Mindfulness-Based Cognitive Therapy (MBCT)

Implementation Resources

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These implementation resources were gathered and edited by Prof Willem Kuyken (Exeter University), Rebecca Crane (Bangor University) and Prof Mark Williams (Oxford University) from materials developed at the mindfulness centres at Exeter, Bangor and Oxford Universities.

The materials have been developed at Exeter by Willem Kuyken, Alison Evans, Claire Brejcha, Lynne Holmes and Jenny Wilks; at Bangor by Rebecca Crane, Jody Mardula, Judith Soulsby, Sarah Silverton and Trish Bartley; and at Oxford University by Mark Williams, Maret Dymond, Melanie Fennell, Marie Johansson and Christina Suraway.

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1. Introduction[1]

Mindfulness-based cognitive therapy (MBCT) was developed as a psychological approach for people at risk for depressive relapse who wish to learn how to stay well in the long-term. It is described in the manual "*Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*" published by Guilford Press in 2002. In recent years MBCT has evolved to be more widely accessible to a range of populations (e.g., Williams and Penman, 2011). This publication provides some key resources that MBCT teachers need to set up an MBCT service, run MBCT courses and evaluate their work.

The MBCT approach

MBCT is based on Jon Kabat-Zinn's Mindfulness-Based Stress Reduction program at the University of Massachusetts Medical Center, which was developed to help people suffering with chronic physical pain and long-term medical conditions. It includes meditation techniques to help participants become more aware of their experience in the present moment, by tuning into moment-to-moment changes in the mind and the body. Groups of 8-30 participants learn the practice of mindfulness meditation through a course of 8 weekly classes, and through daily mindfulness practice supported by audio-recorded guided meditation practices. MBCT for depressive relapse also includes basic education about depression, and a number of exercises derived from cognitive therapy that, for example, demonstrate the links between thoughts, feelings, body sensations and action tendencies and how participants can care for themselves, especially when they notice a downturn in their mood. Through the mindfulness practices participants learn to see more clearly the patterns of the mind, and to recognise when mood is beginning to dip without adding to the problem by attempting to avoid or suppress painful thoughts and feelings, or by falling into analysis and rumination. This helps break the old association between negative mood and the negative thinking it would normally trigger. Participants develop the capacity to allow distressing emotions, thoughts and sensations to come and go, without feeling that they have to suppress them, run away from them, or fight them. They learn to stay in touch with the present moment, without being driven to ruminate about the past or worry about the future.

Developing MBCT: The Next 10 Years

The original MBCT manual published in 2002 had a clear focus on preventing depressive relapse. It was based on a theoretical account of cognitive reactivity and depression and has acquired a robust evidence base (Segal, Williams and Teasdale, 2002). The situation is now developing rapidly. For example:

- Many NHS mental health services are beginning to offer MBCT within their care pathways;

[1] This introduction is based in part on an Editorial: Williams, J.M.G. & Kuyken, W. (2012). Mindfulness-based cognitive therapy: A promising new approach to preventing depressive relapse. *British Journal of Psychiatry*, 200, 359-360. doi: 10.1192/bjp.bp.111.104745.

- The Mental Health Foundation issued a report in 2010 advocating steps to improve the accessibility of MBCT;
- There are now 3 training programmes in the UK at the Universities of Bangor, Exeter and Oxford, and numerous related training initiatives, for example through Breathworks;
- MBCT has taken root in North America, Germany, the Benelux counties, Scandinavia and Australia;
- Mark Williams and colleagues have increased the accessibility of MBCT by producing a self-help manual that helps people with depression to learn mindfulness for themselves (Williams, Teasdale, Segal, and Kabat-Zinn, 2007), and setting out a psychological account of human stress and how MBCT can enhance people's resilience (*Mindfulness: A Practical Guide to Finding Peace in a Frantic World,* Williams and Penman, 2011).

Further large scale clinical trials are now underway, designed to address outstanding questions concerning MBCT's efficacy, mechanisms and acceptability, particularly in relation to the treatment most commonly offered to patients with depression: maintenance antidepressants. Future research needs to interpret research findings suggesting that MBCT is effective only for those with 3 or more prior episodes of depression, and to assess its broader acceptability in real world settings. In the last ten years, theory development and treatment research has extended to people with chronic fatigue, current depression, bipolar disorder, health anxiety, parenting stress and suicidality. Outstanding challenges will be examining the translational gap from efficacy to implementation in the NHS, training sufficient numbers of skilled and adequately trained MBCT therapists, and consolidating and extending the evidence base for innovative applications of MBCT.

2. Setting up MBCT groups and/or an MBCT service

2.1 Implementation of Mindfulness-Based Cognitive Therapy in the UK Health Service

The article below presents the results of a survey of UK MBCT teachers and stake holders conducted during 2011; and reports the outcomes of a workshop on MBCT Implementation offered at the Mindfulness Now conference in Bangor University in 2011 led by Willem Kuyken and Rebecca Crane.

Crane, R. & Kuyken, W. (2012). The implementation of mindfulness-based cognitive therapy: Learning from the UK health service experience. *Mindfulness*. Manuscript in press.

2.2 Bangor – Exeter – Oxford Guiding Principles for MBCT Implementation

The grid below outlines some guiding principles for MBCT implementation. They are drawn from workshop participants reporting on both the barriers and facilitators to local MBCT implementation gathered at a workshop on implementation at the Mindfulness Now conference at Bangor University 2011.

The Nutely et al. (2007) framework for structuring these recommendations is used because it is based on extensive review of the evidence of what contributes to the likelihood of evidenced-based practice flourishing in local circumstances. Nutely et al. (2007) outline eight areas that need thinking through when implementing new evidence: translating research into practice implications, ensuring ownership, identifying enthusiasts, conducting a contextual

analysis, ensuring credibility, providing leadership, giving adequate support and developing integration.

Guiding principles	**How this relates to MBCT**
Research needs to be translated - Research needs to be accessible to services. Typically this involves tailoring the research and consensus development at a local level.	- Make local decisions about target populations/ inclusion/exclusion criteria. - Base decisions on definitive and emerging evidence for MBCT and on local service priorities. - Consider and map out how the new MBCT service will sit alongside existing care pathways.
Ownership is critical - Ownership of the research or of the implementation process by those involved in implementation is likely to positively affect uptake. - System based, top down approaches that 'force' research use in organisation can negatively affect uptake.	- Engage key stakeholders in service planning and commissioning. - Offer taster sessions/intern places for stakeholders to communicate aims and intentions of MBCT to them. - Support grassroots interest (e.g., among clinicians, referrers, service user groups …) through experiential opportunities to take mindfulness courses. - Develop local networks for interested clinicians and stakeholders.
Enthusiasts are key - People who are enthusiastic about the issue/topic/practice can act as champions and promote new ideas.	- Identify one or more "champion(s)" with adequate knowledge and access to key networks. - Champions are needed both within the organisation and external to the organisation. - Former participants in MBCT courses can be compelling advocates.
Conduct an analysis of context - An analysis of the context of	- Analyse local context to identify implementation barriers and facilitators.

implementation prior to designing the strategy can facilitate a particularized approach through the targeting of local barriers and facilitators.	- Set up an implementation steering group to systematically address local barriers and facilitators in the range of challenge areas, to develop and oversee the new service until it is fully embedded.
Ensure credibility - Research use is enhanced by credible evidence, credible champions/opinion leaders and a commitment to process.	- Ensure that key evidence and national guidance on MBCT (e.g. 2009 NICE Depression Guidelines and 2010 Mental Health Foundation Report) is clearly conveyed to staff by a credible champion. - Set up appropriate and realistic service evaluation - Ensure evaluation data is routinely collected and reported to key stakeholders.
Provide leadership - Strong and facilitative leaders at project and organizational level can lend strategic support and authority to the process.	- An overall MBCT service lead is required who can provide clear leadership. - Leadership is needed on a strategic and a clinical level. - Strategic leaders within the organization's management should ideally have experiential understanding of MBCT. - Clinical leaders need in depth training in MBCT so they can teach the course and support other staff in developing their skills through supervision and mentoring. - Leadership on good practice governance is needed using national guidance and contextualizing it locally.
Provide adequate support/resources - Implementation needs adequate resources and support including	- Identify appropriate and adequately trained staff to run MBCT courses who at minimum meet the UK good practice recommendations (UK Network, 2011)

financial, human (dedicated project leaders) and appropriate equipment	- Using epidemiological data, it is estimated that a population of 200,000 would need 2 full-time MBCT teachers to provide a service (Patten & Meadows, 2009). If the service is being offered to a broader client group than recommended by NICE then more teachers will be required. - Support and cultivate competent MBCT teachers. - Support and cultivate (though the courses and reunions) former MBCT participants. - Secure staff time to prepare and run courses - Secure staff time for screening, assessment and orientation of participants. - Secure staff time for providing some individual participant support between sessions in person, or via phone, text or email. - Put in place required training, supervision for on going development and adherence to good practice standards. - Ensure that a fit for purpose room is available. - Ensure that an on going supply of meditation recordings and participant handouts are available. - Secure administrative support for setting up courses and preparing course handouts. - Ensure that equipment for sessions (such as yoga mats, blankets) is available.
Develop opportunities for integration - Activities, changes and new practices need to be integrated	- Integrate MBCT implementation strategy with local and national strategies for increasing access to psychological therapies.

into the organization's systems and processes to enhance their sustainability. Initiatives that fit with strategic priorities are more likely to be given/allocated adequate resources and support.	- Identify appropriate imperatives for MBCT, such as the NICE depression guidance, health economic data or local strategic initiatives. - Establish a service pathway from referral through to discharge and communicate this effectively to all stakeholders. - Cultivate relationships with referrers. - Enhance service sustainability by promoting it and integrate it with other strategic priorities.

Note. Based on Nutely's (2007) synthesis of factors that shape evidence use in public services

2.3 Conducting an analysis of local context for MBCT implementation

One of the principles highlighted in the table above is the importance of conducting an analysis of local context. This can facilitate a particularized approach to implementation through the targeting of local barriers and facilitators. It is suggested that an implementation steering group is set up whose initial task will be to identify and systematically address specific local barriers and facilitators in the range of challenge areas and whose ongoing function is the development an oversight of the new service until it is fully embedded in service frameworks.

The following table offers a structure and checklist for identifying implementation barriers and facilitators in a range of areas influencing implementation.

	Implementation barriers	**Implementation facilitators**
Structural challenge: planning and coordination required to embed MBCT within the organisational fabric (e.g. how MBCT fits with other treatment modalities, assessment issues, inclusion/exclusion criteria, clinical contact hours required per course, risk management, follow up)		
Political challenge: negotiating the politics of MBCT implementation; securing agreement to common goals; dealing with conflict and opposition; building new relationships to enable implementation process to spread through the organisation.		
Cultural challenge: building shared understanding and commitment around MBCT implementation;		
Educational challenge: enabling staff to acquire relevant knowledge, skills, and expertise to underpin MBCT implementation (e.g. recommended profile for MBCT teacher, training required, on going CPD required)		
Emotional challenge: inspiring and motivating staff to join and sustain MBCT implementation process		
Physical and technological challenge: infrastructural support required for the administration and delivery of MBCT courses (e.g. fit for purpose rooms, CDs to support home practice, qualified supervision, administrative support)		

3. Running an MBCT service

3.1. Summary of current and emerging evidence for MBCT

It is helpful for MBCT teachers to be familiar with the current and emerging evidence for MBCT in terms of:

1. Efficacy and effectiveness; that is to say, 'does it work?'

2. Mechanism; that is to say, 'how does it work?'

3. Cost-effectiveness, are the effects we see through MBCT comparable or preferable in cost terms to alternative treatments?

The research literature is expanding rapidly and MBCT teachers might usefully use search engines such as Google Scholar to look for any evidence directly relevant to their work. There is a useful compendium of evidence at the Mindfulness Research Guide which is updated regularly: See http://www.mindfulexperience.org/

Does MBCT work?

In the 10 years since the publication of the MBCT manual, research has primarily been focussed on addressing MBCT's effectiveness. Data from 6 randomized controlled trials (N=593) indicate that MBCT is associated with a 44% reduction in depressive relapse risk compared with usual care for patients with three or more previous episodes. In head-to head comparisons with antidepressants, MBCT provides effects comparable to staying on a maintenance dose of antidepressants (See Piet and Hougaard, 2011). For people looking for a psychosocial approach to staying well, MBCT appears to be accessible, acceptable and cost-effective. Based on this evidence, the National Institute for Clinical Excellence 2009 Depression Guideline recommended MBCT for people who are currently well but have experienced 3 or more episodes of depression.

How does MBCT work?

Even though we know that MBCT works, it does not necessarily follow that it works through its hypothesized mechanism. Understanding mechanisms can help therapists and treatment developers improve MBCT's outcomes by emphasizing key processes.

This literature is growing exponentially, is complex and draws on different research areas and methodologies. It is beyond the scope of this resource kit to review this evidence but what is encouraging is that several key studies suggest that MBCT for recurrent depression and MBSR for chronic physical health problems do indeed change the processes they intend to and that changes in these processes are associated with changes in outcomes. For example, research embedded in one trial comparing MBCT with maintenance antidepressants showed that MBCT cultivates both mindfulness and self-compassion, and changes in mindfulness and compassion explained the changes in depressive symptoms 15 months later (Kuyken et al., 2010). Crucially, when people are able to be more self-compassionate at times of low mood,

this breaks the link between reactivity and poorer outcomes a year later. This provides promising evidence that MBCT is indeed working through its hypothesized mechanism. While this publication is focused on MBCT we include one study of MBSR because it similarly demonstrates that MBSR may work through its hypothesized mechanism (Nyklicek & Kuijpers, 2008). Sixty people were enrolled in a comparison of MBSR with a wait-list control, completing measures of mindfulness, stress, psychological well-being and quality of life before and after the intervention. Mindfulness training was associated with greater changes in mindfulness, perceived stress and quality of life than the wait-list control, and when changes in mindfulness were added as a co-variate the changes in perceived stress and quality of life were reduced to non-significance. This provides preliminary evidence that when people learn mindfulness through an 8-week mindfulness program, the change in mindfulness can explain changes in stress and quality of life.

Is MBCT cost-effective?

Any intervention that can prevent depressive relapse is likely to reduce the overall prevalence of depression and save the substantial costs involved with depressive relapses. MBCT was developed as a group-based intervention in part to maximise its cost-effectiveness by ensuring one MBCT teacher could treat 8-15 patients over 8 weeks. Given MBCT's demonstrated efficacy, it is likely therefore that it would be a more cost-effective relapse prevention approach than individual therapy. NICE has recommended MBCT as a relapse prevention approach for recurrent depression on the basis that it meets NICE thresholds for cost effectiveness. Early research in this area comparing MBCT with maintenance-antidepressants suggests no significant differences in cost-effectiveness over a 15 month follow-up period (Kuyken et al., 2008). Further research is needed in this important area. Nonetheless, given that MBCT is a relatively brief one off group-delivered intervention intended to teach long-term resilience, there is a good chance it will prove to be more cost-effective than either individual therapy or longer-term relapse prevention approaches.

3.2 Participant care pathways

It is important to consider how an MBCT service sits within the local care pathway so that MBCT is integrated with other services. Recurrent depression is typically a serious and long-term condition and people will require, at minimum, ongoing monitoring in primary care and possibly secondary care or indeed tertiary care input at phases in their lives.

In the UK, NICE has published care pathways based on NICE guidance and the weblink is given below.

NICE sets a full pathway for the care of people with depression http://pathways.nice.org.uk/pathways/depression/care-for-adults-with-depression. This identifies MBCT at Step 3 "Persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression." Within Step 3 it is identified as a relapse prevention programme for people with 3 or more previous episodes. The 2009 NICE guidance states:

"Provide mindfulness-based cognitive therapy for people who are currently well but have had 3 or more episodes of depression. Deliver in groups of 8–15 people in weekly 2-hour meetings over 8 weeks. Also offer 4 follow-up sessions in the next 12 months."

It is important to note that to date it is not recommended in other NICE guidance or NICE care pathways (for example anxiety disorders or long-term medical conditions) because we have not yet accumulated sufficient data from UK based randomised controlled trials. This picture may well change.

3.3 MBCT service protocols

It is good clinical practice to have a protocol for a service that sets out how it operates so that anyone involved with the service has an understanding of the service and to safeguard good governance. This is especially important for services involving more than one person.

We include a sample protocol.

Sample Protocol for a Mindfulness Service from the Exeter Mindfulness Network

Following a clinical assessment, patients are sent a letter offering them a place on the group and asking them to opt-in to this by contacting us to arrange an orientation appointment. Suggested orientation appointment dates as provided by the therapist are included in the letter. If the patient is able to attend on one of these dates they are asked to contact the clinical administrator to arrange an appointment. If not, they are asked to email the therapist directly (email address provided in the letter) to liaise with them re: a different date. If patients do not contact us within two weeks of the date the letter is sent, they are discharged to their GP.

The orientation appointment lasts for 45-60 minutes. It is an opportunity for the therapist to explore with the patient any triggers, patterns and early warning signs of depression and what has helped so far (this forms part of the work patients undertake in the latter part of the course.) The other main part of this session is to inform the patient about the group, reunions, home practice and answer any questions.

A final decision about them attending is usually made in collaboration at the end of this appointment. The alternative options are discharge, referral to another treatment option within the clinic, referral to another service or awaiting the next MBCT course.

If a patient is assessed as suitable for MBCT at orientation but cannot attend the next course, a place will be offered on the following course. If this is declined the patient will be discharged and need to be re-referred unless there are special circumstances.

If a patient is not suitable for MBCT at the time of orientation the therapist may choose to offer an orientation for the next group. If the patient is still not suitable they will be discharged or offered another treatment within the clinic.

The course runs for 8 weeks plus a reunion session in the latter part of the course. Patients are encouraged to attend all 8 sessions. If they know in advance that they cannot attend they can let the therapist know and handouts can be given so they can keep up with the home practice. If they cannot make a session unexpectedly patients are asked to phone or email. The therapist will post on relevant handouts/CDs. There will be times that the therapist will make contact with the patient by telephone. An obvious example would be if there was any concern about the patient's mood. Other examples might be if a patient DNAs, or cancels twice in a

row or seems to be struggling with the practice. The therapist uses their own discretion and records these calls in the notes.

Patients receive a handout at each session and a set of 4 CDs over the course. They are asked to practice initially with the use of a CD every day. They complete a home practice record sheet that they are invited to hand in. Over the course of the week the therapist reads it, makes notes and returns it to the patient the following week. After session 4 patients have the option of borrowing a Mindfulness book until the end of the course (*The Mindful Way Through Depression*).

After session 7 patients are given an evaluation form and the final sets of questionnaires to complete and bring back to session 8. A copy of this evaluation goes in their notes. Throughout the course the therapist keeps notes after each session about individuals including information on attendance, interaction and home practice. On discharge these notes are put in the patient's file.

There are no hard and fast rules about how many cancellations a patient makes before the therapist decides to formally discharge them from the clinic. The therapist will use their judgement. It is difficult if a patient misses more than 2/3 sessions for them to keep up with the programme. If this happens a patient might be offered a place on the next course if it is appropriate.

The reunion sessions are open to current MBCT participants and previous participants. We hold approximately 4 each year. If patients do not attend 5 in a row or send apologies their name is removed from the database. The structure of the reunions is around some mindfulness practice with dialogue afterwards and some opportunity for sharing around a theme. There is a mixture of pair work, small group work and large group work, finishing with a more informal tea/coffee slot.

Most of the MBCT groups have 2 interns. These are often staff members from within the University or NHS or other interested professionals who have the opportunity to come to the group and learn by being a participant. Patients are informed about interns at orientation. For the most part interns become group members but are asked to pair together for introductions and any pair work around depression.

Sometimes the MBCT groups are offered as a placement to supervisors or students on the post graduate course as part of their development and training. The MBCT therapist would co-run with them, preparing together beforehand, writing up notes at the end and offering supervision. Patients are informed at orientation and where possible both would be present at orientation.

Most MBCT groups are videotaped providing the whole group has given consent; this is primarily for the therapist to reflect on their work and for supervision. Extracts from these sessions might be used for teaching on the course if consent is given. The DVDs are kept in a locked cabinet in the clinic office.

3.4 Sample information for referrers to MBCT courses

Referrers and people seeking referral to MBCT services need good quality information to make decisions about who and when to refer. It takes time, sometimes a few years, to work with a network of referrers to develop a shared understanding of MBCT, the care pathway, and when MBCT is appropriate.

There are good websites and links (See Section 7, Resources, below).

Some sample information for referrers and potential MBCT participants is reproduced below.

Sample websites with downloadable information leaflets for GPs and patients can be found at:

Bangor Centre for Mindfulness Research and Practice - http://www.bangor.ac.uk/mindfulness/8weekcourse.php.en?catid=&subid=8591

Exeter Mindfulness Network –

http://www.exeter-mindfulness-network.org/

Oxford Mindfulness Centre - http://oxfordmindfulness.org/learn/

The BeMindful website is an excellent resource for referrers and potential participants, including first hand accounts of people who have participated in MBCT courses - http://www.bemindful.co.uk/

3.5. Inclusion and exclusion criteria

MBCT was informed by a clear and evidence-based theory of depressive relapse and a coherent account of why mindfulness training and cognitive-behavioural techniques might help prevent depressive relapse. In brief, for people at risk for depressive relapse dips in mood can trigger emotional and cognitive reactivity that can easily spiral into depression. MBCT teaches people to become aware and respond to these mood and cognitive changes in new ways that nip early signs of depressive relapse in the bud. The first two randomized controlled trials suggested that MBCT was only effective for people who had experienced 3 or more episodes. On this basis NICE recommended MBCT for people who are currently well but have had 3 or more episodes of depression. Sample inclusion and exclusion criteria are set out below for an MBCT for recurrent depression service.

While there are many innovative mindfulness-based applications for a variety of populations and presentations, it is important to answer several questions when establishing inclusion and exclusion criteria for a service.

1. What is the theoretical rationale for offering MBCT to this group of people with this set of presentations? How exactly is MBCT relevant to the particular problems that trouble them, and how would I expect them to make use of it?

2. How would I know that people are benefiting in the way I hope? How can I evaluate my MBCT courses to be able to demonstrate these benefits? (See Section 6 below.)

3. Are there any potential risks? Might I do harm? If so, how do I assess and manage this risk?

MBCT for recurrent depression: Service inclusion and exclusion criteria with a rationale for each of the criteria.

Inclusion criteria	**Reasons for inclusion**
Have experienced 3 or more episodes of depression	There is evidence that MBCT is an effective intervention for those who have experienced 3 or more episodes of depression (Ma & Teasdale, 2004; Teasdale et al. 2000). Most subsequent trials have only included people with 3 or more episodes (e.g., Kuyken et al., 2008). Based on this, NICE (2009) recommended that it only be offered to people who have suffered 3 or more episodes.
In full or partial remission from depression	MBCT is designed for clients who are not currently experiencing depression. It is a relapse prevention programme for people who are currently in full or

	partial remission. There is some evidence that people with significant residual symptoms or indeed current depression might benefit (Barnhofer et al., 2009; Eisendrath et al., 2008; Kenny & Williams, 2007), but this evidence is as yet preliminary and requires some adaptations to the MBCT program in terms of client motivation and risk management.
Committed and motivated to undertake the MBCT programme	The MBCT programme requires that people attend 2-2.5 hour sessions for 8 weeks, as well as finding up to an hour a day for mindfulness practice and other homework. This is a big commitment and it is important to establish that potential participants can make this commitment prior to starting the group. There is some evidence that people who are prone to high levels of rumination are more prone to drop out of MBCT (Crane & Williams, 2011), so at orientation it is important to give extra time to these people in the pre-class interview to ensure they fully committed to the course, supported in working with high levels of rumination during the course and encouraged to seek support from the MBCT therapist if they are considering dropping out.

Exclusion criteria	
Current substance dependence	Substance dependence would make it difficult for the person to engage in MBCT. While mindfulness interventions are used with people with substance dependence problems, they are bespoke to the needs of this group to be able to bring awareness to thoughts and feelings without resorting to substances to avoid unpleasant experience. MBCT is training in awareness and substance dependence is often about mindlessness. It is usually wise for someone to seek help with his or her substance dependence before undertaking MBCT.
Organic brain damage	This would also normally make it difficult for the person to engage in the therapy because of cognitive disabilities required to make use of the un-adapted MBCT programme.

Current or past psychosis, including bipolar disorder	MBCT for depressive relapse targets particular mechanisms thought to underpin recurrent depression and these are likely different from the mechanisms that underpin psychosis and bipolar disorder. However, there are clinical-research groups developing adaptations for people with bipolar and psychosis; these include adaptations made on clinical and theoretical grounds.
Anti-social behaviour	Any anti-social behaviour may put the MBCT teacher and other people in the group at risk.
Already receiving psychological therapy	MBCT requires a significant investment of time and energy that would be difficult to find alongside another therapy. In addition, pursuing two therapeutic paths at once can be confusing for participants, who may receive different and even conflicting messages from each approach.
Significant longstanding interpersonal difficulties (e.g., currently meeting criteria for personality disorder) that require specialist and longer-term psychological treatment prior to MBCT	These difficulties would make it more difficult for a person to engage in the therapy and would likely adversely affect group functioning. However, someone who has received treatment for these interpersonal difficulties might find MBCT as a second line treatment helpful.
Persistent self-harm or suicide risk requiring management	Mindfulness is an intensive training in awareness and for people who use self-injury to regulate their feelings the longer MBCT practices may be over-whelming. Mindfulness is a part of dialectical-behaviour therapy, but here practices are much briefer and designed to help regulate emotion. Moreover, as MBCT is a group-based intervention it can be challenging for the teacher to assess, monitor and manage any risk whilst also teaching the programme.

3.6 Considerations in assessing the safety & suitability of mindfulness- based courses for participants with substantial problems[23]

This guidance is mainly about teaching mindfulness-based interventions (MBIs) such as MBSR and MBCT to participants with substantial physical or mental health problems. It is also important to consider the suggestions below when teaching general groups of participants who are dealing with stress, etc., and when carrying out assessment of participants for any MBI.

GENERAL PUBLIC GROUPS

One consideration is whether you are teaching a general group of participants, or those with a specific diagnosis or problem (see also *Teacher's experience* below); in the latter case you need both training and a setting that will support such a group.

Even if the group is general (such as an evening class in a leisure centre) some participants may still have substantial problems (see *Early trauma, past abuse, and dissociative disorders* below). This is one of the reasons we assess participants' readiness and suitability to take a course, as not everyone will benefit from a mindfulness course at any time, and for some people it may be contra-indicated.

The following is useful information to collect about would-be participants in general groups:

- History of mental illness, especially in the last few years – e.g. anxiety and depression – and any related medication taken
- Medication being taken now
- Physical disability or impairment (consider accessibility of venue and other special modifications, e.g., provision of comfortable chairs, induction loop, wheelchair access)
- Recent difficult life events such as bereavement, divorce, job loss, acute illness and/or its treatment, any major or stressful change such as moving house
- Expected difficult life events in near future (as above)
- Support participant has at present (both through informal networks and professionals)

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3 Acknowledgements to the Center For Mindfulness, University of Massachusetts for use of a version of their 'Screening Criteria for Exclusion from the Stress Reduction Program.'

- GP's name and contact details, or those of someone else the participant has agreed you can contact (this could be their therapist or counsellor) in case of a safety issue with them; you have an ethical obligation to break confidentiality if you think the participant is likely to harm themselves or others
- Why the participant wants to take a mindfulness course at present.

Suggested exclusion criteria for general groups (subject to clinical judgement and experience of teacher, and support available to and motivation of participant):

- Active or recent physical addiction to alcohol or drugs
- Suicidality
- Psychosis
- Post-traumatic stress disorder
- Acute depression
- Severe social anxiety which would make attending a course very stressful
- Physical illness which would prohibit attending a course

Participants who have had a recent severe loss such as bereavement or divorce are usually in too raw a state of distress to find a course helpful; they are well advised to wait till they have worked through the acute stage of the grieving process and are more settled with their loss (see also *Life crises* below).

If participants don't understand the language of instruction they will need interpretation. Those with hearing impairment may require an installed loop system if they have an appropriate hearing aid, or sign language interpretation if they can use this.

Pay careful attention to your own concerns about participants with substantial difficulties, as well as assessing their motivation and understanding and support available to them, and make your own judgement on whether they have enough support, and you have enough knowledge, time, and confidence to work with them.

GROUPS OF PARTICIPANTS WITH SPECIFIC DIAGNOSES

General considerations

Teacher's experience

Ensure you have training in and professional experience of the particular problems/illnesses that participants come with, and an understanding of how these may be affected by practising mindfulness meditation, and working in a group. If not, work alongside someone else with these areas of experience. Experts elsewhere can also be helpful, either through their written

work, or through personal contact. You may also need to consider the setting where you work and how it fits your participant group.

Example 1: Only work with participants with a history of mental illness such as depression or mood disorders if you have training and experience of working with this client group.

Example 2: If working with people in chronic pain or with physical illness, you need to check access and available space, and have considered what kind of mindful movement would be suitable, and whether you have experience or back-up available in first aid should that be necessary. Consult with other appropriately qualified professionals (e.g. yoga teacher, physiotherapist) if required.

Example 3: Only work with participants with a history of psychosis if you have full understanding of this illness and experience of working with it, and understand how it may be affected by mindfulness practice. If you do have appropriate knowledge and experience, consult the chapter about mindfulness training in Paul Chadwick's book 'Person-Based Cognitive Therapy for Distressing Psychosis.'

If you are trained and very used to working with a particular client group, but there is no research on mindfulness training with them, and if you have trained in teaching mindfulness and believe that these clients might benefit from it, you need to:

(a) Consider from your knowledge of your clients and your experience of mindfulness, the different ways that mindfulness training is likely to affect them and their presentation. How precisely might MBCT impact on the specific psychological factors that contribute to developing the problem concerned, and those that maintain it and prevent recovery?

(b) Formulate how mindfulness training could best be used with this client group, including length and kind of meditation practices; how meditation practice is likely to interact with their problems; educational material that would enhance and support their use of mindfulness, in relation to the particular vulnerability factors and maintenance factors identified.

(c) Do some cautious pilot training, evaluate this carefully using appropriate measures, and use your evaluation to improve or cease the mindfulness courses (see Section 6 below).

(d) Ensure you have permission from the organisation (e.g. the NHS Trust's Psychological Therapies Committee) in which the innovation will take place, and put in place the relevant evaluation tools.

(e) Make it clear to all participants that the course is an exploratory development and they are part of a development/evaluation.

Examples: These types of evaluations are being done in the UK with people with acquired brain injury; cardiac disease; obsessive-compulsive disorder, etc.

Participants' attitudes

Participants' attitudes, understanding of their own process, and willingness to work with their experiences and with the teacher are important factors in assessing their readiness to take a

mindfulness course. Participants who are open-minded about what may happen, willing to openly discuss problems that arise with the teacher, and will accept support (and/or leave the course) if necessary, may be able to take a course with more substantial problems or illness than participants without these attributes. Participants who believe mindfulness will magically solve their difficulties are much less likely to do well.

It is always important to encourage participants to find ways of working with the practices that are both safe and helpful for them. This makes the participant's experience central, and empowers them to make the training their own.

Example: If participants suffer from panic or severe anxiety, they may find it very difficult to tolerate lying or sitting still, especially at the beginning of the course. In this case it may be helpful to have them start with a simple walking meditation, keeping their attention as much as possible in sensations in their body. For participants who find the bodyscan frightening, it can help to keep the eyes open, sit up, or mindfully shift positions, until exposure to the practice makes it more comfortable.

When participants are professionals interested in using or teaching mindfulness as part of their work, it is important to point out beforehand that while an experiential course is essential to becoming an MBCT teacher, it does not in itself **constitute sufficient training to become one.** It is essential they fully experience the course for themselves (including doing the home practice) and be willing to let go of their professional personas whilst doing so. Naturally, dual mind is likely to arise for professionals (thoughts about how something might be used in their own work context, or commentary on something the teacher does, for example), and it is helpful for professionals to realise that these are thoughts like any others, and can be worked with in just the same way as other thoughts.

It is also helpful to discuss beforehand how professionals will introduce themselves in the group. Otherwise, the sense of 'being observed' can inhibit other participants from sharing their experiences openly. Teachers often find it better to have no more than 2 professionals on a course (perhaps 3 in a larger group).

Research

It's a part of a teacher's ethical responsibility to be aware of research into mindfulness-based interventions (MBIs) and the useful information this provides.

E*xample 1: Two research studies of MBCT for the prevention of depressive relapse have shown that participants with only 2 previous episodes of major depression (who had their first episode when adult and following a specific life event, and had normal childhoods) were less likely to benefit from MBCT than participants with 3 or more previous episodes (who had started being depressed when younger, and had a history of childhood difficulties (Ma & Teasdale, 2004; Teasdale et al., 2000). These results have possible clinical implications. E.g., people who are experiencing their first or second depression at a young age, and who have had difficult childhood experiences, might benefit from MBCT straight away rather than waiting until they have had a number of episodes. However, to date this possibility has not been investigated through research.*

Example 2. People whose depression is largely triggered by their own ways of processing experience may be particularly likely to benefit because MBCT provides ways of working with these reactive processes.

Example 3: One research study of MBSR for patients with different levels of current depression and anxiety found that patients with all levels of anxiety (from mild to severe) could tolerate and benefit from MBSR; however, while patients with mild to moderate levels of depression could learn to meditate and benefit from it, those with severe levels of depression were unable to do so (see Giommi in ed. Kwee, 2006). But, see studies of MBCT adapted for people with significant depressive symptoms already referred to above, where people with significant depressive symptoms were able to benefit. Maybe this is a difference between MBCT (designed for depression) and MBSR that is not.

Participants with severe problems or vulnerabilities

Participants with more severe problems, e.g. treatment-resistant depression (see Kenny & Williams, 2007) and some cases of PTSD, may be able to take a mindfulness course. It is essential that they understand what it entails, and are given (and give themselves) full permission to drop out of the course if they find it unhelpful (though it may be necessary to debrief fully so as to ensure as far as possible that this is seen as a reflection of the mismatch between person and approach, rather than a reflection of some defect or inadequacy in the person). It is most important that they are fully supported, either by the teacher, or by their own therapist; the former needs to understand the nature of their difficulties, and the latter needs to understand the experiential, intense and potentially stressful or painful nature of learning awareness and acceptance in mindfulness-based approaches. It would be important in the initial interview to clarify that this is in the nature of an exploration, no approach suits everyone and that mindfulness-based approaches may not suit this person, in which case it is a wise choice to leave the course. The MBCT therapist needs to both prepare and debrief participants in these cases.

If therapists are regularly referring clients to you for mindfulness training, give them at least a taster so they know something about it – if possible, get them to do some training themselves – many therapists (and their own clients) say they find this helpful.

Clients with problems that are too severe for them to learn mindfulness themselves can be greatly helped by their carers (professional or family) being given mindfulness training (see Singh et al., 2004). This can also greatly benefit the carers.

Specific considerations

Chronic vs. acute illnesses

MBSR and MBCT are generally used with participants with chronic problems or illnesses, either physical or mental, who are therefore used to dealing with them (though they can learn kinder and more effective ways to do this). Periods of acute illness (or sometimes an acute attack of an existing illness) where patients are dealing with high levels of stress, and can be

getting used to dealing with a new and different way of being, are generally not good times to learn mindfulness practice

Life crises

Similarly, when participants have had a recent bereavement, divorce, cancer diagnosis, etc., is usually not a good time to take a mindfulness course. Pre-existing mindfulness practice is very helpful in dealing with strong, raw feelings such as grief, shock and anger, but these are usually too overwhelming for participants to learn how to meditate while dealing with the recent stressors themselves.

Suicidal tendencies

This is a dangerous vulnerability for new meditators, so people who are feeling suicidal should be asked to wait and take a course when things are better for them, and then be carefully monitored in case of reoccurrence. In Oxford and Bangor there is an on going large research study of presently well participants with recurrent suicidal impulses, with a tailored intervention (a development of MBCT) and carefully trained teachers. The results of this research should tell us more about whether and how to work with such participants.

Substance misuse

If participants are currently physically dependent on drugs or alcohol, they are very unlikely to be able to undertake a normal mindfulness course, as their awareness and ability to stay in the present are negatively affected because they would either be under the influence of a substance (which precludes meditative awareness) or in a process of withdrawal; their lives may also be too chaotic to make a regular commitment. Participants who are psychologically but not physically dependent on substances, and who meet other criteria for taking a course (e.g. well motivated to change, some insight) may be able to engage with mindfulness training, and to work with their reactive use of substances, as would participants dealing with ruminative thinking, anxiety or stress.

Mindfulness-based Relapse Prevention has been developed specifically for people who are working with their own tendencies to misuse substances. In a generic group, when assessing someone where there are concerns about their level of substance use, it would be helpful to have supervision from someone experienced in using mindfulness within the substance misuse field. If the participant is suitable to take an 8-week course, their addiction can be worked with in the same way as any other difficulty.

Psychosis, schizophrenia, etc.,

Participants who are currently psychotic, or out of contact with what is normally considered reality, are unlikely to be helped by mindfulness meditation, and may be harmed. There is a small amount of evidence that meditation has triggered psychotic episodes in some individuals, and although this may not be true of mindfulness meditation, with its emphasis on grounding in physical sensations and other bodily senses, it would make sense to aim for

safety here. See also *Teacher's experience* and *Participants with severe problems or vulnerabilities* above.

Early trauma, past abuse, and dissociative disorders

These are all indications to move into mindfulness training with great care, in-depth understanding of the issues involved, and willingness to support and go at the client's own pace. Mindfulness can be a useful adjunct to psychotherapy with such participants, but should only be introduced when the client has full support from a therapist who understands mindfulness, and when the client is ready to start making connections with what may be extremely painful material.

If a participant reports 'leaving the body' when meditating, although this can on occasion be a spiritual experience, it can also sometimes indicate that there are embodied memories that are too dangerous or painful to face, and the participant is maintaining an important defence strategy by dissociating. If working with such a participant, it is wise to go very cautiously indeed, encourage them to come back into their bodies by opening their eyes and focussing on what they can see (perhaps describing it to themselves or you), shifting position, or getting up and moving about, having a drink of water, etc. Such 'grounding' practices can help clients to re-establish contact with the here-and-now.

Recognise that many people have suffered from trauma, so there may well be one or more in any group (careful pre-course assessment may help to establish this). Some participants may be able to work with the aftermath of trauma using mindfulness, with or without the teacher's knowledge of their past. Participants may be understandably reluctant to talk in the group about difficulties such as flashbacks when meditating, so it is important they feel able to confide in the mindfulness teacher, and/or their therapists, outside the class.

Learning disabilities, and severe multiple disabilities

There has been little use of mindfulness training reported with participants who suffer from learning disabilities, apart from some initial work by Singh (see his 2003 case study on using a simple practice of bringing attention to the soles of the feet for a man with learning disabilities who suffered from outbreaks of anger). Practices would need to be simplified and carefully tailored.

Singh has also researched mindfulness training for carers of men with severe and multiple disabilities, and found that this significantly increased the carers' level of happiness (see Singh et al. 2004).

Asthma and other breathing problems

Participants with breathing problems may not feel safe using their breath as an 'anchor' into the present moment. They can be guided individually to find another part of the body that represents a 'safe place' for them to place their attention, particularly in early sessions. Sometimes taking attention lower down in the body (such as the buttocks on the seat or feet on the floor) can reduce fear and increase calmness. With one or more such participants in a

group, it's helpful to remember to include this in general instructions, e.g. 'return to the breath, or to the connection of your body with what is supporting it'.

Difficulties being in a group

This could be a difficulty for the participant (e.g. social anxiety) that would make working in a group stressful or even impossible (in which case consider 1-to-1 mindfulness training). However, many clients who are apprehensive about being in a group later report that the group context, if managed well, was experienced as therapeutic in terms of normalizing experience, providing support and enabling useful social comparisons of experience.

3.7 Participant assessment and orientation

The process and procedures for assessing and orienting someone for MBCT have several aims:

1) Assess the person's suitability for MBCT, including their readiness (is now the right time?)

2) Orient the person to MBCT, its background and aims, what it involves

3) Develop a relationship between the teacher and participant that includes a sense of trust, confidence and safety.

We include some protocols and forms used in MBCT services.

Outline of pre-class interview for Staying Well After Depression Trial 8-week MBCT courses[4]

Orientation

NB: Teachers will have information on participants from research interview, including a summary of the history, the Time-line and a Crisis plan. Also a message as to whether the person was considered a ruminator-brooder or not, and hence whether extra attention should be paid to this during the interview.

We agreed to have (up to) a 1.5hr individual session for all participants. It was an opportunity to explore particular potential difficulties that might contribute to dropping out, for example being the only man in a class of women, the only young person in an older group or having some of the difficulties outlined above.

Participants were also given a handout to take away, summarising the practicalities of attending the course and the conceptual background to the course.

Orientation to the orientation session

Plan for the time:-

- Your own story
- About the course
- Practicalities (including safety and confidentiality)
- Any questions you have

[4] Protocol used in the Staying Well After Depression Trial (Williams et al., 2010). © Williams, 2010.

- Any questions right now, so we make sure we answer them?

Overview of 'what brings you here' (longest section of the interview)

A summary of your background, your experience

Possible topics (background and experience): -

A) The background information from the assessment

- Life-time episodes?
- How chronic is the depression?
- What particular events in your history were important?
- Let's home in on a specific episode
- What happened in that episode?

B) Let's consider what happens in the present (more detail in this section, with own examples)

- Current phenomenology, triggers?
- Coping, avoidance, withdrawal, suppression, rumination?
- How do you explain it?

Understanding recurrent depression

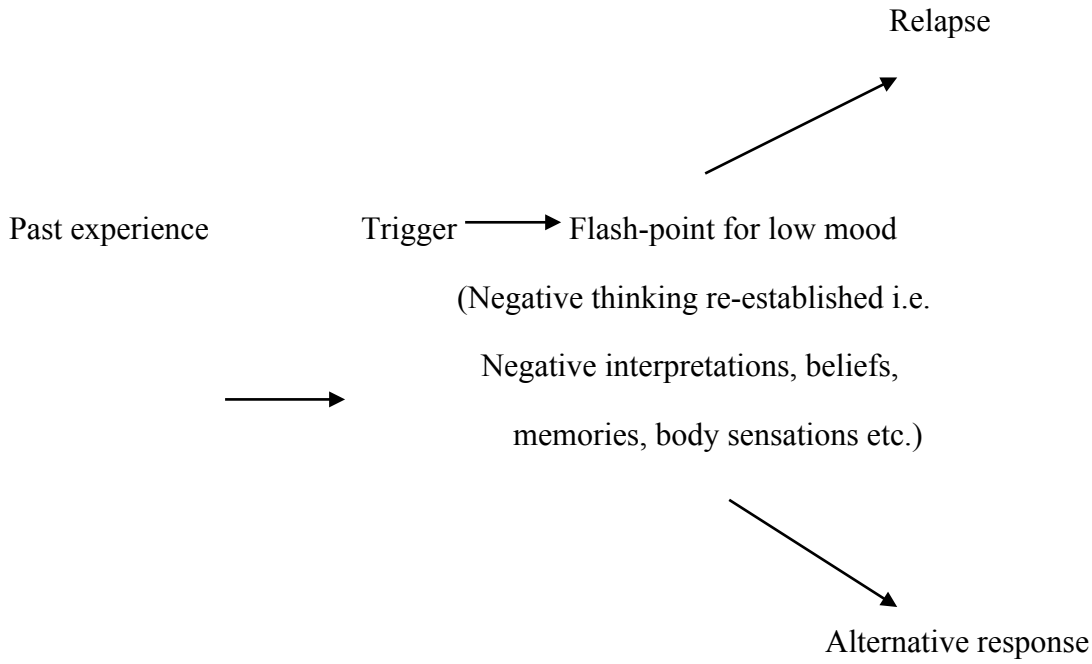
You are here because you have had episodes of recurrent depression. This course based on the latest research on vulnerability and maintenance factors in depression. It draws on a distillation of our knowledge of cognitive behaviour therapy, and mindfulness approaches.

We will be considering vulnerability factors and also what maintains depression once it gets going- what are your own ideas about this?

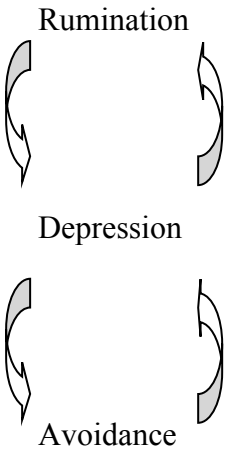
This is how we think it works (more emphasis to sections that seem to fit your particular problems)

- Everyone thinks more negatively when they are depressed than when they are relatively well.
- During the first episode of depression this takes a while to really build up.
- After repeated episodes of depression strong associations are formed, meaning that even small triggers like a dip in mood can be a flash-point for depression.

- A spiral of negative thinking sets in, which can lead to hopelessness and suicidal thinking.
- This in turn makes it tempting to withdraw, and avoid more and more situations.
- It can be difficult to extricate oneself from this, once your old beliefs are activated. It feels a bit like struggling to get out of quicksand.
- Instead of another relapse occurring, it is possible to learn to step back and find somewhere else to go with the problem. We hope to help you find ways to do this.



- Vicious circles of rumination and avoidance: both maintain the depressed mood



Let's consider some examples of your own now (work on this together).

Expectations of the course

- What do you already know about the course?
- What are you hoping for?
- Connect to pre-reading (misconceptions?)
- Any previous experience of CBT? Or meditation?

How will MBCT be helpful to you?

MBCT has been shown to significantly reduce the chance of a recurrence of depression. It teaches you to:-

- Be aware of the workings of your mind
- Recognise patterns
- Stay steady, but learn to stand back a little
- Recognise that you have choices other than slipping back into old patterns
- Learn to taker a kinder, more gentle attitude to yourself
- Refine the capacity to recognise warning signals and take helpful action
- Put less effort into 'fixing' things
- Focus on the here and now. There is no requirement to explore the past
- Do you have any worries or concerns?
- Meditation means many things to many different people. No need to worry about whether you will be able to relax or clear your mind. That will not really be the focus of what we are doing.
- The course is not a space to reflect on the 'why' of your experience, instead it will be inviting a different relationship to experience

There will be lots of different practices for you to try. You will be helped to discover the ones that are most useful for you. We simply ask you to try all of them during the classes. The classes provide the chance for you to also practice being kinder and gentler to yourself.

Home Practice

There will be homework every week, and you will be asked to practice for up to one hour a day. This is a short-term investment, not forever. You will explore towards the end which to carry on with if you wish. Some things you might consider are:-

- Planning how to find the time to practice during the 8 week course
- Resolving to try to do some regular, systematic practice (like watering a seed)
- Warning the family/others you live with what is involved
- Getting hold of a CD player, so you can play the CDs with the practices on them
- Attempting to arrive at a balance of perseverance, awareness of your own responses, and kindness towards yourself

Challenges of the MBCT course

Doing an MBCT course can be challenging for various reasons. However, other past participants would encourage you that it is worth hanging in there, because the realisations you arrive at may reduce the impact of depression. Often the difficulties that come up are not the ones we expected, yet they may be the tip of the iceberg of core difficulties in your life.

(N.B. some potential challenges will be flagged up by the assessor- e.g. ruminative brooding)

What might be some of the challenges for you?

Some of the *(selected)* challenges might be:-

- Being in a group. It takes a while to feel at home, but it can be good to see that you are not alone, and to learn from others
- Feeling under pressure to talk. It is OK to sit back and listen, and to go at your own pace.
- The huge variety of people, from very different backgrounds. What you have in common is the wish to learn to overcome recurrent depression.
- You could be the only man/woman/young person etc. in the group- how do you feel about that?
- Facing emotional issues you might rather avoid. You will learn how to examine these more closely, without getting overwhelmed.
- The difficulties that might come up (boredom, restlessness etc.) might relate to things that are difficult for you in a more general sense.

- It may not always be obvious how the practices will be helpful to you. Be open-minded and experiment. Try to stick with it. Think of it as an investment if you like. It lasts for only eight weeks, so it is worth giving it your best shot.

- Benefits may not be immediately apparent, but it is worth persevering. Changes take time, and people will respond differently, and at different rates.

- There is no right or wrong way for change to take place.

- The commitment to regular practice might be daunting. We do encourage you to do your best to make this commitment, as you will have a better chance of making new discoveries that way. But it is always possible to start again if you have let things slip. At the end of the 8 weeks it will be clearer what works for you.

- It may seem odd that we are teaching you not to strive for results. It could be that trying too hard has been part of the problem

- We encourage you to find the right balance between awareness, perseverance in trying things out, and being kind to yourself.

- You may feel like giving up at times. Your group leader would like to talk this through with you if this happens, and give you some extra encouragement or guidance.

- Think about what you have tried in the past. How well did it work? Is it worth persevering with this new approach, giving it a fair test? (creative hopelessness)

- Give the programme your best shot. We are cultivating awareness using a balanced mixture of gentle perseverance and being kinder to yourself.

Confidentiality

- Confidentiality is required within the group

- Discussion in supervision is anonymous

- If a teacher has significant concern for the safety/wellbeing of the participant including immediate risk to themselves or another, the teacher will discuss this with you, and needs then to contact the participant's General Practitioner, or other professional as appropriate.

- Would your GP or another health professional be the best to contact in emergency?

- We have asked you to consent to us videoing the instructors running the class, to use in supervision of the instructors. Do you have any concerns about this?

Practical arrangements

- The group starts promptly at ….., and finishes at …..
- You will be asked to fill in some questionnaires before you start, so you will need to allow time for this.
- Light refreshments will be available in the break or before the group. You could bring a sandwich to eat before the group if that helps
- Wear comfortable clothing, perhaps bring a small blanket.
- Do you have any physical concerns?
- We would like to emphasise the importance of attending each session and letting the instructor know if you can't be there.
- Practical difficulties can get in the way of the classes- but we would like to hear from you if this happens
- Because the class is challenging there may be times when you do not feel like coming. If this happens we would like you to telephone us and let us know how you are. We can discuss any problems with you.
- Is it alright with you if we phone you if you miss a class and we have not heard from you? We will send you the handouts if you do have to miss a class.
- It can feel difficult to come back if you miss a session, but it is worth it. Sessions build on each other over time.
- Your instructor will be available between sessions for support if this is helpful. We will give you some contact numbers, and it would be good to keep these in your folder with your crisis plan.
- We would like to discuss the social/personal/professional support you have around you at the present time.
- We suggest that it is useful to share with a good friend, family member or professional person that you trust that you are attending this group. You may like to show them this leaflet. They may be able to offer welcome support.

Sample Outline for Orientation Session Used in the Exeter Mindfulness Network

THEME

The initial assessment interview explains some aspects of depression and the MBCT programme, and can be used as a starting point for dialogue between instructor and participants. Forming a therapeutic relationship with each participant and orienting him/her to the rationale for and practicalities of MBCT are likely to enable full participation. It also enables instructors to facilitate enquiry in the groups individualised to some degree to individual's particular history and goals.

AGENDA

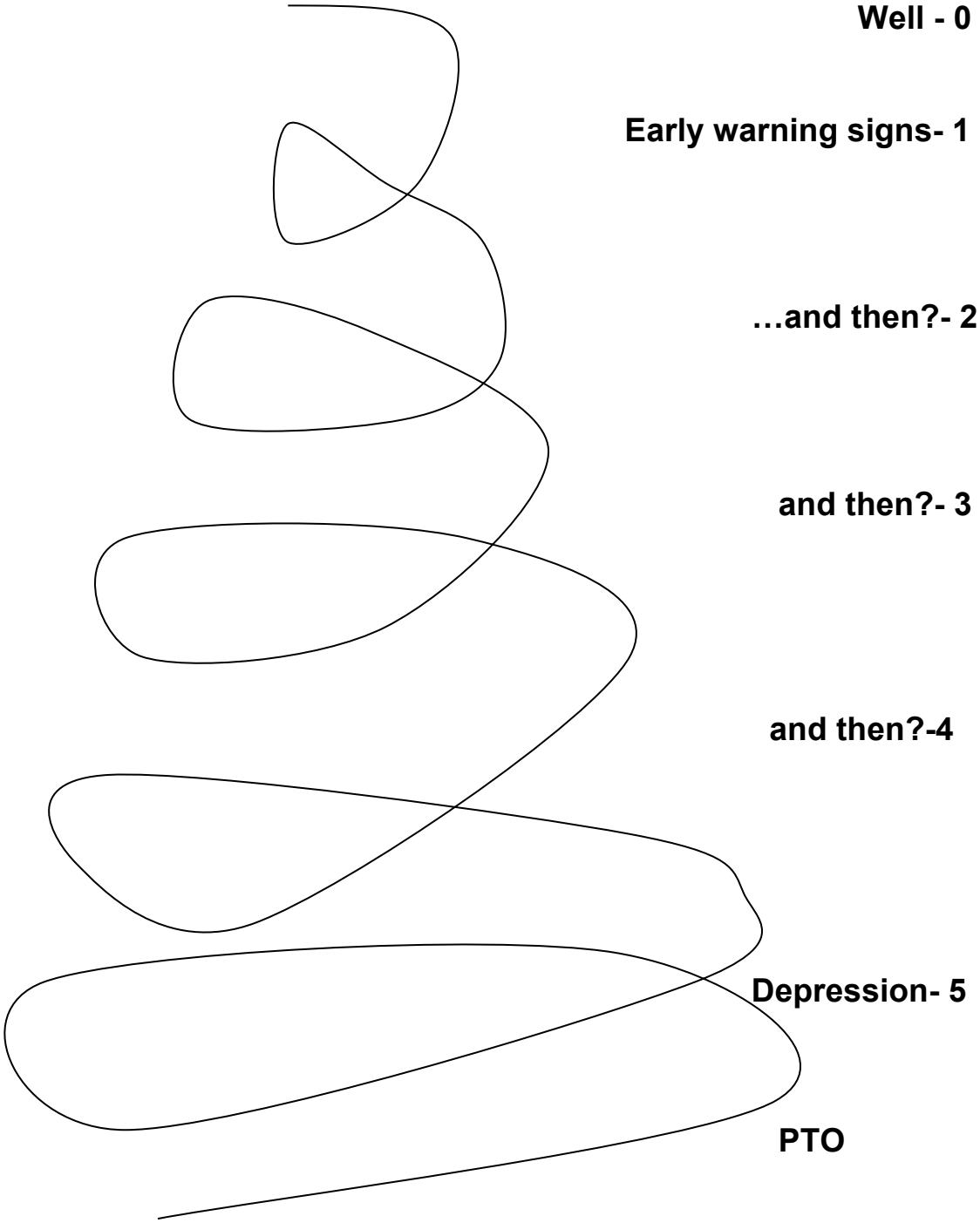
After reading the "Getting Started" questionnaire

- Learn about the factors that have been associated with the onset and maintenance of depression for the person
- Learn about the resources that the person has developed in coping with his / her depression to date and reasons for attending
- Introduce the Niagara Falls metaphor, relapse signature and response plan (Figure attached below).
- Explain something of the background and aims of MBCT and explore with the person how it might help him or her
    - To help people who have suffered depression in the past to learn skills to help prevent depression coming back
    - To become more aware of bodily sensations, feelings, and thoughts, from moment to moment
    - To help participants learn different ways of relating to sensations, thoughts and feelings – specifically, mindful acceptance and acknowledgement of unwanted feelings and thoughts, rather than habitual, automatic, pre-programmed routines that tend to perpetuate difficulties
    - To help participants to be able to choose the most skilful response to any unpleasant thoughts, feelings or situations that they meet.
- Outline structure of the MBCT programme
    - Groups of 8-12
    - Eight weekly 2 hour 15min sessions
    - Home Practice and home practice
    - Video
- Emphasize that MBCT will involve hard work, and a need for patience and persistence in that work, over the course of the 8 weeks

PLANNING AND PREPARATION

- In addition to your personal preparation before the meeting, remember to familiarise yourself with any background information about the person's history of depression and coping resources and bring the relapse signature/response plan and relevant articles.

Relapse Signature and Response Plan



Response Plan (what actions/responses can I choose that will lift my mood, give me energy, give me a sense of satisfaction and nourish me, even if I don't feel like doing them)

When I am well

When I notice early warning signs

When I feel mildly depressed

When I feel depressed

Sample assessment and orientation pro forma

Applicant name**:**
LM ID number:
Contact number:
Orientation completed by:
Date:
Details of professional for LM to contact in case of concern or difficulty: Name**:** Designation: Contact details
Why has the client chosen to do this course at this particular time? Does the client understand the practice requirements and is it practical and feasible for them to do the course at this time (is their living situation settled and do they have the time and space to practice)? Note any issues and discussion about these.
Are there any aspects of the course that are of concern to the client? How are these to be addressed? Does the client have a learning disability? Will the cognitive work be accessible to them?

Current medication
Mental health issues Is the client currently experiencing, or have any history of: Depression Psychosis Schizophrenia Alcohol or drug dependency PTSD Suicidality Other mental health difficulties If yes to any of the above, discuss and note details and implications.
Physical health issues Does the client have any physical illness or disability? Does the client have asthma or any other breathing difficulty? What are the implications of any condition or medication on the client's ability to participate in the course?

Please note if the client has been advised to take the advice of a GP before participating in the course. How will this be followed up? Any special requirements (e.g. access, equipment, diet)
What are the client's strategies and support systems if difficulties arise for them as a result of the course? How do they deal with difficulty and who do they turn to for support? Note if the client's networks are very limited, and what action should be taken by LM in case of difficulties arising (e.g. contacting GP or CPN if we are unable to contact the client)
Is the client planning any major changes (house move, change of job, marriage, divorce etc.) whilst participating in the course? Has the client had any significant life events or traumas in the past year, including those listed above and bereavements? If so, note discussion, advice given and reasons for advising to continue with the course (or not) at this time.
Client's questions:

Information given on: Bodyscan / Mindful movement / Sitting meditation / Group discussion / Group activities / Home practice / Confidentiality (explain bounds of confidentiality re: safety of self or others) Support available through LM /
Action agreed: Confirmed dates, times and venue

Sample orientation pro forma from the Exeter Mindfulness Network

Mindfulness-based Cognitive-therapy (MBCT) Orientation Session

Name:

Date:

Time:

The initial orientation interview explains some aspects of depression and the MBCT programme, and can be used as a starting point for dialogue between instructor and participants. Forming a therapeutic relationship with each participant and orienting him/her to the rationale for and practicalities of MBCT are likely to enable full participation in the groups. It also enables instructors to facilitate enquiry in the groups individualised to some degree to individual's particular history and goals.

Reasons for attending

History of Depression: factors associated with onset

History of Depression: Person's resources

Other factors important to be aware of

I explained the background and aims of MBCT and explored with the person how it might help him or her. I also outlined the practical details of the group.

Signed and dated:

Sample flyer from the Exeter Mindfulness Network given to participants at the end of the orientation if the teacher and client decide together that MBCT is appropriate

Mindfulness-based Cognitive Therapy Groups For People Who Have a History of Depression

This flyer describes the practical details of the Exeter Mindfulness Group.

Facilitators:
Where:
When:
How often and long: Eight two-hour and 15 minute sessions, meeting weekly (with a gas on), with one opportunity to meet others who have participated in previous groups at a reunion session. At the end of the group you will be invited to attend follow-ups offered to all former participants of the Exeter mindfulness groups.

Session	Date
1	
2	
3	
Reunion	
4	
5	
6	
7	
8	

- ***CDs***. To support your home mindfulness practice you will be provided with a series of CDs.
- The following book is available for loan:
  - Williams, J. M. G., Teasdale, J. D., Segal, Z. V., & Kabat-Zinn, J. (2007). *The Mindful Way Through Depression: Freeing Yourself from Chronic Unhappiness*. New York: Guildford Press.
- Another relevant book for working with physical health problems and chronic pain is:
  - Kabat-Zinn, J. (1990). *Full Catastrophe Living: How to Cope with Stress, Pain and Illness Using Mindfulness Meditation*. New York: Delacorte. {available through Exeter Central Library}
- ***Websites.***
  - www.mbct.co.uk.
- ***Contact***: If you have any questions about the MBCT groups contact XX by phone (XX) or e-mail XX.

Preliminary Client Handout for MBCT[5]

DEPRESSION

Depression is a very common problem. Twenty percent of adults become severely depressed at some point in their lives. Depression involves both biological changes in the way the brain works and psychological changes in the way we think and feel. Because of this, it is often useful to combine biological treatments for depression (which act on the brain) with psychological approaches (which teach new ways to deal with thoughts and feelings).

TREATMENT OF DEPRESSION

When you have been depressed in the past your doctor may have prescribed antidepressants. These work through their effects on the chemical messengers in your brain. In depression, these chemical messengers have often become run down, lowering mood and energy levels, and disturbing sleep and appetite. Correcting these brain chemicals may have taken a long time, but most people experience improvements in 6 to 8 weeks.

Although antidepressants generally work well in reducing depression, they are not a permanent cure – their effects continue only so long as you keep taking the pills. Your doctor could continue to prescribe antidepressants for months, or even years, since this is now the recommended way to use antidepressants if further depression is to be prevented by these means.

However, many people prefer to use other ways to prevent further depression. This is the purpose of the classes you will be attending.

PREVENTION OF MORE DEPRESSION

Whatever caused your depression in the first place, the experience of depression itself has a number of aftereffects. One of these is likelihood that you will become depressed again. The purpose of these classes is to improve your chance of preventing further depression. In the classes, you will learn skills to help you handle your thoughts and feelings differently.

Since many people have had depression and are at risk for further depression, you will learn these skills in a class with up to a dozen other people who have also been depressed and treated with antidepressants. In eight two hour sessions, the class will meet to learn new ways of dealing with what goes on in our minds, and to share and review experiences with other class members.

After the eight weekly sessions are over, there are reunions every few months which you will be notified of.

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[5] © Guilford Press. From Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse.* New York: Guilford Press. {The MBCT Manual.}

HOMEWORK: THE IMPORTANCE OF PRACTICE

Together, we will be working to change patterns of mind that often have been around for a long time. The patterns may have become a habit. We can only expect to succeed in making changes if we put time and effort in to learning skills.

This approach depends entirely on your willingness to do homework between class meetings. This homework will take at least an hour a day, six days a week, for eight weeks, and involves tasks such as listening to CDs, performing brief exercises, and so on. We appreciate it is often very difficult to carve out that amount of time for something new in our lives that are already very busy and crowded. However, the commitment to spend time on homework is an essential part of the class; if you do not feel able to make that commitment, it would be best not to start the classes.

FACING DIFFICULTIES

The classes and the homework assignments can teach you to be more fully aware and present in each moment of life. The good news is that this makes life more interesting, vivid, and fulfilling. On the other hand, this means facing what is present, even when it is unpleasant and difficult. In practice, you will find that turning to face and acknowledge difficulties is the most effective way, in the long run, to reduce unhappiness. It is also central to preventing further depression. Seeing unpleasant feelings, thoughts, or experiences clearly, as they arise, means that you will be in much better shape to 'nip them in the bud' before they progress to more intense or persistent depressions.

In the classes, you will learn gentle ways to face difficulties, and will be supported by the instructor and the other class members.

PATIENCE AND PERSISTENCE

Because we will be working to change well established habits of mind, you will be putting in a lot of time and effort. The effects of this effort may only become apparent later. In many ways, it is much like gardening – we have to prepare the ground, plant the seeds, ensure that they are adequately watered and nourished, and then wait patiently for results.

You may be familiar with this pattern from your treatment with antidepressants. Often there is little beneficial effect until you have been taking the medication for some time. Yet improvement in your depression depended on your continuing to take antidepressants even when you felt no immediate benefit.

In the same way, we ask you to approach the classes and homework with a spirit of patience and persistence, committing yourself to put time and effort in to what will be asked of you, while accepting, with patience, that the fruits of your efforts may not show straight away.

THE INITIAL INDIVIDUAL MEETING

Your initial individual meeting with the MBCT therapist provides an opportunity for you to ask questions about the classes or raise issues related to the points made in this handout. You may find it useful, before you come for that interview, to make a note of the questions or issues that you wish to raise.

Good luck!

3.8 Session plans

The MBCT 8 session plans are described in the MBCT manual in eight consecutive chapters; See Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse.* New York: Guilford Press.

However, most MBCT teachers find it helpful to have session plans that provide an aide memoire when planning for and teaching sessions. These may involve some adaptations and changes to the manual that enable teachers to teach to their strengths and in their context.

We include below as an example the way MBCT was adapted in a trial comparing MBCT with maintenance antidepressants (Kuyken et al., 2010). Because these session plans are the copyright of Guilford Press we offer a single session by way of illustration. The section in italics was added for the PREVENT Trial and the rest of the text is as it appears in the original 2002 manual.

MBCT Therapist Pack

Session Outlines and In-session Work Sheets

Example Session 1 Plan (With Ground Rules Handout)

Based on Segal, Williams and Teasdale (2002) – Mindfulness-Based Cognitive Therapy for Depression
Version date 05/10/2009

MBCT Group: Log of Participants and Attendance

Dates of Group-: Start date: _____ End date: _____

Client's Name	Client's Phone	MBCT Attendance								Follow-up Attendance			
		1	2	3	4	5	6	7	8	1	2	3	4
1.													
2.													
3.													
4.													
5.													
6.													
7.													
8.													
9.													
10.													
11.													
12.													

Session 1: AUTOMATIC PILOT

THEME

Mindfulness starts when we recognise the tendency to be on automatic pilot and make a commitment to learning how best to step out of it to become aware of each moment. Practice in purposely moving attention around the body shows both how simple and difficult this can be.

AGENDA

- Establish the orientation of the class
    - *Honour the commitment everyone has made*
    - *Ask that people come and continue coming with an open mind and open heart: "just do it and see what happens"*
    - Set the ground rules regarding confidentiality, participation and time keeping. *Creating a safe place to work.*
- Ask participants to *tune in to their intentions for coming and then* pair up and introduce themselves to each other and then to the group as a whole. *In pairs: (i) name; (ii) why you have come; (iii) what you hope to get out of the programme. Introduce myself: professional work depression, personal angle, empathy & respect for people who suffer depression. Whilst they are in pairs give out their "getting started questionnaires"*
- Raisin exercise
- Feedback and discussion of raisin exercise
- Body scan practice – starting with the short breath focus. *Narrow (spotlight) focus of attention!*
- Feedback and discussion of body scan
- Home Practice: Discuss and assign for the coming week
    - Body scan CD 6 days out of 7
    - Mindfulness of a routine activity
    - Mindfulness of eating
- Distribute CDs and session 1 participant handouts (including Home Practice record forms *to be collected next week*)
- *Summary of session 1, using handout*
- End the class with a short breath focus, 2-3 minutes on the breath

PLANNING AND PREPARATION

- In addition to your personal preparation before the class
- Bowl with raisins and a spoon,
- *CDs – set with all 6 CDs (body scan, stretch and breath, yoga, sitting, combination, exploring the difficult)*
- *Copies of participants' folders for the programme.*
- *Flip chart and pens*
- *Guidelines for the group*

Guidelines for MBCT Group

Housekeeping

- **Toilets, Mobile phones off, fire, bell, chimes/bowl, tea/coffee, video**

Ground Rules

Time-Keeping

- I aim to start and finish on time.

- From now on, each session begins with period of practice so if you do happen to be late, I will always have a chair or mat out for you, just coming in quietly and join in practice when you're ready.

Attendance

- Each session a **significant building block** to the whole so important to try and attend all.

- **But just say you have to miss one** then I'd really appreciate it if you could let me know in advance by phone or email. **And we will miss you if you're not here...**

- **And you don't need to be a certain way to come along** – you don't need to come with a smiling face!

Confidentiality – does anyone know each other here?

- Important that we create a safe place where we can share and learn from each other..... Might be tempting to go home and share what's happening in the group with friends or family and what I would like to suggest is that **it's fine to talk about your own experience or the group in general terms but not to mention any names or speak of anyone else's experience.**

- And if you're out and about and you happen to bump into someone from the group and they're with someone else just to be sensitive to the fact that they may not want to be spoken to….

Participation/Sharing

- We're not here to go over the past or the content of one's problems but seeing instead if we can work more helpfully with our patterns of mind and body **in the moment** – so there may be times when I might i**nvite us all to pause** if I notice we're getting caught up in lots of thoughts and come back to what's happening now.

- I really **welcome you to share your experiences** from the practices but equally there is really no obligation to share – tuning into what feels right for you...

- **Listening** is as much of an active part of being in a group as speaking...

Commitment

- **The sessions but particular the home practice can feel** intense, difficult, You will not necessarily enjoy it – it will feel challenging at times, boredom, impatience etc. may all be feelings that arise. **And this is all part of it – so as best we can letting go of any expectations** about how things should be on this course or ought to be

'just do it and see what happens'

Support out of session

- My number/email address, messages are checked every ……...
- Also available after the group if you need to speak to me.

Open Mind and Heart

- Sometimes it may not be clear how what we're doing links with protecting ourselves from depression but I would just ask you to bring an open mind to each session, each moment…

3.9 MBCT Participant Handouts [6]

The handouts for the MBCT course are provided in the MBCT manual in consecutive chapters; Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse.* New York: Guilford Press.

However, most MBCT teachers find it helpful to use these core handouts but add some of their own that support participant learning. This is particularly true of poetry, where teachers often have preferred poems.

We include below as an example the handouts used in the PREVENT Trial comparing MBCT with maintenance antidepressants (Kuyken et al., 2010).

Because these handouts are the copyright of Guilford Press we offer handouts for a single session only by way of illustration, marking clearly the section in the original 2002 manual and those added for the PREVENT trial.

[6] Copied in large part from from Segal, Williams & Teasdale, (2002). Mindfulness-based Cognitive Therapy. © Guilford Press.

Summary of Session 7:

How can I Best Take Care of Myself

What we actually do with our time from moment to moment, from hour to hour, from one year to the next, can be a very powerful influence affecting our general wellbeing and our ability to deal skilfully with depression.

You might like to try asking yourself these questions:

1. Of the things that I do, what nourishes me, what increases my sense of actually being alive and present rather than merely existing? (up activities)
2. Of the things that I do, what drains me, what decreases my sense of actually being alive and present, what makes me feel I am merely existing, or worse? (down activities)
3. Accepting that there are some aspects of my life that I simply cannot change, am I consciously choosing to increase the time and effort I give to up activities and to decrease the time and effort I give to down activities?

By being actually present in more of our moments and making mindful decisions about what we really need in each of those moments, we can use activity to become more aware and alert, and to regulate mood.

This is true for dealing with both the regular pattern of our daily lives and periods of low mood that may lead to depression – we can use our day-by-day experience to discover and cultivate activities that we can use as tools to cope with periods of worsening mood. Having these tools already available means that we will be more likely to persist with them in the face of negative thoughts such as "Why bother with anything?" that are simply part of the territory of depressed mood.

For example, one of the simplest ways to take care of your physical and mental well-being is to take daily physical exercise – as a minimum, aim for three brisk, 10-minute walks a day and also, if at all possible, other types of exercise, such as mindful stretching, yoga, swimming, jogging, and so on. Once exercise is in your daily routine, it is a readily available response to depressed moods as they arise.

The breathing space provides a way to remind us to use activity to deal with unpleasant feelings as they arise.

USING THE BREATHING SPACE: THE ACTION STEP

After reconnecting with an expanded awareness in the breathing space, it may feel appropriate to take some considered action. In dealing with depressed feelings, the following activities may be particularly helpful:

1. Do something pleasurable.
2. Do something that will give you a sense of satisfaction or mastery.
3. Act mindfully.

Ask yourself: What do I need for myself right now? How can I best take care of myself right now?
Try some of the following:

1. Do something pleasurable.

Be kind to your body: Have a nice hot bath; have a nap; treat yourself to your favourite food without feeling guilty; have your favourite hot drink; give yourself a facial or manicure.
Engage in enjoyable activities: Go for a walk (maybe with the dog or a friend); visit a friend; do your favourite hobby; do some gardening; take some exercise; phone a friend; spend time with someone you like; cook a meal; go shopping; watch something funny or uplifting on TV; read something that gives you pleasure; listen to music that makes you feel good.

2. Do something that gives you a sense of mastery, satisfaction, achievement, or control.

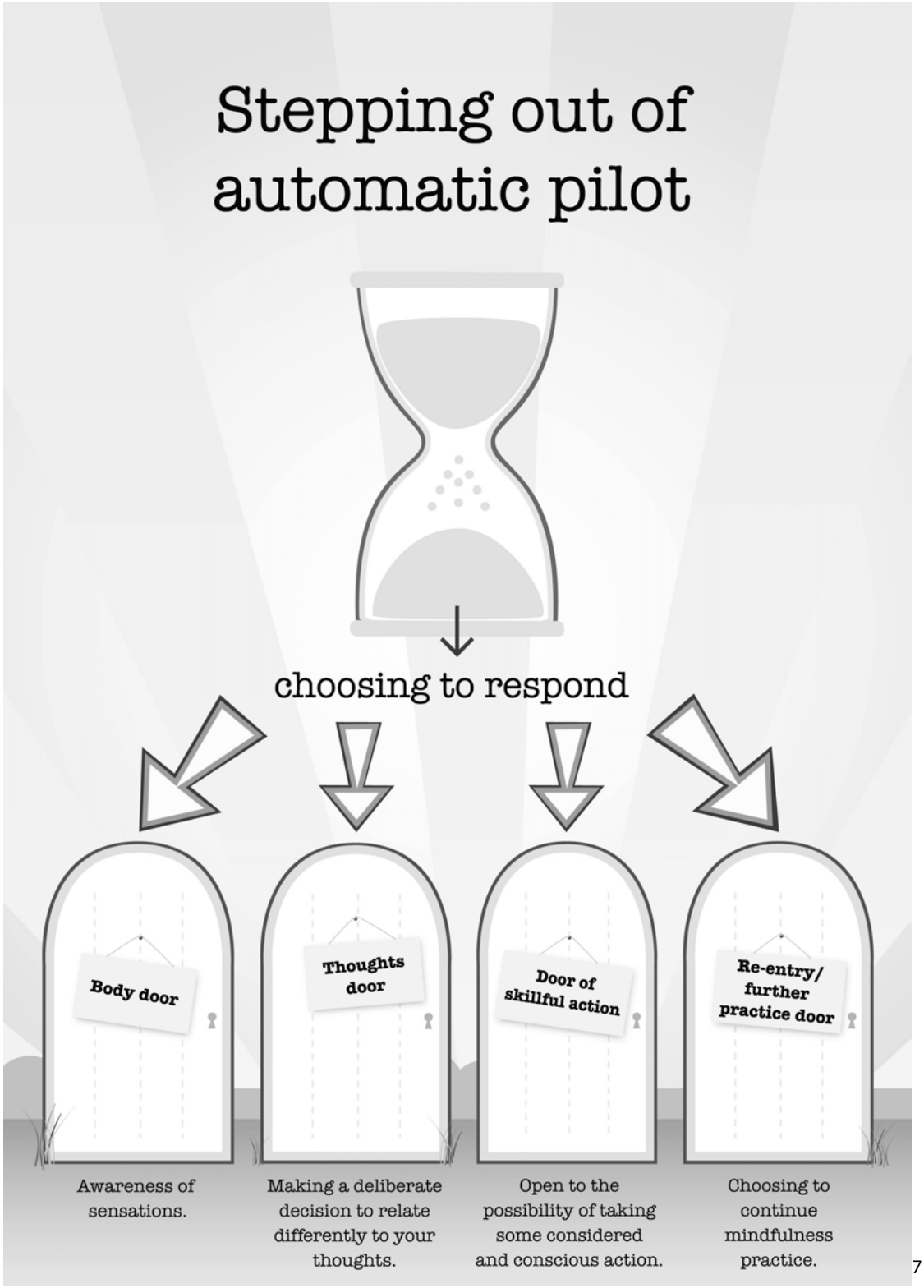
Clean the house; clear out a cupboard or drawer; catch up with letter writing; do some work; pay a bill; do something that you have been putting off doing; take some exercise. (NB. It's especially important to congratulate yourself whenever you complete a task or part of a task *and to break tasks down into smaller steps and only tackle one step at a time.*)

3. Act mindfully (read the 'Staying Present' handout)

Focus your entire attention on just what you are doing right now; keep your self in the very moment you are in; put your mind in the present (e.g. "Now I am walking down the stairs … now I can feel the banister beneath my hand … now I'm walking into the kitchen … now I'm turning on the light …"); be aware of your breathing as you do other things; be aware of the contact of your feet with the floor as you walk.

REMEMBER

1. Try to perform your action as an experiment. Try not to prejudge how you will feel after it is completed. Keep an open mind about whether doing this will be helpful in any way.
2. Consider a range of activities and don't limit yourself to a favourite few. Sometimes, trying new behaviours can be interesting in itself. 'Exploring' and 'Inquiring' often work against 'withdrawal' and 'retreat'.
3. Don't expect miracles. Try to carry out what you have planned as best you can. Putting extra pressure on yourself by expecting this to alter things dramatically may be unrealistic. Rather, activities are helpful in building your overall sense of control in the face of shifts in your mood.



[7]

[7] A3 poster developed by Alison Evans and Claire Brejcha for the PREVENT trial (Kuyken et al., 2010) and now used in the Exeter Mindfulness Network MBCT courses.

When Depression Is Overwhelming

Sometimes you may find that depression comes out of the blue. For example, you may wake up feeling very tired and listless, with hopeless thoughts going through your mind.

When this happens, it may be useful for you to tell yourself, "Just because I am depressed now does not mean that I have to stay depressed."

When things come out of the blue like this, they set off negative ways of thinking in everyone.

If you have been depressed in the past, it will tend to trigger old habits of thought that may be particularly damaging: full of overgeneralisations, predictions that this will go on forever, and 'back to square one' thinking. All of these ways of making sense of what is happening to you will tend to undermine your taking any action.

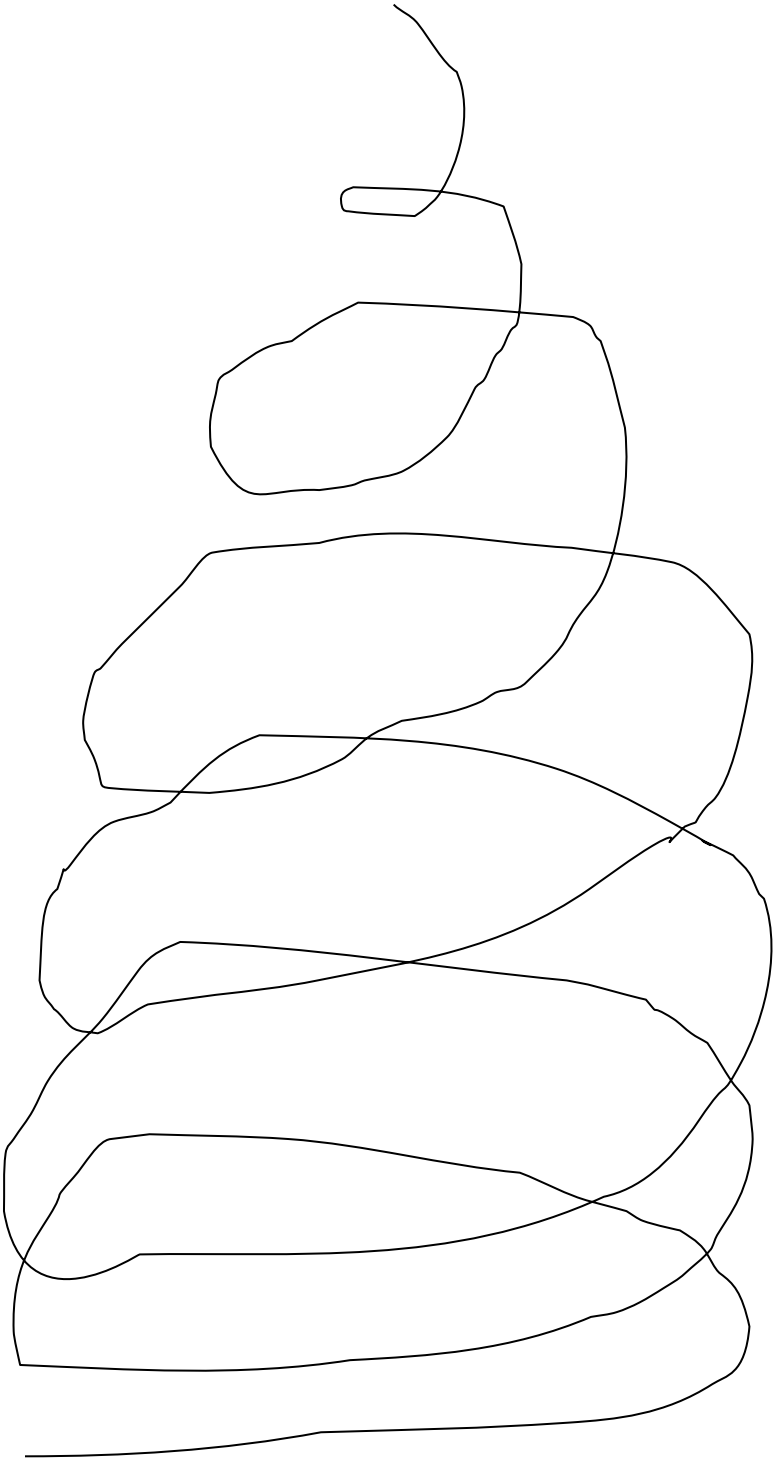
Having these symptoms does not mean that it needs to go on for a long time or that you are already in a full-blown episode of depression.

Ask yourself, "What can I do to look after myself to get me through this low period?"

Take a breathing space to help gather yourself. This may help you see your situation from a wider perspective. This wider perspective allows you to become aware of both the pull of the old habits of thinking and what skilful action you might take.

Session 7

Relapse Signature and Response Plan



Early warning signs1

… and then? 2

… and then? 3

… and then? 4

Depression! 5

Response Plan (what actions can I choose that will lift my mood, give me energy, give me a sense of satisfaction and nourish me, even if I don't feel like doing them)

When I am well

When I notice early warning signs

When I feel mildly depressed

When I feel depressed

AUTOBIOGRAPHY IN FIVE CHAPTERS

1) *I walk down the street.*
There is a deep hole in the sidewalk.
I fall in.
I am lost ... I am hopeless.
It isn't my fault.
It takes forever to find a way out.

2) *I walk down the same street.*
There is a deep hole in the sidewalk.
I pretend I don't see it.
I fall in again.
I can't believe I'm in the same place.
But it isn't my fault.
It still takes a long time to get out.

3) *I walk down the same street.*
There is a deep hole in the sidewalk.
I see it is there.
I still fall in ... it's a habit.
My eyes are open.
I know where 1 am.
It is my fault.
I get out immediately.

4) *I walk down the same street.*
There is a deep hole in the sidewalk.
I walk around it.

5) *I walk down another street.*

-- Portia Nelson

Home Practice for Week Following Session 7

1. From all the different forms of formal mindfulness practice you have experienced, settle on a form of practice that you intend to use on a regular, daily basis for the next few weeks. Use this practice on a daily basis this week, and record your reactions on the Home Practice Record Form.

2. 3-Minute Breathing Space – Regular: Practise three times a day at times that you have decided in advance. Record each time you do it by circling an R for the appropriate day on the Home Practice Record Form; note any comments/difficulties.

3. 3-Minute Breathing Space – Coping plus Action: Practise whenever you notice unpleasant thoughts or feelings. Record each time you do the coping breathing space by circling an X for the appropriate day on the Home Practice Record Form; note any comments/difficulties.

4. Continue developing your Relapse Signature/Response plan. Remembering that it may be useful to involve others. You may like to use the copy you have been working on or complete a separate one to be sent to your GP outlining anything it may be useful for them to be aware of and any ways in which they may support you in the face of lowered mood. Please bring a copy for your GP along with you to session 8.

Home Practice Record Form – Session 7

Name: ……

Record on the Home Practice Record Form each time you practise. Also, make a note of anything that comes up in the Home Practice, so that we can talk about it at the next meeting.

Day/Date	**Practice (Yes/No)**	**Minutes spent practicing**	**Comments**
Date:	CD: R R R X X X X X X X X X X X X		
Date:	CD: R R R X X X X X X X X X X X X		
Date:	CD: R R R X X X X X X X X X X X X		
Date:	CD: R R R X X X X X X X X X X X X		
Date:	CD: R R R X X X X X X X X X X X X		
Date:	CD: R R R X X X X X X X X X X X X		

3.10 Preparing to teach an MBCT course - guidance for teachers

It is important to give yourself adequate time and space to prepare yourself for the teaching. Preparation is needed in several areas:

- Familiarising oneself with the plan for the session, which may mean rereading the appropriate chapter in the MBCT manual
- Reconnecting with the themes that have been arising in this particular MBCT class in previous weeks (on an individual and a group level), and reflecting on how these themes may continue to be woven into the teaching process
- Bring to mind and connect with the individuals who are coming to the class
- Personal practice – in addition to usual daily meditation practice, it is helpful to find a quiet space to settle and meditate immediately prior to teaching (the only instrument we have for this work is ourselves – take time to tune!).
- Practical room preparation – setting out the room, preparing materials, teaching aids, handouts etc.

3.11 Post course follow-up tasks and processes - guidance for teachers

It is important to give time to the teaching process after each class.

- Reflecting on the themes/processes that have been arising within the teaching, within oneself as teacher, within the group, within individuals – make notes/journal while all this is fresh in preparation for supervision.
- Updating client records as appropriate to requirements of organisational context of class.
- Complete the register of attendance
- Make contact with any participants who were not present in the group – sending out hand outs, setting up phone contacts etc.

3.12 Guided mindfulness CDs and the video / DVD required for sessions 4 and 5

The MBCT programme relies on participants engaging in mindfulness practice at home, and this is supported by providing CDs for home practice. The treatment manual and participant hand outs set out the rationale and sequencing for the home mindfulness practice. The main practices taught in MBCT are listed below.

1. Body scan
2. Sitting meditation
3. Stretch & Breath
4. Mindful movement
5. Walking meditation
6. 3 step breathing space

Several teachers have recorded CD sets that you can purchase on line:

Bangor Centre for Mindfulness Research and Practice

http://www.bangor.ac.uk/mindfulness/books.php.en?menu=26&catid=10013&subid=0

Oxford Mindfulness Centre

http://oxfordmindfulness.org/learn/resources/

Center for Mindfulness, University of Massachusetts

http://www.umassmed.edu/cfm/products.aspx

The two following book includes CDs with guided mindfulness practices:

The Mindful Way through Depression and Mindfulness: A Practical Guide to Finding Peace in a Frantic World.

In addition, the MBCT Manual suggests that a video is used in sessions 4 and 5 in which Jon Kabat-Zinn describes the background and rationale for MBSR and people going through the 8-week course.

Bill Moyers. *Healing And The Mind Vol.3 Healing From Within.*

This video can be difficult to get hold of; a place to start is to ask other mindfulness teachers locally or search on line. For example the online seller amazon does have copies available through its approved sellers.

3.13 Sample risk protocol for MBCT participants

Given that depression is one of the most important risk factor for suicide and is associated with self-injury, it is important that teachers work within a framework that assesses and manages any risk issues.

Other risks can arise in teaching mindfulness courses and a thoughtful review of these is important in setting up a service. Below we provide some notes that emerged from a teaching workshop on this topic.

Risk cannot be eliminated. However it can be in our awareness and there can be thoughtfulness around it. There are ways to minimise and manage risk. We can also decide not to take the risk if it is deemed too high.

Issues and risks for participants

- Emotional intensity of meditation may cause difficulty or seem unmanageable
- Physical conditions may be exacerbated
- Individuals may be traumatised by the experience
- Mental health history of individuals may have consequences, unforeseen and unprepared, and unmanaged
- Increase rather than alleviation of suicidality of "at risk" individuals
- Increase rather than alleviation of depression for individuals experiencing depression
- Individuals who have experienced trauma may have flashbacks in meditation
- Individuals who have experienced abuse may be traumatised, e.g. by body scan
- Conflict in the group may lead to disruption and individual distress
- Clients may be put off meditation; may need to leave the group
- Ethical transgression on part of teacher/facilitator may do harm
- Professional boundaries may be broken by teacher
- Transferential issues may arise which cannot be managed, or go beyond the scope of the course

- An individual's expectations may be unrealistic; some may be expecting a therapeutic group for example
- Individuals may have difficulty hearing and accurately comprehending the teacher; there is risk of misinterpretation
- Disclosure of teacher's personal information may be inappropriate and off-putting
- The environment where courses are held may present health and safety risks.

Risks for the teacher/facilitator

- Failure: participants asking for their money back
- Feeling exposed, vulnerable,
- Fear of being seen as a fraud, freezing, humiliation, being criticised
- Fears aroused – ego fear; discomfort-based fear
- Group members may challenge the teacher in ways that feel unmanageable
- Transferential issues, such as projections, may be around in the group, such as anger, destructive emotions, or individuals "falling in love" with the teacher;
- There may be acting out of an individual's issues or chaotic behaviour, which overwhelms the group process and/or teacher
- Potential difficulties of co-working (as well as benefits)
- Lack of awareness of group processes and difficulties with group processes and dynamics
- Meditation may raise issues for individuals which the teacher finds hard to deal with
- Individuals may take more risks with what they bring to the group, the safer they feel in the group, and this may call on more resources on the part of the teacher
- Mental health background and awareness of the teacher may be or feel limited
- Issues may arise outside the experience of the teacher
- Unexpected situations may arise; emergencies

Managing risk

Pre-course

- Initial assessment and orientation – following guidelines, being thorough, choosing to do this face-to-face wherever possible
- Teacher using gut instinct as well as frameworks or criteria for inclusion/exclusion
- Being very clear about the course, and its limitations, i.e. what it is and what it is not
- Doing a collaborative suitability/risk assessment with the participant being equally involved; possibly checking out with their GP, therapist or other relevant professional
- At the orientation and assessment stage ask participants to fill out a form requesting information about physical and mental health issues.
- Consider the timing for the participant – is now the right time to attend a course? Does something else need to happen first?
- Asking whether the participant is in a treatment system of some kind, and considering how that might interact with the mindfulness course
- Asking the participant about support systems, and what support they might need or use
- Clear contracting; clear arrangements for contact during the course
- Consider the value of motivational interviewing techniques
- Choosing a suitable venue, and checking health and safety risks
- Considering the referral process – how do people "arrive" at doing the mindfulness course?
- Consider the referring on process if individuals need this
- Deciding your own boundaries and also accepting that boundaries can change over time
- Consider the relationship with your co-facilitator, including the level of trust, how well you may gel together in leading groups, and the ratio of participants to facilitators
- Have open discussion with any co-facilitator to clarify roles and actions in case of difficulties
- Asking participants to sign waivers to pre-empt/prevent litigation

- Checking on Public Liability Insurance and Professional Indemnity Insurance

During

- Agree ground rules in session one
- Ensuring there is time at end of sessions for participants to speak individually/ make arrangements for some contact if necessary
- Name distress in the group as it arises, without intruding on an individual's personal material
- Take a breathing space if your sense of what is going on calls for a pause, which can offer participants and the teacher a chance to re-centre
- Co-facilitator may help in case of a difficulty, or if a participant is particularly distressed, leaves the room etc.
- Be thoughtful about your choice of language and offer clear and simple instructions; be aware of your voice becoming monotone, sending people to sleep, and modulate it
- If people have given details about physical limitations, offer alternatives for movement, sitting, lying positions.
- Supervision between sessions.

Possible further point for discussion

- What code of ethics is being following?
- What is the complaints procedure for participants?

4. MBCT course reunions

MBCT is a brief 8-week course to cultivate participants' mindfulness and skills for staying well in the long-term. Participants typically come with a long-standing history of depression and in this context an 8-week course is a very brief intervention. Reunions or follow-up classes have the intention of supporting ongoing mindfulness practice and learning. We overview several emerging models from MBSR and MBCT for running reunions, provide an example session plan and an example reunion invitation flyer.

4.1 Different formats for MBCT reunions

- **Regular on going meetings for "graduates."** Some teachers organise on going scheduled and planned meetings for people who have been through their 8-week courses. The frequency is determined by the teacher's intentions for these follow-up classes, available resources and local demand. A typical frequency for reunions is 4-6 follow-up classes per year, although some offer an annual event and others offer weekly sitting groups that graduates can attend.
- **All day meetings that are experiential and/or include further teaching.** Some teachers offer all day mindfulness meetings for their graduates which are either themed in terms of some teaching (e.g., keeping practice going, self-compassion, staying well) and/or are largely practice based (e.g., sitting, movement and walking). Many teachers like to run these as part of an 8-week course, typically between sessions 6 and 7 so that participants in the current MBCT course and graduates of previous courses attend alongside each other.
- **Signposting to existing services / groups**. Some teachers who do not offer on going reunions / follow-ups signpost to local sitting groups or services. However, the usual duty of care with onward referrals applies so that participants' interests and welfare are considered thoroughly. Given the secular nature of mindfulness many teachers give a lot of thought about when and how to refer on to groups that are not secular and either prefer not to refer to non-secular groups or provide full information to enable graduates to make informed decisions about whether to take up such an option.
- **Retreats**. More recently retreats have been offered where graduates can come together for a more intensive experience in a dedicated centre that supports ongoing and deepening practice.

4.2 Example Session Plan for MBCT Reunion

MAINTAINING PRACTICE AND HEALTH

THEME

The key themes in follow-up sessions are reinforcing people's mindfulness practice, helping people overcome blocks to continuing practice, identifying positive reasons to do so and reinforcing changes that are sustaining recovery. Continuing to "weave the parachute" through daily informal and formal mindfulness practice enables people to continue to develop and grow. Use of relapse signatures/response plans enables participants to begin to realise that they can transform early experiences of depression into opportunities for learning and skilful behaviours. Embodying a focus on the present communicates the programmes central message powerfully. Working with difficulties in follow-ups will be a powerful illustration of the programme's application to recurrent depression.

AGENDA (Items can be interchanged but start with practice)

- Practice (Stretching and Sitting Meditation)
- Practice Review
- Review of Practice since the end of the 8 week course (link to positive reasons to continue)
- Practice e.g., Mindful Walking
- Reading of some poetry and discussion
- 3-Minute Breathing Space(s) (dropped in at appropriate moments)

PLANNING AND PREPARATION

- In addition to your personal preparation before the class, remember to bring a reading and any additional resources that may be helpful to participants.

4.3 Example Invitation to MBCT Reunion

Mindfulness-based Cognitive Therapy (MBCT)/ Mindfulness-based Stress Reduction (MBSR) Groups

Staying Well in the Long-term

You are invited to attend a follow-up mindfulness group meeting to support former MBCT/MBSR group participants in staying well in the long-term. We currently have these about every 3 months.

We hope that we will be able to:

- Refresh our mindfulness practice through doing some practice together
- Make contact with others who have attended the groups
- Share any experiences of relapses/habitual patterns/automatic pilot and see what can be learned from these
- Share our experience and learn from each other about ways of continuing to take care of ourselves

Facilitators:

Where:

When:

Please contact XX on XX if you would like to discuss the reunion meeting or if you cannot attend and would like your apologies to be passed on to others from your group. **If we do not hear from you over five consecutive reunions we'll assume you no longer wish to attend.**

5. Training and supervision

5.1 Good Practice Guidance for mindfulness-based teachers

The UK Network for Mindfulness-Based Teacher Trainers is committed to supporting good practice and integrity in the delivery of mindfulness-based courses in the UK. Their website is http://mindfulnessteachersuk.org.uk/

The network is supported by all the main training organisations in the UK who train teachers to deliver MBSR, MBCT and Breathworks courses.

The network meets annually to develop consensus on good practice standards for teaching mindfulness-based courses and for training others to teach them.

UK Network for Mindfulness-Based Teacher Trainers – affiliated organisations

Organisation	Web address
Aberdeen University	www.abdn.ac.uk/education/programmes/mindfulness
Breathworks	www.breathworks-mindfulness.org.uk
Centre for Mindfulness Research and Practice, Bangor University	www.bangor.ac.uk/mindfulness
Exeter University - Post graduate training and workshops in Mindfulness- based Cognitive Therapy	http://psychology.exeter.ac.uk/postgraduate/taught/pgmindfulness/
Integrated Mindfulness	www.integratedmindfulness.com
Mindflow Solutions	www.mindflowuk.org
Oxford Mindfulness Centre	www.oxfordmindfulness.org
Salford University	www.salford.ac.uk/courses/integrated-mindfulness-single-module
Stress Minus	www.stressminus.co.uk
Sussex Partnership NHS Foundation Trust training	www.sussexpartnership.nhs.uk/search/?q=MBCT

UK Network for Mindfulness-Based Teachers

Good practice guidelines for teaching mindfulness-based courses

These guiding principles have been developed to promote good practice in teaching mindfulness-based courses. Mindfulness courses are intended to teach people practical skills that can help with physical and psychological health problems and on going life challenges. The main approaches used in the UK are ***Mindfulness-Based Stress Reduction*** *(MBSR),* ***Mindfulness Based Cognitive Therapy*** *(MBCT) and the* ***Breathworks Mindfulness Based approaches to Pain and Illness*** *(MBPI), all of which are normally taught over eight 2-3 hour sessions. MBSR is a group-based programme developed by Jon 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 (www.umassmed.edu/cfm/home/index.aspx). MBCT is an integration of MBSR with Cognitive Behavioural Therapy (http://mbct.co.uk/). It was initially developed by Zindel Segal, Mark Williams and John Teasdale to help recovered recurrently depressed participants and has been recommended by NICE for this group. MBCT is evolving to be taught to a broader range of people based on psychological understandings of what causes human distress and in a range of settings (e.g., health service, schools, forensic settings). The Breathworks MBPI course is a development of MBSR, specifically for people with chronic pain and / or other long-term (physical) health conditions (www.breathworks-mindfulness.org.uk). Developed by Vidyamala Burch, it combines key elements of MBSR and MBCT with particular approaches to mindfulness in daily life and mindful movement that are suitable to this population. It also includes compassion meditation as a core component.*

A teacher of mindfulness-based approaches should have the following:

A. Mindfulness Based Teacher Training

1. Familiarity through personal participation prior to commencing teacher training, with the mindfulness-based course curriculum that they will be learning to teach, with particular in-depth personal experience of all the core meditation practices of this mindfulness-based programme.

2. Completion of an in-depth, rigorous mindfulness-based teacher training programme or supervised pathway over a minimum duration of 12 months.

B. Training or background required in addition to mindfulness-based teacher training

1. A professional qualification in mental or physical health care, education or social care, or equivalent life experience, recognized by the organization or context within which the teaching will take place.

2. Knowledge and experience of the populations that the mindfulness-based course will be delivered to, including experience of teaching, therapeutic or other care provision with groups and/or individuals, unless such knowledge and experience is provided to an adequate level by the mindfulness-based teacher training itself. An exception to this can be when teaching with the help of a colleague who knows well the population to whom the course will be delivered and has a relevant qualification. They would also need to have an understanding of mindfulness-based approaches.

3. If delivering MBCT, knowledge of relevant underlying psychological processes, associated research and evidence-based practice, unless these are provided to an adequate level by the mindfulness teacher training programme.

4. If delivering MBCT or other mindfulness-based course with a clinical population, an appropriate professional clinical training

C. Ongoing Good Practice Requirements

1. Commitment to a personal mindfulness practice through

− daily formal and informal practice

− participation in annual residential teacher-led mindfulness meditation retreats

2. Engagement in processes which continue to develop mindfulness-based teaching

practice:

− on going contacts with other mindfulness practitioners and teachers, built and

maintained as a means to share experiences and learn collaboratively

and

− regular supervision with an experienced mindfulness-based teacher including:

i. opportunity to reflect on/inquire into personal process in relation to personal mindfulness practice and mindfulness-based teaching practice

ii. receiving periodic feedback on teaching through video recordings, supervisor sitting in on teaching sessions or co-teaching with reciprocal feedback.

3. A commitment to on going development as a teacher through further training, keeping up to date with the evidence base, recording and reflecting on teaching sessions, participation in webs forums etc.

4. Adherence to the ethical framework appropriate to the teacher's professional background and working context.

5.2 Good Practice Guidelines for Trainers of Mindfulness-Based Teachers

The UK Network for Mindfulness-Based Teacher Trainers has developed Good Practice Guidance for trainers of MBCT teachers

Good Practice Guidelines for Trainers of Mindfulness-Based Teachers

Our Good Practice *Guidelines* for teachers are *standards* which teacher trainers need to meet and adhere to. In addition they would normally meet the following Good Practice Guidelines for trainers of mindfulness-based teachers:

1. Have had full teaching responsibility for at least nine mindfulness-based courses over a minimum of three years
2. Have been assessed to be of an acceptable level of competence in teaching mindfulness-based courses
3. Have trained to be a trainer via an apprenticeship with a more experienced trainer
4. To continue to teach beginning meditators alongside training teachers.
5. Be in a regular supervisory relationship in relation to teaching practice and its interface with personal mindfulness practice
6. Attend annual retreats which facilitate practice at depth, some of which are at least 7-10 days in duration and are chosen in discussion with the trainer's practice teacher/supervisor to meet current needs
7. Stay up to date with the current and developing evidence base for mindfulness-based interventions
8. Be up to date with current best practice for methods of assessing mindfulness-based teaching competency
9. Be steeped in the practice and understanding of mindfulness which is informed by both its contemporary applications and its historical antecedents.
10. Be a strong team player - willing to operate in the context of a training team and in connection with others who are training teachers in the UK context.

Mindfulness-based teacher trainers need a well developed skills, understandings and attitudes in the following areas:

1. An experientially gained understanding of the complexity of mindfulness as an approach and its transformational potential.
2. An in depth understanding of the aims and intentions of the full range of curriculum components within the mindfulness-based course they are training others to teach
3. An understanding of the underlying theoretical principles of the mindfulness-based courses they are training others to teach
4. Understand and be equipped to train others in the principles underpinning the adaptation of mindfulness-based courses to different contexts and populations

5. Well developed skills in working with groups, supporting trainees to identify their learning needs, creating a safe and challenging learning environment.
6. Well developed skills in providing feedback to trainees which identifies strengths and weaknesses, and facilitates new learning.
7. An understanding of the complex interface between MBAs taught in a therapeutic context and mindfulness as taught in traditional or specific cultural contexts and a commitment to being transparent in regard to which context(s) mindfulness teaching/training is being offered.

The trainer will work within the ethical framework of his/her profession and will additionally have particularly developed sensitivities in relation to:

- Only training within the limits and boundaries of competence
- Only asking trainees what is asked of self in relation to informal and formal mindfulness practice

5.3 Supervision of MBCT teachers

Definition of supervision of MBCT Teachers:

"A regular space that is contracted between supervisor and supervisee, which enables reflection on the supervisee's mindfulness teaching practice and how this interfaces with their personal mindfulness practice and their life. The process is dedicated to developing and deepening the growth, understanding and effectiveness of the supervisee's application of mindfulness, both personally and in their working life"

Principles for Supervision of MBSR and MBCT Teachers

Supervision of mindfulness-based teachers has a range of roles and functions, including:

- **Supervision as a component in an MBCT/MBSR teacher training pathway**
- **Guiding and mentoring the supervisees' personal meditation practice in terms of:**
  - on going development and deepening of personal practice
  - supporting the interface of personal practice with MBCT/MBSR teaching, therapeutic work and everyday life
- **Investigating and clarifying the integration of mindfulness in the supervisees' professional role including:**
  - Understanding both the essential essence of mindfulness when adapting programme forms to the supervisee's context
  - Supporting the supervisee to hold the paradox of non-striving and non-fixing in secular, results-oriented contexts
- **Using mindfulness practice and teaching skills to:**
  - Bring inquiry to the exploration of the supervisee's experience
  - Mindfully hold and balance the supportive, educational and ethical strands of supervision

Bangor University's Good Practice Guidelines for Supervisors of MBCT/MBSR Teachers

Supervisors need to:

Mindfulness experience and training;

- Fulfil the Good Practice Guidelines for Teaching Mindfulness-Based Courses.
- Fulfil the Good Practice Guidelines for Trainers of Mindfulness-Based Teachers.
- Complete of the CMRP 2-Day 'Supervision of MBSR/MBCT Teachers' Training course.
- Engage in on-going, regular (strongly recommended monthly) supervision with an experienced mindfulness supervisor.

Clinical/Contextual background needed

- Ideally the supervisor will be clinically training and/or have life experience in the field or context to be supervised.

NB

- If the supervisor is not trained or qualified in the clinical field being supervised, the supervisor will limit his/her supervision to non-clinical areas of mindfulness content and process.
- Clinical responsibility is always to be held by a separate clinical supervisor and this must be clearly detailed in the supervision contract.

5.4 Article on training for mindfulness-based teachers

This article offers an overview of the principles and processes which underpin training for MBCT teachers

Crane, R.S., Kuyken, W., Hastings, R., Rothwell, N., Williams, J.M.G., (2010) Training teachers to deliver mindfulness-based interventions: learning from the UK experience, *Mindfulness,* 1, 74–86. DOI 10.1007/s12671-010-0010-9

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ORIGINAL PAPER

Training Teachers to Deliver Mindfulness-Based Interventions: Learning from the UK Experience

Rebecca S. Crane · Willem Kuyken · Richard P. Hastings · Neil Rothwell · J. Mark G. Williams

Published online: 27 April 2010

Abstract Several randomised controlled trials suggest that mindfulness-based approaches are helpful in preventing depressive relapse and recurrence, and the UK Government's National Institute for Health and Clinical Excellence has recommended these interventions for use in the National Health Service. There are good grounds to suggest that mindfulness-based approaches are also helpful with anxiety disorders and a range of chronic physical health problems, and there is much clinical and research interest in applying mindfulness approaches to other populations and problems such as people with personality disorders, substance abuse, and eating disorders. We review the UK context for developments in mindfulness-based approaches and set out criteria for mindfulness teacher competence and training steps, as well as some of the challenges and future directions that can be anticipated in ensuring that evidence-based mindfulness approaches are available in health care and other settings.

Keywords Mindfulness-based approaches · Mindfulness-based cognitive therapy · Mindfulness-based stress reduction · Training · Competence · Experiential learning

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Introduction

5.5 MBCT teacher training routes

There are two broad training routes to gain skills in teaching MBCT:

1. Master's programmes at the Bangor University (bangor.ac.uk/mindfulness); Exeter University (http://exeter-mindfulness-network.org/training-postgraduate-mbct.php) and Oxford University (http://oxfordmindfulness.org/train/).

2. Supervised Teacher Training Pathway. The section that follows summarises the elements that make up this training route.

Supervised pathway for training to teach MBCT/MBSR shared by Bangor, Exeter and Oxford

	Pre-requisite skills and knowledge	**Foundation level/Preparing to teach**	**Beginning to teach through to competency in teaching MBCT/MBSR (assessed using the MBI-TAC)**
Personal mindfulness practice / Personal qualities/ Professional training	A professional qualification in mental health, physical care, education or social care or equivalent life experience Personal requisite relational skills e.g. warmth, empathy Personal Mindfulness practice	Participation in an 8 week MBCT/MBSR course Integration in to daily life a practice of the formal and informal practices taught in MBCT/MBSR Keeping a reflective diary around Mindfulness practice, teaching of mindfulness and the integration of the two Participation in a residential teacher	Continuation of daily practice supported by opportunities for reflection and inquiry, reading, listening to talks Participation in a longer residential teacher led mindfulness meditation retreat with silent periods (approximately 5-8 days) Awareness of the good practice guidelines.

	Pre-requisite skills and knowledge	Foundation level/Preparing to teach	Beginning to teach through to competency in teaching MBCT/MBSR (assessed using the MBI-TAC)
		led mindfulness meditation retreat with some silent periods (approximately 2-4 days)	
Conceptual/ Theoretical/ Research	Knowledge and experience of the population that the MBCT/MBSR course will be delivered to Knowledge of underlying psychological processes and associated research	<u>Basic understandings</u> e.g. Beginning to synthesise mindfulness theory and personal experience of practice, CBT theory, Psychological underpinnings <u>Understanding the 8-week course</u> e.g. Familiarity with 8-week course structure and content intentions and rationale behind course components, delivery of core practices, Inquiry, group processes. <u>Buddhist</u> e.g. Foundations of mindfulness, compassion <u>Research</u> Developing a familiarity with the main evidence base A knowledge of different applications for Mindfulness-based approaches Understanding of simple systems for evaluation Keeping up to date with research, further understandings	
		Through workshops, lectures, talks, reading recommended books/ journals/ research papers, CPD events	
Teacher Training/ Supervision/ Assessment	Experience of running groups	Teaching component parts of the 8-week course in safe settings with peers with feedback from peers and experienced MBCT/MBSR	Moving the teaching in a graded way to work based settings, Maybe co leading a group to begin and moving to further independence. Regular supervision (from an experienced Mindfulness-based teacher) either in situ (as a co leader) or via supervision. Process include to reflection/inquiry of own practice in relation to teaching and periodic feedback on teaching through use of video recording or live observation.

	Pre-requisite skills and knowledge	Foundation level/Preparing to teach	Beginning to teach through to competency in teaching MBCT/MBSR (assessed using the MBI-TAC)
		teachers. May include participating in a group as an observer/support person. Observation of others teaching live and/or via DVD	Summative rating to assess competency using the MBI-TAC by an experienced MBCT/MBSR teacher who has a familiarity with using the assessment tool.

Process for setting up and completing a supervised pathway

1. •Assessment (by mentor) of current experience, skills and knowledge to establish that all pre-requisites are met.
2. •Agreement (with Mentor) on an individualised pathway and timeline that builds on existing experience, skills and knowledge and allows for completion of all the areas from foundation through to competency to teach MBCT/MBSR. Progression and growth allows for moving forward and backwards through the pathway.
3. •Pathway training begins. The student keeps a Portfolio of evidence throughout the process. This may include certificates for CPD events, reflective writings, supervision notes, statements from mentor/supervisor and any feedback notes. The mentor helps to steer the course through the pathway including agreement between mentor and student on readiness for formal assessment.
4. •Formal assessment (completed by an experience assessor using the Mindfulness-based Interventions Teaching Aessement Criteria MBI-TAC) culminating in:
   •level of competency is reached in all domains and pathway ends.
   • or a process is agreed (with the mentor) for further experience, knowledge and skills and a further assessment.
5. •Once competence in all domains on the MBI-TAC is established a Certificate of Competency and Completion of a Supervised pathway in MBCT or MBSR is awarded and the teacher agrees to work within the UK Network for Mindfulness-based Teachers Good Practice Guidelines

5.6 Article on mindfulness-based teaching competency

This article offers an overview of the principles and processes which underpin MBCT teaching competency

Crane R.S., Kuyken, W., Williams, J. M. G., Hastings, R., Cooper, L., Fennell, M.J.V. (2012), Competence in teaching mindfulness-based courses: concepts, development, and assessment, *Mindfulness,* 3, 1-76-84. DOI: 10.1007/s12671-011-0073-2

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Mindfulness (2012) 3:76–84
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MINDFULNESS IN PRACTICE

Competence in Teaching Mindfulness-Based Courses: Concepts, Development and Assessment

Rebecca S. Crane · Willem Kuyken · J. Mark G. Williams · Richard P. Hastings · Lucinda Cooper · Melanie J. V. Fennell

Published online: 22 September 2011

Abstract There has been a groundswell of interest in the UK in Mindfulness-Based Stress Reduction (MBSR) and its derivatives, particularly Mindfulness-Based Cognitive Therapy (MBCT). Many health, education and social work practitioners have sought ways to develop their competencies as mindfulness-based teachers, and increasing numbers of organisations are developing mindfulness-based training programmes. However, the rapid expansion of interest in mindfulness-based approaches has meant that those people offering training for MBSR and MBCT teachers have had to consider some quite fundamental questions about training processes, standards and competence. They also need to consider how to develop a robust professional context for the next generation of mindfulness-based teachers. The ways in which competencies are addressed in the secular mainstream contexts in which MBSR and MBCT are taught are examined to enable a consideration of the particularities of mindfulness-based teaching competence. A framework suggesting how competencies develop in trainees is presented. The current status of methodologies for assessing competencies used in mindfulness-based training and research programmes is reviewed. We argue that the time is ripe to continue to develop these dialogues across the international community of mindfulness-based trainers and teachers.

Keywords Mindfulness-based approaches · Mindfulness-based cognitive therapy · Mindfulness-based stress reduction · Professional practice · Training · Assessment · Competence

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Introduction

The rapid expansion of interest in the implementation of mindfulness-based approaches in a diversity of contemporary settings holds both promise and risk. The promise is of accessibility in mainstream secular settings to a contemplative approach which has a long lineage in supporting people to better know the territory of their interior experience, to train their minds in a certain direction and so to radically

5.7 Mindfulness-Based Interventions: Teaching Assessment Criteria

The Mindfulness-Based Interventions: Teaching Assessment Criteria offer a systematic way of assessing competency in teaching mindfulness-based interventions. They were developed to support training programmes and researchers in assessing MBCT teaching. It comprises six core domains:

Domain 1: Coverage, pacing and organisation of session curriculum

Domain 2: Relational skills

Domain 3: Embodiment of mindfulness

Domain 4: Guiding mindfulness practices

Domain 5: Conveying course themes through interactive inquiry and didactic teaching

Domain 6: Holding of group learning environment

It uses the well-established Dreyfus scale of competency in clinical practice ranging from incompetent to beginner, to advanced beginner to competent, to proficient to advanced.

The assessment criteria can be downloaded from:

http://www.bangor.ac.uk/mindfulness/MBITAC.php.en?catid=&subid=10338

6. Evaluation of MBCT Courses[8]

It is important for teachers to evaluate their MBCT courses because it provides confidence to the teacher and service that the courses are helping participants as intended and are not causing harm.

Evaluation can be undertaken in different ways and this section outlines some broad guidance for anyone wishing to undertake evaluation of their courses. Each approach has advantages and disadvantages and these are set out. It is beyond the scope of this resource kit to offer comprehensive guidance for service evaluation as it will be dependent on the particular context in which the service is delivered, the resources available etc., so rather we offer some notes, ideas and resources for where teachers can access additional guidance.

Why evaluate MBCT?

Evaluation helps us answer several questions and address several issues:

- Does MBCT work in our service setting, with our clients and our MBCT teachers?
- For who is it working / not working?
- To tell us what participants think of our service.
- Challenge our beliefs.
- Explore new applications. That is to say if we adapt MBCT for a new setting / population, is it still effective?
- Maintain / gain funding for our service.

In evidence-based practice the argument is that evaluation makes us accountable for our work by:

- Meeting the public's expectations that we demonstrate that what we do works.
- Meeting commissioners' demands that we demonstrate positive outcomes and cost-effectiveness.
- Providing data for decision making in managing limited resources.

Some principles to guide evaluation

Evaluation works when it:

- Asks "good" questions (this is probably the most important principle to guide your evaluation!),
- Uses valid and relevant methods,
- Improves the quality of clinical care,

[8] The notes are based on a one-day workshop taught by Willem Kuyken.

- Improves cost-effectiveness,
- Is inclusive, collaborative and transparent and
- Commands the respect of service users and professionals

What is the focus of an evaluation?

An evaluation can have a number of different foci (Maxwell, 1984, *British Medical Journal*):

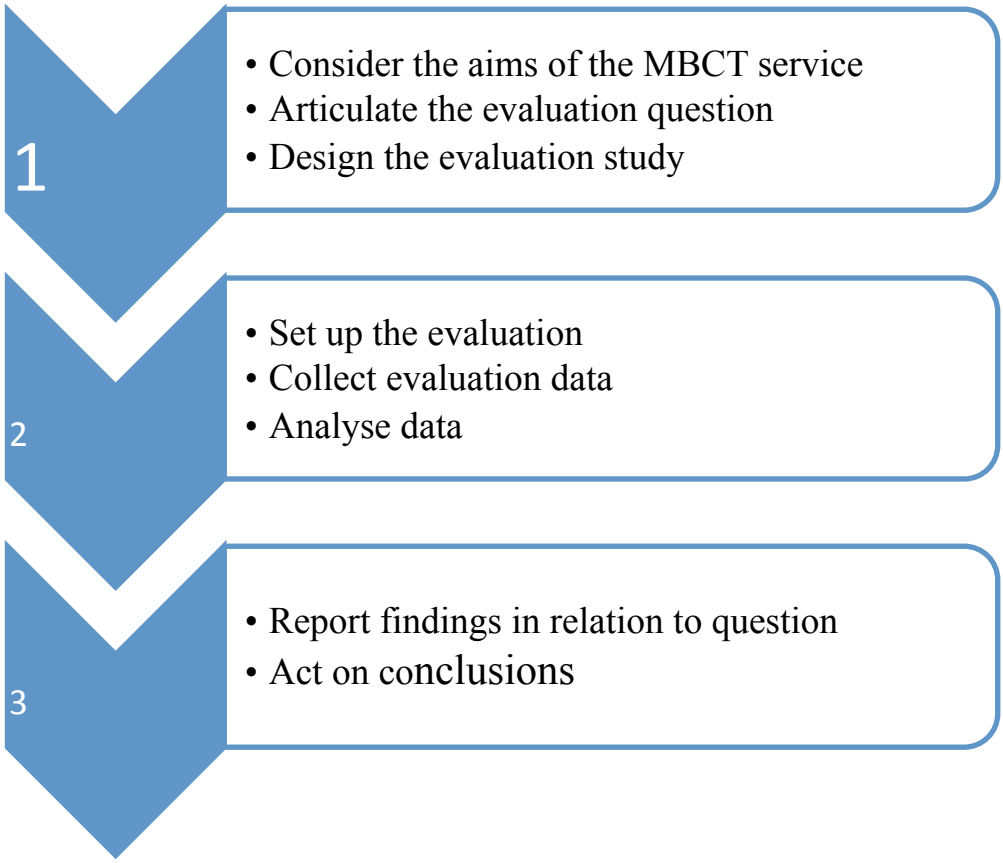
- ***Access to services*** (for the whole community). That is to say, given the community we are seeking to serve, how well are we making our service accessible? This includes waiting times for people who are entering the service.

- ***Effectiveness*** (for individual clients). That is to say, for individual clients who participate in our service, does MBCT work, are changes observed in the intended outcomes?

- ***Social acceptability***. That is to say, does the broader community (commissioners, carers, referrers, neighbouring services) find the service acceptable?

- ***Efficiency / economy***. That is to say, is the service operated with appropriate protocols and governance procedures? Is it run in a cost-effective way? Cost-effectiveness refers to getting the best gains at the lowest costs.

Steps in carrying out an evaluation



Steps in carrying out an evaluation: 1. Asking a good question

The quality of the evaluation question will largely determine the quality of the evaluation and the ease with which it can be carried out, analysed, reported and acted upon. It is therefore a very good use of time to give a lot of thought to exactly what evaluation question you want to answer. Is it about access, is it about particular outcomes, is it about participants' experiences …?

A good question is:
Set in the context of the service: i.e., what are the service aims?

- Specific: i.e., what exactly is the service trying to do, in clear and operational terms?
- Measurable: i.e., the question is stated in such a way that the answer can be measured / observed.
- Achievable: i.e., the intended outcomes are realistically achievable and the outcomes are realistically measurable.
- Relevant: i.e., the question is important, is relevant to the service objectives, to the teacher and to the participants in an MBCT course.
- Time anchored: i.e., the question has an explicit or implicit time frame whereby a particular change or outcome would be expected, normally within a stated window of time and

- Bears in mind the target population: i.e., who are we trying to help, and in what way?

Examples of good questions are:

For an MBCT for recurrent depression service: Do my MBCT courses for people with a history of recurrent depression lead to clinically significant reductions in depressive symptoms and improvements in quality of life from before to after the course? Are rates of relapse a year after my MBCT courses comparable to rates of relapse in the published research trials (approximately 1/3)?

For an MBCT course for the general public: Is my MBCT course for the general public producing positive changes in mindfulness and self-compassion and improvements in quality of life across a range of domains (physical, psychological and social) from before to after the course? Are any improvements sustained six months later? Are clients subjectively satisfied with the service?

Steps in carrying out an evaluation. 2. Choosing a study design

In considering the design for your evaluation there are a few issues to bear in mind.

- If your evaluation question involves looking at changes, you need before and after measures of the dimension you are evaluating.
- Measures need to be the same before and after the mindfulness courses. They also need to be sensitive to change.
- The mindfulness-based intervention needs to be delivered with integrity and competence. Put in place good teacher selection, supervision and CPD to ensure teachers are well supported in teaching MBCT with integrity.

In running an evaluation it is important to consider some governance and ethical issues:

- Informed consent. I.e., have you asked participants for their consent to do the evaluation having given them a full and clear description of what you want to do?
- Protection of participants. I.e., are there any risk issues you need to think through (see Section 3.13 above). Some evaluation measures might expose participant risk issues or care needs? For example some psychiatric measures ask about patient's suicidal ideation / intent. What procedures are in place if someone discloses that s/he is actively suicidal?
- Anonymity. I.e., will you ensure participants' data is protected in line with reasonable safeguards for participant anonymity?
- Data storage. I.e., will you store data in line with data protection guidance nationally and for your organisation?

There are many different ways of designing an evaluation study. These need to be rigorous enough to be able to answer the evaluation question but also pragmatic enough to be feasible in the service context within the available resources. Broadly speaking more rigorous designs can tend to be more resource intensive, so there is always something of a trade-off between design quality and feasibility. However, if a longer-term mindfulness is being established a cost-effective evaluation can be designed into the service.

Several uncontrolled and controlled study designs are described below.

Uncontrolled designs

There are several designs that do not include a control group that are pragmatic, but fundamentally lack the ability to rule out definitively that any observed effects are not simply an artefact of time or some unknown other factors. These are listed in order of increasing strength of design, but also decreasing pragmatism.

- ***Post only design***. After the MBCT some measure or observation is taken and used to answer the evaluation question. An example is the questionnaire that participants complete in session 8 that asks for a rating of the MBCT course from 1 to 10 and qualitative comments in response to several questions about participants' experience of the 8-week programme. These are relatively easy to collect, but they are prone to participants saying what they think the teacher wants to hear, have no way of comparing with any pre-MBCT baseline data and capture only the views of people who stayed with whole 8-week of the course.

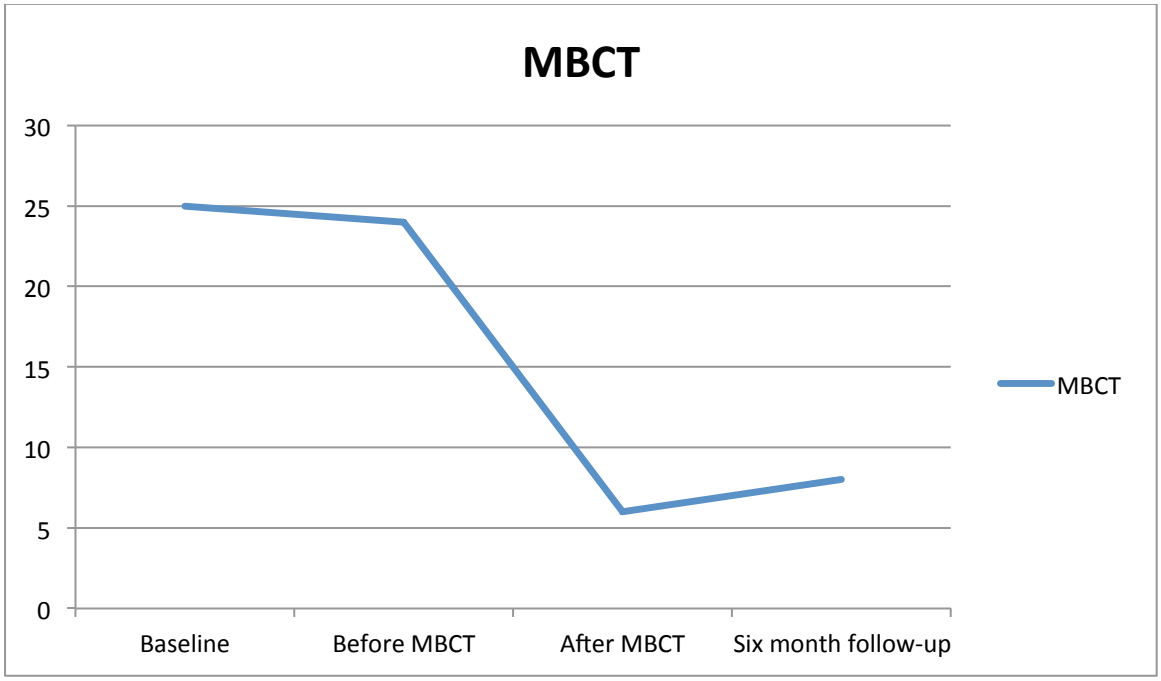
- ***Pre - post design***. This design takes measures that address the evaluation question before and after the MBCT group and typically reports changes in these measures across time. Sometimes with well-chosen measures it is possible to interpret pre-MBCT and post-MBCT levels of a particular outcome of interest in terms of severity of well-being / dysfunction as well as the clinical meaningfulness of any changes (see worked example below). However, with this design it is not possible to rule out the possibility that observed changes are an artefact of time or some unknown other variable.

- ***Pre - post – follow-up design***. This design builds on the design above, but given that MBCT has the intention of cultivating longer-term gains it includes a third point of evaluation at a pre-determined follow up point. This enables an evaluation of the sustained effect of MBCT over time. All the MBCT relapse prevention trials have followed up people over a year, for example.

- ***Stable baseline – pre-post – follow –up design***. This design builds on the design above, but tries to rule out more compellingly the possibility that changes are simply a function of time. It does so by including a period before the MBCT courses where two or more observations are taken, with the assumption that there should be no substantive changes before the intervention on the outcomes of interest. So the

evaluation would predict a stable baseline prior to starting MBCT, with a clinical meaningful change during the MBCT that is sustained into follow-up.

An example of change over time in depressive symptoms (Beck Depression Inventory, Second Edition) from baseline, to pre-MBCT, to post-MBCT, to 6-month follow-up among people participating in an MBCT programme.



By simply looking at this graph, this evaluation can be interpreted as follows. Participants are entering the service with moderate levels of depressive symptomatology that is stable over time before the MBCT course. Average levels of depression drop to the minimal range across the 8-week MBCT course and stay in the minimal range at six month follow up, even though there is a slight rebound in depressive symptoms from after the MBCT course to the six month follow up. It would be possible to test this interpretation with some statistical tests if the numbers of participants was large enough. It is important to look at variability in people's scores at each time point, with small numbers even on a case-by-case basis. This enables you to establish how consistent the pattern is across everyone. It is possible to have this broad pattern of findings but have some people who get worse – this would be important to know.

Controlled designs

Controlled designs introduce a well-chosen comparison group that enables a test of MBCT against the comparison group, thus ruling out the possibility that any changes are simply an artefact of time that would happen without participating in an MBCT course.

- ***Wait-list control***. A relatively straightforward control group is to compare the pre-post MBCT changes on evaluation measures against a group of people who are on a waiting list and not yet receiving treatment, tested over a comparable 8-week period. The assumption here is that we would not expect the wait list to improve as they have not received any treatment yet. While better than an uncontrolled design this design makes the assumption that being on a waiting list is neutral; there is some evidence that people have reactions to being on a waiting list that can be reflected in the evaluation measure. Also, in this design there is also commonly unequal drop out from the two groups for all sorts of reasons.

- ***Non-controlled comparison groups***. An alternative is to compare the MBCT course with another treatment within the service using the same evaluation measures collected over comparable time periods. There are quite a few challenges with this design: the groups of people in the different groups are likely to be systematically different (that's why they were allocated to different treatments) and the evaluation measures may not be equally appropriate for both groups. Finally, the appropriate timeline for data collection may be different for MBCT and the comparison group.

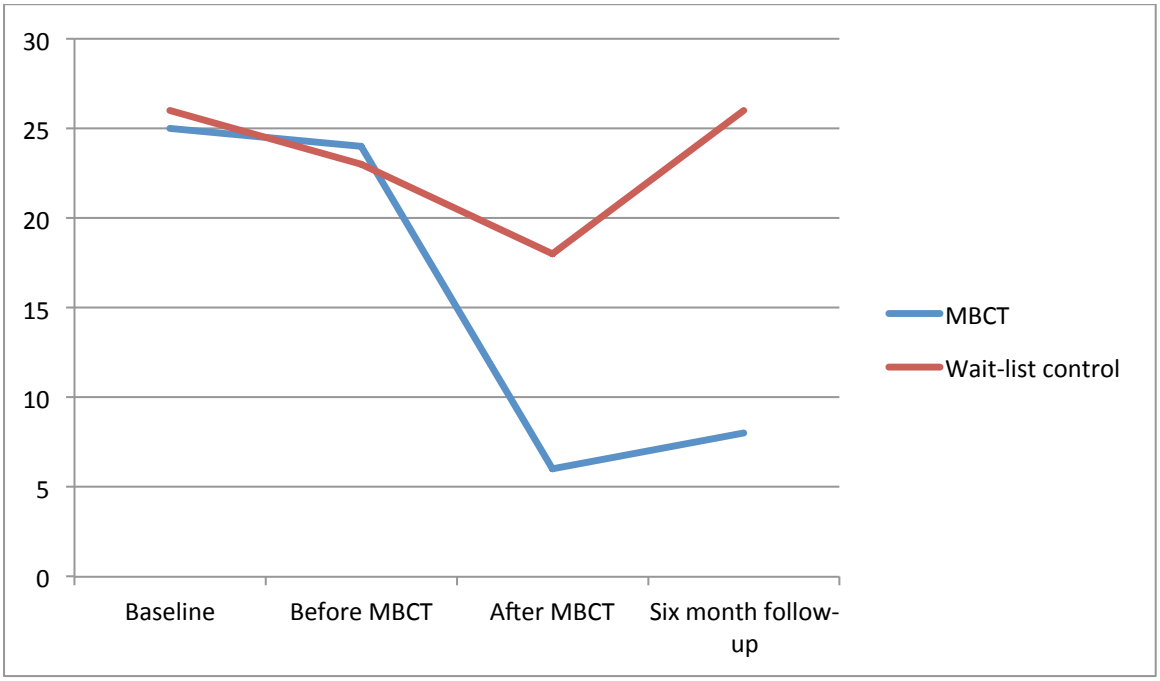
- ***Controlled comparison groups***. This design is the same as above, but care is taken in selecting a comparison group that is matched to the MBCT course on key factors, such as severity of presenting problems pre-treatment, gender, age etc. This enables greater confidence in any comparison being a function of the treatments rather than an artefact of the comparison group selected.

- ***Randomised controlled trial.*** This is considered the best way of evaluating whether a treatment is effective because random allocation means that the only different between the MBCT and the comparison group is the treatment itself. Everything else is standardised. However, a randomised controlled design is rarely appropriate for a service evaluation because random allocation is not normally acceptable in routine clinical practice (people want a particular treatment, not random allocation to treatments) and running a randomised controlled trial requires considerable expertise and resource that is unlikely to be available to most clinical services.

- ***Comparison against norms for population and scales and other data sets***. This final approach is appropriate for all of the designs above. It involves selecting measures for which there are population norms and guidance on how to interpret scores within the evaluation against these norms. This enables the comparison of data collected in an evaluation to be benchmarked against meaningful norms for the population and indeed MBCT trials. This allows a meaningful interpretation of any evaluation results. For example, many quality of life measures provide population norms by age and gender and cut-offs for different levels of quality of life, so you can characterise your MBCT participants before and after the courses on a range from very poor to excellent quality of life. Most major classes of outcome measures include some well standardised measures with these sorts of normative data. In the worked example

above and below the depression scores are interpreted in terms of cut-offs that distinguish minimal, mild, moderate and severe levels of depressive symptom severity. This enables the evaluation to be able to be clear about the level of functioning before and after the MBCT courses and to compare this with normative data or indeed with changes observed in larger scale published trials. This is important, because one of the best predictors of depressive relapse is low-grade residual depressive symptoms, so if your MBCT courses are helping people address these symptoms this is evidence of reducing their risk for relapse.

An example of change over time in depressive symptoms from baseline, to pre-MBCT, to post-MBCT, to 6-month follow-up among people participating in an MBCT programme and a matched wait-list control group (depressive symptoms assessed with the Beck Depression Inventory, Second Edition).



Qualitative methods

Qualitative methods are ways of capturing the experiences of people in an evaluation, and are appropriate in providing a richer and more phenomenological account of clients' experiences of MBCT.

Qualitative research:

- Is concerned with "meaning" and "underlying lived experiences"
- Provides a voice for individuals and groups
- Embarks from a position of "not knowing"

- Is concerned with "whole processes" (without the need to eliminate differences)
- Creates theory from phenomenological accounts. It is bottom-up (rather than top-down).
- Is sceptical about theories or "big ideas" that generalise across individuals / groups
- Investigates and describes (rather than makes hypotheses and objectively tests hypotheses)
- Typically asks that researchers' background and assumptions are explicit in the research process

The following are examples of qualitative methods, broadly organised from more descriptive to more inferential methods for analysing data:

- Content analysis
- Thematic analysis
- Interpretative phenomenological analysis
- Grounded theory
- Discourse analysis

The following are texts for conducting qualitative research to unpack participants' experiences:

Flick, U. (2006) *An introduction to qualitative research* (3rd edition). Pine Forge Press.

Willig, C. (2008) *Introducing qualitative research in psychology (2nd edition)*. Open University Press: Buckingham.

The following are a few examples of papers that used qualitative methods:

Allen, M., Bromley, A., Kuyken, W., & Sonnenberg, S. J. (2009). Participants' experiences of mindfulness-based cognitive therapy: "It changed me in just about every way possible". *Behav Cogn Psychother, 37,* 413-430.

Finucane, A. & Mercer, S. W. (2006). An exploratory mixed methods study of the acceptability and effectiveness of mindfulness -based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry, 6,* 1-14.

Steps in carrying out an evaluation. 3. Selecting measures

When selecting outcome measures the most important consideration is your evaluation question. That is to say, if you want to evaluate changes in mindfulness you need a measure of mindfulness that assesses your understanding of mindfulness. In the example evaluation

questions above, this would be measures of residual depressive symptoms, depressive relapse and quality of life for the first question and measures of mindfulness, self-compassion, quality of life and client satisfaction for the second question. Once you have identified the outcomes you want to evaluate you need to identify the most relevant, well validated measure, which ideally provides scores that you are clinically meaningful and can be comparable with results from other studies.

Below are some issues to consider when choosing measures. The measures should be able to:

- Describe current functioning
- Confirm, refute or modify clinical impressions
- Identify therapeutic needs, highlight likely outcomes in therapy
- Monitor therapy outcomes over time
- Help you in managing risk

It is best to select well-validated measures, which means simply that the measure has been shown to measure what it purports to measure, does so consistently regardless of who is administering the measure and is sensitive to change. These criteria are often described as follows:

- Reliability
- Validity
- Sensitivity to change

Equally important is the acceptability of a measure to clients. Is the measure well formatted, structured, an acceptable length and so on. Getting some client feedback is a good way to establish this for your setting.

Finally, it is important to consider if the measure is free to use or if it copyrighted and there are costs associated with its use.

Two useful references if you are trying to decide on appropriate instruments are:

Ann Bowling, *'Measuring Health. A review of quality of life measurement scales*' (1997), and *'Measuring Disease. A review of disease-specific quality of life measurement scales'* (1995). Both published by Open University Press.

Measures of mindfulness

Often services want to use measures of mindfulness as part of their evaluation. After all, it is a mindfulness-based intervention and it is important to demonstrate that it is indeed leading to changes in mindfulness. There has been quite a lot of work developing measures of mindfulness and self-compassion and all the measures are somewhat different in terms of

their understanding of mindfulness, their focus, their length, their usefulness with particular populations and their psychometric properties. We list the main measures and suggest that the criteria above are used to choose the most appropriate measure. When selecting a measure of mindfulness it is particularly important to read the questionnaire items for yourself to get a sense of their content.

- Kentucky Inventory of Mindfulness Skills (KIMS: Baer et al., 2004) and its derivative the Five Facet Mindfulness Questionnaire (FFMQ: Baer et al., 2006).
- Mindful Attention Awareness Scale (MAAS: Brown & Ryan, 2003)
- Freiburg Mindfulness Inventory (FMI: Buchheld, Grossman & Walach, 2001)
- Southampton Mindfulness Questionnaire (SMQ: Chadwick, Hember, Symes, Peters, Kuipers & Dagnan, 2008)
- Philadelphia Mindfulness Scale (PHLMS: Cardaciotto et al., 2008)
- Self-compassion Scale (SCS: Neff, 2003)

There is an excellent resource where all the key publications relating to these measures are listed: http://www.mindfulexperience.org/measurement.php

Steps in carrying out an evaluation. 4. Running the evaluation, analysing the findings and writing up and acting on the evaluation

Having asked a good evaluation question, chosen a design and selected your measures, the next step is to run the evaluation and analyse the findings. This involves the usual aspects of running a research project, good attention to detail, project management skills, data entry and analysis skills. Some good resources that outline these aspects of an evaluation are listed below. Probably the best single reference that provides an overview of many of the issues outlined above is the book by Barker, Pistrang and Elliott.

Barker, C., Pistrang, N. & Elliott. (2002). *Research methods in clinical and counselling psychology*, Second Edition. Chichester: Wiley. [especially see the chapter on evaluation].

Clark-Carter, D. (1997). *Doing quantitative psychological research: From design to report*. Hove: Psychology Press.

Miles, J. & Gilbert, P. (2005). *A handbook of research methods for clinical and health psychology*. Oxford: Oxford University Press.

Streiner, D.L. & Norman, G.R. (1989). *Health measurement scales: A practical guide to their development and use*. Oxford: Oxford University Press.

Willig, C. (2008) *Introducing Qualitative Research in Psychology (2nd edition)*. Open University Press: Buckingham. Especially chapters 1 and 2.

7. Further resources

* Core resources

Readings

*Allen, M., Bromley, A., Kuyken, W., & Sonnenberg, S. J. (2009). Participants' experiences of mindfulness-based cognitive therapy: "It changed me in just about every way possible". *Behav Cogn Psychother, 37,* 413-430. [A qualitative study of people's experience of MBCT]

*Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology-Science and Practice, 10,* 125-143.

*Baer, R. A. (2005). *Mindfulness-Based Treatment Approaches: Clinician's Guide to Evidence Base and Applications*. Academic Press Inc. [Edited book covering the science and practice of a range of mindfulness-based approaches.]

* Baer, R. A. (2011). Measuring mindfulness. *Contemporary Buddhism, 12*(1), 241-261.

Baer, R. A., Smith, G. T., & Allen, K. B. (2004). Assessment of mindfulness by self-report - The Kentucky inventory of mindfulness skills. *Assessment, 11,* 191-206.

Barnhofer, T., Crane, C., Hargus, E., Amarasinghe, M., Winder, R., & Williams, J. M. (2009). Mindfulness-based cognitive therapy as a treatment for chronic depression: A preliminary study. *Behaviour Research and Therapy, 47*(5), 366-373

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press. (Text that describes CBT of depression that MBCT has drawn on).

Bennett-Goleman, T. (2001). *Emotional Alchemy: How the Mind Can Heal the Heart*. New York: Three Rivers Press.

Bertschy, G. B., Jermann, F., Bizzini, L., Weber-Rouget, B., Myers-Arrazola, M., & Van der Linden, M. (2008). Mindfulness based cognitive therapy: A randomized controlled study on its efficiency to reduce depressive relapse/recurrence. *Journal of Affective*

Disorders, 107, S59-S60.

Bogels, S., Lehtonen, A., & Restifo, K. (2010). Mindful Parenting in Mental Health Care. *Mindfulness*. [Nice theoretical article on why and how mindfulness might be helpful in working with parents].

Bogels, S., Hoogstad, B., van Dun, L., de Schutter, S., & Restifo, K. (2008). Mindfulness Training for Adolescents with Externalizing Disorders and their Parents. *Behavioural and Cognitive Psychotherapy, 36,* 193-209.

Bondolfi, G., Jermann, F., der Linden, M. V., Gex-Fabry, M., Bizzini, L., Rouget, B. W. et al. (2010). Depression relapse prophylaxis with Mindfulness-Based Cognitive Therapy: replication and extension in the Swiss health care system. *J Affect Disord, 122,* 224-231.

Britton, W., Fridel, K. W., Payne, J. D., & Bootzin, R. R. (2005). Improvement in sleep and depression following mindfulness meditation: A PSG study. *Sleep, 28,* A315.

Broderick, P. (2005). Mindfulness and coping with dysphoric mood: Contrasts with rumination and distraction. *Cognitive Therapy and Research, 29,* 501-510.

Brown, K. W., Ryan, R. M., & Creswell, J. D. (2007). Mindfulness: Theoretical Foundations and Evidence for its Salutary Effects. *Psychological Inquiry, 18,* 211-237.

Carlson, L. E. & Garland, S. N. (2005). Impact of Mindfulness-Based Stress Reduction (MBSR) on sleep, mood, stress and fatigue symptoms in cancer outpatients. *International Journal of Behavioral Medicine, 12,* 278-285.

Carmody, J. & Baer, R. A. (2008). Relationships between mindfulness practice and levels of mindfulness, medical and psychological symptoms and well-being in a mindfulness-based stress reduction program. *Journal of Behavioral Medicine, 31,* 23-33.

Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. H. (2004). Mindfulness-based relationship enhancement. *Behavior Therapy, 35,* 471-494.

Chadwick, P., Taylor, K. N., & Abba, N. (2005). Mindfulness groups for people with psychosis. *Behavioural and Cognitive Psychotherapy, 33,* 351-359.

Coelho, H. F., Canter, P. H., & Ernst, E. (2007). Mindfulness-based cognitive

therapy: Evaluating current evidence and informing future research. *Journal of Consulting and Clinical Psychology, 75,* 1000-1005.

* Crane, R. (2009). *Mindfulness-based cognitive therapy*. London: Routledge. (Excellent brief text outlining MBCT).

* Crane, R., Kuyken, W., Hastings, R. P., Rothwell, N., & Williams, J. M. G. (2010). Training teachers to deliver mindfulness-based interventions: Learning from the UK experience. *Mindfulness,* 74-86. [Describes routes to training in the UK]

Davidson, R. J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S. F. et al. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine, 65,* 564-570.

Dimidjian, S. & Linehan, M. M. (2003). Defining an agenda for future research on the clinical application of mindfulness practice. *Clinical Psychology-Science and Practice, 10,* 166-171.

Dumas, J. E. (2005). Mindfulness-based parent training: Strategies to lessen the grip of automaticity in families with disruptive children. *Journal of Clinical Child and Adolescent Psychology, 34,* 779-791.

Eisendrath, S. J., Delucchi, K., Bitner, R., Fenimore, P., Smit, M., & McLane, M. (2008). Mindfulness-based cognitive therapy for treatment-resistant depression: A pilot study. *Psychotherapy and Psychosomatics, 77,* 319-320.

Eisendrath, S., Chartier, M., & McLane, M. (2011). Adapting Mindfulness-Based Cognitive Therapy for Treatment-Resistant Depression. *Cognitive and Behavioral Practice, 18*(3), 362-370.

Elliston, P. (2001). Mindfulness in medicine and everyday life. *British Medical Journal, 323,* 7322.

Epstein, M. (1995). *Thoughts without a thinker: Psychotherapy from a Buddhist perspective*. New York: Basic Books. (Mindfulness from a psychodynamic perspective)

Eyberg, S.M., & Graham-Pole, J.R., (2005). Mindfulness and behavioural parent

training: Commentary. *Journal of Clinical Child and Adolescent Psychology*, 34, 792-794.

Feldman, C., & Kuyken, W. (2011). Compassion in the landscape of suffering. *Contemporary Buddhism, 12*(1), 143-155. [Describes why compassion is key in MBCT – email me for a copy].

Fennell, M., & Segal, Z. (2011). Mindfulness-based cognitive therapy: culture clash or creative fusion? *Contemporary Buddhism, 12*(1), 125-142. doi: Pii 938642598

Finucane, A. & Mercer, S. W. (2006). An exploratory mixed methods study of the acceptability and effectiveness of mindfulness -based cognitive therapy for patients with active depression and anxiety in primary care. *BMC Psychiatry, 6,* 1-14.

* Fjorback, L. O., Rehfeld, E., Schroder, A., Arendt, M., & Fink, P. (2008). Review: randomized controlled trials of Mindfulness-Based Stress reduction and mindfulness based cognitive therapy. *Journal of Psychosomatic Research, 64,* 650. {Good review of trials}.

Fjorback, L. O., Arendt, M., Ornbol, E., Fink, P., & Walach, H. (2011). Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy - a systematic review of randomized controlled trials. *Acta Psychiatrica Scandinavica, 124*(2), 102-119. {Systematic review of trials}.

* Germer, C. K., Siegel, R. D., & Fulton, P. R. (2005). *Mindfulness and psychotherapy*. New York: Guildford. {Good chapters on mindfulness for psychotherapists and working with children}

Giommi, F. (2006). Mindfulness and its challenge to cognitive-behavioural practice. In M.G.T. Kwee, Gergen, K.J. & Koshikawa F. (Eds*), Horizons in Buddhist Psychology.* Chagrin Falls, Ohio: Taos Institute.

* Grepmair, L., Mitterlehner, F., Rother, W., & Nickel, M. (2006). Promotion of mindfulness in psychotherapists in training and treatment results of their patients. *Journal of Psychosomatic Research, 60,* 649-650.

Grossman, P. (2008). On measuring mindfulness in psychosomatic and psychological research. *Journal of Psychosomatic Research, 64,* 405-408. [An interesting short paper on some of the issues around assessing mindfulness.]

Hayes, S. C., Follette, V. M., & Linehan, M. M. (2004). *Mindfulness and acceptance*. New York: Guilford.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *J Consult Clin Psychol, 78*, 169-183.

Hutcherson, C. A., Seppala, E. M., & Gross, J. J. (2008). Loving-kindness meditation increases social connectedness. *Emotion, 8,* 720-724.

*Kabat-Zinn, J. (1990). *Full Catastrophe Living: How to Cope with Stress, Pain and Illness Using Mindfulness Meditation.* New York: Delacorte.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology-Science and Practice, 10,* 144-156.

*Kabat-Zinn, J. (2005). *Coming to Our Senses: Healing Ourselves and the World Through Mindfulness*. Piatkus Books.

Kabat-Zinn, J., Wheeler, E., Light, T., Skillings, A., Scharf, M. J., Cropley, T. G. et al. (1998). Influence of a mindfulness meditation-based stress reduction intervention on rates of skin clearing in patients with moderate to severe psoriasis undergoing phototherapy (UVB) and photochemotherapy (PUVA). *Psychosomatic Medicine, 60,* 625-632.

Kabat-Zinn, J., Massion, A. O., Kristeller, J., Peterson, L. G., Fletcher, K. E., Pbert, L. et al. (1992). Effectiveness of A Meditation-Based Stress Reduction Program in the Treatment of Anxiety Disorders. *American Journal of Psychiatry, 149,* 936-943.

Kabat-Zinn, M. & Kabat-Zinn, J. (1998). *Everyday Blessing: The Inner Work of Mindful Parenting*. Hyperion Books. (Book for parents about bringing mindfulness to parenting).

Kenny, M. A. & Williams, J. M. G. (2007). Treatment-resistant depressed patients show a good response to Mindfulness-based Cognitive Therapy. *Behaviour Research and Therapy, 45,* 617-625.

* Kuyken, W., Byford, S., Taylor, R. S., Watkins, E. R., Holden, E. R., White, K.,

Barrett, B., Byng, R., Evans, A., Mullan, E., Teasdale, J.D. (2008). Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *Journal of Consulting and Clinical Psychology,76,* 966-978. [First trial comparing MBCT with another active treatment].

* Kuyken, W., Watkins, E. R., Holden, E. R., White, K., Taylor, R. S., Byford, S., Evans, A., Radford, Teasdale, J.D. & Dalgleish, T. (2010). How does mindfulness-based cognitive therapy work? *Behaviour Research and Therapy, 48,* 1105-1112. [Study suggesting MBCT is effective through the cultivation of mindfulness and self-compassion].

Lau, M. A., Segal, Z. V., & Williams, J. M. (2004). Teasdale's differential activation hypothesis: implications for mechanisms of depressive relapse and suicidal behaviour. *Behaviour Research and Therapy, 42,* 1001-1017.

Lewis, G. (2002). *Sunbathing in the rain: A cheerful book about depression.* London: Flamingo, Harper Collins. {The perspective of someone who used mindfulness as an integral part of her recovery from depression}

Ma, H. (2004). *Prevention of relapse/recurrence in recurrent major depression by mindfulness-based cognitive therapy.* Unpublished doctoral dissertation, Cambridge University, UK.

Ma, S. H. & Teasdale, J. D. (2004). Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *Journal of Consulting and Clinical Psychology, 72,* 31-40.

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Mason, O. & Hargreaves, I. (2001). A qualitative study of mindfulness-based cognitive therapy for depression. *British Journal of Medical Psychology, 74,* 197-212.

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Miller, J. J., Fletcher, K., & Kabat-Zinn, J. (1995). 3-Year Follow-Up and Clinical

Implications of A Mindfulness Mediation-Based Stress Reduction Intervention in the Treatment of Anxiety Disorders. *General Hospital Psychiatry, 17,* 192-200.

Michalak, J., Heidenirich, T., Meibert, P., & Schulte, D. (2008). Mindfulness predicts relapse/recurrence in major depressive disorder after mindfulness-based cognitive therapy. *Journal of Nervous and Mental Disease, 196,* 630-633.

Nutely S, Walters I, Davies HTO: *Using Evidence, How Research Can Inform Public Services.* Bristol: Policy Press; 2007.

*Piet, J., & Hougaard, E. (2011). The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis. *Clinical Psychology Review, 31*(6), 1032-1040. [Recent meta-analysis of all MBCT trials].

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Segal, Z. V., Teasdale, J. D., Williams, J. M. G., & Gemar, M. C. (2002). The mindfulness-based cognitive therapy adherence scale: Inter- rater reliability, adherence to protocol and treatment distinctiveness. *Clinical Psychology and Psychotherapy, 9,* 131-138.

*Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse.* New York: Guilford Press. {The MBCT Manual.}

Segal, Z. V., Bieling, P., Young, T., MacQueen, G., Cooke, R., Martin, L. et al. (2010). Antidepressant Monotherapy vs Sequential Pharmacotherapy and Mindfulness-Based Cognitive Therapy, or Placebo, for Relapse Prophylaxis in Recurrent Depression. *Archives of General Psychiatry, 67,* 1256-1264. [Key trial]

Shennan, C., Payne, S., & Fenlon, D. (2011). What is the evidence for the use of mindfulness-based interventions in cancer care? A review. *Psycho-Oncology, 20*(7), 681-697.

Singh, N.N., Wahler, R.G., Adkins, A.D. & Myers R.E. (2003). Soles of the Feet: a mindfulness-based self-control intervention for aggression by an individual with mild mental retardation and mental illness. *Research in Developmental Disabilities, 24*, 158–169.

Singh N.N., Lancioni, G.E., Winton, A.S.W., Wahler, R.G., Singh, J. & Sage M. (2004). Mindful caregiving increases happiness among individuals with profound multiple disabilities. *Research in Developmental Disabilities, 25*, 207–218.

Smith, A. (2004). Clinical uses of mindfulness training for older people. *Behavioural and Cognitive Psychotherapy, 32,* 432-430.

Teasdale, J. D. (1999). Emotional processing, three modes of mind and the prevention of relapse in depression. *Behaviour Research and Therapy, 37,* S53-S77.

Teasdale, J. D. (1999). Meta-cognition, mindfulness and the modification of mood disorders. *Clinical Psychology and Psychotherapy, 6,* 146-155.

*Teasdale, J. D., & Chaskalson, M. (2011a). How does mindfulness transform suffering? I: the nature and origins of dukkha. *Contemporary Buddhism, 12*(1), 89-102.

*Teasdale, J. D., & Chaskalson, M. (2011b). How does mindfulness transform suffering? II: the transformation of dukkha. *Contemporary Buddhism, 12*(1), 103-124. [Two lovely papers that help us understand how MBCT works – key reading].

Teasdale, J. D., Segal, Z. V., & Williams, J. M. G. (2003). Mindfulness training and problem formulation. *Clinical Psychology-Science and Practice, 10,* 157-160.

Toneatto, T. & Nguyen, L. (2007). Does mindfulness meditation improve anxiety and mood symptoms? A review of the controlled research. *Canadian Journal of Psychiatry-Revue Canadienne de Psychiatrie, 52,* 260-266.

*Williams, J. M. G., Teasdale, J. D., Segal, Z. V., & Kabat-Zinn, J. (2007). *The Mindful Way Through Depression: Freeing Yourself from Chronic Unhappiness*. New York: Guildford Press. {Lay book describing MBCT with a CD of all the main practices}

Williams, J. M. G., Alatiq, Y., Crane, C., Barnhofer, T., Fennell, M. J. V., Duggan, D. S. et al. (2008a). Mindfulness-based Cognitive Therapy (MBCT) in bipolar disorder: Preliminary evaluation of immediate effects on between-episode functioning. *Journal of Affective Disorders, 107,* 275-279.

* Williams, J. M. G., & Penman, D. (2011). *Mindfulness: A Practical Guide to*

Finding Peace in a Frantic World London, Piatkus & New York: Rodale.

Williams, J. M. G., Russell, I., & Russell, D. (2008b). Mindfulness-based cognitive therapy: Further issues in current evidence and future research. *Journal of Consulting and Clinical Psychology, 76,* 524-529.

There are two **special issues** of *Clinical Psychology: Science and Practice* which have articles with commentaries on Mindfulness:

*Volume 10, Number 2.

*Volume 11, Number 3.

There is a **special issue** of *Contemporary Buddhism* that has papers on many facets of mindfulness, MBSR and MBCT (some of the papers are in the list above).

*Volume 12, Number 1.

The following websites are excellent mindfulness resources:

www.mbct.co.uk. This is a website providing excellent all round information about MBCT.

http://www.mindfulexperience.org/. This excellent site is a resource of key publications, measures and resources that a researcher or someone wanting to find all the latest publications might find invaluable.

http://www.bemindful.co.uk/. This is a recent website put up by the Mental Health Foundation that is a wealth of resources: podcasts with Mark Williams, one of MBCT's developers, GPs and service users familiar with MBCT, overviews of the research and a directory of MBCT groups.

http://www.mindandlife.org. **Mind and Life** is an organization bridging between science (particularly cognitive science and neuroscience) and Buddhism. The Dalai Lama is a central figure.

http://www.umassmed.edu/cfm/. The Center for Mindfulness in Medicine, Health Care, and Society is dedicated to furthering the practice and integration of

mindfulness in the lives of individuals, institutions, and society through a wide range of clinical, research, education, and outreach initiatives in the public and private sector.

http://www.bangor.ac.uk/mindfulness/centre_information.html. **The Centre for Mindfulness Research and Practice** aims to alleviate the effects of ill health and encourage well being by promoting the practice of mindfulness.

http://www.gaiahouse.co.uk/. **Gaia House** offers Insight Meditation (known as Vipassana in the Buddhist tradition) and Zen Retreats throughout the year. The Centre provides comprehensive Dharma (Buddhist) teachings and spiritual practices to realize wisdom and compassion in daily life.

http://www.accesstoinsight.org/. Access to Insight is a website with readings in Theravada Buddhism

http://www.dharmaseed.org/news/. This is a repository of talks by mindfulness teachers, many of whom first brought the ideas that informed MBSR and latterly MBCT to the West. These include Christina Feldman, Joseph Goldestein and Jack Kornfeld. Other recommended talks are by Catherine McGee and Tara Brach.

Listserve

There is an interesting listserve for mindfulness practitioners and researchers that you can sign up from at: http://listserv.kent.edu/cgi-bin/wa.exe?A0=mindfulness

The following are books and articles on mindfulness from a Buddhist (Insight Meditation) perspective.

Analayo (2003). *Satipatthana: The direct path to realization*. Birmingham, UK: Windhorse Publications.

Bodhi, B. (1984). *The noble eightfold path: Way to the end of suffering*. Onalalaska,WA: BPS Pariyatti Editions.

Bodhi, B. (2011). What does mindfulness really mean? A canonical perspective. *Contemporary Buddhism, 12*(1), 19-39.

Brach, T. (2003). *Radical Acceptance: Embracing Your Life with the Heart of a Buddha.* New York: Bantam.

*Feldman, C. (1998). *Meditation plain and simple*. London: Harper Collins.

Feldman, C. (2005). *Compassion: Listening to the Cries of the World*. Berkeley, CA: Rodmell Press.

*Goldstein, J. & Kornfield, J. (1987). *Seeking the Heart of Wisdom*. Boston.

Gunaratana, B. H. (2002). *Mindfulness in plain English*. Somerville, MA: Wisdom Publications.

His Holiness the Dalai Lama (2002). *How to Practice: The Way to a Meaningful Life*. London.

*Kabat-Zinn, J. (2004). *Wherever you go, there you are.* Piatkus Books.

*Kabat-Zinn, J. (2011). Some reflections on the origins of MBSR, skillful means, and the trouble with maps. *Contemporary Buddhism, 12*(1), 281-306. [A key paper for situating MBCT and MBSR in their context, and a personal and historical account from JKT].

Rosenberg, L. (1998). *Breath by breath: The liberating practice of insight meditation.* London: Thorsons.

Salzberg, S. (1995). *Loving kindness. The revolutionary art of happiness.* Boston: Shambala.

Salzberg, S. (2011). Mindfulness and loving-kindness. *Contemporary Buddhism, 12*(1), 177-182.

*Thich Nhat Hahn (1975). *The miracle of mindfulness*. Boston: Beacon Press.

Thich Nhat Hanh (1991). *Peace is every step: The path of mindfulness in everyday life.* New York: Bantam.

These are "beginner's mind" books

Banyai, I. (1998). *Zoom*. Puffin. {Cartoon book with no words}

MacLean, K. L. (2004). *Peaceful Piggy Meditation*. Albert Whitman & Company. {A book about mindfulness written for young children.

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