Abstract

Objective: Given the increasing use of Mindfulness-based Interventions (MBIs) to treat psychiatric disorders, the authors sought to determine the extent and availability of training in MBIs for psychiatry trainees within the Canadian post-graduate training programs. Attitudes about the need for training, and perceived barriers to delivery were also surveyed.

Method: Over a 9-month period, a 10-question survey was electronically sent to program directors and resident representatives of all of the 16 Canadian post-graduate training programs (n=34). Nineteen respondents replied (56% response rate), representing 11 of the 16 Canadian programs (69%).

Results: The program survey had a response rate of 69% (19 respondents from 11 programs). All endorsed the importance of MBI training, and 53% (n=10) indicated this was not reflected in current training. Only two programs reported sufficient training to equip residents to deliver MBIs.

Conclusions: Current training in Canadian postgraduate psychiatry programs is unlikely to equip residents with the competency to assess for referral to MBIs. Training for developing competency in MBI delivery varies widely across programs and few have robust opportunities. Standardized competencies and clear training pathways are needed.

INTRODUCTION

The results of a survey examining current Mindfulness-based Intervention (MBI) training opportunities within psychiatry postgraduate programs across Canada are presented. This survey informed the development of competency-based guidelines for MBI training in Canadian psychiatry programs according to the Competence by Design framework being implemented by the Royal College of Physicians and Surgeons of Canada [1].

MBIs are increasingly indicated as mental health treatments. First introduced to Western medical settings in 1979 by Jon Kabat-Zinn as a treatment for chronic pain, MBIs such as Mindfulness Based Cognitive Therapy (MBCT) and Mindfulness-integrated Cognitive Behaviour Therapy (MiCBT) have proliferated and have been successfully adapted to treat a broad range of psychiatric disorders [2-6].

MBCT was specifically developed to prevent depressive relapse and is now one of the most researched and applied MBI adaptations within psychiatric practice. It has consistently been shown to reduce the risk of relapse in individuals with recurrent depression, with comparable benefits to remaining on maintenance antidepressants, and may be superior in treating residual symptoms [7-9]. It is now considered a Level 1 first-line maintenance treatment in the Canadian Network for Mood and Anxiety Treatments 2016 guidelines [10].

In this context, it is essential that psychiatrists and psychiatric residents have familiarity with the clinical applications of mindfulness. The current Objectives of Training in Psychiatry for the Royal College of Physicians and Surgeons of Canada [11], require competency to assess suitability for, prescribe, and deliver mindfulness training at the “introductory knowledge” level, compared to a “proficiency” level for such psychotherapies as Cognitive Behavioural Therapy and Psychodynamic therapy. All residents are expected to be proficient at assessing and managing “emergent side effects of psychological therapies.” We suggest that, in the current context of a broadening support for mindfulness approaches, it behooves residency programs to provide MBI instruction that will equip residents to assess for...
patient suitability, as well as to appropriately prescribe MBI treatments, and recognize emergent side effects [12]. Provision of mindfulness-based psychotherapies requires advanced training to reach competency, which may be pursued by select residents and psychiatrists who wish to achieve specialized skills in this area.

The delivery of MBCT, MiCBT and other MBIs differs fundamentally from most brief psychotherapeutic modalities used by psychiatrists and thereby requires a modified training approach. MBI clinicians respond to symptoms in ways that are fundamentally different from the analytical paradigms to which non-MBI clinicians are accustomed. Delivering an MBI relies on the therapist’s ability to embody equanimity and receptivity; this requires extended experience with personal mindfulness practice in combination with an understanding of the underlying theoretical framework. Furthermore, inquiry, a form of clinician-guided discussion based on exploration of patients’ subjective experience during mindfulness exercises, is a new skill for many physicians and usually requires extended experiential learning, such as that obtained through formal multi-day MBI training programs.

The nuances of MBI skills training can be further understood via a careful examination of mindfulness practice itself. A clinically useful description of mindfulness is “an alert, receptive, equanimous observation of present moment experience” [13]. When well-developed, mindfulness allows one to be fully conscious of actions, sensations, thoughts and mental states as they arise, moment to moment, and also has a discriminating quality that allows one to know whether each action or thought is supportive of one’s well-being. Development of these capacities supports the recognition of the transient, non-personal nature of experience, which allows for an increased tolerance of the emotional spectrum, as well as a greater capacity to respond to internal events intentionally. Some MBIs, such as MiCBT, emphasize increasing affect tolerance specifically through the development of equanimity. Mindfulness practice thus supports self-management, enabling disengagement from habitual, often maladaptive, behaviours, particularly in the context of stressors that could precipitate relapse [14].

MBIs have some commonalities with third-wave cognitive and behavioural therapies to which residents are exposed, such as Dialectical Behavioral Therapy (DBT) [15], and Acceptance and Commitment Therapy (ACT) [16]. However, skills in MBI delivery are not directly transferable from these therapies, which share a conceptual basis in assisting patients to develop an observer stance towards their experience, including thoughts, but do not do so through longer formal mindfulness practices. These nuances point to the need for targeted elective training in MBIs in order for psychiatrists to competently offer this modality, and highlight the foundational knowledge required by those prescribing MBIs.

**MATERIALS AND METHODS**

To ascertain how Canadian psychiatry residents may be attaining MBI-related competencies, a 10-question survey of training programs was developed through author consensus. The survey queried 34 program representatives about mandatory and elective MBI training opportunities (experimental, didactic, online and supervisory). Program directors as well as resident representatives were surveyed in an attempt to obtain responses from as many programs as possible. Attitudes concerning the relevance of MBI training for psychiatry residents were examined, as was perceived adequacy of training opportunities and the extent to which curriculum developers would benefit from defined standards of competency, specifically adapted for psychiatrists across the learning continuum. Perceived barriers and suggestions for support of training opportunities were solicited.

**ADMINISTRATION**

The study was approved by the ethics review board of University of British Columbia. After indicating their consent electronically, program directors and resident representatives to the Canadian Organization of Psychiatric Educators committee (n=34) completed the online survey between July 9, 2015 and May 4, 2016. A web-link to the survey housed at the University of British Columbia’s Survey Tool webpage was emailed through the University of British Columbia Department of Psychiatry head office. Non-respondents were contacted, either by phone or email, up to four times prior to survey closing, to request participation.

**RESULTS**

Of the 16 postgraduate psychiatry programs in Canada, 11 (69%) responded on the secure website, represented by 19 respondents (out of 34 surveyed; 56% response rate). This means that in some cases there were responses from both the resident representatives and program directors from a single program. In cases where the responses of representatives from the same school were discordant in describing the training opportunities, we clarified the discrepancies through telephone conversations with the respondents. Data were downloaded and analyzed using SPSS software.

Eleven respondents (58%) considered it very or extremely important that Canadian psychiatry residents have training opportunities in MBIs, while the remainder agreed it is important or somewhat important. Fifty-three percent indicated that current training opportunities are not adequate to meet resident interest, or in keeping with the perceived importance of MBIs as a treatment modality (10 respondents). In contrast, five respondents assessed their level of access to MBI training as acceptable, and two described their program as having good or excellent opportunities, although one of these described only minimal training opportunities in responses to other questions. One program noted that all residents are encouraged to “self-practice to enhance resident emotional attunement (and) empathy with patients”. Table 1 describes type and availability of mindfulness and MBI training in the mandatory curriculum.

In the mandated training, seven programs present residents with information on clinical evidence (including indications, therapeutic applications, and patient selection for referral), and five review neuro-functional and structural changes, as well as mechanisms of action of mindfulness therapies. Only three address the potential harms of mindfulness practice and related ethical issues.

Elective experiences supporting varying levels of training are available at a number of programs, ranging from certification in MBI delivery, through to exposure to mindfulness through psychotherapies such as DBT or ACT (Table 2). One respondent noted that their program does not provide elective credit for completion of external MBI certification.
There was universal support for a delineation of specific competencies related to MBIs (19 respondents) and 18 expressed interest in a model curriculum to suggest ways to meet these competencies. A respondent suggested the “opportunity for all interested residents to participate in an 8-week MBI program to develop competence in this area.”

Barriers to providing electives in MBIs were largely considered to be moderate or low (13 respondents) and included residents finding appropriate supervisors, and receiving credit from the postgraduate program for external MBI training opportunities. Another was building capacity among supervisors to support MBI training availability.

Limitations of the study include that respondents may not have been aware of all available training opportunities, as different reports from the same school varied, and therefore results may not represent the actual amount of available training. Accuracy of reported program opportunities was not independently assessed, and respondents may have been susceptible to response bias. Additionally, we were not able to assess all Canadian programs; therefore generalizability across national training opportunities should be further investigated.

DISCUSSION

The survey indicated a discrepancy between the respondents’ emphasis on the importance of MBI knowledge for psychiatry residents, and the accessibility of robust training opportunities within Canadian postgraduate psychiatry programs. For example, only a single lecture on MBIs is provided at 7 of the 11 programs surveyed, which is unlikely to instill “introductory knowledge in assessing suitability for, prescribing, and delivering mindfulness training” as outlined in the national Objectives of Training [11]. Ideally, the mandatory training would include didactic and experiential components that will cultivate an understanding of the practice of mindfulness, as well as the underlying theorized mechanisms of action in MBIs. Lecture content could be reinforced through expert-developed online modules and case-based learning, allowing all psychiatry residents to attain competency in patient selection and in recognizing contraindications and adverse effects.

For residents who elect to do advanced training and develop competency in delivery of MBIs, opportunities across Canadian postgraduate programs were limited. Additionally, the survey revealed that there was incomplete knowledge of the types of specialized training that are required to deliver MBIs with integrity. For example, some psychotherapeutic modalities with a mindfulness component, such as DBT, do not require the therapist to have a personal mindfulness practice, nor have developed inquiry skills. Thus, residents with solely this training might mistakenly believe their skills are generalizable to MBIs, not appreciating the specific competencies underlying MBI delivery [1]. The emphasis on a substantial experiential component for clinicians is reminiscent of training for psychodynamic therapy, which may not be immediately apparent, as MBIs superficially appear to be more similar to other short-term manualized therapies. However, the need for extended experience with the non-analytical mind states cultivated in MBIs before and during one’s delivery of these treatments cannot be overstated.

Four of the surveyed programs offered elective opportunities that correspond to aspects of MBI training as defined by leaders in the field [17-19], however, only two described sufficient components (including a formal training program and ongoing supervision) to equip residents to deliver MBIs at the level described in certification programs. We propose that there are 4 key components to training: developing a personal mindfulness practice, participating in an MBI clinical group for the duration of the group (e.g., 8 sessions), completing a training program that includes theory, experiential practice, and training in inquiry, and that utilizes simulated clinical situations that allow for immediate supervision (e.g., teach-backs or role plays), and finally, co-facilitating three or more manualized MBI groups, and/or providing one-on one manualized MBI to six or more individual patients, with weekly supervision [1]. There is an opportunity for programs to utilize emerging online and distance
training and supervision opportunities to afford interested residents these types of opportunities to become proficient with MBI delivery [20]. This would also address some of the barriers identified by respondents.

CONCLUSION

Although the results and associated recommendations arising from this survey are limited by a lack of representation from all Canadian programs, those surveyed indicated lack of alignment between importance of MBI training and availability of training opportunities. Current Canadian postgraduate psychiatry programs are unlikely to equip residents to competently refer patients to MBIs, which is problematic given the expanding role of MBIs as a treatment modality for a diverse range of mental health conditions.

Few programs offer a full contingent of MBI training experiences to equip residents to deliver MBIs, which may reflect a lack of understanding of the specific requirements, such as prominent experiential training and an emphasis on inquiry. There appears to be strong interest across programs for tools to assist with standardization of MBI training within psychiatry, and in step with the Competence by Design initiative, there is a need for clearly defined competencies for both MBI referral and MBI delivery.

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Compliance with Ethical Standards/ Ethical Considerations: The study protocol and survey was approved by the ethics review board of University of British Columbia. Participants provided consent.

CONFLICT OF INTEREST

Dr. Grabovac is an MBCT Mentor with the UCSD Mindfulness Based Professional Training Institute, and a teacher trainer with the MiCBT Institute.

REFERENCES