

MBCT as an adjunct to individual therapy within a secondary care NHS Psychology and Psychotherapy Service (PPS) - Study of therapist perceived compatibility with psychological therapy offered.

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Context

This poster presents a section of an in-service evaluation of MBCT courses provided within a secondary care PPS. Between January 2013 and November 2014 we delivered 9 MBCT programmes to a total of 69 participants. Mindfulness courses were trans-diagnostic and provided as an adjunct to individual therapy. Participants consisted of both staff and patients from Adult and Older Adult mental health settings. Attendance was high and drop-out rates very low. Written feedback received from staff and patient participants was very positive. Standardised self-report symptom measures collected from patients indicate medium to large effect sizes. Further details of the outcomes of this evaluation are presented elsewhere (Hortynska et al, in submission).

Introduction

There is growing evidence regarding the effectiveness of mindfulness-based interventions for diagnostically diverse participants (e.g. Khoury et al, 2013; Hofmann et al, 2010). However, to our knowledge there is no research investigating MBCT's compatibility with a range of psychotherapy treatment models. In our service, referring clinicians maintained contact with patients after they had participated in the group (either continuing individual therapy or providing follow-ups). We therefore had an opportunity to examine the perceived compatibility of the MBCT course with a range of therapeutic interventions by requesting feedback from referring clinicians.

Rationale

According to Buddhist psychological models, attempted avoidance of the difficult or unpleasant experiences and clinging onto pleasurable experiences are two of the common sources of suffering (e.g. Grabovac & Lau, 2011). This view allows applicability of mindfulness-based approaches to a variety of presenting problems and has additional normalising value. We therefore offered trans-diagnostic groups focused on developing skills in mindfully relating to inner experiences, whether unwanted emotions, thoughts or bodily sensations. We assumed that the emphasis on increasing the awareness of, and changing the relationship with, internal experiences in general (including thinking processes) would be compatible with the range of therapeutic approaches offered in our service and therefore accepted referrals from all PPS clinicians.

A total of 62 referrals were made by 28 clinicians. The majority of these referrals (30) came from CBT-inclined therapists. Patients were also referred by therapists practising CAT (14), psychodynamic therapy (9), integrative therapy (7) or from other parts of the service (2). 54 patients started the course. The average number of individual therapy sessions attended before starting the MBCT course was 13 (range 2-35).

Results

We asked referring clinicians to complete a feedback form for each patient that had started the group. We received 27 forms from 17 clinicians, which indicated that the following therapeutic

approaches had been used with the referred patient: CBT (14), CAT (6), Integrative (6) and Psychodynamic (1). 25 of these forms included numerical ratings of the MBCT's compatibility with the therapeutic approach they used: 20 rated it extremely high (10/10) and 5 rated it as very high (8-9/10).

We used thematic analysis (Braun & Clarke, 2006) to examine comments regarding the following: whether MBCT added anything to the individual therapy offered; overall impact and particular changes observed in their clients; and the reasons for giving particular compatibility rating. The analysis revealed several main themes/ categories, which are illustrated below with quotes from the 19 clinicians who gave their permission for us to publish their data.

<u>Theme</u> <u>Subtheme</u>	<u>Example quotes (individual therapy offered)</u>
<u>General therapeutic benefits</u> Encourages self-observation	<p><i>I think it is compatible as CAT is in part about the relationship with the self which seems to fit with mindfulness. It's about how we see ourselves and keeping an "observing eye" on us in the present. (CAT)</i></p> <p><i>It helps the client become more self-aware, which you need in all therapy. (Integrative)</i></p> <p><i>I think it helped her better recognise when she was starting to ruminate or worry and to realise that she has an alternative to doing it. (BA)</i></p>
Supports awareness of internal processes	<p><i>I think it fits extremely well with brief CAT consultation work which also aims to have strong focus on recognising patterns as they occur. (CAT)</i></p> <p><i>He also gained more insight in terms of how his mind works and this changed the unfounded beliefs that he had dementia. (CBT)</i></p> <p><i>It fits very well alongside and in parallel with CBT. I believe that mindfulness presents a different way of helping people recognise unhelpful thinking styles (as does CBT) and provides alternative ways of responding. (CBT)</i></p>
Offers different relationship to internal experiences	<p><i>Mindfulness has helped my client learn different way of relating to her thoughts and feelings that seemed to be helping prevent relapse. This client had review appointments up to 4 months after the course and continued to be well, in fact improved further over this time. (BA)</i></p> <p><i>Although traditionally CBT has focused on symptom reduction and used methods to 'change' thinking, e.g. thought records, there is growing recognition for the values of normalising difficult internal experiences and rather than working to change the experience working to change the relationship with the experience. (CBT)</i></p>
<u>Supports individual work by offering something extra</u> Frees time to focus on other elements of therapy	<p><i>At times in therapy the process of formulating and understanding leaves less room for focussed experiential practice. (CBT)</i></p> <p><i>It allowed a prolonged space for experiential learning that</i></p>

couldn't be provided as well in 1:1, so it consolidated a lot of what we had covered prior to the group starting. (CBT)
It is an invaluable part of the PPS service and it is good to offer 'package' of interventions rather than single one. (CBT)

Therapeutic effects of being in a group

The group dynamics has been very beneficial in helping him confront some of his fears about group social situations, and has been a very adaptive, normalising and cathartic experience. (CBT)
Also, the group format allowed her to feel less like it was just her, and provided more points for reflection and awareness, even though she found being in a group very difficult at times. (CBT)
I think that being in the group was particularly helpful to this client. She related well to the group members and benefited from hearing about their struggles, as it normalised hers. She was also an active group member and others clearly benefited from her contributions which in turn was helpful to her especially in terms of self-esteem. (BA)
Sharing experiences with others has had a normalising effect, not achieved as meaningfully through 1:1 work. (CBT)

Provides experience of structured programme with expectation of rigorous practice

I do feel she needed rigorous practice to start to feel she could own her mind more and not feel so reactive to traumatic memories. (EMDR/ CFT)
We have utilised mindfulness techniques within our work however, most noticeable change occurred when my client was involved with a structured programme. (CBT)
The benefit of a structured programme has been invaluable. (CBT)

Fits with approach or patient preference

Complements particular therapeutic intervention

The focus on the breath is also the basis of developing self compassion and self soothing so it can be a good primer for CFT too. (CBT)
I think Mindfulness is wholly compatible with CBT and in particular compassion focused therapy that has been the main approach I have used with X. (CBT)
I felt mindfulness was compatible with CAT, I think it needs to be placed within the SDR formulation, either as an exit and/or as a way of self-observation. (CAT)
Complements EMDR and Compassionate mind work that we had been undertaking very well. (EMDR)
It fitted well with acceptance based framework we had used. I think it taught her approach that helped her deal with life that she probably wouldn't have got from other therapies. (BA)
I think it added to the therapy, as a lot of the therapy was about non-judgemental stance and either anxiety about the future or anger or shame about the past. I think it complemented therapy well. (CAT)
It fitted particularly well with interventions in BA aimed at reducing worry and rumination. (BA)

Fits with client's pre-existing interests

*I think Mindfulness Skills Training was compatible with X's difficulties and her own interests, e.g. meditation. (Integrative)
X has heard of mindfulness before and was keen on it before I even mentioned the group. (CAT)*

*My client had previous knowledge of mindfulness, for him it was about consolidation and opportunities for live practice. (CBT)
X had particularly requested mindfulness course having read about it. I agreed it could be helpful in grounding her and helping her to develop a reflective rather than reactive mind. (Integrative/EMDR).*

Discussion

The numerical ratings indicate that the MBCT course was perceived as very compatible with a range of approaches. Written feedback suggested that clinicians thought the MBCT course had several benefits as an adjunct to individual therapy, namely that patients benefitted from an increased level of self-awareness and for some patients group work and/or mindfulness practice significantly contributed to their therapy. We acknowledge that these findings are limited by the return rate of the feedback forms (27/54) and by under-representation of clinicians who use psychodynamic models. Future evaluations should perhaps target referrals and feedback from those clinicians to allow a more complete evaluation of the compatibility of MBCT with models other than CBT. Furthermore, future evaluations would also benefit from patients' feedback regarding compatibility.

In summary, the results of the evaluation indicate that MBCT courses are compatible with, and add an extra value to a variety of therapeutic approaches especially with CBT and related therapeutic interventions (BA, CFT, ACT), but also with CAT and Integrative approaches. We believe that MBCT groups can significantly enhance service delivery in secondary care.

References

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