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Williams, K and Birtwell, K (2018) The double-edged sword of mindfulness: Maintaining integrity whilst increasing access. *Clinical psychology forum* (306). pp. 43-47. ISSN 1747-5732

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Version: Accepted Version

Publisher: British Psychological Society

Please cite the published version

<https://e-space.mmu.ac.uk>

Running head: *Maintaining integrity whilst increasing access*

The double-edged sword of mindfulness: maintaining integrity whilst increasing access.

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The authors declare no conflicts of interest.

Paper Summary

Recent NHS initiatives aim to increase the implementation of Mindfulness-based Cognitive Therapy (MBCT). We highlight considerations for maintaining integrity whilst increasing access through an enhanced understanding of the complexity of MBCT, teacher training requirements, Good Practice Guidelines, and the evidence-base.

Keywords: Mindfulness-based Cognitive Therapy; Mindfulness-based Interventions; mindfulness; implementation; national health service.

The double-edged sword of mindfulness: maintaining integrity whilst increasing access

Mindfulness is continuing to grow in popularity. Although still relatively young in western culture, mindfulness has its origins in Buddhism, with practices and teachings dating back 2,500 years. More recently, mindfulness-based interventions (MBIs) have been developed and offered in a variety of community and clinical settings. In particular, Mindfulness-based Cognitive Therapy (MBCT; Segal et al., 2013) is arguably the MBI with the strongest evidence-base for efficacy in preventing relapse in depression, subsequently recommended by NICE (NICE, 2017).

Evidence now shows that MBIs can increase wellbeing and quality of life, whilst reducing stress, anxiety, and depression-related symptoms (Demarzo et al., 2015). Indeed, there is now evidence to suggest that meditation practice can alter both brain structure and function in regions associated with memory, interoception, and emotion regulation, with evidence emerging that even relatively short eight-week MBIs have similar potential for change (Tang et al., 2015; Fox et al., 2014; Gotink et al., 2016). Mindfulness-based research is growing exponentially and as a result, the UK parliament has produced a report outlining key areas for delivery of MBIs (Group et al., 2015). As such, there is now a push to enable wider access to MBIs in the NHS, in particular with key initiatives to train staff in Increasing Access to Psychological Therapy (IAPT) services to deliver MBCT.

In light of such growing interest and enthusiasm, it is vital that we remain grounded in our understanding of what MBIs and their practices and teachings involve, and how we can deliver mindfulness practices and MBIs safely, both with integrity and a deep experiential

Maintaining integrity whilst increasing access

understanding. Indeed, others have also started to discuss this important issue (see van Dam et al., 2017; Crane et al., 2017). Specifically, in this discussion paper, we discuss practical ways in which we can maintain our integrity in the teaching of, implementation, and research in MBIs, whilst endeavouring to increase access.

Teacher training

Before discussing training requirements it is important to distinguish the different ways of integrating mindfulness into therapeutic work. Germer (2005) describes three ways that mindfulness can be incorporated into psychotherapy:

1. Through the personal practice of the therapist: bringing *mindful presence* to therapy
2. Through introducing concepts and insights from mindfulness into therapy:
mindfulness-informed therapy
3. Through teaching mindfulness practice direct to clients: *mindfulness-based therapy*

Importantly, a personal practice of mindfulness is an essential foundation for any mindfulness-based work. In fact, only after developing their personal mindfulness practice did the developers of MBCT find this proved to be an essential component for its therapeutic success (Segal et al., 2013). Indeed, most teacher training courses recommend a personal mindfulness practice for a minimum of 12 months before learning to teach others.

Mindfulness can be taught to clients one-to-one or as part of a group, or through incorporating mindfulness into existing professional work (e.g. occupational therapy, nursing etc.). Teacher training is essential for all methods to ensure clients are offered services that meet their needs and which are delivered competently, safely and ethically. Currently, there is

Maintaining integrity whilst increasing access

no formal accreditation for mindfulness teachers and with the range of MBIs available, training pathways can vary. MBCT and MBSR (Mindfulness-based Stress Reduction) are the most established MBIs in the UK, with training pathways offered via Universities (e.g., Aberdeen, Bangor, Oxford and Exeter). There are also established training pathways for other approaches including Breathworks Mindfulness for Health, .B, and Mindful Resilience Enhancement (MRE).

However, whilst no accreditation is yet in place, mindfulness teachers are advised to follow the Good Practice Guidelines (www.mindfulnessteachersuk.org.uk). When choosing a teacher training course, it is important to make sure the course information refers to these guidelines and the organisation is ideally a member of the UK Network for Mindfulness-Based Teacher Training Organisations. A good training course will support teachers to understand the theoretical frameworks, will include practical sessions and opportunities for observations of course delivery, particularly including the ‘inquiry’ process whereby clients are supported in understanding and learning from their experience of mindfulness. Most teacher training courses require the completion of theoretical and reflective assignments, competency assessments, and attendance on a retreat for several days. Further, teachers can now be assessed using the Mindfulness-Based Interventions Teaching Assessment Criteria (MBI-TAC; Crane et al., 2013). Ultimately, effective training ensures a teacher can deliver a truly *mindfulness-based* intervention, grounded in the authentic and personal understanding of the ‘territory’.

Alongside training, ongoing supervision from a trained supervisor with experience in the relevant MBI is essential. Good supervision will support the teacher to integrate their own practice of mindfulness with the theoretical framework and their experience of the client or

Maintaining integrity whilst increasing access

group. Without effective training and supervision, the teacher may encounter a situation they may not be equipped to work with, which has the potential to adversely affect both the client and teacher. Inevitably, it is always possible that a client may experience adverse effects when participating in an MBI, or indeed any psychotherapeutic intervention, but a trained and supported teacher will be better equipped to support clients in the face of any difficulty.

We understand that at first glance it can appear easy to set up a mindfulness course or to integrate mindfulness-based teachings and practices into existing work. Some healthcare professionals may be asked to, or even feel pressured to, without adequate training, supervision, or personal practice. In such cases, the intervention may not be truly mindfulness-based; indeed, it may not be evidence-based. Ultimately, without consideration of the guidelines highlighted above, clients may not experience the true value of an MBI and in the worst case scenario, could be at risk of harm.

Organisational challenges

In a busy, pressured, and often under-funded, NHS setting, it might seem difficult or even impossible to meet the above guidelines. Interestingly, even though NICE recommend MBCT for prevention of relapse in depression, Crane and Kuyken (2012) identified a high level of variability for MBCT availability in the NHS. They reported that Psychologists were the largest professional group delivering MBCT and 36% of survey respondents had taught MBCT without any formal training, a concerning result considering the training guidelines above.

Some MBIs, including MBCT, are intensive and involve a time-commitment of typically eight weeks with daily home practice. With increasing NHS demands on both time and staff,

Maintaining integrity whilst increasing access

services may understandably want to shorten or adapt MBIs. Whilst MBIs need to be responsive to individual client needs, it is unknown what impact shortening or removing parts of an evidence-based, structured course may have on clients. However, through ensuring thorough training, supervision, and knowledge of theoretical frameworks and the client group, teachers will be better equipped to make skilful adaptations grounded in both theory and practice. In addition, Demarzo, Cebolla and Garcia-Campayo (2015) proposed a 'stepped care' approach ranging from introductory workshops to more intensive MBIs to help maximise organisational resources. Outcome measures and participant feedback would help to assess adaptations and monitor clinical practice.

Ultimately, without consideration of the above, we risk cutting corners and adversely affecting *both* clients and teachers when implementing MBIs. With training and supervision as a foundation for maintaining integrity there are a number of practical ways to increase access to MBIs. Crane and Kuyken (2012) recommended implementing strategic plans or strategy groups, MBCT champions, and efficacy measures to support MBCT delivery. One could also promote MBIs other than MBCT as public health prevention programmes rather than solely for the treatment of acute symptoms (Edwards, Bryning & Crane, 2015).

Educating staff, senior managers, commissioners and referrers on the evidence base as well as running drop in mindfulness sessions for staff would help in developing a first-hand understanding of mindfulness-based practice (Kuyken et al., 2012). Finally, to ensure Good Practice Guidelines are adhered to and, importantly, that MBI teachers feel supported, services could provide shadowing and co-teaching opportunities for trainee teachers, and consider contracting an external mindfulness supervisor if there is no in-house expertise available.

Integrity of research

With an ever-expanding evidence base for MBCT and other MBIs, considerations for how to maintain integrity are equally important for mindfulness-based researchers. Researchers should ensure that their investigations of MBIs incorporate an understanding of both the evidence base and the needs of the clients. Like any psychotherapeutic intervention, MBIs are not without risks and care should be taken particularly if MBI delivery in this population is new or evidence is limited. If unsure, consulting someone with an understanding of the framework and evidence base for that MBI would help to ensure the quality of the research.

In the context of research studies, the same Good Practice Guidelines need to be considered; MBIs should be delivered by experienced mindfulness teachers with a personal mindfulness practice, under the supervision of a trained MBI supervisor. If an MBI teacher does not meet the Good Practice Guidelines this could not only be unethical and put participants at risk of harm, it could have a detrimental effect on the results and ultimately undermine the quality of the evidence-base. Details of teacher training and adherence to Good Practice Guidelines should be specified in any resulting publications alongside details of any adaptations made to MBIs. Consideration of such guidelines will enable clinicians to draw upon higher-quality research evidence when deciding which MBIs to implement and ultimately, we can ensure that we maintain high standards thereby allowing us to draw meaningful interpretations and comparisons across studies with increased confidence.

Conclusion

In this discussion paper, we have discussed the importance of adhering to guidelines and recommendations for teacher training and supervision, alongside ways of ensuring MBIs are

Maintaining integrity whilst increasing access

delivered in their authentic, mindfulness-based format in busy NHS settings. Further, we have discussed ways in which both clinicians and researchers can continue to develop and draw upon the evidence-base incorporating considerations around teacher training and MBI delivery. Ultimately, we understand that it is not easy to balance maintaining the integrity of MBIs with increasing demand and pressures in NHS services. However, we hope that with an improved awareness and understanding of the complexity of MBIs like MBCT, it will be possible to maintain integrity through a careful and considered approach to both implementation and research.

Total word count: 2,239

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