCs. TLCs commonly include nutrition, exercise, nature, sleep, social connectedness, spirituality and religion, service to others, stress management and recreation (Ilardi, 2009; Walsh, 2011).

TLCs have many advantages. They are affordable and accessible, and they can be implemented and produce positive effects quickly (Ilardi, 2009; McMorris, Tomporowski, & Audiffren, 2009; Roberts & Bailey, 2013). Furthermore, they have fewer side effects, complications and stigma than medication (Amminger et al., 2010; Borgonovi, 2009). Research supports TLCs as a promising intervention for improving symptoms of a variety of mental illnesses, in addition to providing substantial positive secondary benefits such as improvement in physical health, quality of life, and self-esteem (Deslandes et al., 2009).

Due to the enjoyable nature of these healthy behaviours, TLCs can become self-sustaining routines. Many individuals with mental illness are willing to learn more about lifestyle changes (Schmutte et al., 2009). Not only can TLCs be used as a commanding adjunct to psychotherapy, but TLCs can also be a vehicle to empower clients to manage their own health and become more engaged in their own lives.

Nutrition

Diet has been projected as a modifiable risk factor for mental health in various studies (Bodnar & Wisner, 2005; Silvers & Scott, 2002; Smith, 2005). The most substantial research surrounds the effects of consuming of a *pescovegetarian diet* – a diet containing fish, vegetables and fruits (Walsh, 2011). The authors of multiple studies suggest that these diets may prevent or ameliorate psychopathologies, potentially enhancing cognitive and academic performance,

improving affective and schizophrenic disorders, and providing neuroprotective benefits to the brain (Gómez-Pinilla, 2008; Kang, Ascherio, & Groodstein, 2005; Morris, Evans, Tangney, Bienias, & Wilson, 2006; Willis, Shukitt-Hale, & Joseph, 2009). In a study by Jacka and colleagues (2010), the association between depression in adolescents and their diet was greater than the influence of family, socioeconomic, and other confounding factors. Healthy diets can also ameliorate particular comorbid physiological disorders, including obesity, cardiovascular complications, and diabetes (Walsh, 2011).

One of the key elements of this type of diet appears to be the consumption of omega-3 fatty acids. Omega-3s are essential for neural function, offering anti-inflammatory benefits, which balance out the inflammatory effects of omega-6s (Ilardi, 2009). Our brains were designed to best function when these fatty acids are in a reasonable balance. Our ancestors functioned on a ratio of omega-6s to omega-3s that was 1:1 or 2:1 (Simopoulos, 2006). In North America, this ratio is estimated to be 16:1 (Simopoulos, 2002). This change can be attributed primarily the way our diet has changed with time. Omega-3s are found in wild game, fish, grass, and plants, while omega-6s are found in plant seeds, grains, nuts, and a variety of oils which we consume when cooking at home, eating processed food, or eating fast food (Ilardi, 2009). In our Western world, omega-6s dominate the dietary habits of many individuals (Freeman et al., 2006; Ilardi, 2009).

Depression appears to be the disorder studied most closely in respect to the impact of omega-3 intake. It has been found that, in Western society, individuals who are depressed have lower levels of omega-3s (Peet, Murphy, Shay, & Horrobin, 1998). In societies where a greater balance between omega-6s and omega-3s exist, depression is less (Peet, 2004). Vulnerability to depression and the imbalance between fatty acids appears to be mediated by loss of serotonin function, loss of dopamine function, and chronic inflammation (Chalon, 2006; McNamara &

Carlson 2006; Miller, Maletic, & Raison, 2009). Higher omega-3 levels have been found to prevent psychosis in high-risk youth and are associated with less symptom severity in schizophrenic and affective disorders (Amminger et al., 2010). Furthermore, fish oil appears to have help reduce cognitive decline in adults and to improve cognitive performance in infants when taken by their mother or through formula (Freeman et al., 2006; Fohuti, Mohassel, & Yaffe, 2009; Gómez-Pinilla, 2008).

Another dietary supplement related to mental health is Vitamin D. Lack of Vitamin D has been found to be associated with schizophrenia, bipolar disorder, cognitive deficits, and depression, and has antioxidant, anti-inflammatory and neurotrophic effects (Walsh, 2011).

Exercise

The therapeutic benefits of exercise impact both physical and mental health. Engaging in physical activity is therapeutic for, and decreases the risks of, multiple disorders such as cancer, cardiovascular disease, high blood pressure and diabetes (Khaw et al., 2008; Ornish et al., 2008). Exercise has also been found to reduce the risk and severity of neurodegenerative disorders including Parkinson's disease, Alzheimer's disease, dementia, and age-related declines in cognitive ability, as well as to enhance academic performance and aid in stroke recovery (Hamer & Chida, 2009; Quaney et al., 2009; Sui et al., 2009). Exercise also improves autoimmune responsivity (Lovelace, Manz & Alves, 2007).

Exercise has therapeutic benefits for anxiety disorders, eating disorders, body dysmorophic disorders, addictive disorders, and chronic pain (Callahan, 2004; Colcombe & Kramer, 2003; Daley, 2002; Deslandes et al., 2009; Stathopoulou, Powers, Berry, Smits, & Otto, 2006). Furthermore, individuals with schizophrenia have also been found to have improved quality of life following exercise (Callahan, 2004).

Exercise has also been found to have antidepressant effects (Ilardi, 2009; Lee & Russel, 2003). Numerous research studies have found exercise to be as helpful for mild to moderate depression, if not more, as pharmacotherapy and psychotherapy (Borgonovi, 2009; Dowd et al., 2004; Sidhu et al., 2009). Considering that individuals who are depressed often struggle with other mental disorders or diminished physical health (Rohde, Lewinsohn, & Seeley, 1991), exercise is a promising therapy to improve several facets of health.

Exercise has been found to reduce negative mood and to improve cognitive functioning, resiliency, and self-esteem (Callahan, 2004; Lovelace et al., 2007). Sharper memory, clearer thinking, and increased concentration are also some of the effects that exercise has on the brain (Ilardi, 2009).

Nature

From an evolutionary standpoint, it has been argued that humans have not fully adapted to the primarily indoor lifestyle many of us lead (Burns, 1998; McMichael, 2001). Spending time in purely human environments with artificial stimulation may produce a loss of health and vitality, cause exhaustion, disrupt mood, and interfere with sleep rhythms (Stilgoe, 2001; Walsh, 2011). With the rise of technology, individuals are spending more time online than interacting face to face in the natural world, which can have negative effects on connection, conversation quality and closeness (Pryzbylski & Weinstein, 2012). Technology also can impact cognition and attention, and result in addictive behaviours (Walsh, 2011).

It has been found that individuals who live in or have access to natural settings are healthier overall than those who do not (Kaplan & Kaplan, 1989). Being in nature has been associated with a reduction in symptoms of Attention-Deficit/Hyperactivity Disorder (ADHD), stress and depression (Taylor & Kuo, 2009; Taylor, Kuo, & Sullivan, 2001). Research has

supported benefits from both physically being in nature as well as having a natural view, such as from a hospital bed or office (Maller, Townsend, Pryor, Brown, & St. Leger, 2005).

One factor in particular that improves mental health while being in nature is the exposure to light that one receives. Our eyes have light receptors that are connected directly to the brain and that respond only to the intensity found in outdoor lighting (Ilardi, 2009). When we spend too much time indoors under artificial light or do not get enough natural light outdoors, these receptors do not receive the stimulation they need (Ilardi, 2009). This time spent under artificial light can lead to variation in energy and hormone levels as well as sleep deprivation (Ilardi, 2009). Serotonin is produced at greater quantities under bright light and can boost feelings of well-being and mood (Young, 2007). The resulting improvement in mood can also lead to individuals to socialize more and argue less (Aan Het Rot, Moskowitz, & Young, 2008). Simply being exposed to natural outdoor settings can decrease anxiety and stress levels (Ilardi, 2009). The light that is naturally delivered on a sunny day is over a hundred times brighter than that delivered from indoor lighting (Eastman, 1990). In order to experience the antidepressant effects of light, one must be exposed to light as bright as that on a sunny day. When natural light is not available or convenient, use of a light box is an effective and affordable option. Light boxes stimulate the brightness of a sunny morning while being indoors.

Natural light exposure can be combined with other therapeutic lifestyle behaviours, such as exercise and social interaction, and can help improve other areas of TLCs, such as sleep.

Sleep

Sleep, or lack thereof, has a variety of effects on the mind, brain and body. Lack of sleep can lead to decreased memory functions, decreased learning functions, lower attention and

concentration, decreased immune and restorative functions, as well as lower levels of emotional control, creativity and motivation (Tanaka & Shirakawa, 2004).

For many mental illnesses, sleep patterns can be both a trigger and a symptom. For example, a symptom of major depressive disorder is insomnia or hypersomnia nearly every day (American Psychiatric Association, 2013). Research also suggests that before the onset of depression occurs, four out of five individuals experience some type of sleep deprivation (Ilardi, 2009).

Many mental and physical illness are accompanied by insomnia, which contributes to reduced quality of life, disability, and functional impairment (Stein, Belik, Jacobi, & Sareen, 2008). Individuals with frequent sleep insufficiency report general health problems, activity limitations, anxiety, depression, and pain (Strine & Chapman, 2005).

Sleep quality can be improved through engagement in other lifestyle changes. For example, exercise leads to a decrease in night-time awakenings as well as an increase in slow-wave sleep, the deep sleep that plays an important role in recovery and cerebral restoration (Dworak et al., 2008; Roth, 2009).

Social Connectedness

The power of relationships is so ubiquitous and in such plain view that it is often underestimated. We are interdependent beings; research from the field of social neuroscience supports the notion that we are wired for relationships and empathy (Cattaneo & Rizzolatti, 2009). Health risks such as the common cold, multiple psychopathologies, and mortality are reduced by rich interpersonal relationships (Walsh, 2011). Moreover, the health risks of social isolation are comparable to those that accompany high blood pressure, smoking and obesity (Jetten, Haslam, Haslam, & Branscombe, 2009).

One-quarter of individuals do not have any supportive social connections, with many others spending the majority of their time alone (Ilardi, 2009). In Western society, individuals are spending less time with their friends, family and community and have fewer close friends compared to two decades ago (McPherson, Smith-Lovin, & Brashears, 2006). Isolation plays a role in increasing susceptibility to depressive symptoms along with exacerbating depressive symptoms (Ilardi, 2009).

Luckily, psychotherapy is fundamentally social, with the therapeutic relationship identified as the most important variable that influences effectiveness, accounting for one-third of the outcome variance (Duncan, Miller, Wampold, & Hubble, 2009). Individual and group therapy are often viewed as microcosms of real life where individuals can use their social experiences to enrich the relationships they have outside of therapy.

Spirituality and Religion

Koenig (2002) estimates that 90% of the world's population is involved in some type of regular spiritual or religious practice. Such practices act as a means of coping with illness and stress. Koenig, McCullough and Larson's (2001) review found a positive association between mental health and religious involvement, and protective effects of religion on alcohol and drug use, anxiety disorders, depression, suicide, features of personality, schizophrenia and other psychoses, and delinquency. Both non-institutional (e.g., private prayer) and institutional (e.g., attending church) religious involvement are linked to optimism, hope, self-efficacy, self-esteem, happiness, life satisfaction, and well-being (Levin, 2010).

There is an inverse relationship between spirituality and depression, as individuals with depression who are involved in a spiritual community, prayer, meditation, or the reading of spiritual materials recover faster than depressed individuals with less spiritual involvement

(Koenig, 2007). Spiritual involvement has also been associated with decreased anxiety and substance abuse, enhancing social support, and providing purpose and meaning (Koenig, 2010).

Individuals who attend weekly religious services live roughly seven years longer than those who do not (Koenig et al., 2001). Other TLCs, such as contemplative practices, like meditation and yoga, along with social support and service to others, are likely mediating factors (Walsh, 2011). It is likely that that it is not the act of simply attending the religious services that leads to greater longevity, but the benefits of the practices that typically accompany religious practice that results in these individuals living longer.

Service to Others

Those who volunteer more are psychologically and physiologically healthier, and live longer than those who volunteer less or not at all (Borgonovi, 2009; Grimm, Spring, & Dietz, 2007; Post, 2007). Walsh (1999) speaks of the *paradox of happiness* in that an individual is more likely to be happier by making others happier. Volunteerism has been connected to enhanced well-being, happiness and a reduction in symptoms of depression (Krueger, Hicks, & McGue, 2001; Musick & Wilson, 2003).

Five reasons why altruistic behaviours are beneficial were shared by Midlarsky (1991). They include improved mood or more physically active lifestyle, enhanced meaningfulness, increased social integration, improved perception of competence and self-efficacy, and distraction from one's own problems.

Altruism can also impact other TLCs. Volunteer activities such as caring for animals can decrease levels of isolation and increase social connectedness (Ilardi, 2009). Giving back also has ties to spirituality and the enjoyment of volunteering can reduce stress.

Stress Management

Stress is an inevitable part of life that every human being will experience. It could be contended that stress is a side effect that accompanies much of what a psychologist would see in their office, from mental and physical illness, grief, financial strain, trauma, abuse or relationship issues, or a stand-alone issue. Stress has adverse effects on a variety of physiological systems, potentially leading to cardiovascular disease, inflammation, insulin resistance, and metabolic abnormalities (Brydon, Magid, & Steptoe, 2006). Stress can also lead to maladaptive coping strategies and unhealthy behaviours such as smoking, misuse of drugs and alcohol, poor dietary choices, and inactivity, in addition to non-compliance with taking medications (Derman, Patel, Nossel, & Schwellnus, 2008).

Stress is a modifiable risk factor that can be countered with regular physical activity, psychosocial support, relaxation and stress reduction techniques, time in nature, humour, optimism, faith, and pet ownership (Derman et al., 2008; Walsh, 2011). Another way to decrease levels of stress is through self-management skills, including psychological, somatic and contemplative approaches such as guided imagery, progressive muscle relaxation, mindfulness, tai chi, yoga or meditation (Walsh, 2011).

In particular, meditation and mindfulness are two stress management techniques associated with improved mental health. Meditation has been found to be therapeutic for multiple mental illnesses, enhancing psychological well-being and promoting qualities of self-actualization, empathy, and calmness (Shapiro & Carlson, 2009; Walsh, 2011; Walsh & Shapiro, 2006). Large effect sizes have been found when looking at the effectiveness of mindfulness-based therapies for symptoms of depression and anxiety (Hofmann et al., 2010). Furthermore, individuals who practice mindfulness have been found to have greater psychological, social and

emotional health, more positive emotional patterns, and an open and interpersonal style (Prazak, 2012).

Recreation

Recreation encompasses a variety of activities engaged in during leisure, for personal enrichment, enjoyment or pleasure (Gunn, 1990). Through recreational activities, one often experiences positive emotions (Walsh, 2011). The playfulness that accompanies many recreation activities has been found to nurture social skills, improve well-being, and decrease defensiveness in children and adults (Gordon & Esbjorn-Hargens, 2007; Lester & Russel, 2008). Humour can also accompany recreation, and humor has been found to improve mood, support healing and immune function, and alleviate stress (Lefcourt, 2002).

Recreation often involves physical activity - another TLC that leads to a myriad of physical and mental health benefits. Furthermore, recreation is something that can reduce stress, be done with other individuals, and occur outside in nature, whose benefits have been previously outlined as well.

Applying Evidence to Practice

This rich body of evidence supporting TLCs implies the next logical step is putting knowledge into practice. The focus then becomes how a change in health attitudes, beliefs, behaviours, and lifestyles can effectively be promoted in order to support a productive, healthy and wellness-oriented existence in others (Pender, 1996).

Healthcare professionals have a unique opportunity to promote TLCs with clients due to the nature of their shared relationship. Medical practitioners support TLCs in their work with patients; many doctors and nurses promote exercise and diet as a means to improve poor health caused by physical problems such as diabetes, obesity, cardiovascular disease and

hypercholesterolemia (Dailey, Schwartz, Binienda, Moorman, & Neale, 2006; Douglas, Torrance, van Teijlingen, Meloni, & Kerr, 2006; Ribera et al., 2006). In a brief editorial discussing Walsh's (2011) article focusing on TLCs, Thomas (2012) argues that psychiatric nurses are likely more aware of the literature on TLCs than Walsh suggests as the nursing profession is based on a holistic perspective. However, she agrees that insufficient time with patients is a barrier for both physicians and nurses. This observation is consistent with literature highlighting that physicians often cite inadequate time as the reason they can rarely provide adequate counselling on TLCs (Dailey et al., 2006).

Psychotherapists are surely better positioned to promote TLCs than other healthcare professionals given the amount of time spent one-on-one with clients. Comparatively, psychologists generally spend an hour in session with clients on a weekly basis, while physicians rarely spend more than 15 minutes with patients per visit (Dailey et al., 2006). Additionally, psychologists already possess behaviour change skills. The process of working collaboratively with clients to problem-solve and instil TLCs is found to increase one's commitment to success and empower clients (Pollock, 2001). The American Psychological Association (APA) Task Force on Health Research (1976) highlights their expectation for practicing psychologists to focus on the overall health of their clients:

> No other discipline is better suited and equipped than psychology to discover, delineate, and demonstrate the organismic nature of humans and to encourage an ever-broadening realization that humanity's total functional health is threatened whenever either side of the inter-active mind-body equation is neglected. Any program for healthcare and illness management can achieve comprehensiveness and integration only as there is respect for the functional unity of the individuals. (p. 271)

Despite the positive effects of TLCs on mental health, the opportunities and skills psychologists possess to foster change, and the expectation for psychologists to address the total health of clients, TLCs are often underutilized in mental health settings (Barrow, English, & Pinkerton, 1987; Callaghan, 2004; Daley, 2002; Faulkner & Biddle, 2001; McEntee & Halgin, 1996; Phongsavan, Merom, Bauman, & Wagner, 2007; Pollock, 2001; Royak-Schaler & Feldmen, 1984; Walsh, 2011).

A few studies addressing TLC use in counselling practice have been undertaken. Royak-Schaler and Feldman (1984) investigated health behaviours including dietary habits, sleeping, smoking, relaxation practices, physical exercise, and alcohol consumption, and found only 47% of psychotherapists agreed it is important to assess the typical client's health status. Barrow and colleagues (1987) found that 53% of psychotherapists recommended exercise to clients *occasionally* and only 10% recommended it *all the time*. More recently, Phongsavan and colleagues (2007) found that 51% of psychologists surveyed agreed providing physical activity counselling was part of their job, with 40% stating they had recommended physical activity to clients.

Cook, Biyanova, Elhai, Schnurr, and Coyne (2010) surveyed over 2,100 psychotherapists about the frequency of their use of specific therapeutic practices. Among the survey items were techniques that fall within the domain of TLCs. Sixty-percent of psychotherapists surveyed reported that they encouraged *most/all* of their clients to develop healthy recreational activities. Thirty-one percent of psychotherapists reported encouraging *most/all* of their clients to make new friends and create social support networks. Only 17% of therapists reported recommending changes in diet and exercise and only 6% promoted abstinence from anxiety-increasing foods to *most/all* clients. Thirteen-percent reported using relaxation training or tapes and teaching

mindfulness-based skills, such as meditation, and 8% reported recommending acupuncture, massage, meditation or yoga, to *most/all* clients. Promotion of a relationship to God or engagement in a religious community were reported by 11% and 7% of therapists, respectively, to *most/all* of their clients.

One might wonder what led these psychotherapists to incorporate TLCs into their practice at all. Literature indicates that therapists are more likely to suggest lifestyle changes to clients, such as exercise or diet changes, if they themselves make healthy lifestyle choices (Burks & Keely, 1989; McEntee & Halgin, 1996; Royak-Schaler & Feldmen, 1984). Individuals with their own healthy lifestyle may be more health conscious and therefore more likely to have knowledge about the benefits of TLC, particularly in regards to mental health. Contrasting the significant evidence supporting the benefits of TLCs in improving mental health with the large percentage of psychotherapists who do not regularly incorporate TLCs into their work with clients, as outlined by Cook and colleagues (2010), it may be more fruitful to shift from asking "Why?" to asking "Why not?"

Barriers to Incorporating TLCs

There are a variety of explanations for why TLCs are not emphasized more in mental health settings. For psychologists there may exist a professional bias towards pharmacological and psychotherapeutic interventions (Walsh, 2011). Moreover, many clinicians do not see the work they do as relating to the physical body or feel that topics such as exercise are unimportant (McEntee & Halgin, 1996). Exercise is often viewed as inconsistent with many traditional psychotherapeutic approaches (Burks & Keely, 1989; Faulkner & Biddle, 2001; McEntee & Halgin, 1996; Pollock, 2001).

Therapists also face challenges in becoming familiar with the extensive literature on TLCs, gaining the training to implement TLCs, and receiving reimbursement for the considerable time it may take to foster patients' TLCs (Walsh, 2011). Lack of knowledge is a primary barrier for addressing TLCs with clients (e.g., Abramson, Stein, Schaufele, Frates, & Rogan, 2000; Burks & Keeley, 1989; Douglas et al., 2006; Phongsavan et al., 2007; Pollock, 2001). Psychotherapists often report lack of general knowledge and expertise about nutrition and exercise in regards to mental health, and report not receiving any formal training in this area yet believe this knowledge should be taught to psychologists (Burks & Keeley, 1989). It follows that psychotherapists would not address or promote TLCs if they are not being taught about the connection between mental health and TLCs in their training programs.

On the client's end of the equation, Roberts and Bailey (2011) identified barriers to lifestyle interventions as negative staff attitudes, impact of symptoms and lack of support. Social anxiety has also been identified as a prominent barrier (Roberts & Bailey, 2013). Furthermore, in our society, there are entire industries that promote poor lifestyle choices (e.g., fast food, tobacco, and alcohol companies), further influencing clients to make unhealthy decisions (Walsh, 2011). Other barriers commonly dealt with in therapy, such as self-defeating thinking, social context, cultural influences, self-esteem deficits, family dysfunction, readiness for change, negative role models, psychological confidence, motivation, and the client's own goals (which may not include TLCs) can make a psychotherapist's attempts to integrate TLCs a difficult task (Faulkner & Biddle, 2001; Grayson & Meilman, 2012).

Psychotherapists undoubtedly face many obstacles in trying to begin incorporating TLCs into their work with clients, particularly if this is unfamiliar territory. Just like our clients, simply knowing that exercising, eating well, and getting a good sleep are beneficial is likely not enough

to propel us to change our therapeutic behaviour. What would it take to encourage and support more psychotherapists in incorporating TLCs into their practice, and to perhaps step outside of the box of how things traditionally have been done?

We do know a bit about the influences on the adoption and sustained use of new therapies. Cook, Schnurr, Biyanova, and Coyne (2009) surveyed over 2000 psychotherapists; the psychotherapists reported significant mentors, books, training in graduate school, and informal discussions with colleagues as the primary influences on their practice. Furthermore, respondents noted that they would be more likely to try a new therapy if it could be incorporated into what they already provide, if respected psychologists endorse it, and if it is supported by local training opportunities (Cook et al., 2009).

Many of these influences come up against the cited barriers of TLCs. For example, lack of knowledge, cited as a primary barrier to incorporating TLCs, suggests that graduate school or other training opportunities do not provide a sufficient opportunity to learn about TLCs. Also, behaviour change is considered by many to be inconsistent with traditional psychotherapeutic approaches.

Another potential barrier that comes to mind is the likelihood that most psychotherapists may not come across a colleague who respects TLCs, particularly if TLCs are underutilized in therapy to begin with. From this notion emerges the idea that therapists who have found a way to incorporate TLCs into their practice could provide valuable information about how others can effectively adopt and sustain TLC use in therapy.

The Present Study

Given what is known about the evidence for TLCs as an effective intervention for overall wellness, along with an acknowledgment of the role that psychologists could play in facilitating

behaviour change, a deeper understanding of what the incorporation of TLCs looks like in psychotherapeutic practice is worth pursuing. Learning from psychotherapists who regularly incorporate TLCs into their practice could show other psychologists how to do so as well.

Method

The purpose of this study was to gain a deeper understanding of how psychotherapists have incorporated TLCs into their counselling practice. A review of the relevant literature revealed that although research supports the positive impact of TLCs on mental health, they are underutilized by psychotherapists and research on those therapists who do utilize them is warranted.

Researcher's Background and Assumptions

When we seek to understand the lived experience of others from a research standpoint, we develop a philosophical account of their lived experience. As researchers, we must interpret the participant's interpretation of their experience. Phenomenology is more than simply a scholarly assortment of concepts. We are working as researchers to make sense of participants who are making sense of their experiences. This is what is known as a *double hermeneutic* (Smith & Osborn, 2003). As a result, we must not consider only the perspective of the participant, but also the perspective of the researcher, as the researcher is also involved in the sense-making process.

For me, the process of conducting a qualitative study is a new experience. My previous experience in research is primarily quantitative. Through the process of learning about qualitative research and Interpretative Phenomenological Analysis, I have become aware that many of my biases and assumptions are rooted in a quantitative perspective. While I continue to seek to understand more about qualitative studies, I recognize that I have much to learn. Through

this process, I have worked to incorporate feedback from others, particularly my supervisor, and I have engaged extensively in bracketing and writing memos throughout.

I am also a psychologist in training. In the past two years, I have had the experience of being introduced to a variety of orientations and interventions. I have learned a lot about what I *should* be doing and struggled to find out what is best for me and my practice. I think my experience in becoming a psychologist has greatly influenced me to address this study in the manner that I have. I can relate to the experience of choosing to incorporate something new into therapy.

Furthermore, this research study is a product of my own interest in the field of TLCs. Entering into the world as a professional within a few months, I will be looking to incorporate TLCs into my work as well. On the large scale, my intention with this study is to begin to fill in the gap in the literature on TLCs by providing ideas for application of the knowledge that we know to be valuable from TLC research. However, this research is also a means of fulfilling my own desire to learn about how other therapists incorporate TLCs so that I can have a framework as a new therapist for incorporating TLCs effectively into my practice as well.

As a result, I recognize my assumptions and biases toward what the experience of incorporating TLCs might be like for the participants in my study. On one hand, I have done what I could to bracket my biases, to remain open-minded, and to take a stance of *not knowing*. I have had ideas about what could come out of these interviews and I have worked to ensure that those ideas did not impact the way I conducted my data collection or interpretation. I worked to ensure the conversations I had with my participants remained open-ended and I did not lead participants down the path toward my assumptions or towards the answers I wanted to hear. By collaborating with others and receiving feedback of my own throughout the process, I worked to

ensure that my assumptions did not color my ability to learn about each participants' unique experience for what it was. On the other hand, I recognize that I was a part of this research process too, and as a result my experiences are an important part of the study. Without my curiosity, driven by my own assumptions about what this experience might be like, I would not have had the inspiration to develop this study in the first place.

Approach

The primary aim of this study was to gain a deeper understanding of psychotherapists' experiences with incorporating therapeutic lifestyle changes into their counselling practice. The purpose was to try to understand what the lived experience of this process has been for psychotherapists. My intent is to help other therapists learn how to begin to incorporate TLCs into their practice.

This intention is congruent with basis of phenomenological research. Phenomenology is used to describe the universal essence of a lived experience of a shared phenomenon for several individuals (Creswell, 2013). Interpretative Phenomenological Analysis (IPA), a type of phenomenological research, focuses on gaining insight into how an individual makes sense of a given phenomenon rather than to create or to test hypotheses (Smith, Flowers, & Larkin, 2009). IPA is used to explore experience in its own terms, examining how people make sense of these experiences. According to Smith and colleagues (2009), people begin to reflect on the significance of what is happening in their lives when they are engaged in an experience. IPA research aims to become involved with these reflections.

IPA as a research method is grounded in hermeneutics – the theory of interpretation. Smith and colleagues (2009) write that the belief that human beings are sense-making creatures is what drives IPA researchers to gather the accounts of individuals who share their attempts to

make sense of a particular experience. IPA research is committed to grasping the detail about what an experience for a particular person is like and the sense that this particular person is making from this experience. This detailed examination, or depth, is what makes IPA ideographic. The result of this analysis is a rich source of ideas about how to understand a lived experience (Smith et al., 2009).

This is harmonious with the intention of this study. As a researcher, I sought to understand the experiences of psychotherapists who have incorporated therapeutic lifestyle changes into their work with clients. How do they make sense out of this experience? What does this process look like in their work? How did they develop the necessary competence to incorporate TLCs? These are the curiosities from which I developed this study.

Participants

Consistent with IPA methodology, participant samples were collected purposively. This strategy results in an opportunity to gain insight into a particular, specific experience. The participants of this study were chosen based on how they represent a perspective, rather than a population (Smith et al., 2009). The perspective for this study was from practicing psychotherapists who use therapeutic lifestyle changes in their counselling practices.

Participants for this study were chosen based on two main criteria stemming from this perspective. The first criterion was that participants must be licensed psychotherapists who were currently practicing. The purpose of this criterion was to keep consistent with the aim of the study to look at the experience of how trained psychotherapists use TLCs in their practice. The second criterion was related to the use of TLCs. A brief description of the proposed research was provided to each potential participant and they were asked to determine whether or not their work seemed to fit with what the researcher was looking to study. This description stated that

TLCs addressed with clients might include exercise, nutrition, time in nature, spirituality, etcetera, as a means to help improve psychological, and overall, health.

Potential participants were identified based on career information provided on provincial regulatory body websites and through Internet search engines. Sixteen psychotherapists in total were contacted via electronic mail. These individuals were provided with a brief overview of the proposed study and asked about whether or not their areas of work seemed to fit into the realm of therapeutic lifestyle changes. I invited each potential participant to contact me if their work seemed to fit the proposed study and if they were interested in participating in a semi-structured interview about their use of TLCs in their practice for the purpose of fulfilling my Master's thesis research study. I also invited the potential participants to recommend other psychotherapists whose area of work might fit with my study so that I might contact them. This approach is congruent with *snowball* or chain referral sampling (Patton, 1990), whereby individuals are asked to recommend or nominate other participants to take part in the study.

After a process of eliminating potential participants based on inappropriate fit with the study or lack of response, six psychotherapists were invited to participate in the study. Based on participant availability and the timeline of the study, five psychotherapists ultimately participated in the study.

IPA is generally conducted with a smaller sample size than other approaches (Smith et al., 2009). The reason for this lies in the ideographic nature of IPA. Analyzing and writing in detail about each participant is inevitably a lengthy process. The purpose of IPA is to gain depth and to be able to share something substantive about the experiences that the participants disclose - the complexity of which most benefits from a focused concentration (Smith et al., 2009). The focus

is on quality rather than quantity. With this idea in mind, inclusion of five participants in this study was deemed appropriate.

Participants were four women and one man, aged 31 to 53. All were psychotherapists, with 4 to 21 years of experience as fully licensed psychologists. The participants declared drawing from, and being influenced by, a variety of orientations to practice, including cognitive-behavioural therapy, Hakomi, experiential, acceptance and commitment therapy, humanistic, behavioural, psychodynamic, Eastern/yogic philosophy, mindfulness, interpersonal, and holistic. Participants also reported drawing from a variety of theoretical models, including the Readiness to Change model, the Stages of Change model, the biopsychosocial model, First Nations model, the Dynamic Eating Psychology model, the Mind-body Nutrition model, and motivational interviewing.

Participants are addressed by the pseudonyms Ellie, Cindy, Olivia, Gary, and Mary.

Data Collection

IPA is best matched to a type of data collection that offers a detailed, rich, first-person description of an experience (Smith et al., 2009). The intimate focus of an interview on one person's experience provides access to these descriptions and is therefore optimal for IPA studies (Smith et al., 2009). The IPA interview has been described as a *conversation with a purpos*e (Smith et al., 2009). The purpose of the conversation in this study was to provide participants with the opportunity to share, reflect and express their stories at length in their own words in regards to their experiences with incorporating TLCs into counselling therapy. Therefore, an interview was deemed an appropriate approach for data collection in this study.

Before beginning, all participants were given a written description of the study and were asked to sign a consent form. Items on the consent form addressed understanding of the purpose

of the study, study procedures, benefits and risks, confidentiality and anonymity, voluntary participation, and permission to audio-record interviews (Appendix A).

The interviews were conducted in a semi-structured manner using an interview schedule that allowed me to ensure potential questions were framed in an open and suitable manner, the topics I wanted to cover were addressed, and potentially sensitive issues were anticipated (Smith et al., 2009).

Smith and colleagues (2009) state that approximately six to ten interview questions results in approximately 45 to 90 minutes of conversation. This amount of time per interview was deemed feasible for this research study, particularly when considering the time to transcribe and analyze five interviews of this length.

Four interviews took place at the work location of each participant, and the fifth was completed over the phone. Interviews ranged from 42 minutes to 1 hour and 20 minutes. All interviews were audio-recorded using the computer program *Audacity*. Specific research questions included: "When did you decide to begin incorporating therapeutic lifestyle changes into your practice?" "How did you gain the necessary skills and knowledge to competently include TLCs as a part of your practice?" and "What are some of the challenges you've experienced in incorporating TLCs?" Other questions addressed personal experiences in the process of incorporating TLCs, specific TLC interventions used, measuring effectiveness of TLCs, and recommendations for other therapists to incorporate TLCs (Appendix B). Supplemental questions were asked throughout each interview for the purpose of clarification.

In order to ensure richness of data, I worked to utilize active listening skills, open-ended and unbiased questioning, and probes in order to engage deeply with the participant. As a second year Master's student in a Counselling Psychology program at the time of this study, I have had

nearly two years of formal training in therapeutic counselling skills, with specific experience in individual and group counselling. I was able to draw from this counselling training and experiences in conducting these thesis interviews.

The use of a follow-up interview with each participant was considered against the timeline of the research study. The purpose of a follow-up interview would be to delve deeper into the participant's experience in order to capture a richer account. A follow-up interview would be appropriate if the initial interview left questions unanswered about the participant's experience. However, neither myself nor my supervisor had any remaining questions about the data, and therefore follow-up interviews were not conducted.

An important part of phenomenological research is the concept of *epoche.* Epoche refers to the researcher suspending their experiences and judgments in order to approach the phenomenon under study from a neutral perspective (Creswell, 2013). I attempted to remain neutral by trying to provide the participants with space to share their experiences, asking the participants questions from a place of curiosity rather than knowing. However, it is likely that my own knowledge, assumptions and experiences were brought into the interview throughout the process of clarification. A more in-depth reflection of my sense-making is provided in its own section below.

Data Analysis

While IPA as a research methodology does not prescribe a single step-by-step process for analyzing data, Smith and colleagues (2009) recommend a set of steps for novice IPA researchers. This recommended process provided the framework for this research study with the understanding that flexibility and innovation is necessary and welcome.

The first step completed was transcription of the five interviews. Transcription was done through the software used for recording the interviews, *Audacity*, that allows data to be slowed down in order to aid with the process of transcribing. I typed the interviews word-for-word into password-protected Microsoft Word documents, stored in a laptop that was also password protected.

The next step was reading and re-reading the data. I immersed myself into the data, both by reading the transcript and listening to the transcript itself, in order to gain an understanding of the overall interview structure and to begin to understand how sections of an interview may be bound together by the narratives shared (Smith et al., 2009). During this process, I recorded my observations, thoughts, and recollections into a password-protected Microsoft Word document in the form of memos. This process overlaps with the second step outlined by Smith and colleagues (2009) described as *initial noting*.

The next step used to analyze the data was to develop emergent themes (Smith et al., 2009). The transcribed interviews were imported from Microsoft Word into a qualitative data analysis program called *MAXQDA11*. Throughout the exploration process, the data set grew considerably as I began to categorize each thought and experience provided by the participants into emergent themes or codes, in an attempt to summarize and capture the essence of what the participant was saying in a shorter form. I worked to decrease the volume of the transcripts and notes while maintaining the complexity of the data. I did this by reading and re-reading the interviews, considering whether the segments of data within one code were getting at the same idea or whether they were eluding to different meanings.

Throughout this process, I deemed it important to continue to memo about the work I was doing. It is through analysis that the double hermeneutic process is occurring, as I made sense of

a participant's sense-making. It was important that I work to be aware of my own subjective interpretation in this collaborative experience.

The subsequent step is to repeat this entire process with the remaining transcripts. I worked through these same steps with each case, treating each new transcript on its own terms (Smith et al., 2009). The rigor of following these steps systematically was intended to assist me from being influenced by what I had already found.

After identifying emergent themes, I began to search for connections across them. I engaged in mapping in order to help contextualize these connections. I identified patterns through the technique of abstraction or grouping similar ideas into clusters.

Once these steps had been conducted for all cases involved in the study, I began to look for patterns across cases. I considered which themes were consistent across all cases as well as which themes were different. After the patterns across all cases were considered, I considered the level of interpretation. Smith and colleagues (2009) state that it is important to look at the data from a holistic perspective, working backward to increase the depth of analysis, perhaps by noticing a passage that resonates differently than it did initially. I worked with my supervisor to help make sense of the prominent patterns emerging from this data, coming to an agreement with the themes discussed below.

Ethical Considerations

I sought and was granted approval for this study through the Research Ethics Office at the University of Alberta before any contact with participants were established and before any data collection began.

The primary concern a researcher has is in ensuring avoidance of harm to participants. While no safety issues were anticipated for this study, I maintained a level of sensitivity and care

of participants, and I was prepared to offer them any additional support necessary. Throughout the study I recurrently considered steps I could take to continue to inform and protect participants.

Prior to conducting one-on-one interviews, I ensured that informed consent was freely obtained and confirmed that the participants had a clear understanding of the research study (Smith et al., 2009). I ensured that consent was gained for participation in the data collection as well as for the expected outcomes of the data analysis. I explained to the participants what to expect from the interview and gained the participants' permission to include verbatim extracts in the final report, letting them know that this report may be published. Furthermore, I explained the risks and benefits expected from participation in the study.

The raw, unedited transcripts from the interviews were seen only by myself. I informed the participants of the process of safeguarding their anonymity. All identifying information from any gathered information was anonymized. Pseudonyms were used in this final report where appropriate. All documents containing data were password-protected and stored on a password protected computer upon completion of the study. The data will be destroyed five years after publication of the study results as dictated by the American Psychological Association (Smith, 2003).

Most researchers explain to participants that they have the *right to withdraw* at any time. Smith and colleagues (2009) explain that this is rarely the intended message, as researchers generally only mean that participants can withdraw during the process of data collection. I sought to be honest and accurate about the process of withdrawing, and I informed the participants that they could refuse to answer any questions at any time during the interview process. I also let participants know that they hold the right to withdraw up to the point that

publication occurs as it is not possible for participant withdrawal to occur afterwards. I offered participants the opportunity to review the transcript for accuracy along with the opportunity to withdraw any comments in which the participants did not want published.

Establishing Quality

The framework of IPA supports the importance of assessing the quality of the research that will be done. Yardley (2000) presents four general principles for establishing quality of qualitative research, which are congruent with IPA methodology. The first principle, *sensitivity to context*, was demonstrated from the start of the research process by taking time to carefully and purposively select participants for the study. This principle was brought into data collection through the interview process, as I worked to be aware, show empathy and put the participant at ease. Sensitivity to context is important in data analysis as well. In order to make sense of how the participant makes sense of the phenomenon, I became immersed and focused on each participant's account. Smith and colleagues (2009) suggest that sensitivity can be judged indirectly, as a degree of sensitivity to context must exist in order to develop a compelling IPA.

The second principle outlined by Yardley (2000) is *commitment and rigour*. I have aimed to demonstrate commitment through the degree of attentiveness provided to the participant throughout data collection and to each case throughout data analysis (Smith et al., 2009). I have been personally committed in conducting in-depth interviews and paying close attention to what the participant is sharing of their experiences (Smith et al., 2009). I have worked to ensure rigor by working to produce high quality interviews, and I have worked to probe and ask follow-up questions in interviews, seeking feedback from my supervisor on my skills as an interviewer. I have taken notes during the interviews and meticulously reflected throughout the process of analysis.

The third principle is *transparency and coherence.* I have sought to be transparent by clearly describing the steps followed throughout the research study in the final report (Smith et al., 2009). In order to ensure this final piece of writing is coherent, I have spent time revising and re-vising, seeking peer review as well.

Impact and importance is Yardley's (2000) final principle. Whether or not the reader finds the research useful or interesting is considered a valuable measure of quality in and of itself. One measure to assess impact and importance is through peer review. I have done this by sharing my final work with my supervisor and colleagues, receiving feedback and suggestions to improve.

Furthermore, I have attempted to provide *thick descriptions* in the findings section of this report in order to ensure rigor. The concept of thick descriptions is used differently throughout qualitative research literature. My understanding of it is based on the idea of providing sufficient *voice* for all participants (Ponterotto, 2006) by providing long, verbatim quotes from the participants. This allows the reader to get a sense of the cognitive and emotive state of the interviewee, providing a sense of authenticity and credibility.

Smith and colleagues (2009) discuss the use of the independent audit in IPA research. The importance of leaving a *paper trail* is common in qualitative research, including the researcher's drafts and revisions of the research proposal and final report, notes and memos used in data collection and analysis, recordings of interviews and transcripts, and any work done on determining emergent themes (Smith et al., 2009). I have engaged in this process throughout this study. By working to remain ethical, open, collaborative, thorough and aware from the onset of the study until publication, I have sought to ensure that the research study has provided a rich account of psychotherapists' experiences of incorporating therapeutic lifestyle changes into

practice, informing future clinical practice.

Findings

Theme: Being Congruent

Each of the five participants touched on the role that a healthy lifestyle in their own life has played in incorporating TLCs into their counselling practice. They each shared their own personal history, interests and current practices of incorporating TLCs into their lifestyle, and discussed the ways these experiences have informed their practice and lead them to the type of practice they do today. They each shared the belief that it is important to *practice what you preach.*

Some of the participants shared the way TLCs helped them overcome some of their own challenges and barriers in their lives. Olivia shared her experience in adopting healthier lifestyle practices and bringing that into her work:

> I myself struggled in body image issues. Growing up, I was really competitive in sports… It was probably starting at the typical age of university, 18-years-old. I started noticing more about women and their bodies and having more conversations about that with my girlfriends…. I started *noticing* and then I started *comparing* and then I started wanting to perfect my body, and then I became a chronic dieter over the years because I had success. In 2008, I pushed my body to the next level and I entered a body building/figure competition. So… even though I was at my peak physique, I was at my peak stress in my relationship with food and body… it's a mind game. I knew from that point on that I couldn't continue and… through my own work in therapy and going through the program to become a certified Hakomi therapist, you cannot *not* work on yourself. So I started to heal and I started to make shifts and I was in a really great place. By 2010, I felt really

> balanced. I still loved working out and I was in a much healthier, balanced relationship with my body and food...I was at the happiest I had ever been – so free in my relationship with food and body, even though I was at my most voluptuous. I wanted to be able to share that gift with other people who struggle in that similar way.

Cindy shared her story of growing up participating in figure skating, and the similar ideals of body image that she was taught through the sport. She stated that she will often draw from these experiences to connect with clients who are working on their own difficulties with diet or exercise.

Gary also reported having a long-standing history in competitive sport, playing hockey and competing in triathlons. He shared his experience of bringing yoga into his personal life and into his career, having recently developed a yoga and psychotherapy group therapy program:

> There's so much that came out of sport that was so positive and was so growth promoting for me. And one of the things that *wasn't*... [was] that idea that you push right to the edge. I was taught right from 9 years old to push right to the edge. And sometimes that's not good because you find the edge. Now, what are you going to do when you find the edge? Are you going to recognize it and are you going to adjust?... The choice to do the yoga teacher training… was about me looking after myself and I'd been practicing yoga for 12 years. And then used it to get through some significant life events. And used it to come out of a socialization in competitive sport, where it wasn't good enough and you had to push harder… Now you have this way of being that allows you to be where you are and, paradoxically, when you do that, moves you forward and moves you into a place of more health and more balance.

Gary shared that because yoga had led to such powerful experiences for him, he found

himself thinking, “I would really like to deepen my practice for myself and to bring it into my work.”

Mary shared her choice to incorporate TLCs into her own life as a result of a physical health condition:

> I got interested in [health psychology] before internship with my own health scare. A little heart condition issue. And realizing like, “Oh my gosh, am I going to have to go on a heart medication? I’m so young.” I was like 20 years old or something. I was like, “You’ve got to be kidding.” And so, I started to do a lot of research and learn myself in terms of eating better, exercise.

Mary shared that she began learning more about processed foods, making changes to her diet as a result, and learning how to cook healthier. She shared that she became interested in exercising and doing yoga. She shared, “What I found [in] making all the lifestyle changes for me: I got to go off the heart medication.”

Each participant reported using TLCs in their daily life as a way of keeping healthy but also for self-care practices. Cindy spoke of her use of TLCs:

> A lot of it I practice. I’m at the gym 5 days a week. I grew up doing sports, and so, how do you have a private practice and see 30 or 25 people a week without losing your marbles, you know? [Laughs]… Eating healthy, getting proper sleep, learning how to de-stress. What do I do to de-stress *myself*?

Mary also shared the role that TLCs played in self-care while she worked at a maximum security prison: “Scary place. Stressful. I would take advantage of doing yoga several times a week at lunch during work… I tried eating really fresh and developed some good relationships outside of [work]. Things like that.”

Gary shared the importance that his own daily yoga practice holds, above and beyond the yoga he already teaches: “I would not want to get up and not have a day with just the little tiny piece of it in there. And when I don’t, I can notice it.”

Ellie shared that by speaking to her clients about the benefits of TLCs, she is also reminded and challenged to be congruent by regularly using TLCs in her own life: “I think I’m more aware of what I do on a daily basis [Laughs]. You know, what excuses I put up for me. So I can be addressing them, because when you’re working with clients and you’re not living the talk, it’s so much harder.”

Cindy discussed a similar idea, stating that clients may see you as being a hypocrite or less credible if as a therapist you are encouraging clients to adopt healthier lifestyle habits but are not making healthy decisions yourself. Mary shared a related viewpoint: “If, as a therapist, *you* aren’t doing some of these things yourself, or if *you* don’t really buy into whatever your theoretical orientation is…if you’re not working on yourself, you’re not as effective as a therapist.”

The necessity of being true to yourself and practicing what you preach was communicated by all participants. Gary stated, “Being bottom-up and experiential, I really have to feel it before I can just say to people, “Hey, do this!” Unless I’ve done it or felt it… it doesn’t feel right.” Cindy shared a similar belief, stating, “If I’m going to get someone to do it, I should have tried it or done it for myself.”

Participants also shared that their own passion for health and wellness is brought into the work they do on a daily basis with clients, acting as a great tool to encouraging behaviour change in others. Gary expressed: “[Clients] will sense your excitement and your passion about it and your authenticity with it. And that may just be a little something that helps them shift a bit into

trying."

But what about those therapists who do not share the same passion? Each participant gained a lot of their knowledge about the background of TLCs through their own personal interests and experiences. It is important to recognize, however, that not all therapists will have the same personal interest in TLCs, which inevitably could leave some therapists discouraged about beginning to incorporate TLCs into their work with clients.

Participants were asked what they would recommend to a colleague if they expressed a desire to begin incorporating TLCs into their practice but did not know where to start. Mary recommended a starting point for other therapists: "Just thinking [to] themselves, "What do you do for self care?... What do you do to take care of yourself?" Ellie shared a similar notion of self-reflection, stating, "I would have them reflect on their own lifestyle… how are they doing and what would they want to tell somebody else about their lifestyle?"

Gary offered the following perspective on the topic:

> I suspect there wouldn't be – this is just a hunch, right? – that there wouldn't be many people who wouldn't want to live congruently with, you know – practice what they preach. What is keeping them from doing that? And now, we can't be everything. We can't be doing every single thing that we promote. But I wonder if there's just a core essence of certain activities that seem to be kind of important… Whether it's sleep, exercise, social connection, diet… I mean, who doesn't want to live that way? So then we might have to look and go, "Hey, what are we doing? Why aren't we living authentically? What are our priorities in life? Are they *things*?

Mary posed a similar question: "Are you walking the talk and practicing what you preach? So, if you want to get into it, just start trying some of these things. And take stock of

where you're at in your own life."

Theme: Looking at the whole picture

One might view the process of beginning to incorporate TLCs into practice with clients as daunting. However, each of the participants shared the approach that looking at the whole picture and the whole person and asking the right questions is something we are all capable of doing as psychologists.

Ellie shared the way she takes a look at the whole picture. She stated, "I try and think about the different facets of people's lives and inquire about those different facets. So relationships, career, work, hobbies, health exercise, mental health, all those different facets." Ellie shared her typical method for gaining a holistic perspective with each client:

> I start with an intake… I get a sense of how much exercise they do, how much they have for hobbies and fun things in their life. I ask them about eating. Relaxation strategies if that seems appropriate. Their use of substances, whether it's alcohol, caffeine, smoking or drugs. And ask about their medication use. Ask about sleep. So I kind of get a sense of their whole lifestyle and then we delve specifically into the concern that had brought them [to therapy]. I get a sense of how they're doing overall in those areas.

Olivia also spoke to the way she tries to get a look at the full picture of the person during intakes:

> Who would they be if they weren't so focused on their body and food all the time. What would they be thinking about? Where would they spend their energy then? Because then it taps into purpose. Do they enjoy their work? How's their family life? How's their relationships? If they're single, do they want a relationship? If they have no kids, do they want kids? What's the story around all that? So looking at the whole person… I'm

> getting a sense of the whole person. Their sense of boundaries. Their sense of self. How they deal with stress. And then, by the end of the intake they realize it's not just about food and it's not just about my body. But that there are other things here that I need to work on.

Each of the participants offered a variety of questions that they ask their clients in order to get a better sense of their overall lifestyle from a holistic perspective and to gain insight as to where the participants are starting from. Some of the questions they posed included:

- How are you sleeping?
- How are you eating? What are you eating?
- How much do you exercise? What do you do for exercise?
- Is spirituality something that is important to you? How much do you do day-by-day in terms of spirituality?
- If church is important, have you gone?
- What are your relationships like with others?
- Are you doing the things that you find helpful and meaningful to you?
- What are your goals? (particularly pertaining to adopting a healthier lifestyle)
- Asking questions around family history and patterns, particularly pertaining to health and lifestyle
- What do you think would be different if you weighed less? (Or any other lifestyle change – smoked less, ate better, slept better, etc.) What would be different if you had more energy?

Cindy shared that she will also ask about what her clients are watching on TV, what music they are listening to, and what they are reading. She stated that she will also ask about

their hobbies, what they do in their spare time, and what brings them joy. Cindy expressed that she likes to get an idea of what her clients are "putting into their mind", adding, "because they can eat good and you can go for a little walk, but then if you just come home and sit on your butt all day, it's not doing a lot."

Mary added the following in regards to assessing the client's current progress in the behaviour change: "Where are they at? Do they think it's a problem or not? Where are they stuck? Are they recognizing they should change it? What are the barriers?" She added to this thought, sharing that these questions can be used throughout therapy as "a *gauge* for their well-being. "How are you doing? "Well you know, I've slipped a little. I haven't been seeing people as much" or "I haven't been going to yoga." So that can give you a key into how they're doing, too, if they're not doing it or if there's change."

The participants expressed that one does not have to be an expert in all areas of health and wellness in order to ask important questions and gather information. Gary stated, "We're not psychiatrists but we know a bit about the medication. Enough to ask the important questions and to help them to get helpful consultations when they're in there. And even just help them sort out their philosophy about using the meds."

The participants all noted that clients will typically come in with a focus on a psychological issue, and then, as Mary states, "the other stuff comes out. Because we're assessing. We're asking about it." Each of the participants expressed the importance of asking the questions and gathering the information, sharing the belief that this is something all psychologists are able to do to begin to address lifestyle and mental health.

The participants all recognized the complexity of the different ways mental health concerns can present, indicating that without getting a sense of the whole picture, important

details could be missed. Ellie gave the example that, "if you're not eating, you could be tired. And if you're tired, well that might present as depression because you're fatigued." Cindy also shared a scenario where symptoms of depression could overlap with other medical ailments:

> Sometimes they're off to their doctor to get a physical: "Let's see how everything's working." Because you can have a client that comes with a thyroid problem but they present with depression symptoms. And then you want to treat depression, but it's really a thyroid issue. Or *iron* levels, right? Or hormonal changes.

Cindy also shared some of her thoughts stemming from her work with teenagers and the importance of addressing lifestyle and overall wellness. She discussed sleep patterns, and the effects a poor sleep pattern has on teenagers' abilities to learn at school. She also added:

> They have these distorted views on how they should look, what they should eat, and a lot of them are starving themselves all during the day, not realizing that they're really exhausted, because they have no protein in their body, and then we wonder why they're not getting the marks, they can't focus, and all these things.

Cindy shared a second example:

> So you see a teenager, let's say, with some body image issues. You know that she's maybe not eating properly. And then that's affecting her sleep. That affects her mood. It's really a complicated piece, so I think everything goes hand-in-hand.

Mary also provided an example where an understanding of the whole picture of a client's wellness and lifestyle helped in treating a mental health issue:

> Another person I see came in for really kind of like a tic disorder, really, and stress and things like that. And then it comes out that part of the issues and motivation and depression and even, I mean, some of the tic disorder stuff, when we kind of really

> moved this depression, was *weight* and the way she felt about herself and the fact that it just kind of… let slide the past few years. I guess physically, family-wise, metabolism wise, it's not an issue. So she was really, like, "Yeah, it's because I eat junk food. I haven't exercised."

Cindy also shared an example that highlighted the importance of having an understanding of how the side effects of medication could affect one's day-to-day lifestyle:

> Most of my clients are on medications – so identifying that piece of it, too, is very helpful. Sometimes those medications have the side effects like over-eating, eating at night, and then the person's putting on weight. So you have to kind of know a lot of different things and how they interplay.

A few of the participants also discussed the impact a healthy lifestyle impacts an individual's energy levels, particularly when combined with other mental health issues, which inevitably affects their ability to engage in healthy lifestyle changes at all. Mary highlighted this cycle in an example she had with one of her clients:

> Winter comes around and he doesn't do anything. And so we talked about the link between, you know, the kind of cycle of, "You don't do anything, you feel crappy. So then you don't feel like doing anything, so you feel crappy" And around and around you go, and it's too hard to kind of just change your mood.

Furthermore, participants spoke to the way low energy levels can affect the productivity of a counselling session and their efforts to improve their mental health through therapy. Cindy shared an example: "Yesterday I saw somebody. She slept maybe 3 or 4 hours, okay. Well how good is that session going to be?" She also talked about a client who cancelled because of a bad headache, empathizing with her and understanding that it would be, "impossible to focus,

nevertheless have a good conversation." She expressed that if client's energy levels are increased, they can focus more on the psychotherapy and have a more productive session.

Mary shared a similar idea about the effects of TLCs on the therapy session itself:

> I often do work very closely with the naturopath in terms of referring to her to help people incorporate—particularly with nutrition, you know, make those kind of healthy behaviour changes because I feel like that directly impacts what we do here. Their ability to think and concentrate.

Mary also touched on the importance of trying to increase energy through healthy lifestyle changes, in order to help with low energy symptoms of depression:

> I've got a lot of patients who are depressed, low energy. We talk about, "Well how much are you eating?" "Um, not at all" or "Once a day." And so we do a lot of education about how food, eating, not eating, affects your energy levels too.

Participants all shared the perspective that one has to look at the whole person in order to best grasp what is going on for them. Cindy shared her views on inquiring about lifestyle:

> I think it's part of the make up of that person. So you have to look at it. And you can see from the time of working with people, there is such a correlation, right? How do they treat their bodies? How do they treat their mind? How they deal with stress has such an effect on what's going on for them… When you look at the psychology of a person, you're looking at what they're doing with their *time*, with their *money*, with their *energy*. What are they doing with all that?

Theme: Developing Competence

The participants in this study shared a variety of ways they developed the competence to effectively incorporate TLCs into their practices. They all stated that their background

experience influenced the knowledge they had. These experiences included experience coaching, experience as an athlete, and a personal interest in health. Additional training was also another way participants gained the necessary skills. For example, Gary completed his yoga teacher training certification and Olivia completed an 8-month Nutritional Psychology program beyond graduate school.

The participants all shared ways they gained the information necessary for incorporating TLCs. They reported gaining information from the Internet, from conferences and workshops, and from books and other similar resources. Participants touched on the value in gaining knowledge about common medications that their clients use, along with the side effects of these medications. The participants also shared that they draw a lot of information from published research and empirical evidence.

Another common resource indicated was training and guidance received on internship and from supervisors. Ellie reported that her supervisor at her internship encouraged her to question things from a holistic perspective. Mary also reported the value that her internship provided, where she worked alongside physicians, nurses and medical students who were able to provide her with knowledge and training from a health psychology perspective.

One area that participants noted was not helpful overall to their knowledge about TLCs was their graduate program training. Participants reported that these programs did not provide specific training, practice or information on lifestyle and mental health. Cindy stated, “I don’t know if they teach enough about this… you get the buffet and then I just specialized in one appetizer.”

The participants touched on the idea of *blazing their own trail* by taking initiative and being a pioneer. For example, Gary developed a yoga and psychotherapy group by doing his own

research on yoga and mindfulness-based stress reduction in addition to his own yoga teacher training. He shared that he had never heard of it being done, so he created it himself. Mary also developed her own groups on mindful eating, which she co-leads with a naturopath, and also one focused on mindfulness-based stress reduction. She shared that she is working on coming up with a smoking cessation group.

Olivia has also developed a group for body image that incorporates body mapping. She also shared her experience of completing a nutritional psychology program in order to deepen her own practice, indicating that she is one of a kind in the field of nutritional psychology in her city.

Cindy shared that she tries to continually expand her knowledge base and grow, stating, "Every time I go [to a conference], I always grab something and then I'm like, "Oh, okay, that's good. That's new." Cindy shared her perspective on the importance of evolving as a therapist:

> You have to keep growing as a therapist. You have to keep educating yourself, because lots of stuff changes. And you have to keep just on the up-and-up with stuff, right? You have to keep… being sure you're in a healthy place because then you're being able to do the best you can.

Another idea linked to developing competence was the importance of measuring progress in order to determine if the therapy or treatment is working for the client. Participants offered some of the ways that they measure progress. These included the use of quantitative measures, such as the Session Rating Scale (SRS) and Outcome Rating Scale (ORS). Mary reported that she uses a hope and coping scale in one of her group sessions. Mary also stated that she will have clients track their sleep or mood and monitor their progress that way, and will often plot changes so that clients can have a visual of their changes. She also shared that she will have clients keep

track of their goals, asking, “What have you tried? What have you started doing?” Ellie shared that she will sometimes use depression or anxiety screening instruments to monitor changes in mental health. Cindy expressed that she will use more objective measures, such as returning to work, as an indicator that improvements have been made.

Participants also shared more qualitative means of tracking progress. Gary expressed his belief that sometimes change can be “bottom-up instead of a top-down thing”, stating that it can be hard for clients to understand why they’re doing better, but instead simply *feel* better more globally. In his yoga and psychotherapy group, Gary mentioned that he will have clients pay attention to whether they are breathing better or are better able to listen to their body as measures of improvement.

The participants all spoke of relying on self-report from the client to hear how they are being affected by any changes they are making. Checking in with a client about how they feel, their overall mood, their energy levels, or the amount of symptoms they report experiencing appeared to be common markers used by participants for measuring progress.

Olivia shared some of the qualitative indicators she will use with clients to determine whether or not they are making progress. She will ask if they are happier, thinking more clearly, sleeping better, more connected with self and others, more embodied, feeling more in control of themselves or feeling their stress levels decreasing. She shared that her tactic is to look at everything else around the issue for improvements. Olivia also spoke of her intentions to include a pre-screening and exit interview in her upcoming group.

Some of the participants also commented on using their own observations as an indication that changes are occurring. For example, Cindy shared:

> At some point, you just see them and you're like, 'Oh! They *really* have more energy. They're more *alive*. They sit better in the chair. They're not shifting around as much. They're more – you actually can just see it right on them.

Cindy commented on how she will also share her observations with clients, for example, stating, "You look good and you look better. I can tell." She also shared how clients might indicate that they feel better or stronger after losing weight, and noted that she will let them know she has noticed these changes as well.

Another way that participants indicated they can tell if clients are making progress is by checking in on whether clients are keeping up their practices or healthy behaviours. Mary shared that she will check in on how they are doing with incorporating TLCs as a marker, such as finding out if they have been seeing people or going to yoga, for example. She also shared that she will check in with clients about the therapeutic relationship: "How do you feel like we are doing in terms of where you want to be?"

While all of the participants shared several ways that one could enhance their knowledge and skills in regards to TLCs, each of them also touched on the importance of recognizing their own limits. Gary stated, "We can't be everything. We can't be doing every single thing that we promote." He adds, "We don't want to overstep our boundaries." Olivia shared similar concerns about speaking with clients about TLCs from earlier in her career before she had training in Hakomi and nutritional psychology: "I know for myself I shied away from it, because it's a business. You also don't want to get sued, right? And you just don't feel confident enough to apply it. So I stick with what's safe."

Olivia also shared the way she has been tempted to speak from her own experiences on food and nutrition:

> It's hard, like even before this training. There's so much I do want to share about my own knowledge that I've gained from my *personal* life, but there's a line about having to be careful because I know that works for me but that might not work for everyone else. I don't want to be projecting my own stuff onto my clients either. Even if it's *good* stuff. "Hey, this worked for me, so you try it" doesn't really fly compared to, "Hey, I have training in this and I can make suggestions and I know that I can back this up with research now."

Ellie also shared her perspective on speaking to her clients about TLCs, particularly about the specifics of exercise and nutrition:

> I can talk about eating well. But if it's anything specific, I'll get them to talk to a nutritionist or go to the health food store. With exercise, I'll get them to go back to their doctor. Make sure that they can be cleared for exercise, and maybe go join a gym if that's what they want. So, I think I stay with the basic information, but if it's anything technical or specific beyond what I think [my] training could provide, then I get them to reach out to other experts.

This idea of working with other professionals emerged from the experiences shared by all five participants. Mary stated, "If some of these things… [are] out of your wheelhouse, then [know] what the appropriate referrals are."

Experience working in an interdisciplinary setting was common amongst participants, either previously or currently. These settings include hospitals, integrative health centers, or workers compensation organizations. Participants reported working with a variety of other professionals, including physicians, nutritionists/dieticians, naturopaths, psychiatrists, personal trainers, physiotherapists, acupuncturists, massage therapists, nurses, and social workers.

The participants all shared the belief that these other professionals can offer the information or services that they are not able to, and that they are a rich and valuable resource to work alongside. Olivia reported:

> I'm a huge, huge advocate for just resourcing people out to see their naturopath or an acupuncturist… or even doctor. I certainly think there's a place for both Western and Eastern medicine, so just putting it out there for different resources, because I know that I'm not the only person that can help them.

Mary shared that at her work setting, she completes integrative assessments on clients with a psychiatrist, physician, and naturopath. She shared that they "get kind of an overview – clinical interview, history taking, and then that will lead to recommendations of the group therapy or individual." She also shared that she leads some of her group therapy workshops alongside a naturopath, stating "[The naturopath] gives a lot of the education piece of it and I tackle motivation."

Mary also touched on the idea of doing a bit of searching to link clients to other resources: "So, you don't know anything about yoga, but apparently there's some data that says it's helpful, just kind of scouting it out. What are some of the yoga studios in town? And there are a lot of people… doing things for mental health. So, like yoga for anxiety. Things like that."

The theme of consulting or referring seemed to be important for all participants, in that they all ensure they recognize their own limits, but they also take responsibility to provide their clients with links to other professionals who can aid in their overall treatment.

Theme: Finding What Fits

Participants all spoke to the importance of finding out what fits for the client individually when incorporating TLCs into their practice. Gary summarized what all of the participants

expressed in one way or another: “We don’t have a one-size fits all.” In order to find what fits for each client, the participants described checking in on the client’s external and internal situation. The participants shared that they will check in with clients on their process along the way in order to stay on the same page with clients. Some questions the participants said they will ask include, “How are things going?” “What have you tried?” or “What have you started doing?”

Gary shared the way that he begins both his individual and group therapy sessions: “We do a check-in… I’m curious where people are at when they sit down and I don’t assume anymore that people are actually present, grounded and whole-brain processing.” Gary noted that he will encourage his clients to adopt some type of grounding or centering or meditative practice, and that he will use this approach in session to have clients turn inwards:

> That’s how I think I work with it… is helping people find the source, the essence, the quiet. And then that – call that self-actualizing or call that wisdom… and usually when you get people in there it’s a nice place to work and they have access to that motivation and creative ways of starting the process… From that place, we can really connect to what’s authentic, genuine, real, important for them, in terms of what’s in their way and what resources they have.

Gary spoke about the way that this quiet inner space leads to “less distractions and there’s less expectation about whatever everyone else wants or what you *should* do.” He added, “I don’t think we can go wrong, too wrong, helping people ground and center and learn to self-regulate so they connect with that.”

Olivia shared the work that she does to help clients become grounded from a different theoretical approach. She stated:

> I work very much in the Hakomi way. So just go down experientially and help them ground themselves and resources themselves. I like to have clients experience in the moment in our session that they can actually access this calm place inside themselves… and having them implement that in their daily life and looking at ways in how to do that and when things arise out of that calm place… then usually it's just very organic, intuitive unfolding, right? The wisdom of themselves comes out of this process. And it's great. My clients come up with the ideas. I can suggest, but, it's like if they come up with the ideas it's much more powerful, right?"

Gary also spoke of the value of tapping into a client's inner resources and strengths through a grounding practice:

> When you bring people into that meditative state… the work is rich. People don't get a chance to be in that space and so it's very powerful. It's very gratifying to see them connect with their resources and the strengths – or not. Or know that that's work for them to do. Because it's not always, you know, beautifully tied up in a nice bow and everybody lives happily ever after. No. But at the very least what comes out of that work is people get a taste and they get a sense of where they are in relation to being able to do that or wanting that… they have a sense of where to start from.

Gary also spoke to the importance of being flexible in order to find out which approach fits best for the client. He added that the reason one technique might work for someone could be just because they love the feeling of it, while others are more concrete or behavioural:

> I try to meet people where they're at… If that's not fitting for them, then we try to go more concrete and more analytical and more rational logical. So that's fine, too… I can

> take all different kinds of ways of being and bring them through that lens and find benefit in them and be able to *present* them in a way that's beneficial.

Gary added that he learned a lot about the need to individualize the approach through his yoga and psychotherapy group, where he had group members track their progress with a log. "Some people said they liked the logs because they needed the accountability, others – their critics used the logs to berate them and they felt worse and it was actually a barrier to them doing well." Both Mary and Cindy spoke to the value in brainstorming with clients, as there are many different options and ideas in order to help find an approach that fits for the client.

Olivia shared a similar viewpoint, stating "I really go with where the client is – that I meet the client where they are." She added that she felt an important skill in meeting the client where they are at is, "listening more intuitively to the client. Just asking the client what would feel good for their body?" She spoke to the way she will collaborate and negotiate with clients based on what they are ready for:

> I always work very collaboratively with my clients. I'll say, "Okay, maybe that's not such a good fit, but is there something that would be more manageable for you with this suggestion, like tweak it to how you want it to be?"… I'm never really this concrete, but "Exercise 3 times a week" for example, and they say "Oh, that's too much." Then I'll suggest, "Okay, then we can negotiate something, like how about just for half an hour for one day." And maybe that would be more manageable.

Furthermore on the topic of exercise, Olivia addresses the importance of evaluating the client's readiness:

> Some clients aren't ready for exercise, so... I don't push anything. I just say, "Okay, that's okay." Right? "So let's look at what you *would* be ready to do. Maybe it's just

> eating one healthy meal a day. Or maybe going to bed earlier so that you sleep longer and you get a full 8, 9 hours of sleep." It's not like the cookie cutter approach. It really depends on the client.

Cindy shared a similar thought regarding the need to adjust to where each client is. She stated, "For some people going for a 15 minute walk is a big deal. Like that's a huge life change." Mary also spoke of the difficulty that comes with pushing clients to make a change before they are ready:

> In the medical model, you often times see physicians: "You *need* to do this" and they sort of make the recommendation. And like you're *telling* the patient what to do, and you see a lot of resistance with that. So trying to meet them where they are.

Ellie shared similar ideas, sharing that instead of trying to tell clients what they should be doing, she will try to "build on that whatever they're doing isn't working, so if we can kind of meet there, then maybe they're more willing, maybe they'd be more willing to try something if they know what's going on is not working very well."

Gary also spoke of the way that meeting the client where they are at can make behaviour change easier for clients. He stated: "The challenge is to first find out what will fit for people so that they do do it more – it's less of a stretch or it's less work to do it. Or to do it in a way that lets it get some traction, so that it kind of builds, right?"

Part of meeting the client where they are at also seems to include respecting the client's expertise and autonomy. Olivia shared, "If somebody doesn't have a problem with the way they eat, I'm not going to touch it. Like, that's not my issue then. If they think it's fine how they eat, that's great." Gary spoke to this same idea, discussing ways to help clients determine whether or not something truly fits for them:

> Some people just have it all sorted out in their heads. So that's okay. As long as that's not mind clutter and chatter and expectation and perfectionistic, critical… right? As long as we can validate - because a lot of times I'll ask people – we'll be on to something, and I will ask them how they know?... Like "So what sensation, image, feeling, thought or even action that you're feeling compelled to do right now tells you that is fitting for you?"... Then you get into [a] little bit more of their truth, or they, more importantly, *they* get into it.

Gary also added that our job may be to help people find alternatives that fit better, helping clients to make decisions about their lifestyle consciously, with awareness, while accepting where the client is at ourselves:

> That's going to be the work we do. "I don't like all the options and this is who I am and… I can't find a way to incorporate that. So I guess I'm just going to have to *not* be aerobically fit and find another way to manage my stress."

An important aspect of finding what fits is building on clients' strengths and what has worked for them before: "not reinventing the wheel" (Gary). Mary stated that she will look at the client's background and work on motivational enhancement. She added: "Where I start with people is, "When do you feel *good?*" You know? "What is it that you're doing, or that you did in the past…" And it's all behavioural stuff. It's all the TLCs."

Gary provided the example, "Maybe some people swam when they were younger and had some good experiences and can take that." Ellie had a similar approach:

> I might offer a few suggestions. Particularly if those strategies have worked before. So, I'll say, "Well, you know, when you were exercising before, how was that for you?" And

> they might say, "Well that actually was very helpful" So then that makes it easier to re-introduce it.

She added, "I'll ask whether they've ever done it before. Any strategies that have helped. So that's probably where I'll start, you know, "What has worked before?"

Gary shared that he focuses on "finding people's resources and strengths that they can morph into or keep." On the topic of previous background or experiences in healthy behaviour, he added,

> Some people don't though right? They just don't have it. So it is square one. It's building. And so that's a bit different, too. So when I work, yeah, it's seeing – not reinventing the wheel and then if there's not much there to work with we can start fresh.

Gary also shared his perspective that there are many ways to individualize TLCs to fit with each client, and there are different perspectives and approaches we can take:

> There's so many possibilities in all these things to make it fit with a person's strengths and who they are, I think… So, to not be too rigid about what it is they should be doing… Like, you can meditate or you can get out on your boat and just feel the breeze and take it in and feel the excitement and the freedom and the clarity and the non-judgment… all the expectations melt away and boom! And all that regulation is happening. All that centering and recalibration.

Finding what fits can also involve helping clients to *unpack ideas* about the various TLCs and what lifestyle changes could be for them. Gary speaks of the way he will introduce the ideas of TLCs and then create space for the client to explore how these fit for them. He shared that he begins by "starting with those pillars of self-care, and then trying to unpack ideas about what that should be for them and see where they can get a little traction with that."

Olivia shared that she will also work with clients to unpack ideas, particularly around what exercise should be. She shared that she will ask clients:

> "What would exercise look like?" Because a lot of times people think you have to go to the gym, you have to use the treadmill, or you have to use weight. But for me, exercise in the context I work in is just movement. So it could be just blasting the radio on and dancing in your living room. It could just be going for a walk around the block with your dog. So… the purpose of it is just to get the client moving.

Gary also spoke to the way that clients might have preconceived notions about what lifestyle changes, such as exercise, should look like. He stated:

> Maybe there's ways to make it feel less daunting. Because people have idea of what exercise and activity are that aren't always… you know, they're perpetuated by society: "Yea, you run triathlons, so you're… that's what, you know, that's what's really valued and preferenced." No.

Theme: Drawing on Core Psychotherapy Skills

Many psychologists are reluctant to incorporate TLCs into their counselling practice because they feel that they do not have the skills to tackle issues around lifestyle and mental health. However, the bulk of the work that these participants described themselves doing involve skills that therapists already have. Mary shared her viewpoint on our role in incorporating TLCs and encouraging behaviour change:

> I feel like it's the perfect place for psychologists to do the work, because it goes beyond the information given. And you hear that so often: "I know, I know, I need to eat better." It's not rocket science. Eat less and move more. But why is it so hard to even lose any

> weight or, you know… Because all it is often is habit. Changing habits. So, we're in the position. We're the experts in behaviour change.

Gary shared that he believes a lot of the change in clients will come from the connection and the therapeutic alliance we develop with them. He stated:

> We know that 40 years of outcome has taught us that if we have a shared rationale, credibility, and an idea that's concrete and makes sense, and… a healing relationship. And if people can have meaningful emotional activities that are sticking for them, and probably are doing that through the beneficial activities we see in the different approaches. If all of those things are there, people are going to do better.

Gary adds, "If we're humming on most or hopefully, we *try* to be humming on all of them or to some degree, then we're going to get change. It's just going to happen."

Participants all shared the belief that incorporating TLCs ideally happens at a deep psychological level. The psychologists all expressed the idea of *working from the inside out*, looking closely at dealing with the *inner* workings of a person, rather than simply telling clients what they *should* be doing to be healthy.

Mary shares her thoughts on the importance of our role, beyond the medical model:

> Every time we go to the doctor they ask you all the same questions, "How much do you exercise? How much do you drink/ Do you smoke? Well you should really eat better." And they give you like the DASH diet, and you're like "Well… okay." And then they're frustrated when people don't follow through on it. Same thing with weight loss, because we know that there's a genetic component, there's a metabolism component, but a huge component is just getting people to eat differently and exercise more. So why is that

> hard? Well that's where psychology really has a unique position to tackle the motivation and the emotional issues that go along with it.

Olivia shared an example of helping clients who over-exercise, emphasizing how our role is to help them on a deeper level, rather than focus on the prescription of how often they should be exercising:

> What *drives* that person to be such an over-exerciser, so extreme, and what is that about? But not looking at, "Okay, so scale back to this many days" Right? Just going with what's really the driving force… So, it's just working with what psychologists do best. Looking at the issues underneath that *drive*… whether they're over-exercising or a non-exerciser.

Olivia spoke of the way she works with clients on their relationship with food and diet. She expressed that she will go deeper with them than simply looking at their food logs by exploring what drives these issues. She added: "More importantly, it's more about *who* you are as an eater."

Cindy empathized with the difficulty clients have in changing patterns of behaviour, particularly "after years with a certain type of learning, one type of thinking, one type of *living*." She questioned, "What belief systems are keeping that behaviour going?" Cindy also drew attention to the fact that unhealthy lifestyles are often connected to more complex underpinnings. On the topic of obesity, she stated: "This happened somewhere, right? This didn't just come about because I had nothing else to do but just eat chips on a Friday night."

Ellie also spoke to the difficulty in changing behaviours that people have practiced for a prolonged period of time:

> We're dealing with long-standing patterns of behaviour. Some of the clients I see have smoked for 50 years. Well, they're not about to change for me [laughs]. Even if they wanted to, they just… it's so engrained.

Olivia shared that she will often address family patterns and family history "because a lot of [clients] don't realize there's patterns that run in the family and maybe they're carrying themselves in these beliefs because of old history."

Ellie spoke about tapping into the client's self esteem and strengthening self-esteem in order to lead to behaviour change. She added, "If they're feeling better about themselves and their self-esteem is improving, maybe they'll make changes in their marriage or their relationship."

Cindy spoke of the way some unhealthy lifestyle behaviours can play the role of coping skills:

> The link with some of these different things to overeating or comfort eating or different things, because of past issues, abuse or whatever. Like I think it's a coping skill. I think it's no different on some level than addiction to alcohol or a drug. It's like a lack of self-control in some area. So I think there's a lot we can do to help process that stuff.

She added, "So much of our relationship to eating and stuff is what we're thinking and feeling, right? "Oh, I had a bad day, I'm going to go get a chocolate bar" You know?"

Gary shared that he will focus a lot of his work on using meditative or grounding techniques with clients in order to help them to self-regulate. He stated that often people do not find that "quiet place" and posed the question:

> Because why do we not? We don't, because we use these other things to self-regulate. But when we learn to self-soothe and self-regulate and we get into the quiet, we find that "Oh, I don't need that as much" or "I crave the healthy more."

Olivia also shared that she will look at how clients manage their stress on different levels and how they cope. She mentioned that she will address daily stresses, such as work, school, family or relationships, along with unconscious stress, such as past childhood, acute, or post-traumatic stress, and then use interventions accordingly. She added:

> I think our role is to help the person see and understand why they perceive – *how* they perceive the world, and how it is that they form these core beliefs. How is that they develop their coping skills, whatever those are, from poor to high.

Ellie spoke also of the way unhealthy behaviours can be used as coping strategies, but added some caution on trying to push the healthy alternatives on clients:

> Sometimes their lives… they're just so complex, that to take away a coping strategy, which could be smoking or alcohol use or other not-so-helpful things or not-so-healthy things, it doesn't seem like that's a good move if that's helping them cope. But if I think it's going to be helpful in the end, I might gently introduce it.

Olivia shared the way speaking to clients who use food to cope can be a sensitive issue, and spoke to the way we must be careful not to shame our clients:

> "We're kind of innate to have this in us… when a baby cries, what happens? We put the baby on our boob!... and that baby calms down. So we learn that food is soothing. And food *is* soothing. I tell my clients: "When I'm stressed out, guess what? The first thought *is* a food, for me, *still* [laughs]. And really it's—that's okay. That's healthy and that's normal. The *dose* is a poison. So if that's my only option to cope, then that's of a concern

> and we need to expand my resources… Definitely something that I don't want them thinking: "You can't do that at all. You shouldn't be turning to food. That's *bad*" because then the shame just deepens. So it's really important that we support the clients. We make them right. We encourage them to look at other ways of coping, but make them right and acknowledge their feelings and validate their feelings so that shame lessens.

Participants also addressed the importance of addressing boundaries, and the impact that boundaries have on exercise, diet, and relationships. Mary spoke of the way insight can help clients move forward in a healthy direction and set healthier boundaries with people. Olivia shared:

> I try to help people just see: "Let's see how you create your reality. Let's look at how you set your own boundaries, for yourself and with other people." Because I think that has a huge influence just in how we carry ourselves.

Mary added, "We check in to see how they're becoming more assertive or how they're setting boundaries. How they're becoming less passive-aggressive or aggressive." Mary also spoke of the way clients' interactions with others can affect their healthy choices, particularly since social connection is considered a TLC itself. She spoke of the way she will help people work on their communication and assertiveness skills on a deeper level in order to help improve their ability to have healthy relationships with others.

Another core skill that participants said they use to increase the likelihood of behaviour change is by raising clients' awareness of the effects and benefits of TLCs. Participants spoke to the idea that inevitably it is up to the clients to make their own choices. Olivia shared her perspective: "As a psychologist, it's my job to help them see that they are creating their own reality."

Gary spoke of the way he works to raise awareness and show clients different possibilities through exploratory work. He shared that he will create the space for them to explore on their own, stating that he works to, "[ensure] they are living consciously with the awareness of the choices they are making."

Participants also spoke of the importance of helping clients to gain a greater awareness of their own inner experiences. Cindy shared that she will ask questions in order to bring these inner experiences to the client's attention: "How are you feeling? What are you noticing? What do you like about it?" Gary spoke to the benefits of incorporating yoga and psychotherapy in his group, stating, "We can ask about self-talk and self-compassion and inner critics and how that's all going and people can start noticing that. "

Mary's approach to having clients become more aware is through mindfulness techniques, stating that she, "will have people try new things or just be really focused and mindful in any activities that they are doing."

One primary way all participants spoke of raising awareness with clients was through providing them with education on TLCs, along with suggestions on how to make these changes. Ellie shared her perspective on the importance of educating clients, stating "Some people are really not informed or not educated well… Not *well* enough, but just not knowledgeable I guess." She added, "Sometimes, people don't know the benefits of a thing, so they might be more reluctant to try new things."

Cindy spoke of the way she tries to get clients to see how lifestyle changes can improve their mental health. She stated that, for example, she will teach clients about the way stress and depression and cortisol are related and work together, drawing pictures so clients can better understand the relationship. She also shared that she has found books for her adolescent clients

about puberty and their bodies, which also provide information about nutrition. Cindy shared that she believes providing accurate information is important, stating that after being told to improve their health by their doctor, for example, many people will seek the *how to* on their own: "Questions come up later, or people go look on the Internet and there's all this… mixed information. There's lots of different things. There's fads and different things like that."

Mary, Ellie and Cindy all shared that they will send their clients to other professionals for specific information. Cindy shared that she will encourage her clients to speak to those who talk about particular behaviour changes everyday, telling her clients, "Get the information, because knowledge is empowering. Then you know how to make better choices for your life."

Mary and Ellie also spoke to the way they give clients research on particular lifestyle changes and refer to the empirical evidence. Ellie also shared that she will give clients more basic information, such as what they might expect when starting to exercise for the first time, such as muscle soreness.

Because of her training in nutritional psychology, Olivia shared that she is able to make suggestions on diet if the client is open to it, particularly if she sees that they are lacking nutrients or vitamins or supplements. She also shared that she will encourage clients to eat balanced meals, exploring with clients what healthy means. Mary also shared that she will educate clients on the way eating and not eating is related to their energy levels. Cindy stated that she will often suggest clients make small changes to their diet, like starting to eat breakfast: "Make a smoothie and sip on that during the day."

In regards to eating better, most participants touched on the idea that clients likely already know how they *should* be eating, yet struggle to change their own habits anyway. Ellie shared her strategy:

> I'll often get them to see it as a problem themselves. So rather than me saying, "Well you should be eating breakfast", I'll say, 'Well, are you getting enough food early in the day?"… So I get them, somehow, to identify the problem. They'll say, "Well no, my body doesn't like food until lunch" and then I might give them some information on diet then.

Gary shared that he will almost always suggest some kind of meditative or quieting practice with his clients. Ellie shared that she will also make suggestions about clients' lifestyle habits using her own judgment to determine when the right time is:

> Depending on the client, I might suggest, lightly, that they might want to eat better, or they might want to sleep differently, or maybe they want to reduce their smoking or their alcohol use. So I try to gently introduce those ideas. And I might not introduce those changes right away. It really depends on their receptivity and, you know, maybe in the end they'll say, "What do you think I should do?" and I might offer a few suggestions. Particularly if those strategies have worked before.

Olivia also spoke to the importance of discretion when offering clients suggestions in order to ensure clients are open to the idea and not feeling pressure to do things a certain way:

> I really need to read into and *feel* that the client is… they might be more open to it. So, I feel into when and *if* the client's ever ready to be open to those suggestions.

Participants spoke of the way a lot of their work incorporating TLCs involves validating clients and normalizing the experience for clients who are struggling to change their behaviours. Mary stated, "I spend a fair amount of time validating, too, right? That [if] this [wasn't] challenging, then you'd be doing it! They wouldn't need me. So yeah, the 'soothe before you move' mentality, right?" She also spoke to the way she relates to the difficulty clients have in

making changes, by stating, “Yes, we know what we *should* be doing, but why is it so hard and how do we stick with it?”

Participants also spoke of the importance of encouraging and supporting clients as they recognize that behaviour change is hard. Mary shared that she will encourage clients to call up friends or go to yoga. Cindy spoke of the way she encourages clients to make even the smallest changes, stating “One small step and I get excited.” A few participants also spoke to the importance of challenging clients when necessary, by pointing out if they are putting up barriers or making excuses.

Olivia shared that she will work to offer clients another perspective, helping them to see the positive side of their experience: “Having them be able to reflect on, ‘What are the good reasons of this happening?’ There’s a lesson or lessons to be learned here.”

Gary shared that he will often use the opportunity to practice techniques in session, particularly grounding and meditative techniques. He also spoke of the time he spends on process work, when clients say, “I can’t do it” or “It’s too hard.” Olivia also spoke of the time she spends processing whatever comes up for clients, particularly in between intake questions.

Participants also shared that a psychologist’s role also may be holding the client accountable. Cindy stated, “They need to answer to someone. And someone’s going to say, ‘How are you doing on this?’ or ‘Have you done this?’” She shared that she will try to help clients find other ways to also be held accountable. She provided the example of having the client join an exercise program if that would help them feel accountable. Cindy also stated that she will often try to hold the client accountable as well, by including them in the change process. For example, she shared that she will often get clients to research something, find out when programs are offered, or look at their schedule and find a way to make something new fit.

This idea seemed to link to another idea many clients shared – about the importance of empowering clients to take control and responsibility of their own lives and make their own choices. Olivia also spoke of her approach of helping the client "feel more in control and be more proactive."

Ellie shared that she works to encourage people to take control or responsibility also:

> "I can facilitate [change] but it's really up to them to make the changes that they feel they need to make or want to make. When they're ready, they *will* make some of those changes… What I try and get people to do is I'll encourage them taking control or taking responsibility. And I really learned this at my internship where people [were in] a motor vehicle accident that wasn't their fault and now they're injured. Now they have to go to a rehab program and they're told what to do and there's a lot of things happening that aren't in their control. So then I'll encourage where they can take control. So they *can* control what they eat. They *can* control whether they do some relaxation. They *can* control some of their health."

Mary also shared a similar perspective about the way TLCs can be a way to empower clients to take control of their own health and their own lives, stating, "Not only do you take psychiatric medications or even do kind of traditional sit-down talk therapy, but we want to encourage what you can do yourself."

Mary shared her perspective on having the skills as a psychologist to help clients incorporate lifestyle changes for their overall health:

> No matter what theoretical orientation you're coming from, that's kind of just what we do, is getting people to make some sort of healthy behaviour change. It always comes

> back to that… So what skills do you draw on to help people make any sort of healthy change?

While participants highlighted the core skills of addressing underlying issues, raising awareness, and doing process work with clients session-by-session, they also stressed the importance of behavioural activation. As Mary put it, "If you're not doing the things that are healthy and the things that matter, you *won't* feel better." Gary offered a similar perspective on making changes: "You actually have to do it… you can't just come to this one class a week and expect change."

Mary shared her approach to working with clients to make changes, which is based heavily on Acceptance and Commitment Therapy (ACT):

> *Doing*. *Doing* things that are healthy and will improve your mood. And that's kind of the whole framework of TLCs. That if you make these lifestyle changes, if you change your environment, and kind of what you're doing, you'll feel better. Which is what ACT is saying [laughs]: "Don't wait to feel better to live your life." I mean, the whole premise behind ACT is, "Don't wait. Live your life *now*, and then you'll feel better and want to live and you'll start that kind of good cycle."

Olivia also spoke to the importance of getting the client to do something: "You know if the client's not doing anything, getting them to do something is helpful. Getting more oxygen in whatever way they can is helpful."

Mary spoke of the downward spiral that clients often get stuck in, and her focus on getting clients to make even small changes in their behaviours in order to "inspire more positive changes." She added, "A lot of my work is geared toward increasing motivation to do those things, because we know that they're linked to better quality of life/well-being."

A common approach to making change happen for any type of behaviour is through goal-setting. Ellie shared that she will often speak to clients within the first session in order to find out what their goals are for therapy.

While each participant spoke of ways they might help clients to achieve goals (most of which are discussed in the following section on overcoming barriers), the participants seemed to be more focused on the "higher goal" (Olivia) or the deeper issues. Some participants highlighted that Therapeutic Lifestyle Changes are not incorporated by just setting and achieving goals, but by actually making *lifestyle changes*.

Gary defined lifestyle changes in the following way:

> It's something that becomes a routine. It becomes a natural part of your day and what you do and almost—it almost kinda seeps into your DNA… So I think lifestyle, when we say that, it just comes in and becomes so naturally a part of your day-to-day operating that it's, um… yeah. Sometimes you don't even think about it. When you don't have it you think about it and want to get back to it.

Olivia, who does a lot of work with clients specifically around weight and diet, shared that the goal she is helping clients serve is not actually to lose weight. She stated that while losing weight might be a side effect, she wants to get them thinking of a higher goal: "I wanna be able to embrace myself no matter what size I'm in. And if that means I only lose 10 pounds or I don't lose anything at all, that's okay, because everything else inside me changes. Because inside changes, outside changes too."

Mary shared her perspective on goal-setting, and on the difficulties that can arise by only focusing on setting goals in order to change lifestyle behaviour:

> The issue with goal-setting can be—so let's take weight loss for an example. Often times people have like a goal they want to reach. This is like a number: "I want to lose 10 pounds" or "I want to get to this weight." And that can be very motivating, actually, because you start to see results. And then you hit the goal, you achieve the goal… now what? I'm done. "Hurray! I'll celebrate." And often times we see people kind of *slide* back. It's the maintenance part that's difficult. And so we see this up-and-down, yo-yo kind of dieting. And you see that a lot with any sort of behaviour change – smoking, too. Exercise regime. You get all gung-ho and excited. And then at some point I think you kind of reach a goal that you had set and it's hard to get motivated to come up with a new goal or to set a new goal. Or you *have* to come up with a new goal, you can't just kind of… So rather than an actual lifestyle change, it's just a constant trying to achieve these goals. So what I try to have them do is think about the underlying values and stay focused on that, rather than specific goals. Um, and, by the underlying values I mean, "Well, why is this important to you? What are the on-going qualities that you're trying to achieve or develop?" So, for weight loss, if it's more energy, more confidence, um, just kind of healthier eating. That's something that can't ever be checked off and achieved. It's on-going. So if you keep the focus on that, then your goals will come out of the values. So you'll kind of always have an ever-flowing spring of goals.

Cindy also spoke about addressing values with clients, and the way that values will likely be congruent with lifestyle choices:

> Where you spend your time is what you value. You can say, "I value health." But if you don't put any effort into it, you actually don't value it. It's an aspiration for you to value it, but I'm like, "It's not currently valued." Maybe you're currently valuing TV.

Mary spoke of the way that goal-setting can actually be counterproductive in having clients make lifestyle changes, as they may become discouraged if they do not achieve their goals and give up:

> What happens, is if you don't reach goals too, or if you aren't very consistent with whatever your goal is, it can be discouraging. And then we see this all-or-nothing thinking where people just kind of give up. So again, if you focus on the underlying value, then you have more flexibility in terms of your goals. It's more broad than this one narrow idea of goals. So I do a lot of that kind of work with people.

Theme: Addressing Barriers

All of the participants touched on the importance of working to remove barriers in order to increase their clients' chances of adopting healthier lifestyle choices. Gary stated, "Part of it is removing barriers because, right, "I don't shop", "I can't get to that class", "I can't afford that pass."

Mary spoke to Prochaska's *Stages of Change* approach, and the importance of identifying where the client is in that process and identifying the barriers to change. Ellie also spoke to her process of identifying barriers and helping clients become unstuck:

> If they have exercised in the past, I might inquire as to what gets in the way now of doing it? Or what are their thoughts about it or what helps them do it? So what are they thinking when they do it? And if it's sleep, what gets in the way of sleep? So then, if there is things that we can work through, problem-solving… and get people going again.

Mary shared a technique she commonly uses to help clients face the challenges that come with behaviour change called the *Willingness and Action Plan* from the Acceptance and Commitment Therapy (ACT) literature:

> What's my specific goal? What's the underlying value? And then how do I break it down. And then what are the negative things that I can expect and actually be willing to experience for me to achieve the goal. So, again, with the weight loss: "I fully anticipate an urge to eat donuts." You know, "The thought of I'm too tired." "The feeling of anxiety about going to the gym." Or whatever. And then if I'm willing to have those, and I'm anticipating it, then I can continue to go. Only those things won't hold me back. And then there's a piece where it says, "It's useful to remind myself." So when you're putting yourself through all these torturous changes, like, you know, you're on the treadmill, "Why am I doing this to myself again?" Reminding yourself of the values: "Why is this so important?" Rather than just the goal, like, "I gotta lose 10 pounds", it's like, "Why do I need to lose 10 pounds anyway?"

One of the main strategies recommended by the therapists was starting with something small and breaking things down into steps: "Successive approximation. We've got to sort of lead them" (Gary). Ellie shared a similar idea: "I'll encourage them to start slow and start small. Not to do it too hard." Cindy adds:

> You want to build for success, because sometimes it's daunting. And when people emotionally don't feel well or they have pain in the body or whatever, it's so difficult. So I just try to get small things, like a simple thing like eating something for breakfast. "Could you just grab a cracker?"

Mary says she will have clients ask, "What's the *smallest* bit, what's the *tiniest* step I can take, just to start the upward spiral?" Participants suggested things like fitting in 20 minutes of the new behaviour a day, or functionally getting things done, such as walking to work or taking the stairs.

In addition to focusing on breaking things into smaller steps, participants also highlighted the importance of making things easy, accessible, and convenient. Gary shared that he will try to provide participants with resources*, free* resources when possible. Suggestions included finding plans, programs, information or applications on phones or computer. Other suggestions included getting a partner, joining a club, using workout videos, using tools like a heart rate monitor or pedometer, and connecting clients with affordable community resources. Ellie also highlighted the importance of avoiding technical terms. For example, she said she will often use the term *relaxation strategies* instead of *meditation*, as some people may shy away from the latter term.

Another strategy mentioned by a couple of participants was having clients develop a routine or regimen in order to help the behaviour change become easier to do. Ellie also addressed the importance of addressing time, as not having enough time is a barrier reported by many clients. She shared the importance of encouraging clients "to take charge and encourage people to find the time, rather than wait for time. Because people are busy and, so, getting people to realize that they need to make the time if they want to make that change. It's not just going to happen."

Another barrier that was identified was when clients have injuries from accidents or chronic pain. In these situations, participants noted that clients often want to do more but physically can't. Co-morbidities were also identified as a barrier. Participants noted that it can be challenging if the therapist does not know the diagnosis well. Cindy provided an example of the difficulty in incorporating lifestyle changes in someone who is depressed, as individuals with depression may not have the energy to exercise or go to the store to get healthy food or to eat at all. Olivia also noted that different diagnoses could impact what a client could eat and what they cannot. Furthermore, more stressors could come with other illnesses, complicating the issue even

further. Cindy stated that therapists "have to look at the issue as holistic" and recommended getting other professionals to work with these people who have more complex issues, such as diabetes, heart disease or high blood pressure.

A few of the participants also pointed out the influence of our external environment and the way societal norms can be a barrier. Cindy spoke of the way trends in our society support an unhealthy lifestyle, including sitting all of the time at work (therapists as well as clients in their own jobs), lounging and watching TV, processed food and fast food, video-gaming, technology, and not getting outdoors enough. Olivia spoke of our role in speaking to clients about the influences of society on the way we can choose to live our lives:

> Maybe our responsibility is to help them see that the media and the social constructs all create our perceptions, too. And if we choose to focus on specific areas in our life, like specific areas of *media,* then we are going to be more tied to that. We look at the different magazines there are in the library or in the grocery store, and you have a whole bunch of different… you've got gossip magazines, fashion magazines, fitness magazines, but then you also have like, psychology, world magazines, political magazines. And every single magazine's so different. So it's what we choose to be our reality. And, so, I see, you know, as a psychologist, it's my job to help them see that they are creating their own reality.

Another barrier mentioned was low socioeconomic status. Ellie stated, "I think lower socioeconomic status gets in the way, because people just don't have the means sometimes for exercise programming and tools and things." Ellie also suggested ways to work around this challenge: "With eating, making it manageable is one, but also using community resources. So being knowledgeable to what's available." Ellie discusses some of the options in the city she

resides in, including recreation programs for low-income residents and *good food* boxes: "Knowing what's available in your community is really important." Mary spoke to the accessibility and affordability of TLCs: "The beauty of TLCs is that they're like free therapies for everyone."

The participants also touched on the importance of finding ways to connect clients to others and add support in order to overcome barriers. Furthermore, many of the TLCs mentioned by participants are activities that can be done with others (i.e. exercise, social connection, eating well, time in nature, etc.). Gary spoke of the way his group therapy promotes universality, as everyone is in the same boat and shares common struggles. He also spoke of the importance of encouraging clients to enjoy TLCs with others, stating "We try to connect people to doing that with others or sharing that with others so that they get supported to do that." Cindy also spoke of the importance of adding support in overcoming barriers and making change happen: "Support is a big thing. To have someone cheering them on whether they're a psychologist or a personal trainer or anything"

Cindy shared some ways that support can be used to help integrate healthy changes into one's lifestyle:

> You have to really see how it can work into their lifestyle or they can put the kids to bed or how hubby can watch the kid and they can go to aquacise or something like that. And support that… or having a buddy. Getting together with someone and saying, "Let's go meet at the gym at this time."

Ellie shared that she will often bring in the experiences of other clients, letting clients know that "other clients go through a tough time too." She added that she will encourage clients to speak to other members of the rehabilitation center, for example, stating that it is more

palatable coming from other clients. She shared that she will encourage clients to, "gain some support from other people besides me."

Mary expressed that clients will see their therapeutic relationship as a form of support. Gary shared a similar idea about the importance of the therapeutic relationship:

> A lot of clients that I've had… yeah, they find a friend that will support them and be there with them and when it's tougher is people who are isolated and alone and where they have to use *this* as a place to get things started.

Another barrier indicated by some of the participants was their own frustration with clients who are not following through with behaviour change. Cindy shared that while she recognizes it is often very difficult for people to change and to follow through with something new, it is hard for her not to get impatient at times. She shared, "I *know* this is going to help and then you just see someone not doing it and it's kind of frustrating sometimes." Cindy added:

> I think you would look at what the resistance is about: "Why are you not doing things that are going to help you and why would you kind of choose to stay in this?" Because I can guarantee that no one has ever come into my office and said, "Ohhh, I just want to feel crappy" You know? Because what they're doing is, they're getting themselves stuck. People want to just feel better. They want to be happy, right?

Mary also shared that she also can become impatient with clients, stating, "It's one of those, "I know what's good for you. I know what will help." She stated that when clients are resistant, she tries to tackle it like any other motivational issue. She shared:

> It can be really… it *is* frustrating as a therapist. But then you kind of have to go back to, "What are the barriers? What are the challenges?" And often times looking at the therapeutic relationship, too. What's the person's motivation for changing, or not? If they

> started to change and get better, what does that mean? Or is there a problem with the therapeutic relationship where they don't feel motivated to do the work? And I've had kind of interpersonal process relationships where I just kind of self-disclose that it's kind of frustrating, so what do we do now?

Ellie spoke of the way she works with clients who may not realize they are standing in their own way: "At some point I'll point out that they're putting up barriers and that can be one of the strategies – is that when they realize they're putting up barriers, I'll do something to address the barriers."

Olivia spoke of overcoming clients' resistance by being collaborative and negotiating with clients, by finding something that fits better and is more manageable. When asked about how he works with clients who are resistant, Gary stated:

> The idea of resistance doesn't really fit for me. I mean, as far as resistance goes is I can, I think, buy into pre-contemplation of change, especially if the question to the client is, "How's that working for you?" And if the answer is, "Not great.", well then maybe we're pre-contemplative, right?... I think maybe I'm just not providing, either being clear, or providing enough option. Like maybe not being creative enough with them. Because there's so many ways we can do these things, right? I mean there's so many… Life's problems are typically not always linear and step-by-step… So we have to come at things from, you know, just sort of… I don't want to say "thinking outside the box" but I mean that's kind of part of it. But it's just, yeah. Coming at things from different ways and when – so then I would think that: "Are we coming at it too direct? Or are we being open enough? Are we exploring all the possibilities? Or are we just kind of putting people in a bit of a corner, like this is the way it's got to work."

Gary added a further insight on the topic of client resistance and getting *stuck*:

> And maybe it's not that they're not ready, it may be that's just not who they are, right? 'Cause do we want to… right. We want to change behaviours maybe but do we want to change people? The core of who someone is. And for them, I think we look at the fit.

Discussion

In the present study, I sought to gain an understanding of psychologists' experiences with incorporating Therapeutic Lifestyle Changes (TLCs) into their counselling practice and to contribute to the sparse research on the use of TLCs by psychotherapists. Much evidence has been cited regarding the impact TLCs can have on improving mental health, along with other values such as accessibility, affordability and physical health benefits (e.g. Gómez-Pinilla, 2008; Ilardi, 2009; Walsh, 2011). While it has been acknowledged throughout the literature that psychologists could play an important role in facilitating TLCs and providing a vehicle for this type of change (e.g. APA Task Force on Health Research, 1976), research suggests that TLCs are underutilized by psychotherapists (e.g. Callahan, 2004; Walsh, 2011). Furthermore, not much research exists on TLCs or how they might be incorporated into therapeutic practice.

Rather than study the reasons that are keeping psychotherapists from using TLCs, this study focused instead on those psychotherapists who have incorporated TLCs in their work in order to explore what that might look like for others who want to do the same. Participants in this study were asked questions regarding inspiration for beginning to incorporate TLCs, methods of gaining the necessary skills and knowledge to do so, and challenges faced throughout the process.

A study by Katsikitis and Sharman (2013) looked at the process of counselling adolescents about healthy eating behaviours. While the focus of that study is more specific than

the current study, its implications for practice could be applied to more general behaviour change. These suggestions for application include:

1) Conveying threats to health (susceptibility and severity)
2) Exploring benefits and barriers (benefits of healthy behaviour and perceived social costs)
3) Self-efficacy (assess one's perceived ability to eat healthy)
4) Health Locus of Control (do they feel their health is in their own hands?)
5) Working ecologically (family and peer support, parental directions and modeling)
6) Sensitivity to the individual (collaborative partnership, understanding, nonjudgmental stance)
7) Interdisciplinary teams (working with other professionals to promote change)
8) Sustaining change (teach them to help others)

When considering the implications that emerged in the study by Katsikitis and Sharman (2013) in comparison to the themes that emerged in the present study, some of the concepts overlap. For instance, *Exploring Benefits and Barriers* shares some cross-over with the *Addressing Barriers* theme from this study. Both speak to the importance of identifying a client's perceived barriers to behaviour change and looking to problem solve. When considering the disconnect between TLCs as common knowledge to all (e.g. eat well, get enough sleep, exercise, have health relationships, etc.) and the actual follow-through of these behaviours, identifying the barriers to making healthy lifestyle changes might just be an integral part of incorporating TLCs.

Findings of both studies also suggested working with other professionals, either through referral or as a part of a team, in order to maximize outcomes. In the current study, connecting clients to other professionals appeared to be an important way to help clients with specific issues

beyond the therapist's scope of practice. These connections suggest effectively incorporating TLCs might include taking a more interdisciplinary approach in one's practice.

Katsikitis and Sharman's (2013) implication *Sensitivity to the Individual* is similar to the theme from this study *Finding What Fits*. Both ideas address in the importance of collaborating with the client and working with nonjudgmental curiosity rather than imposing a set of beliefs or a particular approach upon them. Participants in the current study all provided experiences and testimonials to the necessity of tailoring treatment to the individual and finding what fits best for each client. That is, there is not a one-size-fits-all method to TLCs, and there appears to be much to say about being flexible, building upon the strengths of the clients, and recognizing that what warrants a *healthy lifestyle* varies. This eliminates the pressure to know prescriptions of how much one *should* exercise or what one *should* eat. Instead, the psychotherapist's role would be to focus on what works best for the client right *now* rather than measuring their choices against what is right or wrong.

The idea of *Working Ecologically* focuses on considering family and environmental contexts that may help tailor interventions and increase adherence to behaviour change (Katsikitis & Sharman, 2013). The theme of *Looking at the Whole Picture* in the current study overlaps somewhat with this concept, in that participants in this study expressed the importance of considering all information relevant to the individual's personal life and circumstances. Furthermore, participants in the current study spoke of the importance of helping clients find realistic supports and resources in their lives, and to consider things like finding a partner to exercise with or joining a group.

The concepts from Katsikitis and Sharman's (2013) study seem to be based largely on the Health Belief Model (HBM; Rosenstock, 1974). The HBM is a widely recognized theory of

health behaviour, helpful in understanding, explaining and altering choices individuals make in many areas of health. Psychologists have been the leaders in developing theoretical methods and models to promote and explain healthy lifestyle behaviour change, and the HBM is but one of these models (Kenkel, Deleon, Mantell, & Steep, 2005). Other theoretical frameworks that could be applied to promoting lifestyle behaviour change might include the Transtheoretical Model of Change (or Stages of Change; Prochaska & DiClemente, 1984), Theories of Planned Behaviour and Reasoned Action (Armitage & Conner, 2000; Fishbein & Ajzen, 1975;), or Motivational Interviewing (Miller, 1983). No specific theory detailing how to incorporate TLCs has emerged from the present study, nor was that the purpose of this study. However, participants in the current study reported working from a variety and combination of theoretical models and orientations. There does not appear to be one *right* approach to use in incorporating TLCs into practice, and research supports that an eclectic approach is best suited for wellness work (Granello, 2000).

One theme in the present study addressed the importance of being congruent or practicing what one preaches, and participants spoke of examining and reflecting upon one's own lifestyle choices. While there does not appear to be any literature evaluating therapist congruence in relation to TLCs, some research has addressed therapist congruence and exercise recommendation in counselling practice. For example, in a study by McEntee and Halgin (1996), only 10% mental health practitioners recommended exercise to their clients, and that these same 10% of individuals were likely to exercise themselves. Does this mean that therapists who struggle to make healthy lifestyle choices will not promote TLCs with clients or that those with a healthy lifestyle are sure to use them? No. However, in some psychotherapeutic approaches, congruence is considered a key aspect of effective therapy, as a means of facilitating

communication and trust with clients (e.g. Rogers, 1961). As mentioned by the participants in this study, reflecting upon one's own current lifestyle choices and how it relates to their mood could be a good starting point for beginning to incorporate TLCs.

When one imagines what it might be like to incorporate TLCs, the idea that this process would require a specific skill set might be one thought that comes to mind. While there may be some aspects of incorporating TLCs that require some extra reading, participants all expressed the belief that much of what psychotherapists can do in helping promote behaviour change with clients involves core skills that every therapist already possesses. For example, participants spoke to the importance of raising awareness, providing validation, expressing encouragement, and helping clients to set realistic and value-focused goals. Furthermore, participants spoke to the unique role that psychotherapists play in taking a look at the deeper, underlying issues of a particular health behaviour, such as exploring boundaries, coping strategies, familial patterns, self-esteem or internal drives. This ability to work from the inside-out, rather than superficially, is something psychotherapists are uniquely trained in, which arguably could lead to long-term change. This is congruent with other research on wellness work in psychotherapy, which purports that most competent clinicians already possess the skills required to work on issues surrounding wellness (e.g. Granello, 2000).

Egger, Binns, and Rossner (2009) state, "Exercise and nutrition are the penicillin of lifestyle medicine; psychology the 'syringe' through which these are delivered" (p. 144). The role that psychology and psychotherapists can have in promoting and assisting in Therapeutic Lifestyle Changes is undeniable. Granello (2000) highlights ways psychotherapists can integrate wellness work into private practice, which directly relates to the work being done with incorporating TLCs. Granello states:

> Although the content may be different, the processes of treatment (assessment of the client, negotiation of goals, development of a plan for guiding the therapeutic process, applying interventions, and encouraging and supporting clients in achieving or completing that plan) are all paralleled in wellness work just as they are in traditional therapy for clients with a mental illness (p. 31).

Participants in this study shared a similar perspective – that even if as psychotherapists we do not have all of the skills and knowledge of specific lifestyle changes, our role in helping clients through the process of lifestyle change is significant. Gary summed it up by stating, "As therapists, we have that – those skills and that ability to meet people where they're at. To deepen them into their experience. To find barriers and use them and our own knowledge to come up with creative solutions and directions to pursue. We have that."

Limitations

As is the case with any study, there were limitations to this project. One of the key limitations was that all participants were from the greater metropolitan area. Rural psychologists were not interviewed, and four out of the five participants resided in the same city. It is unknown how the results would differ for psychologists in other areas of Canada or other countries.

Suggestions for Future Research

Because this study was exploratory and results were quite broad, future research could look at a specific area of incorporating TLCs more specifically. These findings are based on therapists who already incorporated TLCs before being interviewed. Future studies could look at the process of incorporating TLCs with participants who did not previously use TLCs in their work.

While many of the findings appear straightforward and practical, one wonders whether

this will open a door to TLCs being incorporated by therapists, or if it will be overlooked. Future research could look at how to convey the findings of studies like this one, along with the evidence supporting TLCs for mental health, in a way that is effective. Workshops or university courses could also be designed in order to teach psychologists how to incorporate TLCs. I wonder how this information could be conveyed to psychotherapists on a grander scale, rather than only catching the attention of those therapists with a formerly developed interest in lifestyle behaviour.

Are TLCs a stand-alone approach in need of further development? Or, consistent with the experiences of the participants in this study, can TLCs be easily integrated into existing therapeutic approaches? Would TLCs be easy for a professional who works from a more *eclectic* approach to incorporate? What about for the professional who works from a more traditional therapeutic approach?

There are many aspects of the topic of TLCs and its use in psychotherapy that have yet to be researched. Hopefully this study will act as a framework from which to further explore TLCs and their role in a counselling setting, and to begin to bridge the gap between knowledge and practice.

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Appendix A

INFORMATION LETTER

Study Title: How Psychotherapists Incorporate Therapeutic Lifestyle Changes into Practice

Research Investigator:
Kellsey Calhoon
Department of Educational Psychology
6-102 Education North
University of Alberta
Edmonton, AB, T6G 2G5
Email Address
Phone Number

Supervisor:
Dr. Derek Truscott
Department of Educational Psychology
6-102 Education North
University of Alberta
Edmonton, AB, T6G 2G5
E-mail Address
Phone Number

Background

You are being asked to participate in this study because of your experience in incorporating therapeutic lifestyle changes (TLCs) into your psychotherapy practice. I received your contact information from (source), who identified you as an appropriate potential participant for my research study. The results of this study will be used in support of my Masters thesis.

Purpose

The purpose of this study is to gain a deeper understanding about the experience of incorporating TLCs into psychotherapy practice. Past research has outlined that a large proportion of illness and death are caused by preventable risk factors. Healthy lifestyle choices have been found to have positive effects on physical and mental health and research supports healthy lifestyle changes as an effective, accessible and affordable intervention for decreasing rates of morbidity and mortality and increasing health and overall wellness. Psychotherapists play a key role in fostering behaviour change. However, research does not reflect the application of the knowledge about the importance of TLCs into counselling practice. Therefore, by learning about the experiences of psychotherapists who have chosen to utilize TLCs within their practice, it is anticipated that a deeper understanding of the application of TLCs will emerge, aiding in bridging the gap between research and practice.

Study Procedures

This study will be qualitative in nature. As a participant, you will be asked to meet with me potentially three times. The first time we meet, I will ask you to participate in a one-on-one interview with myself. This interview is expected to last approximately one hour. After this meeting, I will begin to type up our interview and determine whether or not I have more questions to ask you. If I do not have any more questions, I will ask to meet with you a second time to review the transcript of our interview. If I do have further questions, I will ask you to participate in a follow-up interview, which may also take up to one hour in length. Following this second interview, I will ask to meet with you a third time to review the transcripts from both interviews.

It is hoped that our interviews will occur in person at the University of Alberta in Edmonton, Alberta. However, depending on your location and availability, interviews may also take place through a more appropriate means, i.e. Skype. All interviews will be audio recorded so that I can transcribe our conversation word-for-word. Once I have your approval on the interview transcripts, I will begin my data analysis. During this time, I will start to read through our conversations and begin to identify themes. I will be checking in with you during this time to ensure that what I am writing matches what you meant in our interviews. This will allow me to ensure that you are being represented the way you want to be represented and that my interpretations of what you have told me are accurate.

In total, I anticipate this research study will take me a total of 8-10 months. However, your time commitment is expected to be approximately 5 hours.

Benefits

Your participation in this study will provide you with an opportunity to share your experiences with incorporating TLCs with a neutral researcher who is interested in hearing what you have to say. It is anticipated that the information you share with me will contribute to the field of TLC research and to psychotherapy research as a whole. It is my hope that the results of this study will help researchers and therapists alike begin to bridge the gap between the research on TLCs and the application of TLCs into practice. I hope that you feel a sense of pride in knowing the importance your experiences, thoughts, feelings and opinions will have to the area of TLC research. Furthermore, it is hoped that learning how to effectively use TLCs as an intervention with clients will empower individuals to take control of their own overall health by engaging in healthy lifestyle choices.

There are no costs involved in being involved in the research.

Risk

Participation in this research includes minimal risk. Since your key role in this study is to participate in one-on-one interviews for approximately one hour in length, there is a potential that you may feel fatigued upon completion. I will make every effort to reduce this risk and we will discuss breaks before we begin our interviews. The interview content is not expected to be sensitive in nature. However, if something sensitive comes up for you, I will provide you with resources for the appropriate support needed. There may be further risks to being in this study that are not known. If I learn anything during the research that may affect your willingness to continue being in the study, I will let you know as soon as I become aware of it.

Voluntary Participation

Please know that your participation is completely voluntary and you are under no obligation to participate in the study. Furthermore, you do not have to answer any specific questions that you do not want to answer even while you are participating in the study.

After you agree to be in the study, you can request the withdrawal of your data from the study up to 4 weeks after our final debriefing meeting. At this point, all of the results from everyone who participates in my study will be joined together and cannot be separated. I will be sure to provide you with a reminder of the specific date of the last opportunity to withdraw your data. If you do choose to withdraw before this point, all information and data collected from you will be erased and destroyed.

Confidentiality & Anonymity

The primary intended use of my research is for my Masters thesis. Upon completion of my thesis, I hope to have my research published in a peer-reviewed journal. Furthermore, I hope to use my results to present at conferences, in order to share my findings with other professionals.

Your personal information will never be used in any of the results or shared with anyone, outside of myself and my supervisor, Dr. Derek Truscott. All research data will be kept confidential. I will make every effort to keep you anonymous. I will be using pseudonyms to replace your real name throughout the data and in the instances where I use verbatim quotations in my report. I will also refrain from using your particular business name or any other identifying information in my reports or presentations. In the case that my research is published or presented at a conference, there is a very small chance that you will be recognized based on the information you choose to share.

All data will be kept in a secure place for a minimum of 5 years following the completion of my Masters thesis. All electronic data will be password protected. After 5 years, all data will be erased or securely destroyed. The only people that will read the interviews will be my supervisor and myself.

It is possible that I may use these interviews again for future research, i.e. doctoral dissertation. The human research ethics board must approve any future use of this data.

Further Information

If you have any further questions regarding this study, please do not hesitate to contact **Kellsey Calhoon** or **Dr. Derek Truscott**. Contact information for both individuals is provided at the beginning of this information letter.

The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (xxx) xxx-xxxx.

CONSENT FORM

Title of Study: ***How Psychotherapists Incorporate Therapeutic Lifestyle Changes Into Practice***

Principal Investigator: Kellsey Calhoon (xxx) xxx xxxx
Supervisor: Dr. Derek Truscott (xxx) xxx xxxx

	Yes	No
Do you understand that you have been asked to be in a research study?	☐	☐
Have you read and received a copy of the attached Information Sheet?	☐	☐
Do you understand the benefits and risks involved in taking part in this research study?	☐	☐
Have you had an opportunity to ask questions and discuss this study?	☐	☐
Do you understand that you are free to leave the study at any time, without having to give a reason and without penalty?	☐	☐
Has the issue of confidentiality been explained to you?	☐	☐
Do you understand who will have access to your study records (including personally identifiable information?)	☐	☐
Do you understand that all interviews will be audio-recorded?	☐	☐

Who explained this study to you? _____

I agree to take part in this study:

Signature of Research Participant _____

(Printed Name) _____

Date: _____

Signature of Investigator or Designee _____ Date _____

Appendix B

Interview Protocol:
What are psychologists' experiences with incorporating therapeutic lifestyle changes into their psychotherapy practice?

Time of Interview:
Date:
Place:
Interviewer:
Interviewee:
Position of interviewee:
Brief description of project and procedures:

The purpose of this study is to gain a deeper understanding about psychologists' experiences of incorporating therapeutic lifestyle changes into their psychotherapy practice.
I will ask you a series of questions about your experiences. If at any time you do not feel comfortable or would like to stop the interview, please let me know. If at any time you have any questions or concerns, I invite you to please ask.

Interview Questions:
1. Before we begin, could you tell me a bit about your professional background and the type of work you do?
2. What are some of the interventions you use that you would classify as therapeutic lifestyle changes?
Prompts: Ask specifically if/how they address exercise, diet/nutrition, stress management, spirituality, voluntary service, time in nature, recreation and interpersonal relationships. Others?
3. When did you decide to begin incorporating therapeutic lifestyle changes into your practice?
Prompts/Clarification: What inspired you to begin using TLCs in practice? What experiences of your own have led you to begin using TLCs as a part of your practice?
4. What has the process of incorporating TLCs into your practice been like for you?
5. How did you gain the necessary skills and knowledge to competently include TLCs as a part of your practice?
Prompts/Clarification: What courses or training have you taken? What knowledge is necessary to effectively incorporate TLCs?
6. How do you measure whether your TLC interventions are effective?
7. Do you base your use of TLCs on any particular psychological theory or model?
8. What are some of the challenges you have experienced in incorporating TLCs?
9. What are some examples of what TLCs as an intervention look like in your practice?
10. If a colleague wanted to begin incorporating TLCs into their practice, but didn't know where to start, what would you recommend?
11. In your opinion, what is our role as psychologists in the 'obesity epidemic'?

Thank you for your participation in this interview. I just wanted to take this time to remind you that anything you have shared today will remain anonymous. If you have any questions about this interview, you are invited to contact me at any time.