Adapting MBCT for Primary Care Clients:

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Below is a summary of points covered at the Minding the Gap symposium:

In 2009 I began to introduce MBCT groups for clients in the NHS Trust for which I work. Initially I followed the MBCT manual (Williams, Segal, Teasdale, Guilford press,2002) very closely, but over time adaptations have been introduced, as it became clear that certain aspects of the MBCT 8 week course as originally presented did not work well for our client-base.

I certainly have no intention of denigrating the important and successful approach developed by Williams, Segal and Teasdale, which put Mindfulness on the map in the realm of psychological therapy, and is the basis for its subsequent widespread adoption in so many fields.

However, we need to remember why the format in which it was initially presented was developed. Firstly, the aim of the original course was to prevent relapse in clients who had experienced multiple episodes of depression. Those selected for the original trials, therefore, were between episodes of depression, and so currently stable.

Secondly, a standardised delivery was necessary for the purposes of the RCT – a comparison of MBCT with standard medication treatments for depression. This had various implications, such as that the clients on whom the original research was based committed to set amounts of daily home practice.

In attempting to transfer the MBCT approach to our own clients, we encountered various differences which led us to adapt aspects of the course, as a result of observing and responding to the needs of our client base

Our Primary Care Team has a narrow brief as part of an IAPT service: IAPT clients are supposed to be in 'caseness', by definition having IAPT measure scores above a certain level – so they are all experiencing acute episodes, not in remission.

Primary Care clients come to us suffering current episodes of anxiety and depression, (often mixed), and sometimes other presentations such as OCD or eating disorders, so we are not only dealing with depression. Further research since the initial trials of MBCT for relapse prevention indicate the efficacy of mindfulness for a variety of presentations, and this has been borne out by our outcomes

As our groups are not over-full with IAPT clients we can include some members from a wider section of Trust clients, and to date we have accepted a wide range of clients, including clients from Community Mental Healthcare, who may have severe and enduring conditions, so long as they are reasonably stable during the course.

We have also accepted clients with the type of complex presentation usually beyond the remit of the Primary care team; some come to a group while awaiting psychotherapy, to help them gain skills to enable them to engage with intensive therapy, and some who have finished a psychotherapy or psychology intervention, come for relapse prevention.

Since we have discovered that many of these clients derive real benefit from attending the course, we tend to let most clients who want to try a mindfulness group have the opportunity. This wide client-base means we have 'mixed ability teaching' requirements – clients are attending in various acute stages or even in recovery, with varying complexities of presentation. There is, therefore, a considerable difference in what they can absorb and put into practice. There are also some who have previous experience of meditation practices and are ready to develop them further.

As a result we have found it necessary to be flexible both in teaching and practice requirements.

Since attention span is affected by stress, many clients are unable to sustain attention sufficiently to follow a long practice.

In addition, many clients cannot tolerate the intensity of a long practice –common obstacles are physical restlessness, frustration at inability to sustain attention, and feeling overwhelmed by heightened awareness of negative thoughts or previously avoided emotions.

We therefore shorten the length of practices, especially at start of course.

We have also found that prescribing a particular focus can be problematic e.g.

- re-triggering of body-trauma memories by body focus
- anxiety caused by attention to breath, which may bring on a panic attack in some clients – especially if they have previously experienced this
- sensitivity to sound – e.g. in cases of tinnitus/autism

Instead of guiding clients to a particular focus, we introduce from the start a choice of focusing anchors. We initially offer focus for quite brief periods on body, breath, and sounds, and explore what arose for the clients in the practice through enquiry.

We then encourage clients to find their own anchors for attention – many choose body, breath or sounds, but we make clear that they can use anything as a focus, so long as it is in the here and now, (usually related to senses/body/ breath) and emotionally pleasant or neutral. In any subsequent practice during the course, they can choose own anchor – even if the spoken guidance has e.g. focus on breath, we will remind them of this option.

We find that the freedom to 'customise' Mindfulness in this way for themselves is empowering, and fits a wider variety of clients.

All practices are invitational in the groups. We tell clients 'if doesn't feel right, stop, do your own practice /move in and out of the guided practice. Listen to yourself and keep yourself safe. Stop when you want. Start again if you want. Or

change the activity. Take the posture you want (though guidance is offered for general comfort, alertness and wellbeing) Move when you want'. We emphasise that 'you can't get it wrong'.

Initially it was difficult to give myself permission to make these changes. Attending Mindful Resilience Enhancement training weekends gave me the courage to experiment, and experience in the groups then convinced me. More clients completed the courses and outcomes improved. Indeed, this type of client-centred adaptation feels very much in keeping with the all-important self-compassionate element of MBCT.

An example of this is the body-scan. We no longer make this a Session 1 practice and we do not introduce it with a long scan. Many clients felt defeated by the Session 1 long body-scan – they became physically uncomfortable, frustrated by inability to sustain attention, and sometimes had negative emotions triggered by trauma memories located in the body. Being in such intense 'proximity' to one's own personal experience can feel threatening and even overwhelming for those who have learnt dissociate to protect themselves.

'De-criminalising' our inability to pay attention is an important aspect of MBCT. Perhaps we now take it a little further with the above changes, and in relation to home practice expectations. We do not ask clients to carry out a specific amount of practice or particular practices – we offer a 'smorgasbord' from which to select as they wish. Mindfulness for those who are very agitated may be more a case of bringing mindful attention to activity than undertaking any formal practices. For all clients, developing the ability to touch base with their inner experience gradually, at their own pace, and safely seems to work best.

We know that the more mindfulness practice clients can incorporate in their lives, the better the effect, but there is a negative backlash to feeling they are not doing all they should which only causes defeatism. Doing what you can as often as possible, for only as long and often as feels all right at the moment, proves more effective than forcing oneself to 'sit it out', which frequently has the result that the mind just 'zones out' or resistance arises. If the experience of practice becomes too unpleasant, clients are much more likely to give it up.

We therefore aim for a slow building of the capacity to pay attention, which feels like a more compassionate approach and accords with current educational principles. In mental health clients the fear factor, and intolerance to fear, are obviously likely to be higher than average. When we introduce the practice of sitting with a difficulty, for instance, we are aware this may be unbearable for some clients during the span of the course –if so, we encourage them to simply attend to an anchor and return to this practice when they feel ready.

For most clients experiencing acute episodes the inner critic is very severe and self-compassion needs to be made very explicit**.** We have found it useful to increase this element of the MBCT course, encouraging it not only through modelling it ourselves but by introducing specific exercises, and exploring barriers to self-compassion with group members.

Another essential element to enabling clients to internalise and establish mindfulness and self-compassion in their lives is to give them the chance to sustain practice together after the 8 weeks, and to build skills over time, at their own pace. Clients can therefore come to a second group if they wish, and can access another group later if they dropped out/were unable to attend, but now feel they are ready.

We also provide monthly follow-up drop-in groups to help sustain and develop practice, and we see real transformation in those who attend over a few years. We notice they really do learn to sit for longer, approach and tolerate negative thoughts and feelings, give themselves compassion when experiencing difficulty, and step back from the content of their thoughts.

It would be naive to expect such profound changes to occur in 8 weeks – but the 8 week Mindfulness course gives an excellent foundation, and with a flexible, invitational, compassionate approach to teaching, few fail to benefit.