Mindfulness-Based Cognitive Therapy
Teacher training and development

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“A human being is a part of the whole, called by us ‘universe,’ a part limited in
time and space. He experiences himself, his thoughts and feelings, as something
separate from the rest – a kind of optical delusion of his consciousness. This
delusion is a kind of prison for us, restricting us to our personal desires and to
affection for a few persons nearest to us. Our task must be to free ourselves from
this prison by widening our circle of compassion to embrace all living creatures
and the whole of nature in its beauty.”
Albert Einstein (Harris. 1995)

Declarations and Statements

This dissertation is submitted in part fulfilment of the requirement for the degree of M.A.

Signed……Date……

This work had not previously been accepted in substance for any degree and is not being concurrently submitted for any degree other than the one for which it is now submitted namely Master of Arts of the University of Wales.

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This dissertation is the result of my own independent investigation, except to the extent stated in the acknowledgements, and except for what is explicitly attributed in the text to other sources.

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CONTENTS

APPENDICES:

Abbreviations used in the study:

- MBSR – Mindfulness-based stress reduction
- MBCT - Mindfulness-based cognitive therapy
- MBCT-AS – Mindfulness-based cognitive therapy adherence scale
- CFM – Centre for Mindfulness in Medicine Health Care and Society, University of Massachusetts Medical School, USA
- NWCMRP – North Wales Centre for Mindfulness Research and Practice, University of Wales, Bangor
- RCT – Randomised control trial
- GAD – Generalised anxiety disorder
- IPA - Interpretative phenomenological analysis
- CBT – Cognitive behavioural therapy
- CMHT - Community mental health team
- UK – United Kingdom
- USA – United States of America
- NHS – National Health Service
- IMSCaR – Institute for Medical and Social Care Research

Abstract

Mindfulness-Based Cognitive Therapy
An investigation of the teaching process

The aim of this dissertation is to investigate the training and development of teachers of mindfulness-based cognitive therapy (MBCT). The project had the specific remit of investigating how MBCT teachers can be selected and trained and their teaching adherence levels and competency can be measured for the purposes of multi-centre research on MBCT; and the broader remit of informing understanding of the training and development of MBCT teachers generally.

MBCT is a new structured group approach to the prevention of depressive relapse, taught in a group setting over 8-weeks. It integrates a mindfulness approach with cognitive behavioural therapy theory and practice. During the first randomised controlled trial of MBCT, completed in 1998, the teaching of the course was carried out by the three developers of the approach. The results from this original research and a subsequent replication indicate that MBCT has the potential to halve the rate of depressive relapse of participants.

The next phase of the research work on MBCT is to investigate the results, when it is delivered in mainstream NHS settings, by teachers who have been trained, but who did not originally develop the approach. This strategy presents the challenge, faced by a new approach, that the necessary requirements of teachers, the optimal training processes and ways of assessing competency and adherence have not been formulated to the extent that is needed. This dissertation intends to further develop the foundational understandings needed to formulate strategies to address these issues.

In chapter one, the development of MBCT as an approach is considered and the literature and research reviewed. To enable MBCT to be seen in the context in which it arose, other mindfulness-based approaches are summarised. Mindfulness-based Stress Reduction (MBSR), from which MBCT developed, is described in more depth.

Chapter two describes the rationale for MBCT, the programme structure content and the teaching methods.

Chapter three reviews current mindfulness-based training paths and the philosophies that underpin them. Current methods for assessing teacher competence and adherence are described.

Chapter four outlines the research questions and the methodology. Semi-structured interviews with six experienced teachers of mindfulness-based approaches were carried out and analysed using Interpretative Phenomenological Analysis.

Chapter five presents the results. The material points to the multi-faceted, complex nature of the subject.

Chapter six draws the dissertation together looking at the implications of the results; the potential application of the learning to the challenge of preparing MBCT teachers to deliver the course for multi-centre research and to the practice of training MBCT teachers more generally. The results of the investigation underline the importance of balancing the importance of formalising MBCT teacher competency alongside awareness of the complexity and subtlety of the teaching process.

Introduction

I currently work as Director of Training within the North Wales Centre for Mindfulness Research and Practice based in the Institute of Medical and Social Care Research, University of Wales Bangor. A trained Occupational Therapist and Counsellor, my work has been in the mental health field and has involved short and long term individual and therapeutic group work. My therapeutic work is person centered and draws on Cognitive Behavioral Therapy and Transactional Analysis. I have had an interest and personal practice in mindfulness meditation over the last 20 years.

I was working in a Community Mental Health Team in North Wales in 1995 when I heard of the work of Professor Mark Williams and his team, who were developing what later became known as Mindfulness-Based Cognitive Therapy (MBCT). This work had a great attraction to me as it drew together a strong personal engagement with mindfulness practice with my professional practice and work.

From the early research into MBCT in the North Wales area, there has been an active group of professionals who were inspired by the work and continued to develop opportunities for the research and practice of mindfulness-based approaches. In 2002, funding became available to form the North Wales Centre for Mindfulness Research and Practice (NWCMRP). I was employed within this Centre to develop training in mindfulness-based approaches and to facilitate the development of the NWCMRP as a resource and focus for the development of MBCT in the UK. MBCT is a new psychological intervention and we are currently the only organization in the UK systematically offering training and information to interested professionals in this area. The NWCMRP therefore has a sense of responsibility to develop and offer sound and ethical guidelines for good practice and developmental training for all stages and levels.

The investigation which follows has offered me the opportunity to deepen my understanding of the ways that experienced teachers of mindfulness-based approaches developed their practice and what was important to them on their journeys. My vision is that the information and understandings that result from the investigation will inform our current specific need to create ways of ensuring a level of adherence and competency in teachers engaged in MBCT research and more generally, our understandings of the ways that training paths for practitioners of mindfulness-based approaches can best be developed and delivered by the NWCMRP.

Chapter One

Review of the literature

Mindfulness and its use as an approach to alleviating difficulty

Aims of chapter one

In this chapter, mindfulness as a construct is described. The ways that mindfulness is being integrated into contemporary approaches in clinical, educational, social and business settings is commented on. The use of mindfulness in clinical settings is described in more detail. The two main mindfulness-based approaches – Mindfulness-based stress reduction (MBSR) and Mindfulness-based cognitive therapy (MBCT) are introduced and described. MBSR as an approach to promote well-being and deal with stress, illness and difficulty and the philosophies underpinning it are reviewed. The development of MBCT is introduced. This is followed by a review of the literature and the research on MBCT.

The chapter aims to offer a broad understanding of mindfulness in its own right; its use as an approach generally and mindfulness-based approaches in clinical settings in particular. This is then followed by a more in depth review of the literature on MBCT.

What is mindfulness?

Mindfulness means *'paying attention in a particular way: on purpose, in the present moment and non-judgmentally'* (Kabat-Zinn, 1996a, p.4). It has been described as a *'journey of self-development, self-discovery, learning, and healing'* (Kabat-Zinn, 1990, p.1). It is simply being aware of what is going on, as it is arising, connecting deeply and directly with this and relating to it with acceptance; a powerful act of participatory observation.

Mindfulness is a core part of a number of ancient spiritual traditions. Within the tradition of Buddhism it is part of a clear path towards understanding the origins and cessation of suffering. The construct of mindful awareness is however neither religious nor esoteric in its nature (Grossman et al., 2003). It is potentially accessible and applicable to all (Kabat-Zinn, 2003; Bishop et al., 2004).

Present-centred accepting awareness is a state of mind which most people have experienced: a moment of being truly awake and fully engaged with one's experience

without experiencing any thought-based formulations or concepts about it. For many though a fog of preoccupations and preconceptions habitually clouds the present moment much of the time.

> *'We may never be quite where we actually are, never quite touch the fullness of our possibilities. Instead we lock ourselves into a personal fiction that we already know who we are, that we know where we are and where we are going, that we know what is happening – all the while remaining enshrouded in thoughts, fantasies and impulses, mostly about the past and about the future' (Kabat-Zinn, 1994, p.xv).*

The human skill of being able to move our thought processes into past and future confers on us an important evolutionary advantage – it enables us to reflect, solve problems and analyse; to learn from the past and to apply this learning to future advantage. Likewise the skill of engaging in a complex activity such as driving a car, without needing to think about the ways of carrying out the separate components of the task, confers on us an advantage in being able to carry out a range of exceedingly complex tasks.

> *'Evolution gave us these skills long before consciousness developed'* (Segal et al., 2002a, p.158).

However, this ability to operate in 'automatic pilot' whilst advantageous in some areas of our lives can become the cause of our difficulties when applied to our thoughts and feelings. The habitual tendency for unawareness or 'automatic pilot' to dominate our mind and for our thoughts to be preoccupied by the past or future brings, for many, a host of potential health damaging risks.

> *'The goal is clear: to escape or avoid unhappiness on the one hand, and to achieve happiness on the other hand. The problem is that this drive for happiness creates rumination: patterns of thinking, feeling and behavior that are unhelpful because they simply circle round and round without producing a resolution…such ruminations can often exacerbate the situation.'(Segal et al., p.158, 2002a).*

It is an irony that the analytic skills of problem solving, which bring benefit in so many areas of our lives can actually increase our difficulties when brought to bear on our own mental and physical suffering.

In simple terms, the rationale for the integration of mindfulness into both MBSR and MBCT rests on the skill, which mindfulness confers, of enabling one to disengage from analytic thought processes; bring the awareness back to the actuality of the moment; and so open the possibility of a wiser responsiveness to the situation. The

core aim is to equip patients with ways of responding to the stress in their lives (in the case of MBSR) and depression (in the case of MBCT) that allow them to step out of those mental reactions that often worsen the stress or depression and interfere with effective problem solving (Segal et al., 2002a).

The skill of being mindful is cultivated through deliberately taking time to practise bringing awareness to one's experience in a non-judgmental manner. This practice is meditation. The individual develops through meditation practice the skill of taking the mind out of 'automatic pilot' into present-moment reality; while non-judgmental acceptance shifts the mind out of analysis and into a wider perspective. Being 'in touch' with present moment reality impacts on physical and mental health in a range of ways which are capitalised on in MBSR and MBCT as will be described in following sections describing these approaches.

In this next section mindfulness meditation practice as it is taught in mindfulness-based approaches is described. In the following section, the use of mindfulness in clinical and other contexts is reviewed.

Mindfulness meditation practice

Mindfulness meditation includes two forms of practice, termed 'formal' and 'informal'. The same process of present–centred awareness in brought to these two different contexts. Formal practice involves intentionally stepping aside from daily activities, to 'practise' the skill of simply being with the direct experiences that arise for the individual just as they are moment-by-moment (Kabat-Zinn, 1996b). These experiences can be any aspect of our direct present sensory experience - body sensations, sounds, sights, tastes, smells and the experiences in our minds and bodies of thoughts and emotions. There is no part of internal or external experience that cannot be included in mindful awareness. The awareness can be focused intentionally on very specific narrow aspects of experience to enable the concentration to develop, and can open out to embrace the broad field of awareness in any moment.

There are two main formal practices:

1. Lying, standing or sitting still and intentionally bringing awareness to chosen aspects of experience.

2. Moving practices that again centre on bringing awareness to aspects of experience (particularly body sensation) whilst deliberately moving. Movement could be walking, stretching or practices drawn from, for example, yoga, tai chi or qigong.

Informal mindfulness practice refers to conscious efforts to bring this moment-to-moment non-judgmental awareness into all aspects of one's daily life (Kabat-Zinn, 1996a). The experience of relating to what arises in an open, accepting way within the practice thus becomes a possibility in everyday life. So, what is happening during the formal practice that facilitates a change in the individual's way of being in the world?

A common formal practice, often done while sitting is to bring awareness to the sensations of the breath within the body. This sounds simple. In many ways it is. Yet commonly, the first discovery for many is how little of the time our awareness is in the present moment. The experience of most people is that the mind does not rest steadily on the breath but moves restlessly from thoughts about the past, to worries about the future, to focusing on discomforts in the body and so on. The instruction is to simply, repeatedly return the awareness to the breath. As one does this direct perception leads to understanding the ways one's mind habitually operates. Through the process of gently guiding the mind back again and again to the direct observation of the breath, or some other aspect of our experience, and bringing an attitude of kindly awareness to all that arises as one does this, one begins to see clearly the mind states that arise and how habitually one relates to them. One sees how much difficulty can be internally created without even being aware that these processes are happening (Kabat-Zinn, 1990, 1994, 1996b; Levey, 1987). We discover how much experience is beyond our awareness. Much of life can be lived on 'automatic pilot' or in 'unawareness' rather than being awake to the moment (Kabat-Zinn, 1990, 1996b). We are lost in our formulations, fantasies, memories, hopes and fears about what is going on rather than seeing the direct, immediate reality of our experience.

As one persists in practising in this way, thoughts, sensations, emotions and all that goes to make up our experience become evident. We observe them clearly with awareness and have the opportunity to see that they are events that continually arise and pass away in our consciousness. This simple realization can be very releasing

(Kabat-Zinn, 1990). If one has more of a felt sense that everything is always coming and going, one can experience things more lightly and easily. One can also see that it is the way that one relates to the coming and going that creates a lot of the difficulties that are experienced. We cling to and hold onto pleasurable experiences or yearn for experiences that we are not having right now; we push away and want to get rid of unpleasant experiences and try to avoid experiences that we do not want; we disengage and tune out in boredom from neutral experiences (Kabat-Zinn, 1990). Epstein (1998, p.109) describes his experience of this:

> *'My chronic tendency was to shrink from the unpleasant and reach for the pleasant. Mindfulness of feelings encouraged a dispassionate acceptance of both.'*

Whenever we react to our experience with attachment, aversion or boredom we will experience difficult emotional consequences such as anger, jealousy, addictions, fear, a sense of worthlessness and so on. All of these reactions and more will arise as we simply give ourselves the space to watch the breath or some other aspect of our moment-by-moment experience. This in turn gives us the opportunity to see clearly the reality of how trapped we can be by our own reactions. In enabling us to see our reactivity, the practice of mindfulness creates a space in which we can make conscious choices as to how we can best respond to whatever is arising for us, internally or in the world around us.

The formal practice creates this space more easily for us, by simplifying what we are paying attention to. We are thus creating our own laboratory in which we can more easily see what is already in the mind-body system. The insight, understandings and connections that arise in this created space of formal practice, can then be brought into the more complex world of everyday life.

> *'The value of cultivating mindfulness is not just a matter of getting more out of sunsets. When unawareness dominates the mind, all our decisions and actions are affected by it. Unawareness can keep us from being in touch with our body, its signals and messages. This in turn can create many physical problems for us'* (Kabat-Zinn, 1990, p.24-5)

A further understanding that arises for many within mindfulness practice is seeing that we are more than the content of our thoughts, our past experiences, our body sensations, our emotions and so on. All these things are not who we are.

> *'It is remarkable how liberating it feels to be able to see that your thoughts are just thoughts and that they are not 'you' or 'reality'…the simple act of recognizing your thoughts as thoughts can free you from the distorted reality they often create and allow for more clear-sightedness and a greater sense of manageability in your life'* (Kabat-Zinn, 1990, p.69-70).

This process of 'disidentifying' with our automatic self-judgments and thoughts leads us to see the 'bigger picture' beyond our own limited internal reactions. One's awareness is always wider than the content of what arises within it. Kornfield (1994, p.200) describes the discovery through meditation that we are not our experience:

> '*When we are silent and attentive we can sense directly that nothing in the world can be truly possessed by us…in the end things, people, tasks die or change or we lose them. Nothing is exempt. When we bring attention to any moment of experience, we discover that we do not possess it either. As we look we find that we neither invite our thoughts nor own them…The same is true of our feelings…Feelings arise by themselves…Our body too follows its own laws…'*

There is a key difference to be noted here between mindfulness meditation training and relaxation training. Relaxation is taught as a goal orientated technique to be used as necessary to combat stress or anxiety. Mindfulness should not be thought of as a technique but rather as a way of being which encompasses all aspects of the individual's life (Kabat-Zinn, 1996a). The practices are taught in ways which emphasise not trying to get anywhere but *'for once in our lives, allowing ourselves to be just where we are, without striving, without actually doing anything – realising that in some sense each of us is whole and complete as we are'* (Kabat-Zinn, 1999, p.234).

Mindfulness is thus cultivated as a way of discovering how to be fully with all of our experience - pleasant, unpleasant and neutral. Emotional reactivity and the full range of emotional states available to human beings are as much valid domains of meditative experience as experiences of calm and relaxation (Kabat-Zinn, 1996).

There is a paradox here which mindfulness embraces. The practice of mindfulness for many is done in the hope of arriving at different states, yet mindfulness has no goal but to simply experience what is present, moment-to moment.

> *'Almost everything we do we do for a purpose, to get something or somewhere. But in meditation this attitude can be a real obstacle. That is because meditation is different from all other human activities. Although it*

> *takes a lot of work and energy of a certain kind, ultimately meditation is a non-doing. It has no other goal other than for you to be yourself*' (Kabat-Zinn, 1990, p.7).

Mindfulness enables one to see that the best way to achieve one's goals is often to back off from striving for results and to start seeing and accepting things are they are in the present.

Grossman et al. (2003, p.4) summarise the assumptions underlying the mindfulness approach thus:

1. *Humans are ordinarily largely unaware of their moment-by-moment experience, often operating in 'automatic pilot' mode.*
2. *We are capable of developing the ability to sustain attention to mental content.*
3. *Development of this ability is gradual, progressive and requires regular practice.*
4. *Moment to moment awareness of experience will provide a richer and more vital sense of life, inasmuch as experience becomes more vivid and active mindful participation replaces unconscious reactiveness.*
5. *Such persistent, non-evaluative observation of mental content will gradually give rise to greater veridicality of perceptions.*
6. *More accurate perception of one's own mental responses to external and internal stimuli is achieved, additional information is gathered that will enhance effective action in the world and lead to a greater sense of control.*

The results, for the majority of people who practice mindfulness regularly, are lasting physical and psychological benefits. These include: an increased ability to relax, greater energy and enthusiasm for life, heightened self-confidence and an increased ability to cope more effectively with both short and long-term stressful situations (Kabat-Zinn 1990, 1996a, 1999, 2003; Santorelli, 1999; Segal, et al., 2002a).

In summary, it is an engagement in an inner work, which involves taking charge of that within ourselves, which we can influence.

> *'When we begin to pay attention and cultivate awareness, our view of the world changes and we can begin to navigate in ways that are highly adaptive, highly supportive of healing, of health, and of a healthier way of being, not only in one's own body but in the world. We do that through the choices that we make, through taking responsibility for ourselves to whatever degree is possible'* (Kabat-Zinn, 1999, p.239)

Having looked at mindfulness in its own right, the next section will discuss the ways in which the transformative potential of mindfulness is being used within contemporary approaches to facilitate change and promote health and well-being.

Mindfulness-based approaches

In recent years, the potential of mindfulness as a skill in managing illness, stress, and the challenges of life has been recognised in the West. Training in mindfulness is thus now being used and accepted in many settings where it would previously have been unheard of. These include health and social care settings, educational establishments, prisons, corporations and more (Kabat-Zinn, 1996b, 1999; Perkins, 1998; Murphy, 1995; Brown, Ryan, 2003; Roth, 1997). Mindfulness, when taught in these contexts, is offered in its own right without reference to the spiritual connections of its origins, which may set up barriers to participation. However, the core essence of the approach and the intention of finding ways of relieving difficulty are the same.

There has been a considerable amount of investigation, research and commentary into the effects of developing skills in mindfulness in a range of settings. Discussion of these would take this investigation too far from its main focus. The focus now, therefore, is on the literature on the use of mindfulness training within clinical interventions. This will be reviewed broadly before examining more specifically the literature on MBCT.

Baer (2003) in a review of mindfulness training within clinical interventions describes five clinical approaches. The first two, MBSR and MBCT are based on mindfulness. The subsequent three, Dialectical Behaviour Therapy, Acceptance and Commitment Therapy and Relapse Prevention, incorporate mindfulness into their treatment programmes rather than being based on it. To ensure this investigation remains focused on MBCT and it's roots in MBSR, these two will be considered in far greater depth than the other three approaches.

Mindfulness-Based Stress Reduction (MBSR)

> *'Mindfulness is a universal human capacity, a way of paying attention to the present moment unfolding of experience that can be cultivated, sustained and integrated into everyday life through in depth inquiry, fuelled by the ongoing discipline of meditation practice. Its central aim is the relief of suffering and the uncovering of our essential nature. Mindfulness-Based Stress Reduction, developed at the University of Massachusetts Medical School, is an expression of mindfulness tailored to health and well being in our contemporary society.'* (Santorelli, 2003, p.1).

MBSR is a group-based programme developed by Kabat-Zinn and colleagues at the University of Massachusetts Medical Centre, Centre for Mindfulness (CFM) for populations with a wide range of physical and mental health problems. Here the ancient practice of mindfulness, adapted from its use as a spiritual practice, is rendered into an accessible form relevant to the difficulties faced by patients suffering from a variety of physical and psychological illnesses. The training is not tailored to any particular diagnosis. Patients attend eight weekly 2.5 -hour sessions, a day long silent intensive mindfulness practice session after session 6 and they also practise mindfulness meditation for 45 minutes daily at home. There are three core formal practices taught in the class – the body scan, the sitting meditation and moving meditations. The programme thus involves intensive training in mindfulness meditation together with discussion on stress and life skills. The central aim is to systematically develop the skill of being present with internal experience (body sensation, thoughts, and mood) and with external experience (interactions with others, actions in the world) and the interplay between these two (Kabat-Zinn, 1996b, 1999).

MBSR has been widely researched and the evidence base is rapidly growing. There is not space here to review this work, but a brief overview is given to demonstrate the extent and range of MBSR research. The effects of the programme were researched in the 1990's, largely through the work of Kabat-Zinn and colleagues. This work investigated the effects of MBSR in treating anxiety and panic disorders (Kabat-Zinn et al., 1992; Miller et al., 1995) (there was no clear distinction made between types of anxiety), psoriasis (Kabat-Zinn et al., 1998), fibromyalgia (Kaplan, et al., 1993) and chronic pain (Kabat-Zinn et al., 1987), all with large and significant overall improvements in physical and psychological status. Since this early research there has been a strong surge of developments evaluating the effects of MBSR in a range of settings, including cancer patients (Carlson et al., 2003; Saxe et al., 2001; Carlson et

al., 2004; Herbert et al, 2001; Shapiro et al. 2003); low income bilingual populations (Roth, 1997; Roth et al., 2004); fibromyalgia (Sephton et al., 2001; Tiefenthaler et al., 2002) and with healthy student and other general populations (Reibel et al., 2001; Astin 1997; Shapiro et al., 1998; Rosenweig et al., 2003; Davidson et al., 2003). This work has all indicated significant positive effects of using MBSR in these wide ranging settings.

In broad terms, the research on MBSR to date has been descriptive of effect rather than investigative of mechanisms of action or analytic of particular effects on target diagnostic areas. Although MBSR was originally developed as a generic intervention it is now being used and researched with specific client groups and disorders. In some cases specific forms of MBSR adapted to particular applications are being created. Given the level and depth of the MBSR developments in the USA, the approach is now considered to be one of the main stream psycho-social treatments and has entered the medical school curriculum.

As Baer (2003) suggests, the current evidence base for MBSR is compelling but there are some methodological flaws and many gaps in this early stage in the investigative process. Grossman et al. came to similar conclusions in a meta-analysis of MBSR.

> *'Only large scale and sound research in the future will be able to bridge this schism between methodological deficiencies, on the one hand, and the potential promises of mindfulness training, on the other, as consistently revealed by a number of positive studies'* (Baer, 2003, p.14).

Mindfulness-Based Cognitive Therapy (MBCT)

MBCT has developed from the generic group-based MBSR programme and uses the same meditation structure and practices. It also is a group intervention, in which participants learn the practice of mindfulness meditation in eight 2 -hour sessions and a schedule of daily home practice with tapes. Unlike the original generic aim of MBSR, MBCT was designed specifically to train recovered. recurrently depressed people to disengage from depressogenic thought patterns believed to mediate relapse and recurrence (Ma, Teasdale, 2002). In the case of depression, the mindfulness component of the course is targeted at enabling participants to notice warning signs of

relapse earlier; to employ attention in ways that starve the self perpetuating, relapse-related thought-affect cycles; and to decentre from negative thoughts. MBCT has the potential also to be of benefit to people with other diagnoses, but the developers' intention is that the approach is used in a targeted way with groups of individuals with the same problem focus.

The goal of the training is to increase patients' awareness of present, moment-to moment experience by extensive practice in learning to keep attention on the present, focusing on the breath and bodily sensations as 'anchors'. These practices when used at times of potential relapse help prevent the cycles of rumination that can initiate, intensify and prolong depression (Williams et al., 1999).

The key ways in which MBCT differs from MBSR are as follows:

- MBCT puts a greater emphasis on working with and understanding the psychological and cognitive aspects of our experience.
- MBCT is taught within a cognitive framework and understanding. It integrates the dynamic, 'in-the-moment-responding' aspect of mindfulness with a clear understanding of the origins and maintenance factors of the psychopathology being dealt with. This understanding is shared with the participants so that both the instructor and the participant know why they are doing what they are doing.
- MBCT includes techniques and exercises from cognitive behavioural therapy (CBT). For example, in session seven of the MBCT programme when working with participants who have recurrent depression, there are clear instructions given for ways of taking action when relapse threatens. There is strong research support in the cognitive therapy literature for this recommendation (Beck et al., 1979; Marlatt, 1985; Williams 1984, 1997).
- MBCT introduces a fourth main practice into the programme: the 'breathing space'. This is a three-minute practice, which is intended to act as a bridge between the formal practice and the informal integration of mindfulness into daily life.
- MBCT has didactic elements, which give the participants information about the particular difficulty they are dealing with. In the case of depression,

participants are given information on the universal characteristics of depression to facilitate them in recognising their relapse signatures (Segal et al. 2002). There are also clear, explicit links made between the learning arising in the practices and their relevance to the target problem(s), which is woven, into the dialogue between the leader and the group participants.

MBSR was originally focused more around the application of mindfulness skills to stress. The programme gives information about stress and investigates with the participants, unhealthy and healthy reactions to stress. There are sessions that address life skills such as communication, self care, health and dietary choices and 'nourishment' in the broadest sense of the word (Kabat-Zinn, 1990).

A more in depth description of the content, structure and teaching methods of the MBCT programme is given in the next chapter.

Other clinical approaches that use mindfulness

Having reviewed MBSR and MBCT, the further three main clinical approaches that use mindfulness within their treatment strategy are now summarised.

Dialectical Behaviour Therapy (DBT) is a multifaceted approach to the treatment of borderline personality disorder developed by Linehan, (1993a, 1993b). Mindfulness skills are taught in DBT to enable patients to make a bridge between and to synthesise two apparently dialectically opposed areas of significance – acceptance of their current difficulties and the development of skills to change.

Acceptance and Commitment Therapy (ACT) is an approach which teaches participants skills which are consistent with the core skills (detailed below) developed in mindfulness training (Hayes, Strosahl and Wilson, 1999).

Relapse Prevention is a cognitive-behavioural approach designed to prevent relapses in individuals treated for substance abuse. Mindfulness is used as a technique for coping with urges to use substances (Marlatt and Gordan, 1985).

The clinical relevance of mindfulness skills

The Baer (2003) review usefully summarises the ways in which the developers of the clinical treatments that utilise mindfulness, have suggested that mindfulness skills can lead to symptom reduction and behaviour change. These areas that overlap considerably, are as follows:

Exposure: the practice of mindfulness skills can lead to the ability to experience pain (or other forms of suffering such as depressive thinking patterns) without excessive emotional reactivity (Teasdale, 1999). This enables the individual to become more tolerant of difficulty and distress of both a physical and emotional origin.

Cognitive Change: developing a mindful perspective on one's thoughts leads to the ability to see thoughts as 'just thoughts' rather than a reflection of reality or truth. As with exposure, this enables the individual to be less inclined to reactivity to the thinking processes (Teasdale, 1999a). Even if the difficulties are not reduced, suffering and distress may be alleviated through this altered stance to the difficulty.

Self-Management: improved self-noticing leads to the individual being enabled to make more informed, wiser behavioural choices. Within MBCT this skill is particularly targeted at enabling the participant to see, and wisely respond to, potential depressive relapse signatures (Segal et al., 2002a).

Relaxation: evidence suggests that although it is explicitly not a goal (the emphasis being on non-judgemental acceptance of present reality), physical relaxation is a common consequence of mindfulness training (Kabat-Zinn, 1992, 1996b).

Acceptance: the core attitude of acceptance within mindfulness encourages the individual to be with their experience as it is in the present moment. This prevents the development of aversion to the unwanted and clinging to the wanted. The aversion and the wanting create extra layers of complication, stress, suffering and difficulty, thus making the possibility of change less likely (Marlatt, 1984). As referred to

previously, mindfulness enables the individual to see how much difficulty can be internally created without even being aware that these processes are happening. Mindfulness-based approaches are, for this reason, particularly appropriate for people experiencing chronic illness. The condition may not change but their approach to it may.

Having overviewed the wider use of mindfulness in clinical approaches this review will now move to a more specific exploration of the literature on MBCT.

The evidence base for MBCT

The initial Randomised Control Trial

MBCT is a new theoretically driven mindfulness-based intervention that was first researched using a Randomised Controlled Trial (RCT) over three sites. Statistically significant effects in reducing relapse into depression over the twelve months after the intervention were observed when compared to the control group who received treatment as usual (Teasdale et al., 2000).

The key results of this initial RCT were as follows:

- For patients who had suffered three or more episodes of depression the treatment approximately halved the rate of relapse over the following year as compared with the control group.
- For patients who had suffered only two previous episodes of depression, there was no significant difference in the rates of relapse between treated and non-treated patients.
- The course of MBCT treatment cost £120 per participant compared to £375 for a course of individual cognitive therapy (Williams et al., 1999).

This initial evaluation was primarily interested in answering the question:

> *'Does this intervention when offered in addition to treatment as usual reduce rates of relapse and recurrence* [in depression] *compared to treatment as usual alone?'*(Teasdale et al., 2000, p. 617).

The results show that there was a statistically significant preventive effect achieved for participants with three or more episodes but no effect for participants with only two previous episodes of depression. The literature on the substantive significance of these findings links the literature on patterns of thinking in people with and without a

history of major depression to the theoretical underpinnings of MBCT. A review of this information is now given.

Patterns of thinking in those with a history of three or more episodes of depression

The processes mediating relapse and recurrence appear to become increasingly autonomous as the individual experiences more episodes – less environmental stress is required to provoke an episode of depression. Increasing vulnerability to relapse and recurrence of depression arises from repeated association between depressed mood and patterns of negative, self-devaluative, hopeless thinking during episodes of major depression, leading to changes at both cognitive and neuronal levels (Teasdale et al., 2000; Segal et al., 2002a). This association means that lowered mood can reactivate depressogenic thinking. The authors suggest that the link between negative thoughts and negative mood remains unseen during remission but is ready to be reactivated. People who have been depressed do not evidence dysfunctional thought patterns while they are recovered (Segal et al., 1999), but they do retain a vulnerability to future relapse through this tendency to be easily switched by a mild low mood into a strong sense of inadequacy. This then leads to ruminative thinking and dwelling on the problem, driven by the desire to resolve their difficulty, which in turn keeps the depressive cycle in place. This means that sustaining recovery from depression depends on learning how to keep episodes of lowered mood from spiralling out of control (Segal et al., 2002a).

The ways that MBCT achieves these effects

Teasdale et al. (2000) assert that the prophylactic effects of MBCT arise specifically from disruption of the processes described above at times of potential relapse and recurrence. Through MBCT participants learn to decentre from their thought processes. They learn:

> *'First to be more aware of negative thoughts and feelings at times of potential relapse and second to respond to those thoughts and feelings in ways that allow them to disengage from ruminative depressive processing'* (Teasdale at al., 2000, p.616).

The mechanisms by which MBCT may work have been explained within a theoretical cognitive framework called Interacting Cognitive Subsystems (ICS) (Teasdale,

1999b; Teasdale et al., 1995; Teasdale and Barnard, 1993). The model suggests that two important ways of reducing the potential for depressive interlock (self perpetuating body and thought based feedback loops) are breaking negative feedback from the body and interrupting ruminative cycles (Teasdale, 1999; Mason, Hargreaves, 2001). Teasdale (1999) suggests that mindfulness and relapse-related mind states are incompatible. By allocating cognitive resources to the former, the latter are unable to develop. Furthermore, in shifting into a mindful mode of being, which involves both acceptance and paying attention to the actuality of the present moment experience, the individual accesses the possibility of new learning, rather than only seeing what is already believed to be true.

Teasdale (1999a) developed this exploration further by making a distinction between metacognitive knowledge (knowing that thoughts are not always accurate) and metacognitive insight (experiencing thoughts as events in the field of awareness). He suggests that the practice of mindfulness develops metacognitive insight, which has more potency in terms of enabling a skilful disengagement from depressogenic thinking.

Further evidence that MBCT effects changes in cognitive processes comes through a study on a subset of the participants from Teasdale et al. (2000). Here Williams et al. (2000) found that those who had completed a course of MBCT produced fewer general memories and more specific memories when asked to recall specific events from their past in response to cue words. Mindfulness training, Williams et al. (2000) speculate, may modify the overgeneral autobiographical memory, which is present in individuals who have experienced depression (Kuyken, Brewin, 1995). The ability to access specific memories leads to improved problem solving capacity.

Subsequent investigations into MBCT

Segal et al. (2002a), who developed MBCT and conducted the first RCT, acknowledge that there are many unanswered questions arising from this early work. The answer to their primary question was an affirmation that in this trial MBCT was of benefit in reducing relapse and recurrence of depression. Unanswered questions include:

- Are the benefits of MBCT attributable to the specific skills taught by the programme or to non-specific factors such as therapeutic attention and group participation? (Teasdale et al., 2000)
- Is MBCT equivalent or superior to another treatment in preventing depressive relapse? (Baer, 2003)
- Are the results replicable in MBCT classes taught by instructors who did not develop the programme? (Teasdale et al., 2000)
- What are the particularities of the mechanisms by which MBCT has a differential effect for people who have experienced three or more episodes of depression and those who have had fewer episodes? (Ma, Teasdale, 2002).
- Are the benefits of MBCT specific to the prevention of relapse in depression or is the approach applicable to other clinical situations? (Soulsby et al., 2002)

Several threads of investigation have emerged following completion of this original RCT.

1. Further exploration of the potential of MBCT in reduction of depression in remitted, recurrently depressed patients.
2. Explorations of the effects and potential of MBCT with other patient populations.
3. Qualitative investigations of participants in MBCT programmes that have taken place in conjunction with quantitative investigations in the above areas. These investigate the ways in which patients experience the effects of MBCT and the mechanisms by which these occur.

These three areas are now detailed.

- **Further exploration into the potential of MBCT in reduction of relapse/recurrence in depression**

A further RCT has been conducted (Ma, Teasdale, 2002) to determine whether the results observed by Teasdale et al. (2000) for individuals with three or more episodes of depression could be replicated and to investigate questions arising from the differential effect observed in patients with only two episodes of depression.

> *'This study replicated both the positive and negative outcome finding of Teasdale et al's (2000) clinical trial. In a group of recovered recurrently depressed patients with three of more episode of major depression, MBCT*

> *more than halved relapse/recurrence rates compared to patients who continued with treatments as usual'* (Ma, Teasdale, 2002, p.24).

The finding that there was no evidence of benefit to patients with two previous episodes of depression was also replicated. Patients in the latter group showed a statistically non-significant greater tendency to relapse following MBCT than patients receiving treatment as usual in both trials. MBCT may therefore be contra-indicated for this group – more research is needed in this area. The trial explored some significant aspects of this differential relapse prevention effect. MBCT is most effective in preventing relapse that is unrelated to current major life difficulty. This is consistent with the mindfulness intervention causing a disruption of autonomous, relapse-related ruminative processes. These processes are reactivated by low mood at times of potential relapse (Ma, Teasdale, 2002). The findings indicate that the two groups of patients had different pathways to depression:

1. The group with two episodes had normal childhood experience followed by difficult major life events that were then followed by depressive episodes.
2. The group with three or more episodes had difficult childhood experience and earlier onset of depression.

As with the original study, this trial lacked another group intervention comparison. In order to assess whether it is the specific factors of MBCT that creates the observed effect, this needs also to be researched.

- **Explorations of the effects and potential of MBCT with other patient populations**

    1. *The application of MBCT within a generic mental health setting*

An evaluation has taken place of MBCT used within a generic mental health setting – an unpublished quantitative and qualitative study 'Further evaluation of Mindfulness-Based Cognitive Therapy' (Soulsby et al., 2002).

This preliminary pilot study conducted by Soulsby et al. (2002) gave support to investigating further the application of MBCT to a population of community mental health team (CMHT) clients with current mental health problems.

> *'Important and significant changes were observed, comparable with the degree of change that is seen in other studies with this type of client.'* (Soulsby et al., 2002, p.8).

Importantly, the trial was investigating treatment for existing difficulty, rather than prevention as in earlier trials (Teasdale et al., 2000; Ma, Teasdale, 2002), and so was investigating potential applications outside of the context for which MBCT was designed.

This trial opens the way to investigation of many other questions. When using MBCT with people experiencing current mental ill health there are a number of areas of questioning:

- For which mental health problems is MBCT relevant?
- How can clinicians measure readiness of clients to engage in MBCT?
- What assessment and orientation process needs to take place with these clients?
- For which clients is MBCT possibly contraindicated? (There is some evidence that MBCT may be contraindicated for those with a history of two or less episodes of depression (Ma, Teasdale, 2002)).
- What safety concerns should there be and what levels of extra support need to be provided to enable the clients with current mental ill health to stay with the process of the intervention?
- What factors contribute to the attrition rate? The pilot study (Soulsby et al., 2002) identified variable rates of attrition from 20% – 57%.

2. The application of MBCT to patients with Chronic Fatigue Syndrome (CFS).

Research on the effectiveness of MBCT as a group treatment for patients with CFS is significant (Roberts, Surawy, 2002*).* The patient group found mindfulness an acceptable approach; it had a positive effect on personal goals, anxiety and fatigue. It is hypothesised that MBCT has its effects here through increasing understanding of the links between fatigue, bodily tension, emotion and thinking. Interestingly, there was no measurable change in the physical functioning of the patients. This is consistent with the view that mindfulness is an effective approach in enabling people to cope better with an existing difficulty rather than actually effecting changes on the difficulty itself.

3. The application of MBCT to patients with a cancer diagnosis.

Research is currently in progress investigating the effects of MBCT with patients with an oncology diagnosis and their carers. The results of this work are not yet available. However, illustrative evidence derived through discussion with the participants in the courses indicates that they find the approach acceptable and that they derive benefit. Typical outcomes described by participants are: improved sleep, feeling more relaxed, feeling more confident about the future, feeling more positive, experiencing more energy, enjoying things more and knowing what to do to handle the 'bad' times (Bartley, 2003, p.1).

- **Qualitative Studies on MBCT**

The three qualitative studies, on the use of MBCT (Mason, Hargreaves, 2001; Ma, 2002; Soulsby et al., 2002) seem of particular value in capturing some of the subtleties of this approach. The diversity of experiences of individuals within the same group is described and the benefit that is perceived by the participant but unable to be measured by hard data is articulated.

Ma (2002) undertook qualitative research with a subset of 30 participants in the second MBCT RCT. This work yielded some further useful information pointing to the complexities of this work:

> *'Directions of change could be quite different in subjects…Changes brought about by the treatment involved an intricate pattern of multiple pathways'* (Ma, 2002, p.25)

Soulsby et al. (2000) undertook qualitative research with three participants of the generic mental health team pilot study on MBCT:

> *'Change was shown to have been effected by: increasing levels of mental awareness and focus, and physical relaxation; gaining ability to take 'time out', and accept what cannot be changed; reduction of ruminative thought patterns, increased awareness of choices and sense of control. Group support during the treatment was seen as an advantage'* (Soulsby et al., 2000).

Anecdotal evidence from the researchers who interviewed participants in the first MBCT RCT indicated that the patients who did relapse in the year following training in MBCT experienced their depression quite differently than they had done before the training. The depression was perceived as part of the tapestry of their life rather than a

major setback and recovery was often quicker (Soulsby et al., 2000). Important information like this can only be fully elicited by qualitative evaluation that was not included in this RCT.

In summary of this section on the subsequent investigations into MBCT, the evidence base on MBCT is in its early developmental stages. Results though, show significant effect sizes and there are therefore many areas of potential fruitful future investigation. The next section explores the possible clinical implications of this research evidence on future work with MBCT.

Implications for clinical practice

MBCT and the prevention of depression

It is increasingly recognised that major depression is often a recurrent lifelong disorder and that, following recovery from an initial episode, future relapse and recurrence is the norm (Teasdale, 1999). The risk for repeated episodes exceeds 80% in those with a history of three or more episodes (Teasdale et al., 2000). The more depressive episodes the individual has the greater is the likelihood of further relapse. Service providers are therefore faced with an ongoing management problem. The increasing current emphasis in mental health services is however on provision for patients with acute severe mental illness.

There have been enormous developments in the last 50 years in treating depression both through antidepressants and through increasingly effective psychological treatments such as CBT. However, as treatments for current depression demonstrated their efficacy, research has shown that a major contributor to prevalence rates is the return of depression in people who have already experienced it (Segal et al., 2002a).

Although it tends not to be high priority in service delivery terms, given the scale of the problem of treating and managing depression, coming to more informed ways of preventing future episodes of depression would seem an important clinical and financial priority. In practice, the main preventative strategy that is used is the ongoing prescription of antidepressant medication beyond the acute phase. This is effective for many people. There are however, many others who cannot tolerate the

side effects, choose not to be dependent on medication or are medically unable to take medication, for example because of pregnancy or because they are undergoing surgery (Segal et al., 2002a). There has thus been a recent emphasis in research, both on the aspect of depression as a chronic, relapsing condition (Keller et al., 1983; Thase et al., 1995) and on psychotherapeutic treatments that have prophylactic effects. Much of this work has focused on developing theoretical models to clarify which skills depressed patients ought to be taught to prevent relapse.

There is evidence that CBT for depression delivered during an episode of depression offers greater long-term protection from future relapse than those who recover with pharmacotherapy alone (Teasdale, 1999). Patients presumably benefit because through the CBT they acquire skills, or changes in thinking patterns that confer some degree of protection against future onsets (Teasdale et al., 2000). There is also encouraging evidence for combining pharmacotherapy for the acute episode with psychological prophylactic interventions (in this instance CBT) administered following recovery (Fava et al., 1994, 1996, 1998 reviewed by Teasdale et al., 2000). This strategy offers for service providers the possibility of:

1. Capitalising on the cost-efficiency of antidepressant medication to reduce acute symptomatology.
2. Avoiding the need for patients to remain indefinitely on maintenance medication to reduce future relapse and recurrence. (Teasdale et al., 2000)

There are however the funding challenges of delivering CBT which is an expensive and time consuming one-to-one treatment to patients who are currently well and therefore not a priority in terms of service delivery.

MBCT increases the potential cost-efficiency of this strategy by offering the treatment to groups rather than individual recovered depressed patients. The cost of a course of MBCT treatment is approximately a third that of the cost of a course of CBT for a patient in remission from depression (Teasdale et al., 2000). Generally, the treatment also confers on the individual the advantage of immediate, tangible benefit in everyday life in terms of increased well-being.

In summary therefore, the potential financial and clinical appeal of MBCT to service providers as a strategy for reducing possible relapse and recurrence of depression is

high. There is research support for its efficacy with the more chronically affected patients who tend to be the greater users of resources. The cost of the treatment is relatively low. Service providers would need to change the current exclusive emphasis on provision of a service to those experiencing a current depressive episode towards services that also aimed at reducing future relapses.

MBCT and its use with other patient populations

- MBCT in a generic acute mental health setting

There is preliminary evidence that MBCT delivered to a population of clients referred to CMHT's with current and chronic mental illness brings about reduction of symptoms of depression, anxiety and global distress (Soulsby et al., 2002). This is of particular potential interest to service providers as this is a population who are actively presenting themselves to the services. The results suggest that:

> *'as well as preventing the recurrence of major depression, as has been proved in two recent randomised controlled trials, MBCT can also be used to treat symptoms of current acute emotional disorders, including depression and anxiety, in the typical range of psychological disorders seen within a CMHT'*(Soulsby et al.,2002,p.1).

For service providers this pilot study (Soulsby et al., 2002) is of interest as it provides evidence of significant benefit at a relatively low cost. The likely alternative in most mental health teams would be one-to one therapy.

The results from this pilot indicate a fruitful area for future exploration in the form of a larger randomised trial of MBCT in the acute mental health setting. As will be discussed in forthcoming chapters this is the intended next area of research focus of the North Wales Centre for Mindfulness Research and Practice (NWCMRP) and this dissertation is a part of the preparation towards this research.

- MBCT with chronic fatigue patients

The work on the application of MBCT to chronic fatigue patients is again of interest to service providers from a clinical and financial view point. The results indicate significant areas of change in clients. Furthermore, the clients for the trial were drawn

from the waiting list for cognitive therapy. Follow-up suggested that service use by these patients was lower than for those who had not received MBCT treatment.

- MBCT with oncology patients and their carers

Many of the oncology patients and their carers who have taken part in MBCT training have reported on its helpfulness to them. Clinicians in the department are encouraged by the early results of this pilot work in terms of acceptability and feasibility.

- MBCT for stress reduction

The eight-week MBCT courses that take place within the University of Wales Bangor are open to the general public. To meet the need of this general population the NWCMRP has developed a version of MBCT that is applicable to stress reduction. This incorporates the curriculum within the MBSR programme on understanding stress reactivity and stress response within the MBCT structure and adapts the focus on depression to a focus on working with life stress and difficulty more generally.

In summary of this section, as the review above indicates, although MBCT is in its infancy, there is considerable evidence-based support for its use with a range of potential clinical applications. Practitioners and researchers of the approach have a strong sense of its potential benefit and applicability in a range of settings. These 'on the ground' observations and understandings need empirical testing with further research. There are many potential areas of investigation, including: further exploration of its effect on depressive relapse; on patients with the spectrum of anxiety disorders; on chronic physical conditions; with young and elderly patients; and generic applications within the primary care setting. However, the development of mindfulness training within clinical settings is relatively new (25 years in the USA and 10 years in the UK) and much work still needs to be done to investigate its potential:

> *'Given the potential benefits and increasing popularity of mindfulness training, it seems critically important to conduct more methodologically sound, empirical evaluations of the effects of mindfulness interventions for a range of problems'* (Baer, 2003, p.140).

There are however, significant challenges faced by researchers of MBCT, which will be briefly addressed in the final section of this chapter.

Preparing professionals in clinical practice to teach MBCT

How widely MBCT comes to be used in current clinical practice rests partly on the availability of skilled teachers to deliver MBCT. The particularities of mindfulness as an approach bring a number of complexities in terms of the training and development of teachers and of assessing their readiness to deliver MBCT. Grossman (2003) describes that many mindfulness studies suffer from a range of methodological deficiencies. These flaws include insufficient information or consideration being given to therapist adherence to the intervention programme and evaluation of therapist training and competence. This area is the focus of this investigation and will be introduced in the next chapters.

The challenges inherent in evaluating mindfulness-based approaches

As has been described above, there is encouraging preliminary evidence on the use of MBCT in a variety of settings. Notes of caution were expressed by Teasdale et al., (2003) and Kabat-Zinn (2003) in their commentary on Baer (2003). The risk is articulated that the rise in interest in mindfulness as a clinical approach will lead to it being seen as a technique, that can be applied generically without a full understanding of the problems being treated or of the particular mindfulness related contribution to change (Teasdale et al., 2003).

> *'It becomes critically important that… mindfulness is not simply seized upon as the next promising behavioural technique or exercise, decontextualised, and "plugged" into a behaviourist paradigm with the aim of driving desirable change, or of fixing what is broken'* (Kabat-Zinn 2003, p.145).

Baer (2003) states that the studies on both MBSR and MBCT enable them to be considered to meet the designation of 'probably efficacious treatments', but that more work would need to be done to bring them to be designated as 'well established treatments' (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). For this, in the case of MBCT, additional studies would be required confirming or otherwise the existing findings (an RCT replicating this original result has now been completed as described above (Ma, 2002)) or showing

MBCT to be equivalent, inferior or superior to other treatments in preventing depressive relapse.

A number of authors (Baer, 2003; Kabat-Zinn, 2000; 2003; Teasdale et al., 2003) describe the difficulties inherent in evaluating mindfulness-based approaches. In developing methodologically rigorous investigations of the effects of mindfulness training, important elements of the effects of mindfulness that are hard or impossible to measure and quantify may be overlooked. Kabat-Zinn (2000) describes how the practice of mindfulness develops the qualities of awareness, insight, wisdom, and compassion. All these are qualities that people appreciate and value but are hard to evaluate empirically. Kabat-Zinn (2003, p.145) concurs with the view that the scientific study of mindfulness and its clinical utility to date *'suffers from a range of methodological problems'*. He highlights that this field is in its infancy and that the first generation of studies has focused on being *'descriptive of phenomena rather than definitive demonstrations of efficacy'* (2003, p.145). This latter is work that needs to be engaged in having now tentatively confirmed the potential value of this new approach and field.

> *'Only large-scale and sound research in the future will be able to bridge this schism between methodological deficiencies on the one hand and the potential promises of mindfulness training on the other; as consistently revealed by a number of positive studies'* (Grossman et al, 2003, p. 14).

It is important that mindfulness-based approaches in clinical settings are put under this rigorous scrutiny. This needs to be carried out in ways which meet the challenge of using and investigating mindfulness within the clinical setting and also embrace and honour the very qualities which, though intangible and hard to quantify, are core to the transformative potential of this way of being.

> *'In encountering the consciousness disciplines and the question of their possible adaptation and application in secular clinical or medical contexts, it is critically important to treat mindfulness and the traditions that have articulated it much as a respectful anthropologist would treat an encounter with an indigenous culture'* (Kabat-Zinn, 2003, p.146)

A very significant part of this process is that of finding ways to establish criteria for competent teaching of MBCT which are congruent with the core principles of the approach and which also satisfy necessary research rigour. This area of questioning is core to the investigation engaged in through this dissertation.

Summary of chapter one

In this chapter the author introduces mindfulness and mindfulness-based approaches. A broad view of the ways in which mindfulness is being applied and adapted to a wide range of contemporary settings is summarised. The use of mindfulness in clinical settings is reviewed in more detail. Five established treatments that use mindfulness are discussed. More detailed consideration is given to the two of these clinical approaches, MBSR and MBCT, which are based on mindfulness rather than mindfulness being one element within the approach. MBCT developed from MBSR, so the latter is discussed and described to enable the background and context for MBCT to be seen. The literature and research on MBCT is reviewed, the clinical applications of it discussed and the potential view on the use of the approach by service providers is explored. The challenges inherent in researching mindfulness are briefly considered.

Chapter Two

Review of the literature

Mindfulness-Based Cognitive Therapy:

development, content and teaching requirements

Aims of chapter two

In chapter two, an historical review of the development of the teaching of mindfulness-based cognitive therapy (MBCT) is given. This is approached by first describing the development of mindfulness-based stress reduction (MBSR) from which MBCT originated and then describing MBCT itself. The content and structure of an MBCT course is described. This is followed by a description of the particularities, the methods and the attitudinal qualities core to the teaching of MBCT. The chapter aims to provide a review of the content, teaching, subtleties and complexities of delivering MBCT as an approach.

Historical review of MBCT

The development of MBSR

As described previously, MBCT evolved directly from MBSR. The work of the Stress Reduction Clinic (later known as the Centre for Mindfulness in Medicine, Health Care and Society (CFM)) where MBSR was developed began in 1979. This was an outpatient clinic in a large medical centre in Massachusetts in the USA. Here Jon Kabat-Zinn began the work of developing an eight-week programme, first known as the Stress Reduction and Relaxation Program and later termed MBSR. The programme involves intensive training in formal and informal mindfulness practice and their applications to everyday life, pain, stress and illness.

MBSR forms a part of a newly recognised field of integrative medicine within behavioural medicine and general health care. It was designed to:

> *'catch people falling through the cracks in the health care system (more accurately, a disease care system) and challenge them to see if they might not do something for themselves as a complement to... the more traditional medical approaches'* (Kabat-Zinn, 1999, p.1).

The CFM has been continuously delivering MBSR to patients within a large traditional American hospital for over 20 years. By 1999 over 10,000 patients had completed the programme (Kabat-Zinn, 1999). They have extended the teaching of MBSR into prisons, into poor inner-city areas, to medical students, and into corporate settings.

The clinical work of the CFM has throughout been rigorously scrutinised by a programme of research, which has played a significant part in bringing the work into

the mainstream. A range of training paths for professionals who want to bring mindfulness-based approaches into their work has also been developed (see Appendix 1 for a summary of these).

The intention from the beginning was that the work of the clinic would serve as a model for other medical centres, hospitals and clinics in the USA and other countries (Kabat-Zinn, 1999). Their work has indeed sown seeds throughout the USA (there are 240 centres in the USA offering MBSR programs (Kabat-Zinn, 1999)), and also throughout the world. The work of the CFM has been significant in the increasing development and recognition of mindfulness-based approaches in a wide range of approaches and settings.

Kabat-Zinn is both a meditator and a scientist (he has a PhD in molecular biology). He spoke in an interview, of the way in which MBSR evolved out of his very personal search for a bridge between art and science:

> *'I felt that we could make use of meditation within medicine itself, working scientifically to explore the clinical effects of meditation practice in people with chronic medical conditions and to elucidate the relationship between health and wellbeing and mind-body phenomena through the lens of mindfulness'* (Elliston, 2002, p.21)

As shall be explored in the section later in this chapter on MBCT teaching methods, the style of teaching in mindfulness-based approaches integrates a scientific investigative empirical style with creative ways that are intended to open up the participants' minds to other possibilities and ways of being with challenges.

The development of MBCT

MBCT developed through the collaborative work of John Teasdale in Cambridge, England, Mark Williams in Bangor, Wales and Zindel Segal in Toronto, Canada. They had been commissioned by the McArthur Foundation to develop a group-based intervention for the prevention of depressive relapse. Being cognitive behavioural therapists their original intention was to develop a group programme based on cognitive behavioural therapy (CBT) techniques. In their book Mindfulness-Based Cognitive Therapy for Depression (Segal et al., 2002a), the evolution of ideas as they were shaped by their discovery and engagement with the work of Kabat-Zinn and colleagues at the CFM is described.

The developmental process of MBCT as described by Segal et al. (2002a) is relevant here as it informs this investigation of the particular ways of teaching in mindfulness-based approaches.

Segal et al. (2002a) were:

> *'Interested in the theoretical and practical convergence ...* [seen] *between mindfulness and cognitive approaches: the need to notice warning signs earlier; the need to decenter from negative thoughts; the need to deploy attention in ways that would starve the self-perpetuating, relapse-related thought-affect cycles of cognitive resources'* (p.50).

Their early approach therefore was to use mindfulness within the regular cognitive therapy format, as a vehicle to teach the principles and practice of decentreing and to reduce the risk of relapse. This early version of MBCT was entitled 'Attentional Control Training'. The mindfulness/awareness components of the training were intended to:

1. Enable patients to notice when they were beginning to undergo mood swings.
2. Refocus attention, as the mindfulness practices would take up resources that would otherwise be supporting rumination.
3. Enable patients to decentre from automatic depression-linked patterns of thought.

The cognitive therapy techniques would then be targeted at enabling patients to deal with any negative thoughts and sad moods that might be reactivated.

The early pilots of Attentional Control Training raised a number of difficulties with this approach. Segal et al. (2002a) discovered that the strategy of first using the mindfulness skills as a technique to enable patients to decentre, and then reverting to cognitive techniques when thoughts and emotions arise that decentreing does not deal with, is a problematic model. They found that there was not enough space in the programme to teach the awareness skills and to employ standard cognitive therapy strategies.

> *'With a group of 10 or more patients, there never seemed to be enough time for the instructor to deal with everyone's problems.* (Segal et al., 2002a, p.53).

Segal et al. (2002a) saw within their early work on Attentional Control Training a weakening of accepted CBT principles and practice and a weakening also of the potential of mindfulness in this programme. They were employing mindfulness as a technique to train patients in a specific skill (a cognitive behavioural approach) rather

than in opening up the possibility of a complete shift to a new way of relating to experience (a mindfulness approach). The developers of MBCT then faced a crossroad, between committing more fully to the mindfulness aspect of the training or reverting to the more familiar territory of developing a cognitive approach to address depressive relapse.

On their next visit to the CFM, the developers of MBCT became more fully aware of the radically different approach to difficult thoughts and feelings that participants in MBSR were being taught. Participants were being encouraged to:

> *'Allow them to be there, to bring them to kindly awareness, to adopt toward them a more 'welcome' than a 'need to solve' stance'* (Segal et al., 2002a, p.55).

Segal et al. (2002a) witnessed that the MBSR instructors were able to go further in their work with patients with negative affect and other expressions of difficulty, than they themselves had been able to do by staying in their cognitive therapist roles.

In looking more deeply at all aspects of MBSR, the MBCT developers saw some very particular underpinnings to the work and to the way that it is delivered to the patients. Fundamentally, the MBSR programme is not teaching a set of techniques to apply to life's difficulties but a shift in the individual's relationship to their problems. The understanding that they came to through this investigation of the teaching of MBSR and witnessing the effects of this on the patients led to a radical shift in the programme they were developing. The programme, which is now called Mindfulness-Based Cognitive Therapy, became deeply grounded in the practice of mindfulness meditation with some didactic elements on depression and cognitive therapy strategies incorporated. They came to see that for depressive relapse prevention, a group CBT therapy approach alone is not as potent. Cognitive therapy:

- Is not easily delivered to a large group as the focus tends to be on detail of thought process and there is not enough time for everyone's detail;
- Is hard to deliver when the symptoms are not current;
- Does not have the core intention to bring about an overall shift in the individual's stance to their difficulties.

All these were important elements to the developers of MBCT. Their increasingly deep understanding of the potential for mindfulness in meeting what they were

looking for led them to make mindfulness the fundamental component of the training, on which the other elements were based.

The MBCT programme

This next section describes the MBCT programme. This description is divided into two sub-sections: a description first of the structure and content of the programme and second, the methods of teaching and delivery. See Appendix 10 for a week-by-week summary of the curriculum. Both these sub-sections draw on the literature and the author's own experience as a mindfulness-based teacher and trainer.

MBCT course structure

The following elements are contained within the MBCT course

- **An individual pre-course session**. This lasts up to an hour and is conducted usually by the teacher with each prospective course participant. This serves as both an orientation to the programme for the participant and an assessment of the individual's suitability for the course. It is an opportunity for the participant to hear about the background to MBCT to explore how it may help them and to understand the importance of commitment to the home practice element. It is an opportunity for the instructor to learn about the factors associated with the onset and maintenance of the problem that has brought the participant to the course and to determine through dialogue with the prospective participant whether the person is likely to benefit at this time (Segal et al., 2002a).

- **Eight weekly sessions** of 2.0 hours in duration. The first and last sessions are commonly half an hour longer to enable space to be given to the group processes of beginning and ending. Each of these sessions include at least one formal guided meditation practice, group discussion, teacher led inquiry into participant experience of mindfulness practice in the group and at home and some didactic elements.

- **A day long guided and structured silent day of mindfulness practice.** This is scheduled during the sixth week of the MBSR programme. It is not described in the Segal et al. (2002a) manual on MBCT. However, many MBCT teachers now

also incorporate this day into the programme. The day offers participants an opportunity to immerse themselves in the practice. This arises both through the continuity of the process through the day and through the silence within the group which exposes participants in a sustained way to their own experience. Many participants come to significant understandings about themselves in this day of silent practice (Kabat-Zinn 1990). A typical schedule of the day is given in Appendix 11.

MBCT course content

- **Instruction in formal mindfulness meditation methods.** There are four main practices taught in the weekly sessions of the MBCT programme, and practiced at home during the eight weeks.

    1. *Body-scan meditation*. This *'involves lying on your back and moving your mind through the different regions of your body'* (Kabat-Zinn, 1990, p.77). The intention of the practice is to enable one to establish contact with the body, whether what comes up is pleasant or unpleasant (Segal et al., 2002a). This is the first practice that participants are introduced to. It is an effective technique for developing both concentration and flexibility of attention simultaneously (Kabat-Zinn, 1990). The experience of the body-scan practice encourages an ability to pay detailed attention to body sensations. This skill is an important foundation for the whole programme. The ability to take awareness into the manifestation of a problem within the body, rather than moving into thought-based processing, is a core skill taught in MBCT (Segal et al., 2002a).
    2. *Mindful movement.* Movement practices become part of the home practice schedule in week three of the programme. These are 'meditations in motion'. *'The focus is on maintaining moment-to-moment awareness of the sensations accompanying our movements, letting go of any thoughts or feelings about the sensations themselves'* (Segal et al., 2002a, p.180). The practices taught are commonly drawn from hatha yoga postures but may also be drawn from other disciplines such as qi-gong or tai chi, depending upon the practice experience of the teacher. The practice of walking

meditation is also taught – being with each step, walking for its own sake without any destination (Segal et al., 2002a).

The movement practices are a useful vehicle for enabling participants to become more anchored into the here and now sensations within the body. *'This anchoring allows a greater sense of who we really are in the present moment'* (Segal et al., 2002a, p.181).

Movement practices are also a useful bridge between practice experience and daily life. It is easy to move into these more active practices in a doing mode. Many participants are accustomed to doing body exercises to achieve something. Just as with all mindfulness practices though: '*We are using it to be where we already are and discover where that is'* (Kabat-Zinn, 1990, p.98). Simultaneously however, the invitation is to move in close to the boundary of what feels possible for the body in each moment. *'You discover that the boundaries of how far your body can stretch or how long you hold a position are not fixed or static'* (Kabat-Zinn, 1990, p.98). For people working with chronic, illness and physical difficulty, this kind of discovery can be a means to developing a moment-by-moment openness and responsiveness to their experience rather than remaining fixed in preconceptions of what may be possible in any moment.

The experience within the movement practice of working with limits, boundaries and intense physical sensations in an accepting, present-centred way can also offer participants a useful parallel. Developing the ability to relate to the entirety of one's experience with awareness and acceptance is core to mindfulness practice. The 'felt' experience of this with physical sensations in the movement practices can enable participants to gain a sense of what may also be possible within their emotional and cognitive experience also. Participants can thus begin to open to the possibility of moving in close to emotional intensity in the same accepting, present-centred way that is encouraged in relation to movement in the movement practices.

3. *Sitting meditation.* Here participants are guided in coming to an erect and alert but relaxed posture and systematically bringing their awareness to different aspects of their experience. A typical full practice sequence

would guide participants through mindfulness of the sensations of the breath in the body; sensations throughout the body; sounds; the process of thoughts and emotions; and to move into 'choiceless awareness' in which one is aware of the process of whatever is the predominant experience in each moment. *'An essential characteristic of this practice is that the aim is not really to prevent the mind wandering but to become more intimate with how one's mind behaves'* (Segal et al., 2002a, p.168). The sitting practice offers an opportunity to witness the usual reactivity of the mind-body. Usually *'every time the mind moves the body follows*…[In sitting practice] *instead of jumping up and doing whatever the mind decides is next on the agenda we gently but firmly bring our attention back …we are practicing accepting each moment as it is without reacting to how it is'* (Kabat-Zinn, 1990. p. 64).

4. *The 3-minute breathing space.* This 'mini-meditation' is intended to enable the formal practice to be brought into daily life. There are three steps to the exercise.
    i. Step out of automatic pilot, recognise and acknowledge one's current experience;
    ii. Bring the attention to the breath;
    iii. Expand the attention using the sense of the breath and the body as a whole as an anchor, while opening to the range of experience being perceived.

    (Segal et al., 2002a)

The use and application of the breathing space is built on in a structured way through the eight-week programme. The home practice schedule for the breathing space is as follows:

> Week three: Practice the breathing space three times per day at preprogrammed times.
>
> Week four: Practice the breathing space three times per day at preprogrammed times plus as a 'coping' practice whenever unpleasant feelings are noticed.

Week five: Practice the breathing space as described for week four with an additional element to the process, that of adding a sense of 'opening to the difficult' within the breathing space.

Week six: Practice the breathing space as described for weeks four and five with an additional perspective of taking a breathing space as the 'first step' before taking a wider view of thoughts.

Week seven: Practice the breathing space three times per day at preprogrammed times in addition to using it as a 'coping plus action' practice whenever unpleasant feelings or thoughts are noticed. The aim here is to use the breathing space as a way to reconnect with an expanded awareness and then to open to the possibility of taking some considered action appropriate to the present moment.

(Segal et al., 2002a)

The breathing space is also brought into the delivery of the course by including it in the weekly sessions at appropriate times in order to bring to bear another mode or perspective (Segal et al., 2002a)

- **Instruction in developing an informal mindfulness meditation practice (mindfulness in every day life).** There are two main elements to this in the course:
    1. *Awareness of pleasant and unpleasant events.* Over weeks three and four participants are asked to fill in a calendar recording, in detail, how they experience firstly pleasant events and secondly unpleasant events. The intention is to cultivate greater awareness of the way *'a situation is classified by the mind as 'pleasant' or 'unpleasant' and the extent to which our thoughts and moods color such interpretations'* (Segal et al., 2002a, p.145).
    2. *Deliberate awareness of routine activities and events such as eating, walking, the weather, driving, and washing.* Participants are encouraged to deliberately bring awareness to routine activities from week one as part of their home practice.

- **Daily home practices of formal practice (45minutes per day) and informal practice for the duration of the course.** The contact time of the MBCT course is relatively small. The backbone of the course is the daily home practice, which consists of the formal and informal mindfulness practices and some other awareness raising exercises as described above. These are scheduled in a structured and explicit way into daily home practices. During each session the experience arising from the previous week's home practice is discussed in depth and the next weeks schedule is given at the end. Participants are given home practice tapes as required during the course.

- **Discussions between instructor and group participants within course sessions.** These discussions are largely orientated around participants' experience of practice both in the sessions and in their weekly home practice. They include exploration of obstacles, difficulties and development of self-regulatory skills and capacities.
- **Didactic elements**. Contextual information is given linking the practices to the particular difficulty that the group is working with (i.e. depression, chronic fatigue, cancer, anxiety etc.) and facilitating participants in connecting mindfulness skills to these difficulties and everyday life.

(This structure for describing the MBCT programme content is drawn and adapted from Kabat-Zinn, Santorelli, 2001).

Having described the content and structure of the MBCT programme the next section outlines the teaching and delivery methods.

MBCT teaching methods

Systematic development of mindfulness practice.

The sequences by which the formal practices are taught are laid out in detail in the MBCT curriculum (Segal et al. 2002a). They have been carefully designed to enable the individual to develop their practice in a systematic way. The practices are the bedrock on which all the other materials are hung and are taught in broadly similar ways in MBSR and in MBCT. Apart from the first session, each session begins with a long practice, so enabling participants (and the teacher) to move into the session in a more mindful way.

> *'Primary attention should be given to the cultivation of non-judgmental, non-striving, moment-to-moment attention framed within the context of a gentle yet persistent commitment to on-going daily practice. Across weekly classes, careful attention should be taken to the introduction, sequencing and systematic development of the 'formal' mindfulness practices* (Kabat-Zinn, Santorelli, 2001, p.12)

Class discussion and didactic elements

A significant amount of time each session is dedicated to exploring the participants' experiences in the formal and informal practices during the week.

> *'This requires the instructor to sharpen his/her ability to listen closely, allow space, refrain from the impulse to give advice, and instead, to inquire directly into the actuality of the participants experience'* (Kabat-Zinn, Santorelli 1999, p.16).

So, although the curriculum of the course is established, the particular trajectory of each class is inevitably different as the teacher responds to the unique texture of each moment. The skill of the teacher is in using their moment-by-moment awareness to inform choices about which ways to guide the class. At times the teacher will guide the focus very clearly to one particular aspect of experience, and at others widen it, to encourage participants minds to open to new possibilities. Mindfulness teachers will draw on the immediate experience in the class to deliver the teaching and will also bring in stories, poetry and quotations, which point to other ways of experiencing. The teacher will facilitate the group in various exercises some drawn from CBT, which enable participants to directly feel some part of experience that is the focus of reflection in that session. Within this process the teacher needs to facilitate a balance in the sessions between delivering the curriculum of the course and responding whatever arises within the group. There are thus a myriad of ways in which the skilled MBCT teacher develops the teaching process.

An important role of the teacher is to also provide a contextual framework through didactic teaching, to help participants develop an understanding of how mindfulness practice can become integral to their lives. In the case of MBCT for the prevention of relapse in depression this is particularly connected to the ways in which recurrent depression occurs and maintains itself. The participants are also given information and education on depression so that they can build a 'map' of their understanding of the 'terrain' of depression. MBCT used with other patient populations would adapt

this element of the course to be targeted at the particular problem area(s) that the group participants are working with.

Rather than lecturing to the participants the skillful MBCT teacher will weave these didactic elements into the contributions and examples of experience given by participants. Whatever feedback occurs can therefore potentially become a starting point for the teacher to bring the core teachings into the fabric of each session.

In mindfulness-based teaching this process of interweaving class discussion on immediate experiences arising for participants with didactic teaching is sometimes termed 'investigative dialogue 'or 'inquiry process.' The teaching aim is to trigger the participants' curiosity into their own experience.

This curiosity is not about the 'why?' but about the 'how?' and 'what?' of the experience. It is an encouragement to engage with the 'bare' experience. When we take away the 'extra' that we habitually add to our experience, what is left? The extra comes in the form of thoughts about our experience - the worries, the yearnings, the formulations, the fantasies and so. A train of inquiry that a mindfulness-based teacher might engage in with a participant who describes feeling sad could be as follows:

'What are the sensations in your body as you feel sad?' This would be investigated in some detail, so that participants are really encouraged to develop their ability to pay close attention to the direct, felt experience within their body.

'How are you relating to the sadness?' The invitation here is to come to notice in detail the feeling tone that we bring to our experience. Is this something I am holding on to and want more of? Is this something I want to get rid of? Is this something to which I am indifferent? Is this an experience I am simply opening to as it is? Again, this is not a cognitive analysis of one's relationship to experience but an engagement with the direct experience of this. A question the teacher might ask here is: *'What are the sensations of pushing away, holding on, tuning out or opening to?'*

'What do you notice about your thoughts, as you feel sad?' This would not be an engagement with the content of the thoughts but with the process of them. The

thought and its content would be acknowledged in the same way as a sensation in the body would be noticed - as a passing event in the field of awareness. The participant would be also be invited by the teacher to notice the interconnections between thoughts, emotions and body sensations.

The MBCT teacher would often then weave into this dialogue the understanding of the potential relationships between these observations of the individuals experience; the understandings about the ways that 'depression mind' (in the case of MBCT for depressive relapse) is triggered and perpetuates itself and the effects of bringing mindful awareness to the processes of the mind.

In these ways participants would be invited towards directly recognising the ways in which experiences such as the feeling of sadness are 'known'. They would be invited towards seeing the interconnected nature of the habitual patterns that emerge at times of changed mood – the streams of thoughts that take one into fears of the future or regrets about the past, and the patterns of reactive behaviours that perpetuate difficulties. They would maybe see the transitory nature of feelings – how the sense of sadness, which feels so all encompassing in one moment, is actually formed from a collection of body sensations and associated thoughts that shifts in each moment as one really pays attention to the components of it. They would maybe see and experience the ways in which bringing careful attentiveness to their experience in the ways that they are taught in MBCT can change the nature of that experience. Whatever they see would be a direct part of each individual's own interior experience. Consequently, the potency of the understanding would be significantly more powerful for being developed in this way (Teasdale, 1999a).

Crucially, however, the way in which the teacher engages in investigative dialogue with participants is in the spirit of pure curiosity: an interest in the ways in which experience unfolds with no goal or end point in mind. This attitude of curiosity is very much in the spirit of making the experience of bringing mindfulness to one's life into an adventure rather than one more thing that one 'has' to do for oneself to be healthy (Kabat-Zinn, 1996b).

Embodiment of the attitudinal qualities associated with mindfulness within the teaching process

The ways in which the teacher facilitates the sessions is core to the potency and authenticity of the programme. The teacher's way of teaching needs to be firmly founded on the attitudinal qualities, which are articulated and developed below. It is through the commitment of the teacher in bringing these into his/her own life and practice that these attitudes can be awakened in the hearts and minds of the participants (Kabat-Zinn, Santorelli, 1999). These attitudinal qualities are foundational to the course and are largely taught through the instructor's embodiment of them. Essentially this involves teaching through 'being' mode. Segal et al. articulate the distinction between 'doing' and 'being' mode – a crucial distinction as recognising and changing modes of mind is a key skill being taught in MBCT.

> ***'Doing mode** is entered when the mind registers discrepancies between an idea of how things are (or how things are expected to become) and an idea of how things are wished to be or how things ought to be…it is goal orientated, motivated to reduce the gap between how things are and how we would like them to be'* (Segal et al., 2002a, ps.70, 73).

> ***'Being mode** is not motivated to achieve particular goals…in the absence of a goal or standard to be reached there is no need to evaluate experience in order to reduce discrepancies between actual and desired states'* (Segal et al., 2002a, p.73)

The mindfulness teaching process challenges the teacher to operate within this being mode of non-judgmental, present-centred awareness even in the sometimes charged and intense environment of the mindfulness-based class. The teacher's actions are thus arising from openness to this moment in its fullness and indeterminacy and to a willingness to not knowing the answer. This is significantly different to potentially limiting actions on the part of the teacher that are based on previous expertise; intellectualisations of the current situation; an inner wanting to do something that would help resolve the difficulty.

> *'If the therapists themselves are not mindful as they teach, the extent to which class members can learn mindfulness will be limited.'* (Segal et al., 2002a, p.56).

> *'It is not just an issue of credibility or competence but of the teacher's ability to embody from the inside the attributes they invite participants to cultivate'* (Segal et al., 2002a, p.84).

The emphasis throughout the literature (Kabat-Zinn, 1999, 2001, 2003; Segal et al., 2002; Teasdale et al. 2003) and in all training programmes for MBSR and MBCT is on the importance of the teacher of mindfulness-based approaches being an engaged practitioner of the approach and thus being able to authentically embody it as they teach.

> *'In order for a class or for a program as a whole to have any meaning or vitality, the person who is delivering it must make every effort to embody the practice in his or her own life and teach out of personal experience and his or her own wisdom, not just in a cookbook fashion out of theory and out of the thinking mind'* (Kabat-Zinn, Santorelli, 2001, p.18).

The experience of the authors of MBCT is again interesting in this respect. Two of the three came to the development of MBCT without a daily personal mindfulness practice but they all had extensive experience of working with individuals in difficulty using a cognitive therapy framework. Their initial view was that it is unreasonable to expect potential teachers of MBCT to invest time in daily practice. CBT training is extensive and involved but does not ask the therapist to become a practitioner of the approach in their personal lives. However, as they came to understand more deeply the ways of teaching and learning within mindfulness-based approaches, they changed their position and came to see that extensive personal experience of the practice and approach is the bedrock of the teaching (Segal et al. 2002a).

Whilst developing MBCT, Segal et al. (2002a) spent much time witnessing the work of the teachers in the CFM in the States and talking with them. They address the question of whether to teach from one's own practice, by describing their experience of watching the work of the teachers of MBSR at the CFM established by Kabat-Zinn.

> *'Part of what was being conveyed was the instructor's own embodiment of mindfulness in his or her interactions with the class…. Participants learn about mindfulness in two ways; through their own practice and when the instructor him-or herself is able to embody it in the way issues are dealt with in the class… If the therapists themselves are not mindful as they teach the extent to which class members can learn mindfulness will be limited.'*(Segal et al., 2002a, p. 56)

They were discovering that it is this embodiment of the essence of mindfulness by the teacher that is the crucial catalyst for planting in others the seeds of potential change. This can only happen through a long-standing cultivation and nurturing of this

essence within the personal life of the teacher. The teaching of mindfulness becomes another aspect of the teacher's own mindfulness practice. Each moment that arises in the class is made to count by consciously holding it in non-judgmental awareness and responding to it from that place.

Mindfulness practice is not random or accidental. There are particular ways of approaching practice that are supportive of the process and are conducive to the development of certain qualities and attitudes. Together these form the 'way of being' or altered stance towards experience that has been referred to a number of times in this investigation. The mindfulness teacher is thus not teaching a set of techniques but a whole approach to life. The embodiment of the essence of this by the teacher is the primary way it is communicated in the MBSR or MBCT class situation. The experience of the teacher in working with their own thoughts and emotions in personal practice enables them to authentically embody, as they teach, the same approach to difficulties that participants are being encouraged to take. The teaching is thus approached with an assumption of continuity of experience between themselves and the patients.

> *'A working principle for MBSR teachers is that we never ask more of our patients in terms of practice than we would ask of ourselves on a daily basis. Another is that we are all students and the learning and growing are a lifelong engagement'* (Kabat-Zinn, 2003, p.150).

The next section provides an overview of the qualities and attitudes that the mindfulness teacher both brings to their own practice and is inviting within the participants of their class. The embodiment of these within the teaching process becomes the main vehicle for communicating the possibility of this way of living to participants within the MBCT class.

The following headings for these attitudinal qualities are drawn from Kabat-Zinn (1990).

- ***Acceptance***

This is very interlinked with the quality described shortly of non-striving. The alternative to being on a continual treadmill of seeking to change, resolve or fix how things are, is to develop a quality of openness to and welcoming of experience just as

it is in this moment. Kabat-Zinn describes this as a *'stance of an impartial witness to your experience'* (1990, p.33).

The Rumi poem, 'The Guest House' (see Appendix 7), is commonly read to participants in an MBCT class as a way of illustrating how one may adopt a welcoming posture to negative emotions and difficulties. Here Rumi (Coleman Barks et al., 1995) invites us to 'welcome and entertain', to 'invite in' all of our experiences. There is an encouragement here to develop equanimity to the range of our experiences. If we are able to embrace with acceptance the reality of each present moment we are better able to work with what is there with wisdom. Likewise within a mindfulness-based class, challenging issues and feelings will be brought to the sessions. As the teacher engages with an individual in the group situation and explores with him/her in an way which is fully accepting and open to the individual and their experience, the participants begin to see other possibilities, other ways of approaching experience.

The essence of mindfulness is to guide people to discover and uncover their own knowing. The teacher can only do this if s/he is willing to open, with awareness and acceptance to the way things are, to the unpredictability of the process as it unfolds and to admit to not knowing where the unfolding will lead.

The experience of being accepting and open to present experience whilst letting go of goals and urges to change and fix is essential to mindfulness. The teacher's understanding of this approach to their experience must come from the interior world of their own practice. Their ability to communicate this to participants in a class would involve other skills also, but would be fundamentally founded on this ongoing, in-depth personal process.

Bringing compassion to our experience and to the ways we deal with our experience is a central component to the quality of acceptance. For many the daily interior world of thoughts is a stream of judgments and criticisms, often directed at self. The alternative being invited in the MBCT course is to bring a kindly attitude to all of our experience – even the judgments themselves. In doing this, one is more able to release

oneself from the 'extra' we add to our experience and deal with the reality of the way things are, with acceptance and understanding.

Embodiment of acceptance involves bringing an invitational, welcoming stance to whatever arises within the sessions; working in compassionate ways with what is arising and the participants; and above all working even within the structure of the curriculum in 'being' mode.

- ***Patience***

  *'We intentionally remind ourselves that there is no need to be impatient with ourselves because we find the mind judging all the time or because we are tense, agitated or frightened…' (*Kabat-Zinn, 1990, p.34)

Mindfulness invites patience with the process of our lives, knowing that things can only emerge in their own time.

- ***Beginner's mind***

This is a mind that is willing to see everything as if for the first time, and involves the ability to bring to one's experience in each moment a freshness and vitality, which enables one to see with clarity, rather than through a fog of preconceptions. As articulated above, mindfulness invites one to bring certain qualities to experience rather than trying to change it. An attitude of curiosity, as described in the section above on class discussion, into the immediate, direct, felt experience is a key part of this process. This is also an encouragement to take an empirical, investigative style towards one's experience.

- ***Trust***

Mindfulness invites a trust and faith in one's own thoughts, feelings and intuition; a consideration that each one of us is the only expert in our own experience.

> *'It is far better to trust in your intuition and your own authority…than always look outside of yourself for guidance…in practicing mindfulness you are practicing taking responsibility for yourself and learning to listen to and trust your own being.'*(Kabat-Zinn, 1990, p.36).

MBCT offers a structure and process for enabling the participant to witness their process and a real encouragement to rely on one's own experience within this in coming to understanding.

> *'In the service of empowerment learning should be based wherever possible on participants' own experience rather than on lectures'* (Segal et al., 2002a, p.92)

For the MBCT teacher trusting the process needs to be an integral part of both personal process and the collaboration with the participants in the teaching process. When one is opening to experience in the ways invited in a mindfulness approach one will at some point encounter and need to work with fear. This also will emerge in the teaching as participants bring difficult experience and feelings to the group process. It is here again that the mindfulness practice process and experience of the teacher is crucial, for it is through practice that the individual learns and experiences other possible ways of relating to their fear. If the teacher responds to their fear in older familiar ways, rather than trusting and opening to the process, they will close off the opportunity for that participant, in that moment, to move in close to their difficulty and thereby come to know it with more wisdom and clarity. The courage of the MBCT teacher in staying and working with difficulties as they emerge in the sessions is crucial to the learning process of the participants. The MBCT developers describe the effect of the absence of this during the early ACT pilot classes. Here they acknowledge the early uncertainties they held in encouraging patients to apply attentional control and observation to emotional upheaval.

> *'In our pilot classes, any suggestions we made to participants to increase awareness of difficult issues were politely refused. We withdrew the suggestions quickly, for we had little confidence that we could deal with such difficulties using this approach.* (Segal et al., 2002a, p.52).

Part of the embodiment process by the mindfulness-based teacher is a lived sense of strong confidence in the simple power of bringing awareness to experience.

- ***Non-striving***

There is a strong emphasis within the practice and the teaching of mindfulness on bringing an attitude of willingness to allow the present to be the way it is. One is explicitly not trying to fix problems through mindfulness. Non-striving is *'having no goal other than for you to be yourself'* (Kabat-Zinn, 1990, p.37).

> ***'They* [the CFM mindfulness teachers] *encouraged participants to let go of the idea that problems might, with enough effort, be 'fixed'… the mindfulness approach was explicit about the danger that such attempts at fixing might merely reinforce a person's attitude that their problems were***

> ***the 'enemy', and that once they were eliminated then everything would be fine.'* (Segal et al., 2002a, p.60)**

Participants in an MBCT course are clearly told before embarking on the programme that the course will not directly address their problems. Rather it will be investigating how they relate to their problems. The MBCT teacher would interfere with the teaching process if s/he came with a misplaced sense of expertise, wisdom and expecting to help participants with their difficulties. Rather his/her role is to facilitate participants in opening to their experience just as it is. There is certainly skill and expertise required but this is not in the area of the participant's own experience.

> *'We don't really do anything for them* [the participants]. *If we tried, I think we would fail miserably. Instead we invite them to do something radically new for themselves'* (Kabat-Zinn, 1990, p.19).

The understanding here is that, unless the helper him/herself has some experience of the space beyond the instinctive need to change and fix problems, there will not be the space within the helping relationship to allow this process to unfold. Mindfulness enables us to see that if one expects or wants something different to happen, in one's own process or that of others, one has immediately moved beyond the present moment and into a future concept with a personal judgment attached to it, which is different from a full embracing and acceptance of the present moment just as it is. This 'non-striving' attitude is what is being asked of participants in MBCT and is therefore what needs to be embodied within the presence and way of communicating of the teacher.

> *'Almost everything we do we do for a purpose, to get something or somewhere. But in meditation this attitude can be a real obstacle. That is because meditation is different from all other human activities. Although it takes a lot of work and energy of a certain kind, ultimately meditation is a non-doing. It has no goal other than for you to be yourself. The irony is that you already are.'* (Kabat-Zinn, 1990, p.37).

The work is therefore inviting the seemingly paradoxical stance of an intentional cultivation of the attitude of non-striving.

Mindfulness-based teachers leave responsibility, therefore, clearly with the participants. They see their role as empowering participants to *'relate mindfully to*

their experience moment-by moment' (Segal et al., 2002a, p.59). In developing MBCT, Segal et al. (2002a) realised that if they were to authentically and fully embrace mindfulness in the programme they were developing this would require a radical shift also in their approach as therapists. In the cognitive behavioral tradition the therapist is responsible for helping patients solve their problems.

> *'It became clear...that unless we changed the basic structure of our treatment, we would continually revert to dealing with the most difficult problems by searching for more elaborate ways to fix them'* (Segal et al., 2002a, p.59).

- **Letting go**

Segal et al. describe 'letting go' of wanting to hold onto the pleasant and get rid of the unpleasant as the core skill of MBCT:

> *'Letting go means relinquishing involvement in these routines, freeing oneself of the attachment/aversion driving the thinking patterns- it is the continued attempts to escape or avoid unhappiness of to achieve happiness that keep the negative cycles turning'* (Segal et al., 2002, p.91)

The MBCT programme is teaching a way of stepping out of self perpetuating cognitive routines. The MBCT teacher would embody this within the sessions by approaching the process flexibly and responsively. This would involve appropriately taking action to move the session into a new area or a different mode; responding when the group's energy is flagging or the discussion has become intellectualized and so on.

One of the core skills that participants are learning through the programme is that of being able to exit unhelpful 'driven' or 'doing' modes of being and being able to intentionally enter 'being' mode.

> *'The practices and the instructor's own presence and way of being, provide powerful opportunities for direct 'tasting' of this mode – hence the importance of the instructor embodying the qualities being developed'* (Segal et al., 2002, p.94).

- ***Commitment, self-discipline and intentionality***

Mindfulness invites us to explore and experience the balance between bringing kindliness to our experience and having a firm intention to stay with this process. Mindfulness practice requires discipline, firmness, intention and precision about how and where the awareness is placed. Some mindfulness teachers have described the stance here as 'warrior like'.

> *'So the practice of sitting is the practice of the Warrior, developing confidence to face whatever arises, to turn towards it ...It's a very brave thing to do...'* (Shikpo, 1979, p.1)

Participants in a mindfulness-based class are often told that it is likely to involve hard work and determination to take the course. The approach is gentle but persistent. There is a strong emphasis on individual effort, motivation and regular, disciplined practice whether one feels like it or not. They are warned that 'things may feel worse or more intense' at times in the process. Opening to the range of our experience can be both delightful and painful. One would only persist through the difficult times with this if one has made a firm intention to continue to practise with whatever arises as best one can.

This requires skillful transmission of the essence of this work by the instructor, to simultaneously facilitate an understanding of the rationale for the work in the participants whilst inviting a non-goal orientated way of approaching it. The challenge is to work with determination but without moving into effortful, goal directed ways of being. The intention is placed on the process not on the desire to get somewhere. This very intentional focus and embodiment of the discipline required is an important skill to bring to the teaching of mindfulness-based approaches.

- ***Process rather than content***

Although this area is not strictly an attitude, it is included here as the stance of relating to the process of our experience rather than to engage in its content, is important both in terms of the teaching style and in the way participants are being invited to relate to their experience. It is an investigation into the patterns, habits and themes that emerge in our experience. Consequently, MBCT courses do not focus on participant's stories and backgrounds – the emphasis is on bringing present-centred awareness to the vividness of this moment and to stepping back from the 'stories' our minds create to observe the process of mental activity itself.

The sessions are commonly called 'classes' which communicates the understanding that the job here is to learn new skills rather than engage in a 'therapy' type process. For this reason the group size can be quite large. Mindfulness-based classes commonly have up to 30 participants. These sizes preclude an engagement in therapeutic work with individuals in the groups. Within this however, there is a strong

emphasis on the course structure providing a ‘community of learning’ (Kabat-Zinn, Santorelli, 1999).

Summary of chapter two

In this chapter the historical development of mindfulness-based teaching is described. In describing the development of MBCT the rationale for the approach is also addressed. The structure and content of the MBCT programme is outlined and described. The final section discusses the teaching methods and attitudinal underpinnings core to the teaching of MBCT. In discussing these areas, the rationale for the emphasis on the teacher having a strong personal mindfulness-practice experience is given.

Chapter Three

Review of the literature

Training professionals to deliver MBCT

Aims of chapter three

The particular research focus for this project, as will be described in chapter four, is ways of developing and assessing mindfulness-based cognitive therapy (MBCT) teacher competence and ability to adhere to treatment protocol for the purposes of research trials. This chapter therefore aims to review current strategies that address the development of competence within mindfulness-based training programmes. This is first addressed generally by summarising the training opportunities and certification process offered by the Centre for Mindfulness (CFM) in the USA for mindfulness-based stress reduction (MBSR) teachers. The more recent trainings on offer to professionals wishing to deliver MBCT are then described. Current thinking on ways of addressing the measurement of teacher competency within the North Wales Centre for Mindfulness Research and Practice (NWCMRP) is outlined.

The particular demands placed on the MBCT teaching process when the course is part of a research process are discussed. Adherence to protocol as a particular need associated with research trials is explored and reviewed in the context of mindfulness-based teaching. The ways in which competency of teaching in research trials on mindfulness-based approaches have been addressed to date is reviewed.

Delivering training in teaching mindfulness-based approaches

Delivering training to teach MBSR - the experience of the Center for Mindfulness (CFM) in the USA.

There is an overriding emphasis by the CFM on the development of a deep and strong mindfulness practice experience on the part of the MBSR teacher:

> *" …to serve as a catalyst for other people's growth and development, the teaching must, above all, come out of our own experience."*
>
> (Kabat-Zinn, Santorelli 1999, p.5)

The CFM are very clear in their sense of what are important experiences, qualities and skills for providers of MBSR:

> ***'Mindfulness, our innate capacity to flexibly and fluidly pay attention from moment to moment is a universal human capacity taught within a contemporary health context as mindfulness-based stress reduction (MBSR)…The effectiveness of the approach is predicated on providers***

> ***being experientially grounded in mindfulness practice and being able to effectively and flexibly utilise MBSR as a method for working with people experiencing stress, pain and illness. These are strong demand characteristics of MBSR requiring an unerring commitment to ongoing growth and learning on the part of the provider.'*** **(Kabat-Zinn, Santorelli, 2001 p.7)**

There are two elements of the CFM's MBSR teacher development work described here – the CFM approach to training and development of teachers of MBSR and the ways of assessing teacher readiness and competency that they have developed.

- **CFM trainings for MBSR teachers**

The trainings offered by the CFM fall into two main areas:

1. *Foundational.*

   These trainings are intended to create an initial familiarity with the curriculum and then a subsequent immersion in the curriculum. They take the form of attendance on:

- an eight-week MBSR course;
- an eight-week MBSR course with weekly seminars, in the form of discrete sessions, exploring the teaching process alongside or an intensive 9-day version of this;
- seven-day residential training retreats in MBSR.

2. *Mid-level training.*

   These are trainings which explicitly instruct on the delivery of MBSR. It is required that attendees have participated fully in the foundational levels and have experience of 5-10 day silent teacher led mindfulness meditation retreats. There are two forms of training offered:

   I. Teacher Development Intensive – an eight-day residential training programme/retreat in which participants are trained in the ways of delivery of MBSR.
   II. Individual supervision of MBSR teaching practice.

See Appendix 1 for a summary of the CFM 2004 training programme.

- **CFM certification process**

In relation to the process of assessing competency to teach MBSR, the CFM, in 2003, took the step of introducing a certification process for teachers. This is an interesting leap, which at first sight seems a departure from their earlier guidance to teachers on assessing readiness to teach:

> *'The CFM resisted the impulse to initiate a certification program in MBSR. Quite frankly while providing professional training programs in MBSR, we had concerns that the premature establishment of certification criteria and standards might inhibit or even worse, arrest the individual and collective creativity critical to the development of an innovative and valid field of inquiry and knowledge..'* (CFM, 2004, p.13).

Prior to certification, the invitation the CFM explicitly offered, was for each individual teacher to engage in a personal inquiry process, which enabled a personal sense to emerge of when the internal and external conditions were sufficient for skilful transmission of MBSR to take place.

A number of factors have led the CFM to introduce certification of MBSR teachers:

- Recognition of the extent of the use of mindfulness-based programmes throughout the world.
- The CFM's sense of responsibility as originators of the approach to ensure good practice.
- The CFM's desire to support practitioners and the ongoing development of mindfulness-based work, by offering a 'qualification' which enables service providers engaging the teacher or participants of the teachers MBSR classes to know that the teacher has satisfied a recognised training process (Blacker, Meyer, 2002).

The certification system that they have devised mirrors the internal processes that the CFM teachers engaged in as they developed their own teaching practice. There are some clear prerequisites that the CFM have formulated for application for certification (see Appendix 1 on the CFM certification process) and then the process involves a group of appointed, experienced MBSR teachers witnessing the teaching of the applicant and forming a consensual view of their teaching practice. The clear impression here is that the sure way of forming a sound judgement on a teacher's level of competence is for experienced MBSR teachers to view their teaching

practice. This enables the range of teaching skills, the approach of the teacher and the 'outer' results of the 'inner' mindfulness practice of the teacher to be assessed. The CFM describe that their clinical experience suggests that there are individuals who meet and sometimes exceed the minimum standards but are incapable of effectively teaching MBSR. Conversely, there are individuals who do not meet the minimum standards but who have developed, via their unique life trajectories, the qualities of a teacher and are capable of effectively elucidating and delivering MBSR (Kabat-Zinn, Santorelli, 2001, p.8). Creating opportunities to view the work of the teacher is therefore important in forming clear judgements about their practice (see Appendix 3 for guidelines for assessing the qulaifications of MBSR providers.)

Delivering training to teach MBCT – the experience of the North Wales Centre for Mindfulness Research and Practice in the UK

- **MBCT training programmes**

MBCT is closely modeled on MBSR. Much can be learned from the far greater length of experience of the CFM in delivering training in MBSR. There are some core differences in the curriculum and emphasis, which were articulated, in the first chapter. These need to be reflected in the training content. There is also a shift that needs to be made to bring the work of training practitioners into the UK context, in ways that are congruent with cultural differences between the US and the UK and which are appropriate to the UK health care system. Further more, the developmental process of MBCT is at an earlier stage to that of MBSR and the training demands reflect this.

The published literature on the training of MBCT teachers is small – currently limited to a chapter at the end of Segal et al.'s (2002a) book on MBCT. They give a number of practical suggestions and resources for potential practitioners to start a personal mindfulness practice and to get the support they need to maintain the process. In terms of learning to deliver MBCT they write:

> *'At the time of writing, there are no systematic training courses for instructors on how to deliver the MBCT program (we hope this situation will change). There are, however a variety of training opportunities for instructors in MBSR. MBCT and MBSR share many common features. Consequently, the professional training available for MBSR provides an excellent preparation for offering MBCT to clients'* (2002a, pg. 326).

The work of the NWCMRP since early 2002 in developing a range of trainings that prepare teachers for MBCT work has been with the intention of addressing this gap. This work itself in its infancy is developmental and changing as we learn through the process. It is the author's intention that this dissertation will further inform the training offered by the NWCMRP. The current trainings offered are as follows:

1. *Introductory trainings:* one and two day introductions to mindfulness-based practice which offer experience of the practices, the style of teaching and introduce the theoretical background to the approach.
2. *Foundational trainings:*
    - Attendance on the eight-week MBCT course. This is offered regularly in Bangor and as a distance-learning course over the telephone. Participants in the latter are invited to come in person to the silent practice day after session 6.
    - Mindfulness Development Programme – attendance on an eight-week MBCT course with weekly seminars alongside to enable an in depth exploration of the teaching process and participants' responses.
    - Teacher preparation courses: Teacher development training retreat – a 6/7- day residential training in which participants engage in direct teaching of mindfulness-based programme and then teach components of the course back to fellow participants, receiving detailed feedback as they do this. Attendance on this training is limited to those who have attended an eight-week mindfulness-based course and have an established daily mindfulness practice.
    - Individual mentoring/supervision of mindfulness-based teaching. This commonly takes place over the telephone.
    - Large scale conferences. The Centre has run a number of large-scale national events, which have served to support and encourage the growing, interest in the use of mindfulness-based approaches.

The NWCMRP also offers four Master's level modules in mindfulness-based approaches as follows:

- Foundation in mindfulness-based approaches: a practice-based module, which enables participants to experience the practices and teaching of

mindfulness-based approaches. This understanding is integrated with the rationale for the use of mindfulness in clinical and other settings, with a particular focus on MBCT.

- Research and evidence base for mindfulness-based approaches: a module which teaches research methodology appropriate to the investigation of mindfulness-based approaches and familiarises participants with the evidence base in this field.

- Group theory and practice and its application to mindfulness-based teaching: an experiential module on group theory, process and practice. This is connected with the relevance of these understandings to the teaching of mindfulness-based approaches.

- Mindfulness-based approaches – applied module. Available for those wanting to bring mindfulness-based teaching into their professional practice. This module is taught as a week-long residential training retreat.

Each module is taken over an academic year. Completion of these four modules and a dissertation leads to the award of MA in Education (mindfulness-based approaches).

See Appendix 5 for a summary of the NWCMRP training programme.

The NWCMRP training programme is evolving in response to the growing interest and subsequent need for developmental training. The training to date in the UK has largely been focused on opening interest in the field; enabling practitioners to develop their own practice and for those that have an established practice facilitating them in translating this experience into their clinical work. Mindfulness-based practice is becoming a more mainstream part of current clinical practice in the UK and there is an increasing need for more advanced and in-depth trainings.

The developers of MBCT in collaboration with an experienced MBSR teacher are also engaged in developing trainings for professionals wanting to bring MBCT into their work. These have taken place in Canada, USA and Denmark. They are open to professionals who both have mindfulness practice experience and are trained in CBT.

These take the form of a seven-day training in the context of a retreat. Participants are taught the curriculum of MBCT over the first half of the week and in the second part of the week teach the work back to fellow participants under the supervision of the trainers.

- **Assessing MBCT teacher competency**

In the UK there are no formal ways of recognising, measuring and assessing competency to teach MBCT. There is a general feeling amongst many MBCT teachers that it would be unhelpful to institute an MBCT certification process. This issue will be revisited in the final chapter.

The NWCMRP is currently the only organisation in the UK dedicated to offering courses and training in this approach. An important element of the Centre's work, in this early stage of MBCT development, is to communicate clear good practice guidelines for practitioners delivering MBCT (see Appendix 4). The NWCMRP has developed an internal system for assessing the competency of Centre teachers. All teachers who join the Centre teaching team need to undertake and satisfy this process. This is part of ensuring that both internal ways of appointing teachers to work within the Centre and ways of bringing about high quality teaching on ongoing basis are fully congruent with the NWCMRP's own good practice guidelines. Essentially the process involves initially ensuring that the teacher meets some prerequisite criteria, and then the teacher's teaching practice is observed and assessed by two experienced MBCT teachers. An outline of the Centre's internal accreditation process is in Appendix 6.

Measuring mindfulness-based teaching adherence and competency in research trials

There is little in the literature on ways of quantifying mindfulness-based teaching adherence and competency. Grossman (2003) cites this as an area to which not enough attention has been paid in MBSR research to date. A lot of the published MBSR research in the USA has been conducted by a range of teachers who are not

working through the CFM. One area of weakness in some of this work is the uncertainty around the skills of the teacher and the potential inconsistencies within the curriculum which they are teaching (Grossman et al., 2003).

> *'Insufficient consideration or information was typically given about…therapist adherence to the intervention programme, evaluation of teacher training or competency'* (Grossman et al., 2003, p.14).

The three originators of MBCT developed the 'Mindfulness-Based Cognitive Therapy Adherence Scale' (MBCT-AS) (Segal et al., 2002b). They state that:

> *'While efficacy data are central to the development and evaluation of any new treatment, it is also important to be able to measure the degree to which the intervention as described in its treatment manual is actually being administered.'* (Segal et al., 2002b, p.132)

A treatment manual specifies how the treatment is to be carried out; an adherence measure offers a way of quantifying how faithfully the treatment has been provided (Segal, et al., 2002b).

> *'Without measuring adherence, it is difficult for studies of comparative outcomes to verify whether the independent variable of interest, namely treatment, has been successfully manipulated'* (Segal et al., 2002, p. 132).

The study on the MBCT-AS (Segal et al., 2002) demonstrated clearly that delivery of MBCT can be assessed, with a quantifiable measure of adherence to treatment protocol.

> *'These findings are important in that they provide future trials of MBCT with an instrument to assess treatment integrity, the assurance of which is a foundational necessity for comparative treatment research.'* (Segal et al., 2002b, p. 135-6)

The MBCT-AS involves an independent rater watching an audiotape of the group and scoring the adherence of the teacher to the protocol. However, whilst this scale is a useful tool in measuring an important aspect of teacher skill (that of adherence to the manual) it does not address ways of assessing the competence with which the programme is delivered.

The MBCT programme was being developed as the original trial was taking place so there were no systems to enable the issue of teaching competence to be addressed in a systematic way. The three developers worked with this by videotaping the sessions

and submitting these for peer review by each other and for review by experienced teachers from the CFM.

In order to put MBCT to the test in everyday clinical situations the programme needs to be researched by greater numbers of trained teachers working in everyday clinical settings. Herein lies the challenge of both offering to these teachers what they need to develop their MBCT teaching practice, and putting in place what the research needs to ensure its validity by having consistent levels of teacher competence and adherence to manual. The process of developing ways of measuring competency in the teaching of MBCT is a huge project with a number of layers of subtlety and complexity. This is one of the areas of questioning for this investigation and so will be revisited in subsequent chapters.

Summary of chapter three

In this chapter, the current status of training programmes in MBSR and then MBCT are outlined and discussed. The teacher certification process for MBSR and the internal MBCT teacher accreditation system within the NWCMRP are described. The ways in which the mindfulness-based teaching process has been quantified for research purposes to date are summarised.

Chapter Four

Research Methodology

Aims of chapter four

This chapter outlines the focus for the research project and the ways in which the author approached it. The institutional context in which the research took place is outlined. The research issues and questions are detailed. The chosen methodology and the rationale for its selection are described. The limitations of the project are discussed. Ethical considerations are addressed.

Research issue

It is the author's intention that the evidence produced in exploring the research questions will inform in practical ways the preparation that the North Wales Centre for Mindfulness Research and Practice (NWCMRP) is making to conduct multi-centre research on the effects of mindfulness-based cognitive therapy (MBCT).

The development of MBCT teaching is in its early days. Much of the research into the approach has investigated the effects of MBCT groups taught by first generation teachers - the developers of the approach itself. An important element of this investigation is an exploration of the qualities required of, and the training and development needed, by subsequent generations of teachers.

Work has taken place within the community of mindfulness-based teachers to address the area of assessing and assuring adherence and competence. The Centre for Mindfulness (CFM) in the USA has been for many years elucidating guidelines on competent teaching of mindfulness-based stress reduction (MBSR) (see Appendix 2 and 3). More recently, they have developed a certification process to measure MBSR teacher competency (see Appendix 1). In addition, the NWCMRP has been actively engaged in developing guidance on good practice for MBCT teachers and ways of assessing teacher readiness (see Appendix 4 and 6). As described in chapter three, during the original MBCT RCT an adherence scale (MBCT-AS) was developed to measure adherence to the treatment protocol. The understanding reached through these processes is relevant to this investigation and provides useful groundwork for exploring the questions.

Research Questions

The overall questions to be addressed here are:

What are appropriate selection criteria for MBCT teachers and by what methods can the adherence to protocol and competency of approach of teachers taking part in multi centre MBCT research be assured and measured?

The three main components of this question that will be explored in the research are:

1. What should the optimal requirements be for a teacher to be considered to take part in multi-centre MBCT research?
2. What development and training will be required to enable these selected teachers to deliver MBCT in competent ways to the patient population in question?
3. How will the competence and adherence of the teaching be assured and measured?

The author recognises that there are no straightforward answers to these questions. The process of teaching mindfulness-based approaches is intricate and subtle and not easily measured and quantified. These are areas therefore which deserve ongoing detailed exploration and considered investigation.

The author is also aware that it is appropriate during research trials to fully address the issue of teacher adherence to protocol to ensure that the results can be interpreted with confidence. There is however a need, particularly in a field as young as the teaching of MBCT, to be evolving the work and responding to new learning. Mindfulness teaching demands of the teacher responsiveness to the moment that can be stilted by an overemphasis on adherence to a manual.

Although the focus of these questions, for the purposes of this dissertation, is targeted at a particular research driven need, the intention is that the resulting understanding will have the broader benefit of furthering our understanding more generally of the optimal training and development approaches for MBCT teachers.

Contextualisation

The research took place within the context of the author's work as Director of Training with the North Wales Centre for Mindfulness Research and Practice (NWCMRP). The Centre is a part of the Institute of Medical and Social Care Research (IMSCaR) within the University of Wales, Bangor.

The NWCMRP was formally established early in 2002 when funding became available for the post the author currently holds, developing and coordinating training in mindfulness-based approaches. Some of the Centre's early development work had taken place before this date through a group of interested professionals in the North Wales area. These were an active group of professionals who were inspired by the work and came together to develop opportunities for mindfulness-based training, research and practice. Some members of this group now form the teaching team for the Centre and are core to the development of the Centre and the work generally.

The NWCMRP aims to bring together people who are dedicated to bringing awareness into the world and our lives and to promote good practice in the teaching and researching of clinical approaches based on mindfulness, in particular, MBCT, stress reduction through mindfulness, and other mindfulness-based approaches. There are five main threads to the work of the Centre:

1. **Practice:** promoting the provision of mindfulness-based work through running classes from the centre and through facilitating the development of classes in National Health Service settings.
2. **Training:** providing developmental training opportunities for professionals in mindfulness-based approaches.
3. **Research:** expanding the existing evidence base on mindfulness-based practice, especially in health and social care.
4. **Information:** serving as an information source and exchange for other practitioners and researchers using mindfulness in their work, both in the UK and in Europe.
5. **Development:** promoting the increasing availability of mindfulness-based approaches to users of UK health, education and social services.(Adapted from the NWCMRP website, www.bangor.ac.uk/mindfulness, 2004)

The Centre has two arms: a research arm and a training arm. The Centre has a Research Fellow who is engaged in research on MBCT within the University of Wales, Bangor and also offers support and networking to other researchers in mindfulness-based approaches. On the training side there is a Director of Training within the Centre who coordinates and develops the training activity. The Centre has five trained teachers who have been accredited to teach through the Centre (see Appendix 6 for NWCMRP accreditation process) and five other teachers who are actively engaged with the Centre and developing their MBCT teaching practice. The Centre has close links with some other MBCT teachers working in clinical practice in the North Wales area. The Director of IMSCaR offers general direction to the work and chairs the team meetings; the Deputy Director of IMSCaR supports the business development of the Centre and an administrator takes care of general administration, housekeeping and coordination of the Centre's work. The Centre engages past and present MBSR teachers from the CFM to offer trainings.

As detailed in chapter three, the training activity of the NWCMRP includes the eight-week MBCT course; a range of follow-up workshops and events for those who have competed the eight-week MBCT course; short introductory workshops for professionals; week long residential training retreats for professionals and larger scale conferences and trainings. The Centre now also offers four Master's level modules on mindfulness-based approaches.

The research activity of the Centre has developed from the original MBCT RCT. One of the three centres for this trial was based within the University of Wales Bangor, under Professor Mark Williams one of the three developers of the approach. The focus of the current research is a pilot study investigating the effects of MBCT with oncology patients and their carers. This includes both qualitative and quantitative analysis. As detailed previously, work is underway developing a bid for a multi-centre trial with clients who are currently presenting to mental health services rather than in remission from depression.

The NWCMRP operates within the Institute for Medical and Social Care Research (IMSCaR), a research department within the University of Wales Bangor. IMSCaR is committed to rigorous and practical research to support health and social care across Wales. It has working within it specialists in psychology, public health, gerontology, health economics, biostatistics and more. It is made up of a number of self-resourcing Centres and specialised research groups as follows:

- Centre for the Economics of Health
- Centre for Social Policy Research and Development
- Dementia Services Development Centre
- National Public Health Service (North Wales section)
- All Wales Alliance for Research and Development
- North Wales Section of Psychological Medicine
- Wales Organisation for Randomised Trials and Health technology assessment
- North Wales Centre for Mindfulness Research and Practice.

These different groups within IMSCaR support and interconnect with one another. There are regular department meetings; some staff contribute to more than one Centre and the Director and Deputy Director of IMSCaR take an overview and manage the whole department. Therefore, although the NWCMRP itself is small it is able to draw on the expertise and resources of a strong research department. This is reciprocal. Apart from the research and training work that the NWCMRP is engaged in there is a strong sense that the presence of a mindfulness team within the department has contributed to the pleasant, humane and caring working ethos. Several members of staff from other Centres within IMSCaR have attended the eight-week MBCT course for the general public aimed at reducing stress.

Methodology

Qualitative or quantitative-how best to gather the information required?

There are two main approaches to designing research in health care, quantitative and qualitative methods. Quantitative methods collect facts and study the relationship of one set of facts to another (Bell, 1999). This methodology seeks to enable clear and

generalisable conclusions to be drawn. Qualitative methods seek insight rather than statistical analysis or definitive conclusions (Bell, 1999). This methodology is suitable when one is seeking to draw out the individual's perceptions of an area in question. Results derived through sound qualitative methodology should, however be replicable.

The author's intention with this study was to deepen insight into the subject. The study was seeking to elicit views on the research questions and to understand the ways in which experienced MBCT teachers and researchers perceive the work of MBCT rather than extracting hard data on the reality of their experience. The participants' views and opinions on the research questions are being sought. Qualitative methods are more appropriate to this human angle on the subject area. It was therefore decided that the author would conduct semi-structured interviews and analyse them using interpretative phenomenological analysis (IPA) (Smith, Jarmon and Osborn, 1999). MBCT has developed and evolved in part through a process of collaborative investigation and reflection between colleagues. This methodology therefore formalises a process that is familiar to most in the field.

Collection of the evidence

The research involved interviewing experienced teachers of MBCT and MBSR using a semi-structured interview process that addressed the research questions.

The participants were teachers who have five or more year's experience of delivering MBSR or MBCT; have experience of training others to deliver MBCT or MBSR and/or have carried out research into the approaches. Six interviews were conducted. The teaching experience of three of the participants was largely with MBCT; two participants had experience of both approaches and one participant's teaching experience was with MBSR. The interviews were conducted between April and June 2004.

The interview process was semi-structured to enable reflection on the research questions to be a focus for the inquiry. A framework was established by selecting

topics around which discussion took place. Bell (1999) describes the process of a semi-structured interview thus:

> *'Certain questions are asked, but respondents are given freedom to talk about the topic and give their views in their own time. The interviewer needs to have the skill to ask questions and, if necessary, to probe at the right time, but if the interviewee moves freely from one topic to another, the conversation can flow without interruption'* (p.16).

All the interviews were one-to-one and were up to one hour in length. Due to the spread geography of the participants the interviews were conducted on the telephone. The interviews were recorded to enable the material to be revisited as often as needed. Notes were taken of salient points during the interviews to enable the interviewer to hold and remember areas to refer back to. Transcripts of the data were not made as the time constraints of the project precluded this. This strategy would have enhanced the analysis of the data further.

Interview Guide

An interview guide provides an outline for the semi-structured interviews. The questions developed should be:

> *'Specific enough to guide the moderator but general enough to leave ...enough latitude to further probe and elicit information'* (Vaughn, 1953, p. 124).

The following is the interview guide. The questions were divided into the three main areas of focus:

1. Optimal requirements for MBCT teachers to teach for a proposed multi-centre research trial:
   a) What general experience is required?
   b) What MBCT teaching experience is required?
2. Subsequent training to ensure adherence and competency:
   a) What subsequent training would be required to ensure that the teachers adhere to an MBCT manual?
   b) What subsequent training would be required to ensure that the teaching is competent?
3. Methods of ensuring competence and adherence to treatment protocol:
   a) What methods could be used to measure adherence?
   b) What methods could be used to measure competence?

Whilst recognising considerable overlap and interconnection between these areas of questioning they essentially form a time line:

1. Criteria for initial selection of teachers.
2. Training and development process of MBCT teachers.
3. Assessing and measuring the competence and level of adherence of the teaching as it takes place.

These main questions formed the structure for the interviews. They form a logical sequence and are general in their nature. Participants were given the interview questions in advance of the interview to enable them to reflect on their responses. The evidence required here was not the participants' immediate responses on the day but their considered thoughts.

The guide was used as a basic structure. However, there were variations in the interviews. The participants were chosen for their expertise in the field. Some of the interviewees had particular expertise in teaching, training or research and so the interview content would emphasise appropriate areas. Hence, the guide was used as a flexible rather than firm structure. Open-ended questions were asked such as: 'Are there any other elements, which you would like to raise within the area of teacher competency?' These enabled interviewees to raise issues that may not have had space had the structure been very tight. The author recognises that these strategies entail risk of bias and subjectivity but the decision was made that the nature of the investigation lent itself to this strategy.

The interviewer encouraged participants to articulate their perceptions of the questions through reflective listening techniques. These included reflecting back and summarising what has been said, asking questions to elucidate or clarify meaning and requesting examples of statements made. When necessary, prompts and probes were used. Prompts are directed to what participants know but have not yet said. They encourage people to talk but must be used in ways that do not lead the interview. Probes invite different answers of the same kind, asking them to clarify and explain – they develop the answer already given (Drever, 1995).

Risk of bias and collusion

The author is aware that qualitative approaches are inhererently more prone to the risk of bias, subjectivity, collusion and missing the obvious than quantitative approaches Furthermore, the research questions are areas of considerable personal interest to me. Mindfulness practice is an area of deep significance in my personal life and is also a central part of my professional role. All the people whom I interviewed are known to me through my work. The community of MBCT practitioners is not large and therefore investigations of this kind inevitably raise these difficulties.

I aimed to work consciously with areas of potential subjectivity and to discover and examine them as they arose. In this way, my intimacy with the field and with those working in it strengthened my investigation and added richness to the data. At times the research process arose out of an interaction between the data and my inner investigation and experience of the field. I intended throughout to make this process conscious and to be explicit. I aimed to make my personal perceptions and interpretations and the perceptions of others clearly sourced throughout. As described in the next section the strategy of analysis was chosen to enable the author to consciously use her experience within the process.

To enable clarity regarding the sources of assertions, chapter five gives an account purely of the participants' views of the research questions whilst chapter six offers a discussion and analysis incorporating the author's perceptions of the material.

Analysis of the evidence

The analysis followed the approach of interpretative phenomenological analysis (IPA) (Smith, Jarman and Osborn, 1999). The aim of IPA is to explore in detail the subject's view of the topic under investigation. Thus, the approach is phenomenological in that it is concerned with an individual's personal perception or account of an event. At the same time IPA also recognises that it requires the researcher's own conceptions and interpretation to make sense of the subject's personal work. Hence, the term

‘interpretative phenomenological analysis’ is used to signal these two facets of the approach (Ma, 2002).

Materials addressing the research questions were also gathered through the author’s own observations and reflections during the research period. These arose through my lived experience of the questions; through understandings arising within the engagement with participants during the research; through interactions with fellow MBCT teachers and through observations of the training process of participants in the NWCMRP trainings. My intention in analyzing this part of the data was to acknowledge and frankly examine my own subjectivity. As already stated, the account of the research results in chapter five, contains only views put forward by participants. The author’s views are included in the discussion of the results in chapter six.

The recordings of the interviews were listened to, to look for themes. As clusters of ‘overarching themes’ emerged within the overall available data, a master list of these was created. These were then arranged in a coherent order and further examined for ‘subcategories within the themes’ that point to multiple qualitative facets of potentially significant areas. These themes and categories should not be seen as independent entities as they emerge from the participants as part of a holistic expression of their experiences.

Due to the small number of participants (further work with more participants would enrich the investigation), it would be difficult to ensure total confidentiality if the findings had been presented in an individual case study format. The decision was therefore made to identify the themes arising and present and discuss the evidence in this form.

Limitations of the project

The focus for this study was very specific. It was deliberately targeted at a particular current area of questioning by members of the NWCMRP. This is in part due to the

word limit on this dissertation, and in part to enable a particular service need to be addressed.

The overall population of experienced MBCT teachers is small, and the subgroup within it that has a number of years' teaching experience and has experience of research and/or training in the approach is smaller still. There are greater numbers of experienced MBSR teachers, but the author intentionally invited a larger proportion of teachers with MBCT teaching experience, as this was the focus of the study. The participants in the study are therefore drawn from a small sample, but this does represent the population for the purposes of this study. The interviews were conducted over the telephone as the participants are geographically spread and the times of the interviews were arranged with participants' convenience in mind. It was therefore not possible to control the environment or achieve consistency of interview times and days. It is recognised that these have an effect.

In preparing for a large multi-centre research trial of MBCT we are moving into uncharted territory in several ways. One of the unknowns is how the adherence and competency of the teachers who will be delivering the treatment can be addressed. The author is tantalisingly aware that there are many other unexplored areas within the whole area of the training and development of teachers of MBCT. This study excluded exploration of many of these potentially useful areas. However, a possible useful outcome from the current specific exploration, is that the questions that lie in related areas may become more clearly articulated. Future studies in this area may thus be informed by the understandings developed in this investigation. There is much potential for replication of this type of investigation and other investigations in the area of MBCT teacher development and training. The author had areas of specific focus in mind, in terms of the application of the results to the questions around researching MBCT and to the development of the MBCT training programme at the University of Wales, Bangor. The generalisability of the results therefore may be limited. There is also the interesting question of whether the data would have been interpreted differently by another author.

Ethical Issues

Foster's 'three-approaches model' was used as a framework for evaluating the ethical issues raised by the research protocol.

> *The three-approaches model works well for the purposes of considering the ethics of research on humans because it can form a framework for ethical review of research projects'* (Foster, p.133, 2001).

The framework exploits three moral theories; goal-based, duty-based and right-based. Foster's view is that each element has something of value that is useful to bring to bear in ethical review of medical research.

1. Goal-based theory.

   The goal that Foster (2001) describes here is the goal of maximizing happiness. Applying this to research, one examines the goal of the research and determines whether the means are the appropriate way to achieve this.

The study is preliminary work towards a larger scale research project. The aim of the latter is research into an approach, which has the potential to reduce suffering to the patient population in question. The consequences of the research are therefore intended to increase the general quantity of happiness (Foster, 2001). It is the author's view that the methodology chosen is a reasonable means to address the research questions. It is highly unlikely that the research strategy could cause harm to the participants.

The study is intended to examine the optimum balance to be achieved between meeting the needs of the teachers delivering MBCT for research purposes and the needs of the research to ensure adherence to protocol and competency of delivery. There are ethical issues within this. Some potential methods employed to assess competence and adherence could be considered as stressful and intrusive to the teacher. The research has an intention to draw out these possible areas of tension.

2. Duty-based theory.

   Moral rightness involves acting out of respect for moral duty, irrespective of the consequences (Foster, 2001). One determines ones duty by asking oneself

the question: ‘Could I approve of everyone acting in the same way in which one intends to act?’

A principle, which lies within Foster’s (2001) second element is that it is never permissible to use others merely as a means to one’s own or others’ ends (2001). It is the author’s hope and intention that the study addresses the participants’ needs in addition to furthering the development of MBCT. The experienced MBCT and MBSR teachers who were engaged in the individual interviews are generally supportive of means towards furthering the evidence base on and clinical use of mindfulness-based approaches.

The evidence will be kept as long as it could be potentially of benefit. An alternative could be to state a period of time after which it would be destroyed. This could potentially conflict with Foster’s (2001) principle within the first element: the rightness or wrongness of actions being determined by their consequences. It could be that some years hence the evidence would be potentially useful for further MBCT research and if it had been prematurely destroyed the benefit of it would not be available.

There is a research governance issue and an ethical duty to ensure that the evidence used can be audited. A master record was kept of the sources of the evidence used in the discussion and analysis of the evidence. This is held securely and is only available to the author and her supervisor. This process ensures that there is an audit trail enabling the research to be crosschecked.

3. Rights-based theory.

   The third element of the framework involves the appeal to the rights of the individuals involved in the research.

   The salient right Foster (2001) identifies is that of ‘self-determination’ (p.47,). This requires seeking the consent of subjects before recruiting them into research trials and also respecting their confidentiality.

Letters of consent were signed by each participant (see Appendix 9). These ensured that their permission was sought in the first instance for taking part in the study and

will be further sought should any part of the work be submitted for publication.

Ensuring the confidentiality of participants is a significant ethical consideration here. Due to the small number of participants and a number of the participants being familiar to each other there is a greater than usual possibility that contributions could be traced to their originator. Consequently, greater than usual care and precautions about confidentiality needed to be taken. Details that could potentially identify the source were altered. Any third parties that were mentioned in the interviews also had their identity obscured. (See appendix 8 for letters to potential participants).

It was decided that the use of pseudonyms was not, in this case a sufficiently rigorous way of ensuring confidentiality. The evidence was therefore presented and analysed thematically rather than by individual participant. When using direct quotes a numerical system of codes was used. These are kept on a master version of chapter five which is held by the author and her supervisors; the version that was submitted has the referencing system removed.

Participants were given a copy of the dissertation prior to its submission to enable them to have the opportunity to comment. As discussed above, in using the IPA approach the author was explicit in making interpretations from the evidence. In discussing the evidence, the intention was twofold: firstly to give an account of the evidence and secondly to offer an interpretation and contextualise it. The intention here was to give the participants an opportunity to comment on the interpretations made and to include this commentary in the final discussion where appropriate.

Summary of chapter four

In this chapter the research issue and questions are stated. The institutional context within which the research took place is described. The methodology employed to investigate the research questions is described and the rationale for its choice discussed. The ways in which the data was collected is described. The interview guide used for the semi-structured interviews and the focus group is stated and discussed. The potential areas where bias and collusion might contaminate the results is

discussed and explored. The methods used to analyse the evidence are discussed. The various limitations of the project are discussed. Ethical issues raised by the work are investigated.

Chapter Five

Presentation of the results of the research

Aims of chapter five

The aim of chapter five is to give an account of the data. Chapter six offers discussion and reflections on the wider implications of this material.

The data is presented within the overarching themes that arose in analysing the material. Each theme is summarised in general terms and then the categories within the theme are used as a structure within which to present the material. There is much interconnection between the areas under discussion so whilst for the sake of clarity they are subdivided, they should also be viewed holistically by the reader.

As discussed in the previous chapter, the material is analysed as a whole rather than on an individual participant basis to both to offer a thematic reflection of the material and to enable the confidentiality of the individuals participating to be preserved.

The research issue

By way of summary, the area of this investigation is an exploration of the methods by which mindfulness-based cognitive therapy (MBCT) teachers taking part in multi-centre research on MBCT can be selected and the adherence to protocol and competency of their approach can be assessed and measured.

These questions were divided into three areas of exploration, which formed the structure for the interview guide. This was detailed in the previous chapter and is restated below to enable links to be made between this and the discussion of the data.

4. Optimal requirements for MBCT teachers to teach for a proposed multi-centre research trial:
    c) What general experience is required?
    d) What MBCT teaching experience is required?
5. Subsequent training to ensure adherence and competency:
    c) What subsequent training would be required to ensure that the teachers adhere to an MBCT manual?
    d) What subsequent training would be required to ensure that the teaching is competent?
6. Methods of ensuring competence and adherence to treatment protocol:
    c) What methods could be used to measure adherence?
    d) What methods could be used to measure competence?

This overall dissertation is about the training and development of MBCT teachers generally, whilst the research component was focused on the training and measurement of MBCT teaching for research purposes. The data that emerged from these interviews covered areas relevant to both the clinical and research use of MBCT. In this chapter, the research specific issues are given more prominence and areas of wider implication are drawn out in the following chapter.

Six interviews were conducted with experienced mindfulness-based stress reduction (MBSR) and MBCT teachers. Some participants had more MBSR experience and others more MBCT experience. Four participants were cognitive behavioural therapists and their experience of using MBCT was in its original context as an approach to preventing depressive relapse. The themes which emerged of the value of cognitive behavioural therapy (CBT) experience to MBCT teachers and the differences between MBSR and MBCT reflect this leaning. As they are relevant both to the selection and subsequent training of MBCT teachers, they are included in this chapter.

The following table outlines the overarching themes and their subcategories that emerged within the data. In the presentation of results that follows, the themes are subtitled within the overall category headings. By viewing the interview questions and the table below together the reader can see that the themes which emerged are closely linked to the original questions.

Overarching themes	Subcategories of the themes
Selection criteria for MBCT teachers	Research specific considerations Mindfulness skills and understanding Inquiry skills Knowledge of the MBCT curriculum Group facilitation skills Didactic skills Personal qualities Core profession and clinical skills **Subtlety and complexity**
MBCT teacher training and development process Adherence to MBCT treatment protocol Competency in teaching MBCT	Levels of adherence Methods of measuring adherence General ways of assessing MBCT teaching skills **Methods of assessing competency of MBCT teaching for research trials**

It is important to highlight here that the complexity and subtlety of the subject area, which was articulated, by a number of the participants in various ways became an ever present theme for the author in working with the material. It felt entirely possible that in seeking to categorise and clearly articulate the required elements for the use of mindfulness in research and clinical settings the essential qualities of the approach in facilitating change may be lost. This theme recurs whilst exploring the categories outlined above.

Quotations from the interviews are formatted in italics and are given 'single quotation marks'. They have sometimes been slightly changed to clarify meaning and to ensure confidentiality, with added words or commentary in [square brackets]. Dots (...) indicate where repetitions or verbal sidetracks have been omitted. Bracketed codes referencing each quote which enable the author and supervisors to trace the data are contained on a master copy of this chapter. The version that is submitted will not retain any referencing system to further ensure confidentiality of participants. To enable the material to be clearly and logically presented much of the data is presented in the author's words with selected direct quotations used, which summarise, illustrate or clearly articulate the area under reflection.

The following discussion is structured using the four overarching themes in the table above as main headings and the categories within these as subheadings. A short overview of each theme is given at the start of each section followed by a more detailed exploration using the subcategories as a structure.

Selection criteria for MBCT teachers

Participants' responses articulated the interconnected mixture of skills and inner qualities involved in teaching MBCT; some of these being quite definable and tangible and others perceivable only intuitively by another through a 'felt' sense of the quality. There was general concurrence that it is challenging to clearly state exactly what is required of an MBCT teacher, so that whilst it is important to clearly identify what are the optimal skills required, it is equally important to remain open-minded when assessing potential teachers. Holding awareness of the subtlety and complexity of the teaching process, whilst simultaneously holding awareness of the

need for standard levels of competence for research purposes is challenging. How one can build bridges and find ways of integrating these paradigms is core to this investigation. The section that follows presents the participants' range of responses to this question of the necessary skills and selection criteria for MBCT teachers.

Research specific considerations

Several participants emphasized that the criteria for teacher selection for a research trial would vary depending upon the research question that is being addressed. There are phases to the research process for complex interventions such as MBCT. The first phase being to establish whether: *'when done optimally is the treatment effective?'* Subsequent phases involve testing what happens when the approach is carried out in a real world setting. Inevitably, one is going to dilute the effects when one starts to deliver in less than ideal situations, so the first phase needs to be carried out fully before dissemination of the approach is tested. In the first phase one would therefore need to '*select and train very rigorously'*. In subsequent phases one would need to establish where the level of teaching competency needs to lie, striking a balance between ensuring high levels of competency to give the best chance of an effect and being realistic about what is possible with the pool of available teachers and the settings in which they work.

Mindfulness skills and understanding

The articulation of the importance of a solid personal mindfulness practice to the skillful delivery of MBCT was common to every participant. There were however some differences in the level of rigour brought to views on the length and depth of mindfulness practice experience which prospective MBCT teachers should have. The majority of participants took a strong line on this, emphasising that one of the core areas of investigation in assessing prospective teachers is the depth of their understanding of mindfulness practice. Three participants emphasised the importance of regular silent retreat experience.

> ‘If the teacher does not have an understanding of what happens when you practice in a retreat context then the teaching will not be as good – if you only practice in the everyday world then you don’t get that experience.’

One participant put forward that there is no teacher who has enough practice – it is a life long process that needs to be held with ‘love, reverence, humour and curiosity,’ *and stated that his/her level of commitment to the process was crucial. In bringing the practice out into the world, it was felt that a* ‘conscientious line’ *needed to be taken in which there were stringent levels of practice commitment required of teachers. This line would serve both the teachers and the world better. It was acknowledged that this was not an easy process for the teacher, but that this level of commitment to the process is a prerequisite for the skillful teaching of mindfulness-based approaches.*

A minority of participants was willing to compromise on this area. Given that longer practice experience does not necessarily lead to better teaching, one participant expressed the difficulty of finding a valid way of measuring quality of practice:

> *‘It is important that people have a mindfulness practice but tricky to assess the level of it. Length of practice is not always the best measure – you may have someone who has initiated an active practice in the last year who has a very inquiring mind and is in touch with the early challenges of establishing practices.’*

Inquiry skills

The depth of the teacher's inquiry process, which would emerge through their personal practice, but would also need integration with all the other skills was highlighted by the majority of participants in various ways as crucial. The process of exploring 'someone's understanding in the field of awareness' *was described as requiring considerably refined skills. The participant described how the teacher is inviting the MBCT course participant's curiosity into their own experience and this once triggered is a motivator to a questioning mind. Skillful implementation of this process is the bedrock of the MBCT process and, as recurred many times in talking with participants, can only truly be assessed through seeing this investigative process in action in the MBCT sessions.*

MBCT course curriculum

The importance of a deep familiarity with the course curriculum was highlighted by several participants. The early stages of training were put forward by several participants as best approached by developing increasing familiarity with the material, through repeated exposure to the eight-week course. This would initially be entirely as a participant in the process but later would naturally, through the process of increasing exposure to the material, integrate a wider understanding of the approach and its effects universally. This area will be revisited in the section on training.

Group facilitation skills

Group skills in managing a diversity of participants; creating a sense of 'safety'; encouraging appropriate dialogue and discouraging inappropriate dialogue; developing a sense of community; sensing changes in group mood and energy and responding to this appropriately and keeping the group engaged whilst leading

discussions and teaching didactically are illustrations of the types of commentary given by participants on the relevance and importance of group skills.

One participant described the importance of the ability within the teacher to balance and blend three areas of significance: the MBCT curriculum, the groups own agenda and the teacher's needs and personal qualities. The participant described the skill of being able to 'hold' the group in ways that balance these elements both in the moment and to be able to draw and weave in the questions and comments from other times in the class.

Didactic skills

The importance of well developed skills in clearly addressing the need for information and contextualisation of participants' experiences of the mindfulness practice was highlighted. This area will be developed further in the section on professional training and clinical experience.

Personal qualities

The area of less tangible teacher qualities and skills was addressed in a variety of ways by participants. Having detailed various specific criteria for selection of MBCT teachers, one participant stated that: *'beyond these it comes down to the person.'*

There was universal general commentary on the importance of assessing teachers as individuals. Many participants described experiences of witnessing the teaching of colleagues who they expected to be able to teach MBCT with skill and being surprised at the lack of skill and vice versa.

> *'It is clear that there are people who do have extensive experience of mindfulness practices…you would think they would be very effective, but actually when you see them in operation…either they need fine tuning or somehow things just don't deliver'*

Some other particular personal qualities that were highlighted as important were a sense of humour; the ability to tell stories and read poetry; qualities of flexibility; having a wide range of affect; having emotional intelligence and having a strong sense of 'self'. Appropriate body language was also described as crucial. This was not just in the everyday sense of this but also in the ways in which the teacher embodies

through their body language the qualities of compassion, presence, acceptance and so on. One participant described the importance of the ability to be challenging to participants – in opening participants minds to different potential ways of relating to their difficulties it is necessary at times to challenge them to view things from different angles.

Professional training and clinical experience

Most participants mentioned the importance of a core professional training. There were various elements to this area of reflection including, the importance of mental health training and experience if the MBCT teaching is taking place in this setting, the relevance of CBT skills to the teaching of MBCT and within this an exploration of the differences between MBCT and MBSR. The participant's reflections in these areas of exploration are now presented.

The importance of mental health training and experience in teaching MBCT was connected to the understanding that it is important to deeply understand the conditions that the participants are experiencing - in particular what triggers the condition and what are the mechanisms which maintain it. This emphasis is an interesting contrast to the stance taken by the generically orientated MBSR approach. This is explored further below.

One participant described that experience in a mental health or similar setting offers exposure and familiarity with working with people who are in distress. One would want someone who is able to recognize that:

> 'When people express distress it is bearable…I would have thought at least two to three years of this experience …with patients. It is unbeatable in terms of exposure to people in distress…'

The ability and courage to stay with investigation of experience with participants when they are expressing difficulty, without moving into a problem solving mode or backing away from the intensity before the participant had had the opportunity to experience and explore, to the level that was appropriate for them, was highlighted a number of times. This requires an integration of clinical understanding and experience with mindfulness practice understanding and experience.

The other area that was extensively developed by participants was that of the relevance of CBT skills to the teaching of MBCT and within this an exploration of the differences between MBCT and MBSR. The CBT trained participants talked of the importance of the ability to integrate two different skill sets – mindfulness and CBT. Some participants felt that structured therapy training other than CBT also confers on the teacher the therapeutic skills needed for MBCT teaching. CBT or structured psychotherapy training gives to the practitioner an understanding of the importance of having a theoretical framework and model within which to deliver the programme, which is helpful in orientating both teacher and participant. It ensures that there is the recognition within the teacher of the importance of working within existing theoretical structures and confers the skill in implementing the strategies involved:

> *'One of the less obvious aspects of MBCT and one of the ways I think, it differs from MBSR is how much it is pervaded by the cognitive model, so that all the little interchanges between the instructor and the patients…would ideally be informed by a fairly clearly thought through model of depression in relation to depressive relapse…that comes most easily from those with a CBT background…those coming from* [other backgrounds] *might not work in such a tight way…they might rely more on the general effects of bringing awareness to experience rather than trying to tune the particular intervention …to a particular way of making sense of what is going on…'*

Three participants in various ways said that one of the risks of selecting teachers who do not have training in structured therapy is that they may believe that the simple application of awareness and acceptance to experience is enough. MBCT aims to develop these skills in participants but also offers a contextual framework for understanding their experience. The other risk highlighted is that those without this structured training may be more likely to diverge from the curriculum without a clearly formulated intention.

One participant described how an inquiry process with a participant in an MBCT session would have a layer that is generally not included in the MBSR teaching model. The first level of inquiry would be eliciting the bare experience of the participants; the second layer might be a fuller exploration of what they noticed with some constructs, such as noticing what changes when one brings mindful awareness to experience; and the final layer which is specific to the MBCT model is developing an understanding of the connection between these observations and ways of understanding and responding skillfully to depression (or whatever other condition is being worked with). This final layer '*is where you need to have some training in models where things are made explicit'* such as CBT.

These clear and explicit understandings of the ways in which the MBCT approach is intended to have its effects on the target difficulty are formulated in the mind of the teacher. They are made transparent and articulated to the participant from the first contact in the initial interview and throughout the programme session-by-session. The particular skill needed here is that the entire programme is delivered through the medium of mindfulness so that these theoretical understandings are transmitted to the participants in ways that are entirely related and woven in with their direct felt experience and are not goal directed. As one participant stated, there is an inherent challenge faced by MBCT. As it is a very closely woven blend of theory and mindfulness there is more potential than in MBSR teaching, for the balance to shift to the conceptual. *'With the more targeted focus, it can be trickier to convey the practice.'* It is therefore, in this participant's view, of paramount importance that the emphasis on strong mindfulness practice process within the teacher is stressed.

One participant talked further of the potential difficulties conferred by having a CBT or similar training.

> 'If the teacher has extensive therapy experience it will give them a lot of ideas, which are helpful but not if you believe that they tell the whole story. They are informative but one needs flexibility. One thing that I notice about teachers who are very experienced in CBT but not in mindfulness is that when they are up against the wall they can revert to what they know.'

This is an area where the integration of mindfulness skills with the range of other skills that the practitioner brings is important. It is through a long, extensive and deep mindfulness practice that the teacher would have the courage to make a *'leap into unknown territory.'* The participant here highlighted that the ability and courage to go beyond personal fear is crucial and would not be possible if the teacher were to remain within an imagined area of safety that the expertise of their therapy experience would offer.

There is a strong theme here of the need for the teacher to develop an inner blending of an experiential and a conceptual understanding of the approach. The six participants came from differing backgrounds so there were interesting differences in levels of emphasis. However, there was a common thread of expression of the importance of having *'a very full map of the territory'* of MBCT which is rooted in experiential understanding of mindfulness practice and is also deeply integrated with a conceptual and theoretical framework which gives a rationale for the

approach. This theme is returned to again in the following sections, and in chapter six.

Subtlety and complexity

A strong theme, which pervades all the other areas of discussion and was expressed by all participants, is that of the subtlety and complexity of the subject and the challenge in finding words that convey the teaching process.

One participant described that the differences between teaching, for example, in a goal orientated way or an open way; or the difference between trying to use something to 'fix' a mood state as opposed to taking care of oneself while one is in a mood state, are so subtle, but also so crucial to the integrity of the approach.

Another participant described the importance of flexibility of approach in using participants' experience, so that the teacher does not mechanistically use everybody's experience and make a teaching point but on the other hand does not didactically teach the curriculum without integrating this with the participants' experiences. So there is intuitive skill that enables the appropriate choices to be made on which teaching points to bring out at which points.

Another participant elucidated the inner qualities, which are not measurable but are central to the teaching process:

> *'This kind of teaching is different from others in that although skill is vital it is not the only thing we are looking at: the elements of wisdom and compassion,... the ability to merge and unite with the class and the confident unshakable faith in the practice – these are wonderful things and very hard to quantify.'*

A further complexity raised by one participant inherent in the process of MBCT teaching is that it is long-term work. The full effects of the work may only be measurable over the longer term on the recipient. Furthermore, each learning trial is eight-weeks in duration with additional substantial time also needed for setting up the group so the learning

cannot very quickly be fed back into the process. The development of the teaching practice of the individual teacher therefore can be slower than in other treatment approaches.

> 'The outcome of MBCT isn't immediate or obvious…if your outcome is the prevention of relapse…it is difficult to let the outcome modify what you are doing…having some kind of sense what the immediate process is that's crucial would be helpful…because of the time scale *[with]* which these skills are acquired and percolate through peoples being, one cannot look to the short term to see if it is being done well…it does seem a very complicated thing.'

This section has offered only a small sample of the range of commentaries on the subtlety and complexity of the process, but aims to give a flavour of this element within the process.

MBCT teacher training and development processes

The MBCT teacher development process needs to develop along a trajectory that enables concurrent threads of experiential and conceptual understanding to mature. These are not abilities that the teacher is able to cultivate quickly. The training process is not therefore comparable to some other therapeutic interventions in which the practitioner is taught understanding and skills but is not also required to

systematically develop an experiential, 'felt' inner understanding of the approach. The discussion of the participants' commentary on the training and development process of MBCT teachers follows.

In reflecting on training paths, several participants emphasised the inappropriateness of taking a linear approach and the importance of it being very personally tailored to the individual.

> *'Clearly the crucial thing is what is the effect that* [the training] *has on them or where they already started or where they end up as a result of it so …you can't simply say…if they have had training x then they are ready to do the business. …You really need to keep looking at people.'*

In a similar vein, several participants commented on the need, discussed in the section above, for concurrent threads to the training process. In developing mindfulness-based teaching practice one needs to develop one's training along a number of simultaneous lines:

> *'There are three streams to training: there is the mindfulness-based training itself; there is academic training…where people are pursuing academic training in their own field…. and then the third stream is practice-based training.'*

As one participant stated, in practice, what is often offered to teachers by trainings such as those within the CFM and the NWCMRP is a way of integrating and developing existing personal mindfulness practice experience with existing experience and training in their professional field. There was a familiar theme which emerged here of the ways in which training in teaching mindfulness-based approaches need to address the challenge of building bridges, connections and integration between mindfulness practice, its potential applications in the world and the need for theory based understanding.

The early stages of training would emphasise as mentioned earlier an increasing level of familiarity with the approach and the curriculum, with understanding of the clinical applications emerging through this experiential immersion and concurrent theoretical understanding. For the purposes of selecting teachers for the proposed research trial this early training would have already happened and the assessment process would be to ascertain the depth of the teacher's resulting understanding.

The importance of allowing the teaching development process time to evolve was a common theme. This willingness to give it '*time to mature within one's own being'* was stated as an important part of the commitment to being an MBCT teacher. One participant stated that a good model was to offer a training programme with built-in gaps. This offers space for people to develop their own mindfulness practice; to practise with colleagues and reflect on this; to practise teaching skills with colleagues and ultimately, when appropriate with clients. The next training space then offers an opportunity to feed in the learning from this and to engage in inquiry on the process.

There was commentary on the depth of reflection and inquiry that teachers bring to trainings as they develop their personal mindfulness practice and their teaching practice. There was a strong sense communicated here of mindfulness practice developing dimensions of awareness which are crucial to an in-depth inner understanding and to skillful teaching. The material will impact in different ways and new elements of understanding will emerge as the development process evolves.

There was commentary on the rapid increase in the UK just now, in interest in the clinical use of mindfulness-based approaches, largely in the professional mental health community and amongst practitioners with existing mindfulness practices. Several participants expressed pleasure in this but also caution. The risk of potential practitioners moving in to engagement with MBCT teaching from the perspective of the ways it may benefit their clients, without allowing time for a personal experiential understanding of the actual ways in which mindfulness may have its effects was considered to be high. This may result in the work being transmitted to clients in ways which undermine its transformative potential – for example, mindfulness teachers having difficulty in moving in towards or staying with awareness of strong expression of negative emotion; employing problem solving strategies to difficulties that are raised by clients; teaching the practices as techniques rather than embodying them as ways of fundamentally altering one's stance to experience and so on. Also, the enthusiasm that some professionals experience of being able to bring a personal interest (in mindfulness practice) very actively into their professional practice in 'legitimate' ways was described as potentially undermining to skillful teaching:

> ‘These are procedures that are easily done badly and because of peoples’ enthusiasm for mindfulness and their belief that here at last they can bring their personal and their professional interest together …there is an issue that you may get people enthusiastically doing it in unskillful ways.’

The seven-day residential MBCT training was commonly stated as being a sound model. Although concern at the cost of training elements in potential research projects was mentioned all prospective teachers working within an MBCT trial would need this foundational training:

> *‘The week long MBCT training model is good – there would be no good reason to change it – lots of practice and going through the programme session by session…Through the training process,* [one] *could also see the teacher’s practice and could assess at this point too whether it was right for them to be a part of the trial.’*

The model being used within the University of Wales, Master’s modules on mindfulness-based approaches was highlighted as a sound developmental approach to training.

> *‘Given the amount of thought that has been put into the development of this programme, it seems a good model…taking a class simply for the personal experience, then doing the class again and exploring the teaching themes, trying out the teaching, having feedback and later having supervision of the first class that is taught.’*

The strengths and potential gaps in this training programme are discussed in chapter six.

Having had basic training in teaching MBCT, the ways in which teachers can continue to support their development were reflected on in a variety of ways. The elements that were felt to be important were developing ways of enabling MBCT teachers to network together. The sense of community amongst teachers who are doing this work was described as of deep significance; and ensuring that teachers find

ways of supporting their personal practice in their local area – this would ideally be alongside others who also use mindfulness therapeutically

> *'There are a lot of people who have mindfulness practices …but they do it for themselves…they don't do it to also inform their therapy practice and they don't know how to build a bridge between the two.'*

The use of individual supervision was a common training method presented by participants. Skillfully done, this combines the teacher's own mindfulness practice and process with that of their teaching practice, thus facilitating a move towards deeper understanding of all the elements – the inner practice, the outer expression of it in the teaching and the interconnection between the two.

Adherence to the MBCT protocol

This section presents participants' reflections on their sense of the degree to which it is important that teachers stay close to the core curriculum of MBCT, and ways of measuring this process. There was general concurrence that in teaching MBCT the level of adherence necessary for clinical trials was far greater than for teaching of MBCT in clinical practice.

Levels of adherence

Participants universally stated the importance of assuring a certain level of MBCT teacher adherence to the curriculum and methods of teaching is important if the group is a part of a research trial. Some differences were expressed about the level to which it is important to take this. There was also commentary on the ways in which an over emphasis on adherence which took the form of rigid conformity, could interfere with the creative teaching process. Some participants felt that it would be important to minimise potential variables so that areas such as sequences of postures used in the movement practices and which poetry is read would need standardisation. One participant stated that although this in some ways compromised the responsiveness to the moment, it is still possible to teach a

tightly manualised approach entirely though the medium of mindfulness and so stay true to the core of the approach. Other participants felt that sufficient consistency would be derived if participants stayed entirely to the sequential teaching of the practices, the homework schedule and the course material for each week, but differed in such areas as exactly which poem or story was read, or the sequence of movements used. Significant diversions were considered to be introducing different practices such as 'loving kindness meditation' (a meditation on the development of a compassionate mind derived from the Buddhist tradition) and omitting components of the intervention specified in the manual.

Methods of measuring adherence

Participants responded in very consistent ways to questions on appropriate methods of measuring adherence to the MBCT protocol. This was described as a relatively straightforward process, which essentially identifies the presence or absence of the core components of the intervention and the inappropriate presence of components that are not a part of the intervention.

> *'On the adherence side there is a fairly standard procedure that you go through: you specify the necessary requirements - both the specifics of each session and what is required more generally and then you articulate those as precisely as possible …You generate an item pool…weed out redundancies in that item pool…then get consensus about what is necessary and what isn't…do studies to demonstrate that people can use these measures reliably…you keep going until you can get two separate raters to agree…'*

In this way, the adherence scale, 'mindfulness-based cognitive therapy – adherence scale' (MBCT-AS) was developed for measuring adherence of teachers teaching MBCT for prevention of depressive relapse. Further development of the MBCT-AS would be needed should the protocol be adapted or developed in any way, as is likely if the focus of the target client group is shifted.

One participant talked of the particular way the adherence scale could be used during the research phase to facilitate decisions on which data to include in the evidence pool. The

first MBCT course that each teacher ran for the trial could be measured using the MBCT-AS and thereafter, two sessions of each course could be randomly selected and rated. If the teaching was scoring below a certain level on the adherence scale that course could not be a part of the trial and the teacher would be asked to bring their teaching back in line. Ultimately if the adherence did not reach the necessary level the collaboration with that teacher would need to be terminated.

Competency in teaching MBCT

There was general concurrence that working with assessing competency was a significantly more complex area than that of adherence.

> 'You could have someone who adhered 100% but
>
> still be completely ineffective because of the way
>
> they did it.'

The importance of developing systematic ways of working with competency issues was universally felt to be important but the challenge of it was equally universally highlighted. There was commentary that the MBCT teacher competency issue is hugely under explored to date. Several participants commented that it is very difficult to see how one could get a well-validated competency scale due to the subtlety and complexity of the MBCT teaching process.

> *'I do worry about the potential variability of instructors… you are going to get it in cognitive therapy but I think more in this therapy…the more subtle it is the more scope there is for doing it badly.'*

Whilst there is considerable overlap between the areas the following discussion is divided into general ways of assessing MBCT teaching skills and strategies for assessing competency specifically for teaching in research trials.

Ways of assessing MBCT teaching skills in general

Having established the presence of the relevant professional, personal and mindfulness practice experience, there were several methods of teacher assessment which were put forward by participants. The universally expressed method was that of seeing the teaching – ideally in person or if this is not possible through videotapes of the sessions. Further methods put forward were interviewing potential teachers; self-ratings by teachers and ratings of the teacher by class participants

There was much commentary on the power of using videotapes of the teaching to train, assess and supervise MBCT teaching practice. An example of this is:

> 'So much of the skill of this seems to be in the way it is done and you can't really get that from verbal description…simply sitting down together and looking at videos of sessions enables the person themselves to see what is going on…it is a more gentle way….the person supervising and the person who did it …are looking at the same evidence and trying to figure out what was going on and what could be done differently…more of a collaborative thing…it is not …an easy situation to give that feedback to people particularly where …it is more in the area of the way it is done, …the minutiae of it.'

There was also acknowledgement that this process can be challenging for the teacher and it is therefore important to engage in this with sensitivity and skill:

'What you really need is to see videos …it is very nerve racking though to subject oneself to this…seeing people in action for this sort of thing though is unbeatable.'

One participant articulated the way in which the practice itself can help the process of assessing prospective teachers:

'The more you practice the more you become aware of what is important in somebody else…so it is not just a question of being able to deliver it oneself but also recognizing what is important in others.'

The participant who put forward the suggestion of interviewing prospective teachers suggested a range of ways of enabling teachers to express their experience in the field. Suggested areas of questioning were: What ways does the teacher keep his or her heart open to life? Is the teacher's orientation to life based upon love? What ways does the teacher work with his or her own fears? Is their life too scary so that there is a tendency to close in around the intellect? What has happened in their life that enables them to be open and spacious? What would the teacher do if there were someone in the class that they don't like? The suggestion was that the assessor would need to really listen to the teacher and get a thorough sense of them as people including such intangibles as their level of wisdom and compassion. Much of the assessment process was described as being *'visceral' i*n that one was operating intuitively to gain a sense of the prospective teacher.

Another strategy put forward was self-ratings of the teacher. It was suggested that the teacher could write a narrative description from their point of view of each session, including where the session deviated from the curriculum. This could also be used as a tool during supervision sessions. Ratings from the participants of the course teacher using a form developed for this purpose was another assessment strategy that was suggested.

One participant stressed the importance of using a range of approaches. Particularly if videotapes were used rather than assessment in person, as tapes do not give a sense of the intangibles in a group situation.

All the participants supported strong and rigorous standards of practice, though there was again differing levels of stringency about the level and depth of assessments that one would make of teachers. There was, however, a universal assertion that despite

the challenge it is important to ask prospective teachers to make their teaching practice available for scrutiny and feedback.

Methods of assessing competency of MBCT teaching for research trials

Given that the evidence base on MBCT does not currently include validated measures of competency, the general view of participants was that the strategy that could be best used in place of this is the consensual view of expert teachers:

> 'In the long run those measures of competency would have to be measured against outcome in trials but that would be a huge undertaking and I guess for now one just has to work with consensus.'

Several participants described ways of developing processes for this so that it became more objective and consistent. This would involve collaboratively identifying the key skills of teaching MBCT; and then once there was agreement of what was being rated there would be a process of a group of experienced MBCT teachers consensually rating prospective teachers, until the point where there was agreement so that rating could take place independently. Whilst adherence could be rated by a trained graduate, competency would need to be rated by a group of experienced MBCT teachers.

One participant put forward that one could therefore, through the process of the proposed research trial, develop a scale, possibly based upon a [seven-point] scale of competency, to take into account high and low competency. The scale would incorporate definitions of the components of competency through a list of such areas as: the ability to weave together people's experience into the teaching points;

to tolerate silence; to work in a non-striving manner and so on. It would also list the elements of the programme such as the core practices; the homework review; the CBT components and so on. The rating would then be applied to this list of the session components using the components of competency as a structure for the rating. One could rate competences of whole sessions or elements of sessions. Within a trial one might rate two sessions taken at random from the eight sessions and randomly select from those sessions four components of the session to rate on the scale.

The process therefore of assessing competency of MBCT teaching, is an area which all participants expressed as being extraordinarily complicated if one is to do it in a way which takes account of the myriad layers of subtlety that are a part of this teaching. In terms of developing workable strategies for this within a clinical trial, one would need to balance the importance of assessing and measuring competency against the resource cost. Done fully the process is very time intensive of highly experienced teachers. One participant stated that *'one has to be realistic but not compromise.'* One would need to express confidence to grant awarding bodies that one has experience of training MBCT teachers and working with adherence and competency issues. One would need to balance this with ways of communicating that this is 'work in progress' and that there is much investigation that needs to be carried out to understand more fully what is involved here. The attitude that emerges here is a sense of the importance of balancing the articulation of the challenge of working with competency issues in such a complex teaching system with the importance of expressing confidence in experience and ability in this area.

One participant also stated that it might not be necessary to develop validated ways of measuring competence in an MBCT research trial:

'There are very few trials that assess adherence and competence thoroughly and then look at that in relation to outcome …it is very good if you can but often

you need enormous resources to do this…[Rating competence] *is very labour intensive…in terms of paying people to rate these things it may be more important to independently rate the clinical outcome interviews* [with clients] *in a trial…'*

As was articulated by several participants the strategies outlined above are some distance from a fully validated competence scale which has been measured against outcome in trials, but would be potential workable strategies which would further the understanding of the processes involved here.

Summary of chapter five

In chapter five the results of the research component of the dissertation are presented. This is approached by exploring the issues within four over-arching themes: selection criteria for MBCT teachers; MBCT teacher training and development process; adherence to MBCT treatment protocol; competency in teaching MBCT. The categories within these themes are used as a structure for presenting the participants experiences.

The reflections on the area of selection criteria pointed towards the need to balance the importance of developing and assuring standards of MBCT teaching practice with the need to remain open-minded to the range of people who are suited to this work. Likewise when investigating the area of potential training and development routes for MBCT teachers, there was a theme of teachers needing to develop both their experiential and their conceptual understanding of the approach and to have the ability to clearly articulate the connections between these areas. There was also a theme of the importance of giving the development and training process plenty of time to mature. The issue of adherence to the MBCT protocol produced reflections on the importance of balancing an emphasis on the maintenance of a strong faithfulness to the curriculum and methods of teaching with a potential rigid conformity, which could stifle the present-centred responsiveness needed for skillful MBCT teaching. The area of measuring MBCT teacher competency was universally acknowledged as exceptionally complicated and underexplored to date. Whilst recognising the complexity, there was discussion on potential ways of developing current methodology which addresses this area. A discussion of this material is given in the next chapter.

Chapter Six

Discussion and Conclusions

Aims of chapter six

Chapter six discusses the results of the research presented in the preceding chapter and offers some interpretation, analysis and reflection on the wider implications for mindfulness-based cognitive therapy (MBCT) training and assessing generally and for the teaching requirements for MBCT research. The four category headings that emerged through the research process are used again as a structure for this discussion, followed by participants commentary on a final draft of the dissertation and a general conclusion.

Selection criteria for MBCT teachers

Both 'inner' and the 'outer' understandings and skills were considered important to all participants. However, some interesting differences in emphasis amongst the participants emerged in terms of the level of priority given to the teachers' duration of mindfulness practice experience and their ability to contextualise the teaching within a theoretical framework. This variation in emphasis on practice experience seemed to connect to the way in which MBCT does have a greater level of conceptual underpinning to that of mindfulness-based stress reduction (MBSR) and also to the different developmental stages of the two approaches. These areas are now discussed in turn.

Experiential and conceptual

One potential reason for this differing emphasis in participants on the issues of selection criteria for MBCT teachers is the difference in the balance of emphasis between the MBCT and MBSR programme. Those coming from an MBCT and cognitive behavioural therapy (CBT) background were strong in articulating the ways in which MBCT differs from MBSR in terms of the ways in which the teacher integrates a cognitive understanding of people's experiences within the mindfulness-approach. There was a resulting leaning to the importance of this 'structured therapy' background in the training of the teacher. The clear emphasis here is on the use of this background to enable the MBCT teaching to take place within a framework of theoretical understanding. The challenge for teachers with a therapy background, as was highlighted by two participants, can be the propensity to move into ways of working which are familiar to their therapy work but are not consistent with the

mindfulness frame within which MBCT is delivered. This may include an emphasis perhaps, on the story and details of participants' experience, on goal-orientated styles of working or on conceptualising processes prematurely.

The importance of this 'blending' of inner and outer understanding, the ability to relate to the MBCT approach from an experiential and conceptual viewpoint and to interconnect these areas came over as a crucial component of MBCT teaching. One aspect of the learning within the research process for the author, was the level of significance within MBCT of this weaving into the teacher's understanding and teaching a theoretical understanding, which can facilitate the subsequent understanding and the articulation of the processes for the participants also.

The different developmental stages of MBSR and MBCT

Another possible reason for the differing emphasis amongst participants could be a reflection of the different stages in the development of the two approaches. MBSR has been used clinically for 22 years whilst the clinical use of MBCT dates back only about 5 years. The spread of MBSR in the USA particularly, but also throughout the world is extensive whereas MBCT, although the interest is extensive, is currently taught in only a handful of clinical settings.

One of the issues faced by MBCT in this early developmental stage is that there is not a pool of available teachers ready to deliver the intervention for clinical or research needs. One of the core areas of questioning that is being addressed in this investigation is around clarity on the necessary requirements of teachers who are teaching for MBCT research trials and are in the early stages of developing their skills. If the required level of competence were set too low, the research results would become too diluted to answer any questions. MBCT, the participants and the teachers would not be served well by this. If the level of competence is set too high there would not be enough teachers to enable the approach to develop.

Given this early developmental stage of the work and the scarcity of available MBCT teachers, there was a leaning within some of the participants with an MBCT background to being more inclusive of potential teachers rather than establishing criteria that could exclude practitioners who were developing their teaching practice.

This was in contrast to other participants who felt that a stringent line would best serve the process of MBCT development.

The author's understanding of much of the MBCT teacher training that has been offered to teachers to date is that it has been 'introductory' and 'foundational'. These are the words used in the North Wales Centre for Mindfulness Research and Practice (NWCMRP) literature on training (see Appendix 13) and they are intended to be descriptive of training stage. It has been appropriate to have open criteria for these trainings which enables potential MBCT practitioners to expose themselves to the training process and develop their early teaching practice. The process has a natural momentum, as those who are 'in tune' with the approach will seek and ask for the further training that they need to support their on-going learning. It becomes appropriate at more in-depth stages of training to institute more stringent entry criteria, much as the Centre for Mindfulness (CFM) do for in-depth MBSR teacher trainings (see appendix 1). There seems also a need, however, to balance the need to establish 'blanket' criteria for entering trainings with the importance of having a personal connection with participants, so that judgements on participants' suitability is made on the basis of engagement with them as people.

Given the complete personal engagement in mindfulness which MBCT teaching requires of its teachers, there is a sense in which the process of developing the approach needs to be a 'grassroots' process. It could not, for example, be a purely strategic decision to bring MBCT teaching into a department. The impetus for the teaching would necessarily come from interested practitioners on the ground. This certainly describes the evolution over the last few years of the process of MBCT development in the UK.

MBCT teacher training and development paths

The discussion on this area of the research process divides the exploration into four areas:

1. Implications for the training of MBCT teachers generally.

2. Potential areas of improvement within the short to medium term in the North Wales Centre for Mindfulness Research and Practice (NWCMRP) training programme.
3. Research specific MBCT training considerations.
4. Visions of the longer term potential of the NWCMRP training programme.

1.Implications for the training of MBCT teachers generally

In this section some general principles underlying the training of teachers of MBCT that emerged through the research process, are gathered together.

- Training in teaching MBCT needs considerable space and time to develop. Space is needed in the life of the teacher to enable them to develop the level of personal practice experience required in the form of both daily practice and regular retreat experience and to integrate the understanding of this into daily life. Time is needed to enable personal and teaching process to evolve. The developmental process is ongoing throughout the life of the teacher.
- Training in teaching MBCT requires the concurrent development of a number of areas including:
    1. Mindfulness practice experience.
    2. Theoretical understandings of both mindfulness and cognitive approaches.
    3. Mindfulness-based training which integrates mindfulness practice experience and theoretical understanding and develops skills in teaching MBCT.
- Making the choice to teach MBCT is a life decision that will permeate the life of the individual. To consciously and intentionally cultivate awareness requires a genuine commitment to the integration of learning in all aspects of personal and professional life.
- There is a continuity of experience between participants in MBCT courses and teachers delivering and receiving training in the teaching of MBCT. The ways of learning in mindfulness-based approaches are the same throughout the process and therefore the teaching methods and core attitudinal underpinnings of MBCT described in chapter two holds for all stages of training. The process of learning is in many ways cyclical. The learning arises through the practitioner, again and again, coming back to the directness of their inner and outer experience in each moment.

- There are general threads to the training processes engaged in by MBCT teachers and yet the process is individual and personal. It is possible therefore to identify common pathways towards developing skillful MBCT teaching and there are some training aspects that all practitioners need. There are also, however, a myriad of accidental life experiences and intentional individualised methods which shape MBCT teachers' experiences and develop their practice.
- The mutual interconnection and bond between teachers and trainees is a strong element in the teaching process. This relational experience of acceptance and respect is a core way in which many developing mindfulness-based teachers experience the transforming potential of mindfulness. The experience of such connection can often be a gradual catalyst for changing their relationship with themselves and their experience.

2.Potential areas of improvement within the short to medium term in the North Wales Centre for Mindfulness Research and Practice (NWCMRP) training programme

There are a number of areas of potential development in the NWCMRP training programme that have been highlighted for the author through the process of this investigation. This is a relatively long section and has been subdivided under the following headings:

- development of MBCT specific training;
- development of more in-depth training;
- development of opportunities for networking and support amongst mindfulness-based teachers;
- development of more explicit guidance on possible training pathways for the potential MBCT teacher;
- explorations on the issue of formal recognition of teaching competence;
- reflections on and developments within the mindfulness-based approaches Master's module programme.

These areas are now considered in turn.

- **Development of MBCT specific training**

The current NWCMRP professional training programme offers participants an understanding of mindfulness-based approaches in general with a leaning towards an MBCT emphasis. This has been felt to be appropriate given that:

I. Participants are often from a range of professional backgrounds and so both, do not always have the clinical and CBT training required for MBCT teaching and are looking for the understanding that mindfulness-based approaches confers in a range of settings.

II. The development of mindfulness-based approaches in the UK is in its early stages and many participants to date have been seeking general and early understanding and skills.

III. A general training in mindfulness-based approaches enables participants at introductory and foundational levels to have a wider view of the field and from that understanding develop their teaching practice in ways which suit their experience and clinical setting. In this way participants can develop understanding of the range of potential generic and specific applications of mindfulness-based approaches.

IV. Using the models of both MBCT and MBSR in an integrated way helps teachers to develop, in informed ways, mindfulness-based programmes which are suited to their particular training background, client group and work setting.

However, there are some losses from this strategy of generic teaching. There is a need for teachers who want to teach either MBCT or MBSR specifically, to have greater in-depth immersion in the curriculum of the respective approaches than the current training opportunities offer. Within the field of MBSR teaching, the advice of the NWCMRP to those who want in depth training in the approach would be to do this through the extensive training programme at the Centre for Mindfulness (CFM) in the USA. Within the field of MBCT teaching, the need for specific and in-depth training arises through the strongly expressed interest in its clinical use and for the implementation of MBCT research. There is an intention therefore within the

NWCMRP to develop a form of residential training retreat that is specific to MBCT. This would also address the need discussed next for more in depth training opportunities.

- **Development of more in depth or 'advanced' trainings** (in MBCT and mindfulness-based approaches generally)

As has been described in chapter three, the MBCT training programmes both within the NWCMRP and delivered by others in the USA, Canada and Denmark have only been in place over the last 3 years. The research participants' commentary, the author's personal experience and understandings derived through witnessing the development of participants in the NWCMRP trainings, underline the necessity for the development of mindfulness-based teaching practice in an individual to be a process, which both unfolds over an extended period and needs a range of personal development and training input. In many ways trainings to date have focused on early teaching development. Though as was highlighted in the research process, the ways in which training is received varies according to previous experience and the personal qualities of the trainee. There are some highly skilled MBCT teachers now who have developed their practice through current MBCT trainings.

The research process informed a number of potential development areas within the NWCMRP training programme, which could offer a greater availability of ways of enabling experienced teachers to further develop their practice. Some of the author's thoughts on this are as follows:

I. As described above, to develop a week-long residential training retreat which is specific to the MBCT programme; is delivered by an experienced MBCT teacher with CBT experience; has rigorous entry criteria (i.e. participants must have engaged fully in foundational trainings in mindfulness-based approaches, have a structured therapy background and have attended 5-10 day silent retreats).

II. Develop the provision of supervision and mentoring for mindfulness-based teachers. The need for mindfulness-based teachers to have individual supervision of their personal and teaching practice is explicitly a part of the

NWCMRP good practice guidelines (see Appendix 4). The research participants highlighted this need and the experience of the teachers within the Centre has been that this process is an important part of ongoing development and reflection. It is by its nature individually tailored to the needs of the teacher. Increasingly, the NWCMRP is being asked to offer this service to teachers with a range of experience – from those who have not yet started teaching and want support and guidance in the process to experienced teachers wanting to develop their process in an ongoing way.

The research process emphasised the importance of this supervision process and this has led the author to see that offering a greater clarity and structure to the provision of this within the NWCMRP would be helpful to MBCT teachers. Material will therefore be developed within the NWCMRP that describes clearly the process, structure, contractual arrangements, boundaries and other such areas to this supervision and mentoring process. It may also be a useful strategy to explicitly link this with offering direct feedback on practice to MBCT teachers who would like this, through supervisors witnessing their teaching and integrating feedback into the supervision process. This currently happens but the potential for using the supervision in this way is not clearly articulated to training MBCT teachers.

III. Develop more opportunities for mindfulness-based teachers to network and support each other. This area is addressed in the next section below.

- **Develop opportunities for networking and support amongst mindfulness-based teachers**

As a significant part of ongoing teacher development the research participants highlighted the importance of developing systems for MBCT teachers to interconnect with one another. The impetus for this often largely comes from the teachers themselves who naturally seek this sort of engagement. There is a strong commitment, locally in Wales, nationally in the UK and internationally, to network and interconnect in various ways with others who are teaching mindfulness-based approaches. Why is this? This way of working does ask of the teacher such a strong

personal involvement and engagement, that the connection with others who are engaged in exploring this work is an important way of sustaining and nourishing the process. It is also through this process of interconnection, supervision and mentoring amongst mindfulness-based teachers that much of the transmission of the approach takes place. Formal training is only a part of the picture. Certainly, the author's own development process as a mindfulness-based teacher has grown and been shaped immeasurably by connection and engagement with the North Wales local group of mindfulness-based teachers.

Given the strength that the NWCMRP has in having an unusually large collection of, now relatively experienced, mindfulness-based teachers, there is the opportunity to offer support to less experienced mindfulness-based teachers in the UK. Many of these opportunities could be available at quite low cost which, given the cost of the relatively high cost of the training process more generally, would enable more teachers to access them. These opportunities would be available for teachers who have engaged in foundational trainings and are currently teaching. They could be in the form of invitations to join the Centre peer supervision process; development of peer led retreats and development of networking and training meetings.

The delivery of international conferences by the NWCMRP is also intended to enable practitioners to meet and network.

- **Explorations on the issue of formal recognition of teaching competence**

For reasons highlighted above on the section on the early developmental stage of MBCT and for the pure practicality of the challenge of instituting and managing a certification process, it is generally felt inappropriate to institute a formal certification process for MBCT teachers. MBSR is so widely used now that it is appropriate to 'narrow the funnel' and develop means of recognising those who are practicing to levels that fulfil competent practice guidelines. MBCT is at an early developmental stage and therefore requires opening out and developing. There is a need to balance the requirement for standards with the need to be inclusive and flexible, but at this stage in the development of the approach it would not be helpful to make it harder for potential teachers to embrace the work.

The NWCMRP is not the only provider of MBCT training and therefore any certification system that was instituted in the future would need to be done with full dialogue with other providers. A future possibility is that a system of 'recognition' of MBCT teaching skill could be given by the NWCMRP to those who have engaged in Centre training, supervision and have had their teaching work seen and assessed by experienced teachers. This would be a step removed from a full certification process, but would meet the need expressed by some participants in MBCT training programmes for something that offers an outer recognition of their inner development, training experience and teaching skill. There is also the potentially challenging area, highlighted by some participants, that there are some practitioners who are trained but do not have appropriate skills. A certification process would also be a way of not recognising these practitioners.

Learning is also contained within the processes of the MBSR certification system in terms of defining, more clearly, possible training pathways to becoming an MBCT teacher. This is discussed in the next section.

- **Development of more explicit guidance on possible training pathways for the potential MBCT teacher**

There are ways in which one can clearly articulate to potential MBCT teachers, the training paths that may be helpful to them, and good practice guidelines that enable them to have a structure to work within. Essentially, one is therefore enabling teachers to take their training process through to the point at which certification would be awarded, if there were such a system, without actually having a formal marking in the shape of an award. Appendix 13 contains a draft version of a summary of possible training paths within the NWCMRP, which was prepared by the author following the understanding of greater need for clarity in this area which this investigation highlighted.

- **Reflections on and developments within the mindfulness-based approaches Master's module programme**

As described in chapter three, the current programme of Master's modules in mindfulness-based approaches at the University of Wales Bangor contains four modules: an experience based foundation module, a module on group theory and practice and mindfulness-based teaching, an applied module on teaching and a module on research and evaluation into mindfulness-based approaches. Although, to the participants this programme contains the possibility of gaining a full Master's degree in mindfulness-based approaches, from a teacher development angle there are some areas that could be usefully addressed through the development of further modules.

The research process highlighted some gaps in current training provision which could potentially be addressed through further master's degree modules. There are three potential modules that are likely to be of interest to developing practitioners of mindfulness-based approaches:

I. *Cognitive Behavioural Therapy and its integration into MBCT.*

Given the understandings that were articulated by the research participants on the importance of CBT training to those delivering MBCT and the numbers of potential MBCT teachers who do not have this background, it would seem helpful to offer this training opportunity. Most usefully, this would be delivered within the mindfulness-based approaches modular structure to enable the teaching to directly link in with the CBT understandings and skills that are pertinent to MBCT teaching.

II. *In depth MBCT teacher training module*

There is the potential that the training suggestion, described above, of an MBCT specific, in-depth residential teacher training retreat could be integrated with the master's programme with the addition of appropriate practical and academic assessed work.

The greater level of stringency of acceptance and assessment that would be contained in this more advanced module, may in some ways address difficulties

that have emerged in the teaching and assessing of the current applied teaching module.

The teaching for the current module is delivered in the form of a residential training retreat. This is explicitly aimed at practitioners who have taken the foundation module, have a personal mindfulness practice and who have either not yet started teaching but have an intention to, or are in the early stages of developing their teaching practice. These entry criteria are not stringent and it is possible for potential teachers to join the module who are some way from being ready to skillfully teach mindfulness-based approaches. A third of the assessment process involves assessment of teaching in action but it would be possible for participants to gain very low marks in this and still to pass the module if they were strong on writing about the approach.

Although the information on the modules explicitly informs participants that the modules are not a complete preparation to teach mindfulness-based approaches, there is the risk that the gaining of a formal recognised 'Master's qualification' in the approach would give inappropriate recognition to some teachers. Entitling the current module as an 'introductory' training on the teaching of mindfulness based approaches and developing an 'advanced' or 'in-depth' training, may in some ways address these difficulties.

III. Mindfulness-based approaches and their applications within individual therapeutic work.

Many of the current participants on the NWCMRP training programme are counsellors and therapists who are engaging in mindfulness-based training to inform their individual therapy practice. The applied module and the residential training retreats are orientated around teaching mindfulness-based approaches in the structured group-based setting of MBCT and MBSR. Many of these practitioners have expressed that in-depth training that was relevant to their individual therapy work would be of interest to them.

3.Research specific MBCT training considerations

As was highlighted in chapter five, the research participants stated the importance of teachers for MBCT trials being fully trained in the specific curriculum and methods of the approach. As has been discussed above, current training opportunities in the NWCMRP do not fully address this area. The suggestions on developing a more in-depth and specific MBCT training programme with more stringent entry criteria would also help to address the need for highly trained teachers working within MBCT trials. In establishing the level at this place, one would therefore have gone some way towards defining necessary competency for teaching on MBCT research trials. Teachers would need to have fully engaged in foundational stages of training, to have a structured therapy background, to have a strong personal mindfulness practice and experience of silent teacher led retreats.

The research process highlighted that seeing the teachering in action, assessing this along some guidelines established for the purpose and interviewing the teacher seem to be the best methods available for selecting appropriate teachers for research trial teaching.

It became apparent through the research that there will need to be considerable trial resources in the form of experienced MBCT teacher time, allocated to the process of consensually developing criteria for selecting teachers; assessing their teaching and supporting their development.

4.Visions of the longer term potential of the NWCMRP training programme.

It is challenging to reflect in definitive terms on the future direction of the NWCMRP. The longer term potential of the NWCMRP is both extensive and precarious. There is enormous interest in the development of mindfulness-based approaches and there is a team of committed practitioners working within the NWCMRP. It is precarious in that the funding streams are uncertain and to fully cost training events often renders them inaccessible to many potential participants.

It is certainly clear that all who work within the NWCMRP are there because of a strong personal knowledge of the potential of this work in their own lives and a subsequent commitment to facilitating the increasing availability of mindfulness training to others. All the mindfulness-based teachers in the NWCMRP have experienced for themselves and witnessed others experiencing, the relief inherent in

simply seeing that one does not need to constantly be striving to fix and change things. Professionals who come to the NWCMRP are often drawn by an inner need to find ways of sustaining and nourishing themselves while living and working in a driven goal orientated world. As one of the research participants said: *'the world needs this practice so much'.*

Whilst the outer expressions of the work is developing and bringing mindfulness-based practice into the world in accessible ways, there is a simultaneous need to develop the foundational underpinnings to the NWCMRP itself. It is important to address the core values, principles, structures, methods and organisation in ways which are congruent to the principles of mindfulness itself, if the outer expression of the work is to be fully aligned with the underpinning principles. Crucial though this work is, it does not bring revenue into the NWCMRP. There is this consequent ongoing challenge of bringing the practice into the world in ways which do not compromise its essence whilst also approaching this in ways which enable the NWCMRP's work to be financially viable and to operate within the demands of it's institutional context.

In bringing mindfulness-based work into the world, there is at times, an experience of working on an edge: the coming together of the forces of a goal driven modern world with the underpinning qualities core to mindfulness of openness, acceptance and non-striving. The mindfulness principles underlying the paradox described in chapters one and two of working with intention *and* in non-striving, non-goal driven ways need also to be at the core of the work of the NWCMRP. It is easy for a vision for the work to become a mission, in the process of which the core principles are left behind. Yet, in order for the work to happen there is a need at times for practitioners to 'swim against the tide' in uncomfortable ways.

Constantly, dynamically working with these edges of both trusting the unfolding of the process of the development of the work and taking appropriate action in each moment is immensely challenging. Sustaining this process whilst simultaneously working congruently with the principles of the work is not something that anyone can claim to do at all times. The paradox highlighted above that is at the heart of mindfulness work is again apparent here though: remaining congruent with the

principles of the work is at the heart of supporting oneself in sustaining the process of the work itself. In taking care of the process the outcome of what we do will often take care of itself. Mindfulness-based practitioners perhaps have a greater than usual responsibility to 'walk their talk', through taking care to balance times for inward reflection and practice with outer expressions of the work in the world and to be responsive to personal and family needs.

Adherence to MBCT treatment protocol

This was one of the least controversial areas of reflection amongst participants. Ensuring the straightforward presence or absence of components of the programme does not present difficulty. It is worth though commenting here on the underlying assumptions regarding adherence to protocol.

One of the participants talked of the need to balance three elements of the programme: the curriculum, the group and the teacher. Inquiring around this, the feeling expressed was that it is important that each of these elements are recognised in the delivery – if any one is lost or overemphasised it would be to the detriment of the teaching. If the curriculum is not covered the clients will not receive the teaching or conversely will receive it in a potentially mechanistic way if it is covered at the expense of present-centred responsiveness; if the group's needs are not addressed then the teaching that is transmitted through the teacher embodying a responsiveness to the moment will be diluted and conversely if the teacher is 'hijacked' by the group away from the core teaching there will be a loss; finally if the teacher does not teach through his/her own 'being' there will be a difficulty in congruently embodying the approach and conversely, if the teacher has a very idiosyncratic way of teaching that strays away from the core there will be a loss. It seems important to balance these areas through a constant dynamic moment-by-moment responsiveness that cannot, by definition be prescriptive or definitively pre-planned.

It is interesting to consider that adherence scales are better at measuring the curriculum elements of the programme than the other components. One participant talked of an MBCT group that they had just been facilitating, in which following the first practice and review of this, the home practice review had become the main

feature of the session. The sense described was that there was so much that the group members were bringing to this, that that was immediately pertinent, it would have been an arbitrary and unresponsive decision to move the focus away to the exercises that are scheduled to take place in that session. The teaching choice was made to weave the teaching themes of that week and the introduction of the breathing space practice into this home practice review. The author's view is that this sort of flexibility is important in the skilful teaching of the approach, but is likely to be a skill that is acquired by teachers who are deeply familiar with the programme. It may well be that early teachers need to prioritise the curriculum over the other elements and that as the teaching matures the teacher is able to develop a greater level of flexibility and responsiveness. The risk of departures from the curriculum at an early stage in the teaching experience, is that the foundation of the programme may not be fully understood and any teaching choices would not then be based upon either appropriate experience or the theoretical understanding of the teacher. As one participant said, it seems important to be able to question, both in the heat of the moment in the session, and through reflective practice at other times – '*what is the intention behind the departure from the manual?'* For MBCT teaching that is taking place in the context of a research trial, there is also the question of whether any departure is acceptable in this context, as was commented on in the results in chapter five.

There is also an active area of investigation in exploring the applicability of MBCT to other situations than that for which it was originally developed as described in chapter one. Adaptations to the programme, informed by appropriate choices and based on the needs of the client group in question are an important part of developing the approach.

There is the need therefore to determine for the purposes of the proposed trial the level of adherence that will be required of teachers. What is core to the curriculum and what level of adaptation to meet such areas as the perceived needs of the group and the particular way of teaching of the teacher are acceptable?

Competency in teaching MBCT

As in the discussion in chapter five, this discussion is divided into commentary on ways of assessing competence generally and ways that are specific to the needs of research trials.

Assessing MBCT teaching competency generally

Participants' commentaries on the need for the teaching of practitioners to be seen to enable assessments to take place was interesting alongside the frequent recognition also of the challenge and difficulty associated with this sort of engagement.

In all areas of human engagement it is challenging to be able skillfully to make judgments about another and to use that information wisely. There may be a particular difficulty for mindfulness-based teachers in doing this together because the work has such a strong emphasis on bringing a non-judgmental stance to our experience. All mindfulness-based teachers, the author has had had contact with, have no difficulty in supporting strong and rigorous standards of practice. The challenge can be when the elements of non-judgmental attitudes and standards of practice come together and there is a need to be active in making choices and discriminations about teachers.

It has been an interesting and challenging process for the teachers within the NWCMRP to develop a strategy, which enables internal teacher assessment to be made, to carry this out together and then to work and engage together with the outcomes of the process. Each stage of the process required the teaching group to move in close to some challenging interpersonal areas. There is a great deal of sensitivity and skill required to acknowledge on an individual and collective level the effects of these processes.

There has been much learning for NWCMRP teachers in this process. One aspect of the experience of developing and implementing this peer mentoring process is that, if done skilfully, it can be highly collaborative and the learning is rich for all involved. The view that has developed within the teaching team at the NWCMRP is that this openness about one's teaching practice and willingness to receive feedback is an important part of MBCT teaching practice generally. It is enormously challenging but

inherently rich in learning possibilities for all participants in the process. An outline of the process used by the NWCMRP is contained in Appendix 6.

There was interesting commentary by participants, on the relative value of videotapes of sessions and being there in person to make assessment. The teachers in North Wales who have been involved in the NWCMRP internal teacher assessment process have said that it is easier to make the assessment through being there in person rather than the somewhat removed view one receives on watching a videotape. The next best is to have been present in person for at least one class - the video evidence of the other classes then is more meaningful having seen the fuller context. Commentary was made by a research participant on the value of watching a videotape of the session with the teacher and the person offering feedback alongside each other. This is a process that has not been used within the NWCMRP team and may be a useful learning tool for the future development of MBCT teachers for research and general teaching.

There was further interesting commentary on other methods of feedback on teacher competency. It may be useful for teachers to receive more detailed and specific feedback from participants on their teaching (see Appendix 12 for a form developed by the CFM for this purpose). The current feedback forms used within the NWCMRP are general in their nature and do not capture such a detailed level of feedback. The possibility of the teacher writing a narrative of the sessions is also a potential useful learning tool that could be incorporated into supervision and mentoring processes for teaching in research and other contexts.

Methods of assessing competency of MBCT teaching for research trials

The processes suggested by participants have, whilst underlining the complexity of the area, offered some tangible strategies for working with competency issues within a trial situation. Building on the existing means of

assessing competency of MBCT teachers these suggestions offer the beginnings of a road map in a difficult area.

It seems possible as one participant suggested, that a group of experienced teachers could use their understanding to develop a condensed list of core competencies in the teaching of the MBCT programme. This will need to be done through a process of team reflection, debate and then a testing out of the list by using it in assessing teaching and then repeated processes of refining and distilling. There is much work that has been done in this area already: the participants comments contain, in an unsystematic way, description of the core areas; the NWCMRP has developed good practice guidelines (see Appendix 4) that are used as a structure and guide in their internal assessment process and the CFM have long been articulating their sense of what is competent practice in the teaching of MBSR (see Appendix 3). The challenge is to distill these into a concise and workable framework that would ultimately enable a group of teachers to make individual assessments consistently. However, there is much initial work that would need to be done consensually to enable this stage to be reached.

Given the likely resource implications, one of the areas of choice will be how far to go in terms of formal measurement of competency. It is essential to develop internal systems within a trial that would enable informed and consistent choices about who is appropriate to be a part of this process; to offer teachers appropriate training, supervision and support; and to develop strategies for monitoring their working practice. It may not be essential, as one participant suggested, to formally develop measures of competence but it could explicitly be a part of the research protocol to clarify the necessary strategies for attaining and measuring competence in MBCT teaching.

Participants' commentary

As described in chapter four, the six participants were sent a final draft of this dissertation and invited to make commentary (see appendix 8). Due to the time scale for submission, commentary that would be included in the final version was needed within a three-week period. This limited the quantity and depth of response from participants. Four participants responded: two, by e-mail, giving general and positive feedback on the value of the study and expressing the intention to use the understandings in their work; and two offered similar general feedback plus some specific commentary on content as follows.

Both the latter two participants commented on the potential value of instituting some training input in cognitive behavioural therapy for MBCT teachers that would include cognitive models and their implications for psycho-educational aspects of MBCT.

One participant commented on and affirmed the value of developing a form of 'recognition' as opposed to 'certification' of competent MBCT teachers. It was suggested that '*participation in MBCT research could be linked to explicit acknowledgment of a level of expertise: not accreditation but maybe some kind of recognition.'*

The ways in which competency issues have been addressed in this study were highlighted as being a potential strong area when presented to a grant awarding body for a proposed MBCT trial. It was suggested that this *'would be unusual in specifying more clearly than most research, both adherence to a manual and competency in style as well as content of teaching in relation to the mindfulness (and cognitive view of depression) models.'*

There was commentary that it would seems logical to seek to *'have the teaching of each generation evaluated by one or more of those from a previous generation'* of teachers. This was highlighted in connection with the strong consensus seen in the research that observing the teaching in action is the only way to know how well people are teaching no matter what threshold of prior training is set. The subsequent

need was expressed that in any proposed MBCT trial there would need to be a number of layers of supervision and mentoring of teaching practice which incorporated the practice of those teachers who were evaluating the practice of others.

Conclusion

It is tempting to seek definitive, tangible outcomes to this process of seeking greater clarity around necessary MBCT teaching competencies. All that this investigation can claim to have achieved is to be a part of a collective and collaborative process towards greater clarity. It would be premature and unhelpful to be definitive and prescriptive about future developments in this complicated area. The investigation has certainly enabled the author to reflect deeply and extensively on the issues and has greatly extended her understanding of the processes involved and potential ways of working with them. In many ways this is already having an effect on working practice within the NWCMRP.

It seems important to acknowledge here that this is work in progress. As Einstein said '*If we knew what it was we were doing, it would not be called research*' (Harris 1995). If we are truly to work mindfully with where we are right now, we have to use the understanding that is available to us now, whilst acknowledging that this is only a part of the full picture. If we remain open to the process, the insights that emerge in the process of investigation will inform future ways of working with competency issues both in the clinical and research use of MBCT.

The process of developing research on mindfulness-based approaches, teaching mindfulness and learning about mindfulness all contain the same underlying principles. If, as mindfulness-based practitioners, we are truly to 'walk our talk' it is crucial that all aspects of the work are engaged in, or if appropriate not engaged in, with awareness, presence and integrity.

The understanding the teacher brings to the MBCT teaching process is based on his or her own experience of the process. In order to work congruently with aspects of teacher development and assessment for research trial purposes it is important to acknowledge the experience we do have in the field. It is equally important to acknowledge that there are many areas of unknowns. In the spirit of adventure that is core to learning in mindfulness-based approaches this process of exploration can become a mutual and collaborative venture between all those engaged in it.

Albert Einstein was quoted at the beginning of this dissertation and it seems appropriate also to end with his words:

> *'Only what you have experienced yourself can be called knowledge. Everything else is just information'* (Harris, 1995)

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