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Mindfulness Based Cognitive Therapy for Mental Health Professionals: A long-term qualitative follow-up study

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Abstract

The aims of this study were a) to explore the long-term impact of attending an MBCT programme upon the personal and professional lives of a sample of Clinical Psychologists, and b) to assess how their experiences might inform existing theoretical and practical discussions around training for MBCT facilitators. Semi-structured interviews were conducted with seven Clinical Psychologists who had attended an MBCT programme some eighteen months earlier. The transcribed interviews were analysed using Interpretative Phenomenological Analysis. None of the participants was following a regular, formal, meditation practice and for most this was a barrier to facilitating their own groups. Instead, participants described using mindfulness in a more informal, ad hoc, way to enhance pleasant experiences and/or deal with stressful situations. Mindfulness was associated with being able to de-centre from strong emotions and feel more grounded, though some equated this with avoidance. Participants used elements of MBCT with their clients tentatively. The results suggest that attending an MBCT programme is associated with perceived benefits for Clinical Psychologists. However, some core principles of MBCT such as non-judgemental awareness, compassion, and regular formal practice seem more elusive from these accounts. Further research is needed to establish the importance of these elements and their impact on the training requirements for MCBT facilitators.

Keywords

mindfulness; mindfulness based cognitive therapy (MBCT); mental health professionals, meditation, qualitative; Interpretative Phenomenological Analysis (IPA)

Introduction

Mindfulness Based Cognitive Therapy (MBCT) is a group intervention designed for people with a history of recurrent depression (Segal, Williams, & Teasdale, 2002). The role of mindfulness in this context is twofold: 1) to provide an early warning system to detect depressogenic thought patterns and 2) to limit elaborative processing (e.g. rumination) by focussing on the present moment. MBCT borrows many elements from the Mindfulness Based Stress Reduction programme (MBSR) originally devised by Kabat-Zinn (1982) for people experiencing chronic pain and stress-related disorders. It includes *formal* guided meditation exercises such as mindfulness of breathing and the body scan, and *informal* practice where mindful awareness is cultivated during ordinary activities such as walking, standing and eating. Homework includes practising the above exercises for at least 45 minutes per day, six days per week.

Two randomised controlled trials of MBCT (Ma & Teasdale, 2004; Teasdale et al., 2000) found that the risk of relapse in depression was approximately halved for people with three or more previous episodes, compared to a waiting list control group. As a result of this research, MBCT has now been included in the UK's National Institute for Clinical Excellence (2009) guidelines for relapse prevention in depression. Unlike other cognitive behavioural therapies, MBCT requires instructors to develop their own daily meditation practice, with the rationale that instructors embody or model the underlying principles of mindfulness i.e. non-judgemental, present-moment awareness. As these principles can be difficult to sustain, a regular practice is viewed as essential. Kabat-Zinn (2003) advocates attending meditation retreats at Buddhist centres or professional training programmes in MBSR. This recommendation is also endorsed by Segal et al. (2002) in their MBCT manual.

As a first step, Segal et al. (2002) suggest that interested professionals participate in an MBCT programme themselves. The first paper in this three part series (Ruths, De Zoysa, Frearson, Hutton, & Williams, *in press*) conducted a preliminary evaluation of such a group. The authors reported a significant improvement in measures of mindful awareness and attention and psychological well-being immediately after the group and at 3-month follow-up. Furthermore, approximately two thirds of the group reported continued meditation practice (formal and/or informal) at 3-month follow-up, and amount of practice correlated with improvement in mindfulness. The second study in this series (De Zoysa, Ruths, Walsh, & Hutton, *in press*) found that meditation practice and improvement in some psychological measures were sustained at 18 month follow-up. However, levels of mindfulness were no longer related to amount of overall meditation practice. Contrary to expectation, levels of mindfulness were found to be positively correlated with increased life events and perceived stress.

The above findings suggest that the maintenance of mindful awareness and attention is a complex area. Within the literature, the requirement of a regular, formal meditation practice is a debatable issue. In Dialetical Behaviour Therapy (Linehan, 1993) a personal formal practice is not required, but instead therapists are recommended to practise mindfulness more informally in their daily lives. Linehan suggests that personal practice is a private decision, outside the bounds of what a therapeutic model can require (Dimidjian & Linehan, 2003). Furthermore, J. C. Smith (2004) argues that the commitment required by an approach such as MBCT may be needlessly long, which risks alienating clients and potential therapists. The suggestion that meditation practice is an unrealistic or unwelcome prospect for clinicians has not been substantiated by research. Qualitative methodologies would be well suited to explore the subjective experiences and attitudes of this population.

To date, there has been very little qualitative research in this area. There has been some research investigating patient attitudes regarding MBCT (Allen, Bromley, Kuyken, & Sonnenberg, 2009; Griffiths, Camic, & Hutton, 2009; Mason & Hargreaves, 2001; Smith, Graham, & Senthinathan, 2007). However, data regarding the experience of professionals is lacking. Cohen-Katz et al. (2005) reported nurses' experiences of attending an MBSR group. However, this study focussed more on emotional well-being and impact on working relations rather than the maintenance of the practice itself. It was also not expected that the nurses would go on to run patient groups themselves and hence the issue of the programme as a training vehicle was not addressed. Since Clinical Psychologists are the main providers of psychological therapies within the British National Health Service (NHS), it is reasonable to expect that they may play an important role in delivering MBCT programmes.

This paper reports the final study from a three-part series. It is a qualitative study addressing the impact of MBCT upon the personal and professional lives of Clinical Psychologists, 18 months after attending an MBCT programme. Its aim was to explore the benefits and challenges of asking Psychologists to meditate and consequently inform the theoretical discussions regarding training for MBCT instructors. Interpretative Phenomenological Analysis (Smith, Jarman, & Osborn, 1999) was chosen to analyse the data because it supports a broadly realist ontology (i.e. a belief that verbal reports relate to underlying cognitions, affect and behaviours). Such an approach allows research to be applied to practical concerns, such as integrating mindfulness into the NHS.

Method

Participants

The population of interest was Clinical Psychologists who had attended at least half of the 8-week MBCT programme described and evaluated by Ruths et al. (*in press)*. Out of the 14 eligible participants, one was uncontactable, one was ineligible (due to their involvement with the research), five declined and seven consented to take part. A small sample size was justified within the context of a qualitative approach which aims to provide an in-depth analysis of a research question (Willig, 2001).

Participants' ages fell within the range of 32 to 45 years and the length of experience post qualification ran from 3 to 14 years. The gender split was 2 males and 5 females. Six participants were 'White, British' and one 'White, unspecified'. Six reported having no religious affiliation and one was self-defined as Christian. During the interviews, two participants mentioned not being particularly "spiritual" or "religious", three participants mentioned a vague interest in Buddhist ideas and two made no mention of their personal spirituality. Most participants spoke about having "dabbled" with meditation before; encountering it through one off sessions or yoga classes, but no one had committed to a regular practice prior to the programme.

Interviews

Interviews were conducted by the first author and each lasted between one and one and a half hours. Interviews were tape recorded and transcribed. All identifying information was removed to protect confidentiality. Two areas of the interview schedule focussed on the impact of the MBCT programme upon their personal lives and their professional practice. The interview schedule was developed following guidelines from Smith (1996). In summary, broad open-ended questions were initially

used with neutral prompts to invite detailed accounts. A move between general views to more specific concerns was facilitated using a funnelling technique. Example questions included: *What's been your experience of maintaining a practice? What are your thoughts about the benefits /drawbacks of being mindful? What's been your experience of mindfulness in your work life?*

Analysis

Interpretative Phenomenological Analysis (IPA) was used to analyse the data. IPA is an analytical tool designed to explore a participant's personal lived experience and the sense they make of that experience. It is coupled with a subjective and reflective process of interpretation, where the central role of the analyst is made explicit (Smith, 1996; J. A. Smith, 2004; Smith et al., 1999). The analysis method was guided by the recommendations made by Smith et al. (1999). A summary of the stages involved in the analysis is given below:

1) Interview summaries (made after each interview) were re-read to gain a general sense of the issues raised. The transcript that showed the most comprehensive coverage of the issues was selected as a starting point.
2) On the first reading, a brief description of the content of each section of text was made.
3) On the second reading, emergent themes were identified and labelled and specific quotes were highlighted.
4) The emergent themes were listed in one table and relationships between them were considered. This resulted in a clustering of themes into superordinate categories.

5) To ensure the analysis was grounded in the data, illustrative quotes were added to the above table for each emergent theme.
6) The remaining transcripts were analysed in the same way to identify:
    a. Further examples of the pre-identified emergent themes
    b. New emergent themes
7) When new emergent themes were found, they were checked against earlier transcripts and if appropriate, a reorganisation of the superordinate categories was made.
8) Once all transcripts had been analysed, the superordinate categories were reorganised into master themes.
9) The list of master themes was used as the basis for writing up the analysis, along with the identified verbatim quotes.

Despite the linear presentation of these steps, the analysis was an iterative process moving between transcripts and stages.

A validation check was conducted by the second author who was given a sample transcript and table of clustered themes derived from the transcript. Both were read with a view to assessing whether the participant's account had been misrepresented by the analysis. The second author reported that the coding was clear and systematic and fitted well with the data.

Ethical considerations

Ethical approval for this study was obtained from both the relevant NHS Trust and the University of East London Research Ethics Committee. Informed consent was received from all participants to partake in the research and have their responses tape

recorded and transcribed. Both tapes and transcripts were labelled by a numeric code to preserve anonymity.

Results

Four master themes are presented below relating to the impact of the MBCT programme on the lives of the Clinical Psychologists interviewed. Themes are accompanied by excerpts from the interviews. Ellipses (…) indicate a pause in speech and square brackets ([…]) refer to omitted/inserted material, edited for brevity or clarity.

Formal practice: "I should do it more but …"

In contrast to the original aims of the MBCT programme, none of the participants was following a regular formal meditation practice when interviewed. Yet, nearly all participants seemed to express a desire for this to be different. It was associated with being psychologically healthy, stimulating one's brain and improving concentration levels.

> *There's something slightly enjoyable about it, which was kind of maintaining a sort of discipline and doing something regularly, that made you feel like, I'm doing something which is quite good for me and it's a worthwhile thing to do*. (P4)

Whilst viewing meditation as worthwhile, three participants also spoke about the pressure and sense of obligation they associated with it.

If you added up all the things you ought to do in your life, like go to the gym, do mindfulness, you'd be there all day. (P7)

Most participants spoke about the practical barriers which prevented them from maintaining a regular practice. This included the length of the daily practice and life events such as having a baby and moving house.

That's what made a big difference between whether people carried on doing it or not because they had a time when they were doing it regularly. If it's part of your routine then you do it, if it's not, then it's much more erratic and out the window basically. (P4)

Six out of the seven participants spoke about the mental effort required to do the practice which also made it difficult to adhere to.

I mean it's quite effortful, maybe I had the idea before the groups that it was going to be something kind of relaxing like having a hot bath or something like that but it's not at all, it's something that you really need to try at doing. (P10)

Aside from the time and effort required, certain attitudes towards the value of the practice also influenced people's commitment. Participant 3 and participant 7 both spoke about the irritation of not being able to elaborate on thoughts and participant 12 felt that the effects of a regular practice were too gradual.

It was just too difficult to shut off my mind from all these things, checking "have I phoned […] *had I done this, had I done that?" and it was just easier to let myself go through those because it just felt like a more helpful task than trying to block them all out.* (P7)

… all the time I've got that secondary conversation going on "what am I getting from this, what am I achieving at the end of this?" and I think that that's what it [the barrier to regular practice] *is*. (P12)

Ad hoc practice: "A sticking plaster"

In contrast to a regular, formal meditation practice, all participants were using some of the techniques (such as the breathing space or mindful walking) in a more ad hoc way. Elements of the practices were used as a way to enhance daily living by making experiences more vivid.

I went [on holiday] *last year, I just decided to just stop and just really appreciate the sort of amazing … taking in the sun and you know, just everything …I was having a mindful moment.* (P12)

it's a greater sense of being alive and in touch with what's going on in the world (P1)

Conversely, mindfulness techniques were also used to detach from unpleasant experiences such as a headache, going to the dentist or travelling on the underground transport system.

In addition to using specific meditation techniques, some participants found they could access a mindful state in other ways such as reading about mindfulness or recalling certain memories.

> *when I've sort of taken a deep breath in the day at work or re-read a Kabat-Zinn book and then had that same, slightly different shift of mind, as you might do after sitting for a bit … I can kind of remind myself of that state of mind without necessarily having to <u>be</u> in that state of mind and that in itself is quite helpful. (P10)*

The ability to call upon this mindset when needed was something which most participants seemed to find containing or grounding.

> *this is something that I'm very glad to have now, I can always use, if I remember (laughs) in the moment, I say well "I can always do that" when I'm feeling, thinking about many things at the same time and I'm getting stressed.* (P8)

Although all participants used mindfulness techniques in an ad hoc way, three participants felt that mindfulness should be viewed more as a preventative rather than reactive measure.

> *P: I kind of think there's something not very helpful about using mindfulness as a fix for something, like as a reaction to feeling stressed or miserable, that it probably is not working that way* […]
> *I: Why not?*
> *P: … because I would want to view it as something, kind of positive and natural rather than a sort of medicine or fix for something. (P10)*

Psychological processes: "A more balanced appraisal"

All participants mentioned that mindfulness had some sort of positive impact on their processing of strong emotions. Four participants felt they were able to step back from certain negative emotional experiences.

> *P:.. if things get a bit too much, it's almost like I can switch into a different mode of ... stepping back from it, still feeling it but, you know, I'm watching it ... instead of actually feeling it.(P4)*

> *I think it does allow you to not be caught up in your own emotional world.* (P7)

However, three participants also expressed ambivalence regarding whether this detachment was necessarily a good thing. They felt this might lead to a dulling of emotional experiences, which could be viewed as "avoidant" or "boring".

> *I don't really want a passion-less world, I want to be ... to feel things strongly, to get very excited, to be able to, you know, be angry at times, to experience my emotions fully really and I think that mindfulness perhaps detracts from that. (P7)*

> *I'm kind of thinking, well, you know I should really expose myself to these unpleasant emotions and that, by taking a mindful state of mind, am I actually just <u>not</u> exposing properly? (P4)*

Six participants spoke about feeling calmer and less reactive to things, which in turn allowed them to make plans, be aware of their choices and respond in a more considered way.

> *you can just take that moment to pause and make more of a deliberate decision on how to respond* […] *rather than automatically being kind of cross or irritated you can just think to yourself whether you want to say anything or just let the situation go or whatever.* (P1)

As well as managing emotions, half the sample strongly associated their practice of mindfulness with greater concentration and focus. These participants spoke about re-focusing their attention (if it had drifted away) in a gentle and non-judgemental manner and for one participant, this was in direct contrast to their previous behaviour.

> *I will sort of more gently escort my attention back rather than … I think previously I might have been slightly punitive about it, so this is more that … not evaluating it particularly but just bringing it back. (P3)*

However, a few participants expressed irritation and critical judgement towards their attempts to be mindful.

> *I think sometimes I can be a bit mentally lazy,* […] *I can be really rubbish and not concentrate for very long, do ten minutes and then look out the window a bit. (P7)*

Nearly all participants associated mindfulness with reduced rumination. Thoughts which would have previously been pursued and elaborated were now allowed to pass. For three participants this was associated with a reduction in reactive striving.

> *I think in our culture it is quite achievement oriented and driven and I think being able to step out of that and just be in the present moment and accept how things are is more helpful. (P1)*

For three different participants however, the main value of decreased rumination was associated with improved concentration and therefore increased productivity.

Practicing what you preach: "Didn't claim to be an expert"

None of the participants had run an MBCT group since the end of the programme. There was a sense that people did not feel sufficiently qualified or experienced to teach mindfulness in a formal way. Most participants believed that having one's own practice was essential for running a mindfulness group.

> *it is an experiential thing, something that you have to experience, it's not just a technique … so if you never have experienced that as a therapist, I think it's very difficult that you can convey the experience to somebody else. (P8)*

> *I think there is a big experiential component, you need to kind of go along there with your client, rather than, tell them to go there. (P10)*

Three participants also spoke about the importance of the therapist modelling mindfulness through their behaviour and commitment to the practice.

there is a lot of be learnt from seeing people that are very skilled at mindfulness teaching it, embodying the principles and, yeah, behaving in that way.(P1)

I would have felt that I was pushing my clients to go somewhere that I hadn't been, unless I had done it myself before. (P10)

One participant in the sample however, held a different perspective to the dominant viewpoint.

people think it should be very highly trained people that do it and no one else and gradually it becomes diluted and probably the results aren't as good but whether there's no place for it, I'm not really convinced about that. (P7)

Instead of leading MBCT groups, all participants spoke about borrowing elements of mindfulness to incorporate into their work, such as the underlying philosophy, the tapes and books or introductory exercises. They applied these elements to a wide variety of clinical groups and the approach was tentative:

I sort of didn't claim to be an expert, I just said "listen, this is the book, it's supposed to be helpful, you know, the research suggests it's helpful. You're better now, some of these strategies might be useful". (P3)

Three participants found mindfulness particularly helpful with exposure work:

[Clients] can really be unwilling to experience strong emotions and there's something about mindfulness which kind of, maybe allows you to feel things in a kind of safe way (P10)

The same participants felt that mindful awareness might be the endpoint of CBT and possibly the driver for change within CBT.

What people get actually get out of cognitive therapy …is this kind of higher realisation that actually, they are just thoughts, and actually you could just let them go, you don't really have to do anything with them (P4)

However, participants also expressed some concern about using mindfulness as an avoidance strategy and some confusion about when to challenge and when to let go of thoughts.

I think [the client] *just got confused between things like whether he should be suppressing thoughts or not suppressing them or being mindful towards them or distract himself, it all became a bit muddled really …(P7)*

… well it's almost like avoiding an emotion in a way because you're sort of not going with it in the way that you would do otherwise – maybe you'd be bawling your eyes out (P4)

… the more I thought about it, really we were just using it as another distraction technique for these people (P3)

Discussion

None of the seven participants was still following a regular formal meditation practice, yet most felt this would be a good thing to do. Instead, participants used mindfulness in more informal ways, either to enhance pleasant moments or as an on the spot technique to cope with stressful situations. As well as specific techniques, participants referred to a more general shift in awareness which could be triggered by other factors such as reading. Mindfulness was associated with being able to decouple from strong emotions and feel more grounded. This enabled a flexibility of responding, but for some participants was also conflated with the concept of avoidance. Participants introduced elements of the programme to their clients but with a cautious and tentative approach.

It should be noted that the current study was conducted with a specific sample of Clinical Psychologists, working within a particular institution. Therefore, the views expressed here may not necessarily be representative of all Clinical Psychologists. The accounts from this study were also obtained via a face-to-face, recorded interview with a Trainee Clinical Psychologist. It is possible that participants may have felt uncomfortable disclosing personal information or unfavourable views about the MBCT programme within this interview setting. However, a mix of both positive and negative experiences of mindfulness emerged from the interviews, suggesting that the accounts were not biased in an overly favourable way.

It is interesting to note the contrasts between the intentions of the MBCT programme and its actual application in real life. There was a strong association within this group between mindfulness and increased concentration and productivity. Allied to this, a few participants mentioned a sense of obligation to do it 'properly' which felt pressurising. Although mindfulness incorporates some intentional effort and

concentration, it has a wider remit in encouraging an accepting, non-judgemental awareness of the present moment (Segal et al., 2002). It has been suggested that focussing merely on sustaining one's concentration, can mean that the practice itself can give rise to anxiety and agitation (Epstein, 1990). Hence, even amongst a group of mental health professionals there was evidence that mindfulness could be taken out of context and associated with striving and self critical judgement. This suggests a greater emphasis towards non-judging and non-reactivity may be needed, if it is to be faithful to the underlying principles of MBCT.

All participants were using mindfulness to enhance pleasant experiences (through informal practice) or make negative experiences more manageable (through ad hoc practice). Yet, formal practices were associated with boredom, effort and frustration, which was one barrier to adopting a regular practice. It could be argued that participants were choosing the more accessible parts of mindfulness (i.e. those that provide a clear short-term benefit) and shunning the parts that required sustained effort without an immediate benefit. The creators of the MBCT programme (Segal et al., 2002) suggest that using mindfulness techniques to escape, fix, or avoid things tends not to make for lasting change and may in itself be a form of experiential avoidance. In contrast, mindfulness is about allowing any emotional experience to unfold without goals or preference. Moss & O'Neill (2003) suggest that this approach doesn't fit easily within a hyper-consumerist "what's in it for me" (p31) society which reflects some of the dilemmas of this group in trying to adopt a formal practice.

The participants in this study mostly associated being mindful with positive mental health benefits e.g. feeling grounded, decreased rumination and less reactivity. However, this was not contingent upon having a regular formal meditation practice. Positive psychological changes were associated with ad hoc practice, reading,

memories of the group and a shift in beliefs/values. Again, this contrasts with Segal et al. (2002) who viewed a regular formal practice as necessary to effect meaningful change. This view is based on the MBSR approach, led by Kabat-Zinn, who claims that informal practice alone loses the ability to stabilise the mind if not combined with formal meditation practice. He goes on to suggest that "Mindfulness is not merely a good idea such that, upon hearing about it, one can immediately decide to live in the present moment" (Kabat-Zinn, 2003, p.148). In effect, this is exactly what some participants in this study have suggested.

One clinical implication from this study is that psychologists are using techniques from MBCT in a piece-meal way, for a variety of mental health problems. This could be viewed as expanding their clinical tool box and thus providing greater therapeutic flexibility. However, it is at odds with evidence-based practice, and mindfulness has been accused of "getting ahead of the data" (Corrigan, 2001, p189). However, it is understandable that once given a 'taster' of mindfulness, participants are keen to try this in their clinical practice. What is of interest, is the participants own reluctance to run an MBCT programme and their unanimous agreement that one needs to have at least some practice before teaching others. This reflects the messages from mindfulness centres such as Bangor and Oxford in the UK regarding trainer experience. Only one participant challenged this dominant viewpoint. Given the issues raised above (concerning some straying from the programme's original intentions), their hesitation in leading a group may be warranted.

The question of how to train meditation instructors for clinical interventions is a challenging one. "Are therapists to be trained to do therapy through long Zen retreats?" (Hayes, 2002, p103). Shapiro (1992) suggests that the motivation or drive to meditate evolves as experience increases. She reports that intentions shift along a

continuum from self-regulation, to self-exploration, to self-liberation. According to this model, most participants in this study appeared to be at the stage of self regulation. This raises the question of how far along the continuum potential MBCT trainers need to progress? The results from this study suggest that professionals with minimal training are liable to fall into the same traps as patients, in terms of an over emphasis on concentration, struggling to maintain a formal practice and using mindfulness to enhance pleasant experiences and detract from more negative ones.

The above concerns may support the argument for more intense training and support. However, if more substantial training is required, this study suggests that a single eight week programme is inadequate to sustain a formal practice over the long-term. Additional follow-up sessions or weekly support groups may be needed if such a requirement is to be adhered to. This has clear cost implications if it is to be supported by health service funding. There are other interventions within Clinical Psychology which also make use of mindfulness such as DBT and ACT. However, unlike MBCT, these approaches place less emphasis on formal meditation. It would be useful to compare the experiences of psychologists across these different therapeutic models. Different approaches may offer novel solutions to the dilemmas of integrating mindfulness into clinical practice.

In conclusion, the current research suggests that mindfulness persists in a diluted form, but is nevertheless associated with perceived benefits. The question for the NHS concerns how MBCT can be disseminated to those who may benefit most from it. At present, MBCT requires instructors to follow their own regular, formal meditation practice. The conclusions from this study question the viability of this in terms of personal time commitment, maintenance and cost. In addition, the research also reveals that after an eight week programme, some core principles of MBCT

(equanimity, compassion and regular practice) are less well established. Further research is needed to assess whether these elements are pivotal to improved patient outcomes and thus warrant a greater commitment to ongoing training.

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