Pilot Study of Mindfulness-Based Cognitive Therapy for Trainee Clinical Psychologists

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Background: It is recommended that Mindfulness-Based Cognitive Therapy (MBCT) instructors should undertake MBCT themselves before teaching others. Aim: To investigate the impact of MBCT (modified for stress not depression) on trainee clinical psychologists. Method: Twenty trainees completed questionnaires pre- and post-MBCT. Results: There was a significant decrease in rumination, and increases in self-compassion and mindfulness. More frequent home practice was associated with larger decreases in stress, anxiety and rumination, and larger increases in empathic concern. Only first-year trainees showed a significant decrease in stress. Content analysis of written responses indicated that the most commonly reported effects were increased acceptance of thoughts/feelings (70%), increased understanding of what it is like to be a client (60%), greater awareness of thoughts/feelings/behaviours/bodily sensations (55%) and increased understanding of oneself and one’s patterns of responding (55%). Participants reported increased metacognitive awareness and decentring in relation to negative thoughts. Eighty-five percent reported an impact on their clinical work by the end of the course. Conclusions: Trainee psychologists undergoing MBCT experienced many of the psychological processes/effects that they may eventually be helping to cultivate in clients using mindfulness interventions, and also benefits in their general clinical work.

Keywords: Mindfulness, rumination, acceptance, clinical psychology, psychotherapy training.

Introduction

The decision to offer a Mindfulness-Based Cognitive Therapy (MBCT, Segal, Williams and Teasdale, 2002) course to clinical psychology trainees was based on three main considerations. First, given the increasing interest in mindfulness as a key component of a number of different therapeutic interventions, it seemed important to provide an experiential course to inform the trainees’ study and critical evaluation of these relatively new approaches.
In addition, there is a high level of consensus amongst those using mindfulness-based approaches that it is essential to experience mindfulness practice from the inside before instructing others (e.g. Segal et al., 2002). MBCT was chosen rather than Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 1990) because MBCT is recommended in UK clinical guidelines for depression (NICE, 2009) and is therefore likely to be provided more often by clinical psychologists in National Health Service settings than MBSR. A second consideration was that, whether or not the trainees choose to use mindfulness interventions with their clients, the practice of mindfulness may contribute to the development of their skills of self-awareness and reflection, and thus make a positive contribution to their training as therapists. In a recent model of therapist skill development, Bennett-Levy (2006) describes mindfulness as one of three overlapping attributes (the others being empathy and reflection-in-action) of the interpersonal perceptual skills of attunement and receptivity, which he sees as a key part of the procedural system of therapist skills. The final reason was that, as well as providing an opportunity to learn potentially useful specific and more general therapeutic skills, MBCT might be helpful as a stress-management intervention. Mental health work can be stressful and up to 40% of clinical psychologists report “caseness” levels of distress (Hannigan, Edwards and Burnard, 2004). As students at different stages of the 3-year course had differing work demands and experience, preliminary analyses were undertaken to investigate any indication of a differential impact depending on the stage of training.

Method

Participants

Participants were 20 female trainees from the Institute of Psychiatry clinical psychology doctoral training course who had responded to an invitation to participate. Nine were in the 1st year, six were in the 2nd year and five were in the 3rd year of training.

Measures

Questionnaires used to assess stress, anxiety and depression and empathic concern were the Perceived Stress Scale (PSS; Cohen, Kamarck and Mermelstein, 1983), the Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983) and the Interpersonal Reactivity Index (IRI; Davis, 1983). Questionnaires to assess possible processes of change were the Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer and Toney, 2006), the Self-Compassion Scale (Neff, 2003), and the Ruminating-Reflection Questionnaire (RRQ; Trapnell and Campbell, 1999). A Mechanisms of Mindfulness Questionnaire was devised to investigate other possible processes. Participants were asked multiple choice and open-ended questions to further assess the impact of the course and their home practice. (More detailed information about the measures is given in the extended online report).

Procedure and intervention

Information about the mindfulness course was emailed to trainees. Respondents had a brief interview and gave informed consent to participate. A researcher not involved in this study emailed participant codes to the trainees so that the questionnaire responses were
anonymous to the investigators. Questionnaires were completed in the first and last session. The content of the 8-week MBCT course was based on Segal et al. (2002) but parts specific to depression were altered to focus on stress. It was delivered by the two investigators, who were undertaking a post-graduate certificate/diploma in mindfulness-based approaches at Bangor University.

Analysis

Paired t-tests were used to compare measures taken before and after the MBCT. Preliminary analyses examined whether 1st year trainees (n = 9) showed a different response to 2nd and 3rd years (n = 11; these years were combined because of the smaller numbers). Independent t-tests were used to compare change in questionnaire measures (post scores minus pre-scores) between the 1st years and the 2nd/3rd years. Pearson’s correlations were used for preliminary investigations of the associations between changes in the different questionnaire measures and i) changes in stress and ii) amount of home practice. Only significant results or marginally significant trends are reported below. For written responses to open-ended questions, content analysis was undertaken with independent ratings by the two authors.

Results

Attendance and home practice

Seven participants attended all eight sessions, six attended seven sessions, five attended six sessions, and two attended five sessions. The mean amount of weekly home practice was 91.9 mins (SD = 74.3). Self-reported average number of days per week of home practice was as follows: 0 days, n = 3 (15%); 1–2 days, n = 11 (55%); 3 days, n = 3 (15%); 4–6 days, n = 3 (15%).

Changes between pre- and post-MBCT

There was a significant decrease in rumination (Pre-MBCT Mean = 38.9, SD = 8.8; Post-MBCT Mean = 34.1, SD = 7.7; t = 4.9, p < .0005), and significant increases in mindfulness (Pre-MBCT Mean = 124.7, SD = 11.7; Post-MBCT Mean = 133.1, SD = 15.2; t = 3.0, p = .0008) and self-compassion (Pre-MBCT Mean = 19.0, SD = 2.9; Post-MBCT = 20.3, SD = 2.4; t = 3.1, p = .016).

Comparison between participants in different years of training

The 1st years showed a significantly larger increase in self-compassion than 2nd/3rd years (t(19) = 2.4, p = .025) and a non-significant trend for a larger reduction in stress (t(19) = −2.0, p = .058). As this trend was potentially important regarding the optimum time for providing MBCT training, it was explored further. A paired t-test indicated that the 1st years showed a significant decrease in stress after the MBCT course (Mean Pre-MBCT = 24.6, SD = 8.1; Mean Post-MBCT = 20.3, SD = 6.2) after the MBCT course (t(8) = 2.7, p = .028). Inspection of mean scores indicated that the 2nd years showed a small decrease in stress (Mean Pre-MBCT = 22.7, SD = 5.2, Mean Post-MBCT = 21.5, SD = 5.0) whereas the 3rd
years showed an increase (Mean Pre-MBCT = 21.8, SD = 7.7; Mean Post-MBCT = 26.0, 
SD = 5.0). There was no significant difference in home practice duration between the 1\textsuperscript{st} years 
and 2\textsuperscript{nd}/3\textsuperscript{rd} years (t(18) = 0.8, p = .79).

**Associations between changes in stress and other psychological variables**

Reductions in stress correlated significantly with reductions in rumination (r(19) = 0.63, 
p = .004) and anxiety (r(19) = 0.53, p = .020) and increases in empathic concern (r(19) = 
−0.55, p = .015).

**Relationship between home practice and change in psychological variables**

Greater duration of home practice per week was significantly correlated with larger decreases 
in rumination (r(20) = −0.49, p = .039) and larger increases in empathic concern 
(r(20) = 0.484, p = .042). More days per week of home practice were significantly correlated 
with larger decreases in stress (r(19) = −0.557, p = .013), rumination (r(20) = −0.650, 
p = 0.002) and anxiety (r(20) = −0.602, p = 0.005) and larger increases in empathic concern 
(r(20) = 0.511, p = 0.021).

**Mechanisms of Mindfulness Questionnaire**

Items with the highest ratings of change since the MBCT were: “Take a ‘step back’ from 
negative thinking rather than becoming taken over by it” (Mean = 1.3, SD = 1.0); “When 
I’m having negative thoughts, recognizing them as just thoughts and not facts” (Mean = 1.2, 
SD = 0.9); “When I have upsetting thoughts, just noticing them and letting them go” (Mean = 
1.1, SD = 0.9); “Attend to the present moment rather than thinking about the past or present” 
(Mean = 1.1, SD = 0.8) and “Accept my feelings” (Mean = 1.1, SD = 0.7). Please see the 
extended report (Table 3) for the full results.

**Content analysis of written answers about impact of MBCT**

The most commonly reported effects were increased acceptance of thoughts/feelings (70%), 
increased understanding of what it is like to be a client (60%), greater awareness of 
thoughts/feelings/behaviours/bodily sensations (55%) and increased understanding of oneself 
and one’s patterns of responding (55%) (see Table 1).

**Multiple choice questions about impact of the MBCT**

Ninety-five% (n = 19) of participants said they had responded or coped differently with 
particular situations or issues as a result of taking the course. Eight-five percent (n = 17) 
said that MBCT had changed the way they respond to negative thoughts or feelings. Eighty-five percent (n = 17) said the course changed the way they thought or felt about psychological 
problems or stress. Seventy-five percent (n = 15) said that it had changed the way they thought 
or felt about themselves. Eight-five percent (n = 17) of those responding said that the course 
had impacted on their clinical work.
After MBCT, the trainee psychologists showed decreased rumination and increased self-compassion and mindfulness. The effects most commonly reported in open-ended written responses were also consistent with key aims of MBCT: greater acceptance of thoughts and feelings, greater awareness of thoughts/feelings/bodily sensations and their own patterns of responding, and pausing before reacting. Furthermore, items concerning a “decentred”
perspective and metacognitive awareness in relation to negative thoughts showed the largest mean ratings on the retrospective Mechanisms of Mindfulness Questionnaire. This promising pattern of findings indicates that the trainees were directly experiencing many of the processes that they would be aiming to help cultivate in others using mindfulness teaching. This experience is likely to help improve their understanding and modelling of these processes. Furthermore, trainees also reported some beneficial effects for their general clinical work, including greater understanding of what it is like to be a client, the difficulties of doing homework, and group processes.

There were no significant reductions in anxiety and depression, which is not surprising given that these were well below clinical levels of severity before the training. Their mean pre-MBCT stress levels were not as high as those reported by health professionals who had been specifically recruited for a stress/burnout reduction mindfulness intervention (Shapiro, Astin, Bishop and Cordova, 2005) but were slightly higher than the mean levels reported in a general population US sample (Cohen and Williamson, 1988). The 1st years, who had the highest pre-MBCT stress levels, were the only year to show a significant decrease in stress, and after training their stress levels had reduced to general population levels. The 3rd years reported higher perceived stress post-MBCT (though the numbers were too small to analyze statistically), which may have at least partly reflected their increasing work demands.

Greater frequency of home practice was associated with greater reductions in stress, anxiety and rumination and larger increases in empathic concern. This did not account for the greater reductions in stress in the 1st years. With this study design the nature of these associations cannot be ascertained. The lack of a control group means that it cannot be concluded that the observed changes are actually attributable to the MBCT. For example, the changes in the 1st years may have been caused by a process of general adjustment to their new role rather than the mindfulness training. Furthermore, the “first come, first served” recruitment method may have led to biases in the sample, for example towards increased inclusion of those trainees who were more enthusiastic or felt in greatest need of help. Other limitations of the study include the small sample size, possible demand effects as the trainees were aware of the rationale of the intervention, relative inexperience of the instructors, and lack of independent verification of intervention adherence.

Results from this pilot study of MBCT indicate personal benefits for trainee clinical psychologists as well as positive effects on their clinical work. A randomized controlled trial is now required.

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References

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