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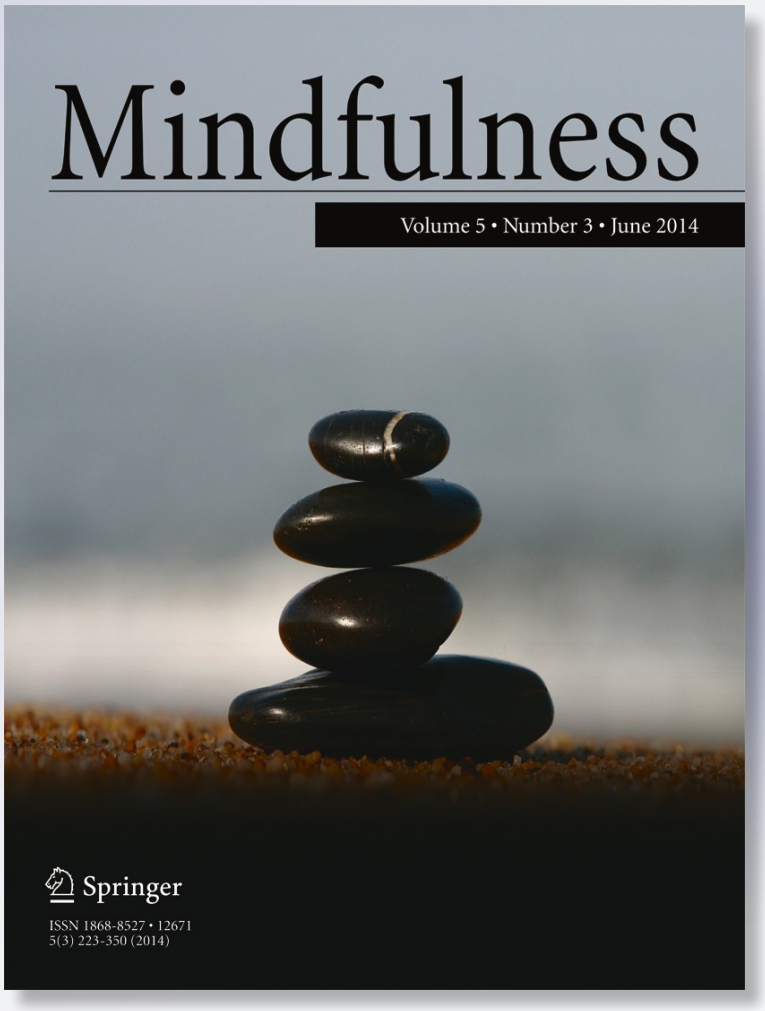

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ORIGINAL PAPER

Training Clinicians to Deliver a Mindfulness Intervention

Carrie Gibbons · Melissa Felteau · Nora Cullen · Shawn Marshall · Sacha Dubois · Hillary Maxwell · Dwight Mazmanian · Bruce Weaver · Laura Rees · Rolf Gainer · Rupert Klein · Amy Moustgaard · Michel Bédard

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Abstract Mindfulness-based cognitive therapy (MBCT) is a relatively new therapeutic approach that is rooted in mindfulness-based stress reduction and cognitive behavioral therapy. Leading MBCT requires a radically different method than other forms of group facilitation. We are currently conducting a multi-site, randomized controlled trial (RCT) of a mindfulness intervention for individuals with a traumatic brain injury where the development of the facilitators' capacity to provide the intervention is as important to the study as the RCT component itself. Thus, the first year of the study was devoted to training ten clinicians to deliver the intervention. The training included a 2-day retreat to introduce mindfulness, teleconferences, support from an experienced instructor and other facilitators within the group, a 5-day professional MBCT training program, and the development of a personal meditation practice. It culminated with trialing the intervention with "healthy" participants (e.g., friends, family, colleagues). Sessions from six facilitators were recorded and assessed by an external reviewer experienced in the delivery of MBCT who provided qualitative feedback. Four facilitators demonstrated consistency and adherence to the skills assessed. Upon completion of the trial intervention, 93.5 % of healthy group participants indicated that the classes were engaging or stimulating and 96.9 % reported that they used the skills acquired. We feel we provided a training program that remained flexible to the needs of the facilitators.

Keywords Clinician training · Mindfulness-based approaches

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Introduction

Mindfulness-based cognitive therapy (MBCT), which was developed by Segal et al. (2002), is a relatively new therapeutic approach rooted in cognitive behavioral therapy and mindfulness-based stress reduction (MBSR; Kabat-Zinn 2009). Through MBCT, one learns a greater awareness of thoughts and feelings to assist in decentering from problematic thoughts by viewing them as mental events rather than as truthful reflections of reality. It is consistently effective in preventing relapse in recurrently depressed individuals (Ma and Teasdale 2004; Segal et al. 2002, 2010; Teasdale et al. 2000) and is a recommended therapy for relapse prevention in the UK (National Collaborating Centre for Mental Health 2009). MBCT has also been used with a variety of clinical populations including individuals with anxiety (Evans et al. 2008), cancer (Foley et al. 2010), and psychosis (Langer et al. 2012), as well as with people who had a stroke (Moustgaard et al. 2007).

Given the unique nature of mindfulness therapies, concerns have been raised about the training provided to the facilitators leading such programs (Baer 2003; Crane et al. 2010; Cullen 2011; Fjorback et al. 2011; Grossman et al. 2004). Teaching MBCT requires a radically different approach, one in which some have argued the facilitator must have his or her own mindfulness meditation practice and embody a mindfulness approach (Segal et al. 2002) at the risk of diluting program integrity (Crane et al. 2012). As Crane et al. (2010) point out, this differs considerably from other therapies where the focus is on gaining skills and less emphasis is placed on personal practices of the clinician. As mindfulness therapies such as MBCT are increasingly offered as a part of regular clinical practice, it is essential to find ways to support the learning needs of facilitators so they can effectively lead such interventions.

We pilot tested an MBCT program modified for individuals with a traumatic brain injury (TBI) and depression and the results indicated a significant improvement in health status and depression symptoms (Bédard et al. 2003, 2005, 2012). We are currently conducting a multi-site, randomized controlled trial (RCT) of this program. The development of the facilitators' capacity to provide the intervention was as important to the study as the RCT. Thus, the first year of the study was devoted to training clinicians. The training culminated with training group trials to give the facilitators the opportunity to practice in preparation for the clinical groups. Year 2 comprises the RCT for individuals with TBI and depression (currently ongoing). Thus, the main purpose of this report is to describe the process that we developed to train the facilitators. The training program represents our attempt to maintain the integrity of the mindfulness-based approach while at the same time increasing clinical capacity to deliver the intervention.

Method

Revised MBCT Curriculum

The curriculum of our mindfulness intervention draws upon elements from the MBSR program (Kabat-Zinn 2009) and the manual of Segal et al. (2002) for MBCT. It was modified by one of the investigators (MF) to address issues associated with TBI (e.g., problems with attention, concentration, memory, fatigue). The intervention was increased to 10 weeks with one and a half hour weekly sessions, along with a 20–30-min daily meditation home practice. Further adaptations included simplified language, the use of repetition to reinforce concepts, and visual aids. More attention was paid to fostering learning conditions to encourage an environment of trust and nonjudgment. Connections between learning activities were also made more explicit. For example, participants recorded their observations and questions on "new learning" forms to encourage deeper reflection on usual modes of behavior and habits of mind in day to day activities. Although some components of the intervention were designed specifically for a TBI population experiencing depressive symptomatology, training group participants were encouraged to learn what they could from these sessions (i.e., everyone can feel blue or down) and were reminded that the intention of the group was to give the facilitators the opportunity to practice. They were supplied with the book *The Mindful Way through Depression*: *Freeing Yourself from Chronic Unhappiness* (Williams et al. 2007). It was not required reading, but participants were instructed to use the accompanying CD to complete guided meditations. At the end of the final class, participants were asked to provide feedback on their experiences in the program by completing an evaluation form which comprised three questions as well as space for written comments.

Facilitator Training

Our facilitator training process integrated knowledge about educational practices from adult learning principles and psychotherapeutic educational initiatives (Greben and Segal 2004; Martin et al. 2003; Persad and Leverette 2003; Ravitz and Silver 2004). It comprised a longitudinal, experiential

program with several components that were learner-centered, active rather than passive, relevant to the learner's needs, engaging and reinforcing (Davis et al. 1999). The first step in the training process was facilitator selection. Potential facilitators were required to submit formal applications to the research team at one site. They were selected by either a supervisor or a study investigator at the other two sites. Selection criteria included openness to novel treatment techniques for depression in the TBI population, clinical experience in the treatment of TBI in a mental health setting, and the ability to commit time to both the training and facilitation processes. There was no expectation of previous meditation or mindfulness experience.

Ten facilitators (nine women and one man) were recruited (four at site 1, two at site 2, and four at site 3) and comprised healthcare professionals from various disciplines including a psychologist, three social workers, three speech pathologists, two occupational therapists, and a rehabilitation therapist. All facilitators provided direct care in rehabilitation programs for individuals with neurological disorders (e.g., stroke, traumatic brain injury) in both inpatient and outpatient settings. Three facilitators had no experience with any component of MBCT, one had previously attended yoga classes, two had limited experience with both meditation and yoga, one had a formal meditation practice approximately 2 years in length, one had yoga experience spanning 20 years, another had practiced yoga for 8 years and had tried meditation, and the last one had no experience with meditation but received formal training in experiential psychotherapy where the focus of each session with a client is on the here and now. Before participating in the study, facilitators and their direct work supervisors received an information letter detailing the study objectives, training, and RCT components. Each facilitator signed a commitment form and obtained the signature of a supervisor to indicate workplace support.

Given the diverse background of the facilitators, the training began with a 2-day retreat to introduce mindfulness. Moreover, the retreat provided the opportunity for facilitators to begin their own personal meditation practices (considered a key component for those delivering mindfulness interventions). It was led by one of the investigators (MF), an experienced meditator who modified the MBCT curriculum for individuals with TBI and delivered the revised intervention previously. Topics included an historical review of MBCT, an introduction to the intervention's core elements, and an assessment of perceived learning and program planning needs. Facilitators participated in mindfulness activities such as awareness of breath, body scans, sitting and walking meditations, and mindful movement. Each activity was discussed by the group to gain further insight into the experience. The facilitators were provided with selected readings from Segal et al. (2002, 2002), Kabat-Zinn (2005a, b), and Williams et al. (2007). They were paired with a "meditation buddy" from another site to contact on a weekly basis throughout the training process. During these telephone calls, facilitators could discuss their experiences and lead each other in short meditations.

For a 4-month period following the retreat, facilitators were expected to develop their own daily mindfulness meditation practices beginning with 6 min daily working up to 20 to 40 min daily. Facilitators also took part in bi-weekly teleconferences led by one of the investigators (MF) to support them in the development of their individual mindfulness meditation practices. This was meant to help the facilitators embody the qualities of mindfulness when leading a group. They also reviewed each session of the mindfulness program developed for individuals with TBI. An on-line discussion group was started to support facilitators between the teleconferences. However, it was difficult to access for some facilitators given internet security restrictions at one site and was discontinued.

The facilitators next took part in a 5-day MBCT training program provided by the Center for Mindfulness, University of California at San Diego, and co-taught by Dr. Zindel Segal, Dr. Steven Hickman, and Dr. Sarah Bowen. This intensive training designed for healthcare professionals provided facilitators the opportunity to learn the MBCT curriculum as developed by Segal et al. (2002). They participated in numerous teach-back sessions, joined in small and large group learning sessions, and took part in group meditations and shared experiences.

Upon returning, facilitators were grouped in pairs and led one of five trial groups to practice their skills. They continued with bi-weekly group teleconferences and regular contact with their meditation buddies. An external reviewer experienced in MBCT was contracted to assess facilitator skills and provide qualitative feedback. The reviewer was guided by questions from the Mindfulness-Based Cognitive Therapy Adherence Scale, (MBCT-AS; Segal et al. 2002). Given modifications made to the intervention, some sections on the MBCT-AS were not applicable. For example, question 11 ("use of video material about mindfulness-based stress reduction") did not apply as there is no video in our intervention. As a result, formal scores were not assigned but global ratings were provided. The sessions led by six facilitators at two sites were video- or audiotaped. Logistics prevented the recording of four facilitators at one site and the skills of these facilitators were not assessed. The external reviewer produced a final written report shared with all facilitators (even those not assessed). Issues

raised in the report were addressed during the bi-weekly facilitator teleconferences. The reviewer also held teleconferences with the facilitators both individually and in pairs. At the site where recordings were not made, the facilitators also had two opportunities to teleconference with the reviewer to discuss any issues or concerns that had arisen during their experiences leading the intervention.

Training Group Participants

Training group participants were recruited by word-of-mouth and comprised other clinicians, family members, and friends to provide the facilitators with the opportunity to practice delivering the intervention before interacting with the clinical groups (i.e., individuals with TBI and depression). Exclusion criteria included presence of a brain injury or unusual psychological processes as determined by the Symptom Checklist 90—Revised. No participants were excluded for these reasons. There were 46 participants from all three sites (group 1=11, group 2=8, group 3=12, group 4=7, and group 5=8). Ethics approval was obtained at both the sponsor university and the local hospital ethics boards. Participants gave informed consent prior to taking part in the study.

Results

External Reviewer Feedback

The external reviewer noted that while the MBCT-AS measured adherence, levels of teaching competency were not assessed. The reviewer concluded that four facilitators (two pairs) demonstrated consistency and adherence to 15 items on the MBCT-AS. This included facilitating group cohesion, setting and reviewing homework, using the 3-min breathing space, describing different behavioral strategies of mood regulation, and supporting ways to commit to practice and relapse prevention. Facilitators did not demonstrate use of extended systematic awareness exercises. Two individuals (one pair) were rated as struggling with the skills identified on the MBCT-AS.

The reviewer outlined three main areas for improvement for all facilitators. First, facilitators needed to demonstrate a clear understanding of the various themes, rationales, and intensions for each mindful practice. Next, the reviewer provided an overview of the attitudinal foundations of mindfulness (e.g., patience, trust, beginner's mind, non-judging, acceptance) and suggested ways for facilitators to reflect each attitude in their weekly sessions. Finally, the reviewer encouraged facilitators to further develop inquiry skills. Facilitators were encouraged to draw upon their personal mindfulness experience in order to enable participant inquiry into present moment experiences. To support continued learning in these three areas, increased supervision of the inquiry process and further personal mindfulness meditation practice (e.g., attending a silent retreat) were outlined. Supplementary MBCT training (i.e., a teacher training intensive) was also suggested.

Training Group Participant Feedback

There were 33 training group participants (71.7 %) who provided feedback. The majority found the facilitators were effective and were using what they had learned (see Table 1). They found the program engaging. Written comments were generally positive and encouraging. Participants felt that a binder would be helpful to keep course material organized (this was incorporated into the RCT). There were also suggestions to reduce the amount of material covered in

Table 1 Mean feedback scores from training group participants

Question	Group 1 (n=7)[a]		Group 2 (n=6)		Group 3 (n=8)[a]		Group 4 (n=5)		Group 5 (n=7)		Total (n=33)	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
1. How would you rate the facilitators overall teaching effectiveness?[b]	4.86	0.38	4.33	0.82	4.25	0.47	4.80	0.45	4.57	0.54	4.54	0.56
2. How frequently do you use the information provided in the program?[c]	4.57	0.79	4.67	0.52	4.25	0.71	5.00	0.00	4.29	1.50	4.51	0.87
3. Overall how would you rate this course?[d]	4.33	0.52	4.00	1.10	4.25	1.04	5.00	0.00	4.57	0.54	4.41	0.80

[a] Facilitators for these groups were assessed as adherent to the protocol

[b] Possible responses are 1=almost never effective, 2=rarely effective, 3=sometimes effective, 4=usually effective, and 5=almost always effective

[c] Possible responses are 1=almost never, 2=yearly, 3=monthly, 4=weekly, and 5=daily

[d] Possible responses are 1=a sleeper, 2=boring, 3=distracting, 4=stimulating, and 5=engaging

each class to avoid rushing and after further discussion with the facilitators changes were made to this effect. There were two comments indicating that the facilitators appeared rigid or scripted.

Discussion

Facilitator training was a key component of our RCT. Initiation of personal mindful meditation practices, professional training, and support began the process. The training group interventions offered facilitators the opportunity to practice their skills. An external reviewer indicated that four of the six facilitators demonstrated adherence to the majority of skills assessed. The reviewer and facilitators had opportunities to discuss these points as well as any other concerns. Written comments from the reviewer were integrated into on-going, bi-weekly meetings to maximize support provided to the facilitators. Feedback received from training group participants was insightful and was incorporated into the intervention. However, it is important to note that there are limitations to the data collected from the training group given that many of the participants were known to the facilitators (i.e., family, friends, and colleagues) which may have resulted in response bias.

In our initial training plan, the bi-weekly teleconferences were to end upon completion of the training group trial. However, as a result of reviewer feedback encouraging on-going supervision, the teleconferences continued for the duration of the RCT. Additionally, one study investigator (MF) began teleconferences with the facilitators selected to lead the intervention at each site to review inquiry skills and discuss issues that arose during sessions with RCT participants. The facilitators indicated that this level of supervision was necessary as they began to work with clinical groups and continued to develop their own personal mindfulness meditation practices. Several of the facilitators also took part in longer meditation retreats on their own time. The two facilitators who struggled in the delivery of the intervention were offered additional supervision and support but were not involved in the RCT portion of the study.

While we feel that each component of our training program makes intuitive sense (e.g., the development of a personal mindfulness meditation practice, running a practice trial), we did not examine the contribution of each to achieving facilitator competence in delivering the intervention. For example, anecdotally, we heard from the facilitators that they found the teleconferences with the reviewer beneficial. However, we did not collect formal feedback from the facilitators. Hence, it is difficult to demonstrate that each component of the intervention was necessary. Future work to systematically examine the training value of each component towards the successful delivery of the intervention would be valuable to streamline training programs and to demonstrate facilitator competence.

A number of training suggestions and programs have been developed and include components such as prior meditation practice, on-going support and supervision, detailed examination of the mindfulness intervention, and teaching a full course (Lehrhaupt 2010; Woods 2009). Crane et al. (2010) outlined training stages for MBCT instructors beginning with foundational training and progressing to basic and advanced teacher training. Basic teacher training contains similar components to our study (e.g., relevant clinical background, participating in MBCT teacher training). We have encouraged the facilitators in our study to continue to advance their training and several have chosen to do so. The UK Network for Mindfulness-Based Teachers recently released Good Practice Guidelines for Teaching Mindfulness-Based Courses (UK Network for Mindfulness-Based Teachers 2011) and this information has been provided to our facilitators.

Our training program attempted to provide facilitators with the skills and support that they needed to be effective in the delivery of the intervention. We feel we provided them with a comprehensive training program that achieved this goal, yet remained flexible to their needs. We are unaware of other RCTs of mindfulness interventions for individuals with TBI that included the training of clinicians with no to very little prior experience in mindfulness meditation. The ultimate proof of our success in training the facilitators will rest with the RCT we are conducting for individuals with TBI and depression.

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References

Baer, R. (2003). Mindfulness training as a clinical intervention: a conceptual and empirical review. *Clinical Psychology: Science and Practice, 10*(2), 125–143.

Bédard, M., Felteau, M., Mazmanian, D., Fedyk, K., Klein, R., Richardson, J., & Minthorn-Biggs, M. B. (2003). Pilot evaluation of a mindfulness-based intervention to improve quality of life among individuals who sustained traumatic brain injuries. *Disability and Rehabilitation, 25*(13), 722–731. doi:10.1080/0963828031000090489.

Bédard, M., Felteau, M., Gibbons, C., Klein, R., Mazmanian, D., Fedyk, K., & Mack, G. (2005). A mindfulness-based intervention to improve quality of life among individuals who sustained traumatic brain injuries: one-year follow-up. *The Journal of Cognitive Rehabilitation, Spring, 2–7*. doi:10.1080/0963828031000090489.

Bédard, M., Felteau, M., Marshall, S., Dubois, S., Gibbons, C., Klein, R., & Weaver, B. (2012). Mindfulness based cognitive therapy: benefits in reducing depression following a traumatic brain injury. *Advances in Mind-Body Medicine, 26*(1), 14–20.

Crane, R. S., 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, 1*, 74–86. doi:10.1007/s12671-010-0010-9.

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

Cullen, M. (2011). Mindfulness-based interventions: an emerging phenomenon. *Mindfulness, 2*, 186–193. doi:10.1007/s12671-011-0058-1.

Davis, D., O'Brien, M. A., Freemantle, N., Wolf, F. M., Mazmanian, P., & Taylor-Vaisey, A. (1999). Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? *Journal of the American Medical Association, 282*(9), 867–874. doi:10.1001/jama.282.9.867.

Evans, S., Ferrando, S., Findler, M., Stowell, C., Smart, C., & Haglin, G. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder. *Journal of Anxiety Disorders, 22*, 716–721. doi:10.1016/j.janxdis.2007.07.005.

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. doi:10.1111/j.1600-0447.2011.01704.x.

Foley, E., Baillie, A., Huxter, M., Price, M., & Sinclair, E. (2010). Mindfulness-based cognitive therapy for individuals whose lives have been affected by cancer: a randomized controlled trial. *Journal of Consulting and Clinical Psychology, 78*(1), 72–79. doi:10.1037/a0017566.

Greben, D. H., & Segal, Z. V. (2004). Psychotherapy education: innovation and evolution. *Canadian Journal of Psychiatry, 49*(4), 219–220.

Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits. A meta-analysis. *Journal of Psychosomatic Research, 57*(1), 35–43. doi:10.1016/S0022-3999(03)00573-7.

Kabat-Zinn, J. (2005a). *Loving kindness meditation coming to our senses: healing ourselves and the world through mindfulness* (pp. 285–295). New York: Hyperion.

Kabat-Zinn, J. (2005b). *Meditation—it's not what you think coming to our senses: healing ourselves and the world through mindfulness* (pp. 58–63). New York: Hyperion.

Kabat-Zinn, J. (2009). *Full catastrophe living: using the wisdom of your body and mind to face stress, pain, and illness* (15th ed.). New York: Random House.

Langer, A. I., Cangas, A. J., Salcedo, E., & Fuentes, B. (2012). Applying mindfulness therapy in a group of psychotic individuals: a controlled study. *Behavioural and Cognitive Psychotherapy, 40*(1), 105–109. doi:10.1017/S1352465811000464.

Lehrhaupt, L. (2010). *Institute for mindfulness-based approaches.* From http://www.institute-for-mindfulness.eu/homepage.html. Accessed 6 Jan 2012.

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*(1), 31–40. doi:10.1037/0022-006X.72.1.31.

Martin, L., Saperson, K., & Maddigan, B. (2003). Residency training: challenges and opportunities in preparing trainees for the 21st century. *Canadian Journal of Psychiatry, 48*(4), 225–231.

Moustgaard, A., Bédard, M., & Felteau, M. (2007). Mindfulness-based cognitive therapy (MBCT) for individuals who had a stroke: application of a novel intervention. *The Journal of Cognitive Rehabilitation, Winter, 25*(4),4–10.

National Collaborating Centre for Mental Health. (2009). *NICE clinical guideline 90: depression: the treatment and management of depression in adults (partial update of NICE clinical guideline 23)*. London: National Institute for Health and Clinical Excellence.

Persad, E., & Leverette, J. (2003). Training issues in psychiatry in Canada. *Canadian Journal of Psychiatry, 48*, 213–214.

Ravitz, P., & Silver, I. (2004). Advances in psychotherapy education. *Canadian Journal of Psychiatry, 49*(4), 230–237.

Segal, Z. V., Teasdale, J. D., Williams, J. M., & 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. doi:10.1002/cpp.320.

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: The Guilford Press.

Segal, Z. V., Bieling, P., Young, T., MacQueen, G., Cooke, R., Martin, L., & Levitan, R. D. (2010). Antidepressant monotherapy vs sequential pharmacotherapy and mindfulness-based cognitive therapy, or placebo, for relapse prophylaxis in recurrent depression. *Archives of General Psychiatry, 67*(12), 1256–1264. doi:10.1001/archgenpsychiatry.2010.168.

Teasdale, J. D., Williams, J. M. G., Soulsby, J. M., Segal, Z. V., Ridgeway, V. A., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology, 68*, 615–623.

UK Network for Mindfulness-Based Teachers. (2011), *Good practice guidelines for teaching mindfulness-based courses.* (2011). From http://mindfulnessteachersuk.org.uk/pdf/teacher-guidelines.pdf. Accessed 6 Apr 2012.

Williams, M., Teasdale, J., Segal, Z., & Kabat-Zinn, J. (2007). *The mindfulway through depression: freeing yourself from chronic unhappiness*. New York: The Guilford Press.

Woods, S. L. (2009). Training professionals in mindfulness: the heart of teaching. In F. Didonna (Ed.), *Clinical handbook of mindfulness* (pp. 463–475). New York: Springer.