



Mindfulness and Mindfulness-based Psychotherapy

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Recent studies have highlighted the promising benefits of mindfulness-based interventions for a range of clinical issues. The growing interest among practitioners in using mindfulness as an intervention raises issues of therapeutic potential, practical application and potential adverse effects. Mindfulness meditation is defined as paying attention to ongoing sensory experiences and mental contents, deliberately and intentionally, and in a non-elaborative and non-judgmental way. The history and psychological mechanisms of mindfulness meditation are discussed as well as the ways it differs from traditional cognitive therapies. Empirical evidence for mindfulness meditation as a therapeutic technique is considered in addition to costs and benefits, potential adverse effects and practitioner issues such as skills and training. Finally, we examine the proposition that interest in mindfulness meditation has spawned a number of new therapies that appear to have high efficacy and represent a new conceptualization of potentially active ingredients in psychotherapy and psychological change.

There is a current exponential increase in the number of psychotherapists expressing an interest in mindfulness-based psychotherapy (Baer, 2003; Allen et al., 2006). Much has been in response to recent studies that highlight the promising benefits of mindfulness-based interventions for a range of problems, including anxiety (Kabat-Zinn, 1990), depression (Ma & Teasdale, 2004; Teasdale et al., 2000) chronic illnesses such as cancer (Tacon, Caldera & Ronaghan, 2004), chronic pain, eating disorders, and more recently psychosis (Bach & Hayes, 2002; Gaudiano, 2006).

Although much of the existing literature on mindfulness-based approaches has methodological problems (e.g. small sample size, lack of properly conducted randomized controlled trials), the current literature offers increasingly promising results. This interest raises a range of issues important for the practitioner including

therapeutic potential, the practical application of mindfulness and whether there are any potential adverse effects. Drawing on a recent paper by the Melbourne Academic Mindfulness Interest group (Allen et al, 2006) this article explores the practical, clinical and philosophical issues of interest to clinicians.

'Mindfulness', in simple terms, means non-elaborative attention to thoughts and present moment awareness. It requires a sustained attention to ongoing sensory experience and mental contents, without elaborating upon or judging any part of the experience (Kabat-Zinn, 1994), and represents '*a form of naturalistic observation*' (Grossman, Niemann, Schmidt & Walach, 2004, p. 36). It is a state of mind, a characteristic mode of attentional focus, and is inherent in a range of cognitive skills and tasks. It may be enhanced through both formal and informal training, although

the literature has tended to focus on the formal practice of mindfulness meditation (MM).

Mindfulness meditation, in the formal sense, has existed for over 2500 years (Epstein, 2003). The concept and methods in the psychological literature have been taken largely from Buddhism, where they are a fundamental component of all meditative practices. However, there are other ways to develop mindfulness, including tai chi, yoga and other meditative practices, all of which cultivate a state of mindfulness through the focus of attention in the present moment. Indeed, the principles and practices can be found readily in many cultural, philosophical and religious traditions outside Buddhism, such as tribal shamanism, Hinduism, Sufism (Islamic mysticism), early (mystical) Christianity, and the Jewish mystical tradition of Cabalism (Bjerklie, Park, Van Biema, Cullotta & McDowell,

2003; Walsh & Shapiro, 2006).

However, it is possible to cultivate and practice mindfulness in the absence of religious and cultural traditions. Ott (2004) states that (MM) when used to help alleviate patient suffering it *"allows for more spaciousness and kindness toward self and others. Regular practice promotes the development of stability, inner calmness and non-reactivity of the mind, which in turn, allows individuals to face, and even embrace, all aspects of daily life regardless of pain, anxiety or fear"*. (p.25)

'Mindfulness', in simple terms, means non-elaborative attention to thoughts and present moment awareness.

In so doing, individuals come to understand that mindfulness is more than meditation or relaxation. It is an approach or attitude that can be applied to a range of life situations.

Indeed, mindfulness is inherent in daily life, with many activities that both require and develop a certain degree of mindful awareness. For instance, mindfulness may be practiced by health practitioners in the therapeutic setting and teachers in the classroom. First, there is attention to the present moment. Second, the attention is purposeful, in that it carries an intention to be helpful, and third, it is exercised with a particular attitude, for example, with an attitude of acceptance and kindness.

More universal activities, such as playing sport or engaging in hobbies, can also engender enhanced mindfulness. As a result, people who engage in such activities frequently report feeling as though they are focused on the present moment, momentarily free of worries, and that there is purpose to, and often great enjoyment in, what they are doing.

Psychological mechanisms

Kabat-Zinn (1994) has defined mindfulness as *'paying attention in a particular way: on purpose, in the present moment, and non-judgmentally'* (p.4). This conveys the key psychological

mechanisms responsible for therapeutic change.

Paying attention on purpose and in the present moment

MM promotes alertness to the passing parade of thoughts, feelings, and sensations, and in so doing, anchors the practitioner to present moment experience.

Through sustained and deliberate effort, the MM practitioner increases their ability to notice when they lose this presence and clarity, and start to

awareness that MM facilitates an adaptive, flexible, and sensitive style of responding to current environmental contingencies, as opposed to one that is habitual, rigid, rule governed and not based on current circumstances (Hayes, 2004).

Paying attention non-judgmentally

Perhaps one of the most important qualities of MM is the emphasis on noticing sensory experience, states of mind, and bodily sensations without elaboration and with a non-judgemental and accepting attitude (Hayes, 2004; Ramel et al., 2004). Rather than evaluating cognitive and emotional experiences, MM teaches the practitioner to simply observe them. In particular, this non-judgmental philosophy enables one to focus on present moment experience even when the experience causes significant distress. As highlighted by Orsillo and colleagues (2004), acceptance is intended to increase processes such as decentering, defusion, and metacognitive awareness. These processes reinforce the transient nature of internal events, and thus counteract the potential for certain mental events to be perceived as threatening or to be avoided. Such an approach is also

ruminate on past experiences or future events. Indeed, such present-moment focus is, in general, incompatible with rumination (Hayes, 2004; Ramel et al., 2004).

By enhancing the ability to bring attention back to the present moment, MM promotes an increased sense of mastery over attentional processes. It is perhaps through this present-moment



Illustration: Savina Hopkins

useful for letting go of whatever arises, as opposed to becoming entangled in it.

Thus, *non-judgmental acceptance* stands in stark contrast to *experiential avoidance*, or effortful attempts to control or change cognition and affect. Indeed, evidence suggests that, in general, attempts to change or avoid experience result in poorer long-term outcomes, and can even amplify adverse effects (Orsillo, et al., 2004; Wilson & Murrell, 2004). In contrast, a willingness to observe and accept psychological events enables increased opportunity for exposure to, and desensitization of, potentially adverse psychological experiences (Kabat-Zinn, Massion, Kristellar, Peterson et al., 1992; Orsillo, et al., 2004; Teasdale, Segal, & Williams, 2003). MM thus allows the practitioner to seek a balance between avoiding contents of the mind that have the potential to be distressing, and becoming absorbed in them (Allen et al., 2006; Bishop, et al., 2004; Ramel, Goldin, Carmona, & McQuaid, 2004; Teasdale, 1999).

Differences between cognitive therapy and mindfulness-based approaches

Although there are similarities between traditional cognitive behavioural approaches and mindfulness-based interventions, there are notable differences. In particular, mindfulness-based approaches focus on changing one's relationship to cognitions, rather than changing the content of thoughts themselves (Allen, et al., 2006; Orsillo et al., 2004; Ramel, et al., 2004; Segal, Williams & Teasdale, 2002). Thus, whilst within traditional cognitive-behavioural frameworks there tends to be a focus on the *content* of cognitions, within mindfulness approaches the focus is on cognitive *processes*, and in particular, on the allocation of attention. Also, traditional cognitive approaches direct their intervention efforts toward identifying specific types of stimuli and modifying their associated responses. This may include, for example, anxious cues and physiological reactions (Orsillo et al., 2004). In contrast, as noted previously, mindfulness-based approaches generally do not encourage disputation or deliberate attempts at

changing or modifying 'dysfunctional' cognition.

Efficacy of MM as a therapeutic intervention

The empirical support for the application of mindfulness meditation within psychotherapy and counselling is encouraging (Baer, 2003; Ma & Teasdale, 2004; Specia et al., 2000; Teasdale, Segal & Williams, 2003), as are research outcomes on the utility of mindfulness-based stress reduction (MBSR) interventions for distress resulting from chronic illness (Mills & Allen, 2000; Specia et al., 2000; Tacon, Caldera & Ronaghan, 2004).

The application of mindfulness-based cognitive therapy (MBCT) was explored in a clinical trial with 87 patients who were in current remission from depression (Teasdale et al., 2000). The findings indicated that, at the 12 month follow-up, patients assigned to MBCT (n=48) plus treatment as usual reported 30% of relapse in depressive episodes compared to a reported 66% relapse for the control group (n=39) who only received treatment as usual. Interestingly, the reduction in relapse was most pronounced for patients who reported three or more previous depressive episodes as compared to patients who had two previous depressive episodes (Ma & Teasdale 2004). Ma and Teasdale suggest that this may reflect a difference between people who become depressed in response to current adverse life events, versus those who experienced adversity throughout their development.

However, Williams and colleagues (2000) found that participation in a course of MBCT facilitated a reduction in over-generalisation in the autobiographical memory of participants. They argue that this reduced their tendency towards rumination, a key symptom of depression.

Studies with patients diagnosed with borderline personality disorder further support the efficacy of mindfulness-based interventions (e.g. Bohus, et al., 2004; Lynch, Morse, Mendelson, & Robins, 2003; Linehan, et al., 2002). Across studies, participants who received MM as a component of their treatment were

found to report greater reductions in substance abuse, self-mutilation and other impulsive behaviours, suicidal urges and ideation, and greater adherence to treatment, compared to wait-listed control groups.

Tacon et al. (2004) reported significant reductions in stress, anxiety, and sleep disturbance in 27 women with breast cancer following their engagement in an 8-week MBSR program. Similarly, Chang et al. (2004) reported that an 8-week MBSR intervention program with 43 participants selected from the general community led to significant reductions in levels of stress, and increased post intervention levels of positive states of mind. Tacon et al., (2003) also found that the implementation of an MBSR program within a small group of women with cardiovascular disease led to significantly lower levels of anxiety and negative affect post intervention than a comparable control group. In a non-clinical context, Chambers, Allen and Lo (2006) found that participants undergoing a 10-day intensive MM retreat reported significant decreases in depressive symptoms and significantly higher levels of mindfulness.

Therefore, whilst the research so far has been confined largely to smaller group studies, and often to particular disorders, there is an emerging base of empirical evidence to support the continued use and application of mindfulness-based approaches to counselling and psychotherapy. An extension of this research is now required that includes a more implicit examination of the exact nature and structure of mindfulness-based interventions and practices, and their relationship to physical and psychological wellbeing. Furthermore, studies are needed that expand the focus of this approach beyond remediation of illness, to include prevention of illness and maintenance of health. Issues related to client readiness, propensity for compliance, motivation; practitioner's expertise, level of engagement, duration of practice and so on all need to be addressed as we continue to research this area. The following section addresses some of these matters.

Costs, benefits and potential adverse effects

All therapeutic tools have potential adverse effects. It is likely that mindfulness-based interventions are no different, despite a long history of their use as tools for personal and spiritual development. The following section provides a preliminary discussion of some potential concerns. As the current literature on the adverse effects of mindfulness meditation is limited, the following discussion will broaden to include studies on a range of other meditative practices. These techniques contain an element of mindfulness—they require sustained concentration on a meditative object and that thoughts or feelings arising during this sustained period of concentration be acknowledged nonjudgmentally and non-elaboratively.

1. Time investment and associated costs

MM and associated therapies are practices that require some investment of time. Little research has been dedicated to determine the optimal amount of time, but most programs expect around 20 to 40 minutes, over one or two sessions a day (Kabat-Zinn, 1990). This may necessitate adjustment to daily routines. However, such a time commitment may be mitigated by the fact that ultimately practitioners become autonomous from practitioner input, and avoid any further time or financial burden. Added to this, there are reports of meditative practice that leads to improved efficiency through enhanced attentional capacities (Carrington et al, 1980; Chambers et al, 2006; Fiebert et al, 1981), better sleep quality with concomitant reductions in sleep requirements (Cohen et al, 2004; Gross et al, 2004), and potentially reduced healthcare costs.

2. Psychological side-effects

There are no large trials that have quantified the risks associated with meditative practices in general, or MM in particular. There are, however, some case reports and a small amount of empirical data on possible negative consequences of meditation practice. Most of this literature concerns Transcendental Meditation (TM) which, aside from MM, is the most

extensively studied variety of formal meditation practice. TM is a form of mantra meditation with a long tradition in both the east and west. In mantra meditation, attention is focused upon a word or phrase (often with an apparent esoteric meaning), that may be repeated either aloud or

literature is that it comprises mostly case reports or small series studies.

Adverse effects reported in the literature appear to vary greatly in their apparent intensity. French et al. (1975) reported an instance of 'altered reality testing' in which involvement in TM prompted grandiosity, unusual

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internally. As with MM and other meditative practices, any physical, mental, or emotional experiences that arise during recitation of the mantra are acknowledged simply without judgment or elaboration. Such practice results in the mind of the practitioner becoming calm and clear of disturbing emotions. When recitation of the mantra ceases, the practitioner momentarily experiences a state of mindfulness.

The key differences between the techniques is that MM often focuses on sensory experience rather than a mind-created object such as a mantra, and that MM entails being open to whatever arises in the mind, while practices such as TM aim to restrict the focus of the mind to a single object. However, it could be argued that training such 'one-pointedness' facilitates the ability of the practitioner to remain more engaged with momentary experience—that is, more mindful.

Reported side-effects of mindfulness seem especially pronounced following longer-term retreats (e.g. ten-day). Since such intensive practice is not recommended for 'novice' patients within current mindfulness-based approaches, so the applicability of these reports to clinical mindfulness interventions is limited. Nevertheless, some patients seek them out independently as a way of making rapid progress, and intensive retreats (albeit usually of less than 10 days) are often offered as a part of therapist training. A significant and major limitation of this

behaviour, euphoria, and intense dysphoria. Kennedy (1976) reported two cases of meditators experiencing depersonalization. Yorston (2001) reported a case of mania precipitated by meditation. At an arguably more extreme end of the scale, VanderKooi (1997) and Chan-Ob and Boonyanaruthee (1999) both reported cases of psychosis following intensive meditation training. However, they also indicated that many of these people had an apparent history of psychosis or schizotypal personality, but not all. Perhaps MM, in enhancing awareness of mental and emotional states, may aggravate such symptoms. Thus, a past history of psychosis might be a relative contraindication for intensive meditation training, although there is some preliminary literature to suggest that mindfulness training during remission may possibly play a beneficial therapeutic role (Bach & Hayes, 2002; Gaudiano, 2006).

MM may play a role as an adjunct to cognitive therapy, both helping to reduce stress (a recognised trigger for relapse) while also providing a method to cope with thought disorder if relapse occurs. Such hypotheses have yet to be confirmed by well performed trials. For people currently experiencing psychotic symptoms, 'mindful' engagement in activities such as tactile crafts or practices such as yoga or tai chi, may have more potential benefit than the internal focus of formal 'sitting meditation'. The specific risk posed for such individuals requires further empirical investigation before

sound conclusions can be drawn. In the meantime, mindfulness or other meditation practices should be used with such people with caution, by experienced practitioners, and under close supervision.

Other isolated but documented adverse effects after training in TM relate to increases in negative affect, anxiety, negative thinking or obsessive rumination (Lazarus, 1976; Epstein & Lieff, 1981) associated with instances of suicide attempts, exacerbation of depression and a sense of ineptitude. Shapiro (1992) explored the experience of 27 long-term meditators. More positive than negative effects were reported, but 17 of the participants reported experiences that could be interpreted as adverse effects during and after meditation, and two reported significant adverse effects including relaxation-induced anxiety and panic, paradoxical increases in tension, less motivation in life, boredom, pain, impaired reality testing, confusion and disorientation, feeling 'spaced out', depression, increased negativity, becoming more judgmental, and feeling addicted to meditation.

Although the more significant adverse effects are obviously of concern, a question arises as to whether the far more common, but milder, experiences described as 'adverse effects' are really 'adverse'. It is one of the essential aspects of meditative practices that they will increase awareness, or 'shed light on' the many physical, cognitive and emotional processes that often operate below the threshold of awareness. For example, MM initially enhances awareness of disturbing emotions, habitual thought patterns, and mental distractibility. This is an essential component of the process. Sustained practice soon shows that reactivity—attempting to suppress experiences like lowered mood or negative thoughts—simply directs increased cognitive resources to them, thus heightening their effects. This naturally leads the practitioner to recognise the value in observing such phenomena nonjudgmentally and non-reactively – that is, equanimously. This brings into question the oft-held assumption that pleasant experiences are always 'right' and healthy, and that

unpleasant experiences are 'wrong' or unhealthy. Questioning this point of view allows otherwise 'adverse effects' to be viewed, possibly more appropriately, as valuable learning opportunities to be welcomed rather than resisted. Understanding the process and how to respond to clients' experiences is an essential part of the instructor's role. If handled unskillfully the client may heighten the very thing they are wishing to be free from. It is also worth noting that some deeper meditative experiences—a profound sense of peace, transcendence, 'emptiness' or a lack of a need to control—can be so foreign to one's usual state that they can illicit fear or be misinterpreted, unless one has a way to assimilate them.

While most approaches that utilize MM in therapeutic settings emphasise the advantages of adopting and maintaining a consistent mindfulness practice, they would also emphasise not forcing or imposing the practice upon the student. If a student of mindfulness ever has significant concerns, they should defer practice until they can seek guidance (Hassed, 2002). It is important for clinicians and clients to be aware that the practice of mindfulness is sometimes a difficult one, and so relevant supervision is vital, especially where psychological problems are more significant. Future research will need to better identify the nature and prevalence of true adverse effects, and distinguish between problems due to the technique itself and problems due to inappropriate patient selection, excessive practice, unskillful instruction or inadequate supervision.

Issues for the practitioner

For practitioners newly engaged with mindfulness-based therapies, some personal and practical questions present themselves. In this section we pose some of these questions and offer for consideration some of the views held by experts in the field, the long history of traditional teaching, and ongoing observational experience of applying mindfulness-based therapies. Unfortunately, as yet there is little solid evidence from well-performed research in this field and so answers to these questions are preliminary.

1. Is mindfulness compatible with pharmacotherapy or substance abuse?

Unfortunately, there is little solid research to answer this question. In some cases mindfulness-based interventions may be a valid alternative to pharmacotherapy for selected and motivated individuals with conditions such as mild to moderate anxiety or depression, or who are resistant to the notion of taking medication. More often, however, mindfulness-based therapy is seen as being adjunctive. Whether pharmacotherapy, such as sedatives or antidepressants, help or hinder mindfulness-based therapies, and in what cases it is most suitable as an adjunctive or alternative, are questions that need future research.

Although mindfulness-based interventions may play a role in drug rehabilitation, many respected instructors (e.g. Kabat-Zinn, 1990) would recommend clients against active substance use while undergoing mindfulness programs due to the greater risk for adverse effects and reduction of its therapeutic potential.

A related point here is that the mindfulness-based therapies detailed in the literature are generally employed while patients are 'stabilized'. For instance, the MBCT paradigm (Teasdale et al., 2000) consists of a stabilization phase, in which patients' depressive symptoms are treated with cognitive therapy and pharmacotherapy (where needed), followed by a treatment phase (where participants receive the MBCT training). It remains unclear in the literature whether mindfulness-based interventions are appropriate for patients in the acute phase of psychiatric illness, although a recent uncontrolled trial of treatment resistant depression suggests that MBCT may be useful in these cases (Kenny & Williams, in press).

2. Does a practitioner need to personally practice mindfulness as a prerequisite for teaching it to others?

It has been a tradition for teachers of meditative practices to be experienced practitioners themselves. Indeed, a number of mindfulness programs subscribe to this tradition (e.g. MBSR: Kabat-Zinn, 1990; MBCT: Segal

et al, 2002) and will not credential practitioners without extensive training. Such training is implemented via experiential programs where practitioner learning is facilitated by the teacher, but is based upon the practitioner's own experience, insights and questions. The rationale is that practitioner commitment and example is vital to patient participation, and that a person cannot understand properly or teach the practice without having had substantial experience in it themselves. Some even suggest that a lack of acknowledgement of the need for personal practice is an indication of a lack of a theoretical knowledge of mindfulness. Lack of practice is seen as evidence of a limitation of understanding, and as one cannot communicate authentically what one does not fully understand, there is an increased risk of misleading the student. Another perspective is that the teacher of mindfulness is often 'teaching without words', i.e. by their modeling of mindfulness as they run the group. Indeed, Teasdale and colleagues (2002) suggest that much of the learning of participants in MBCT courses occurs as a result of their being able to model the open, accepting, and inquisitive (i.e. mindful) nature of the course facilitator. As mentioned above, they thus require all facilitators in their programs to have extensive, ongoing personal mindfulness practices. This belief is also held by Kabat-Zinn (1982; 2003), whose MBSR model underpins much of MBCT.

It should be noted that this view is not universal in the literature. An alternative position is advocated in Acceptance and Commitment Therapy (ACT: Hayes et al, 1999) and Dialectical Behavior Therapy (DBT: Linehan 1993)—people who use mindfulness-based therapies do not need to be mindfulness practitioners themselves. If they can gain sufficient experience to understand the process and to describe it they do not need to practice after that point. Mindfulness from this perspective has a coherent theoretical model and the ideas are conveyed as easily by a practitioner who practices little or not at all. It will be interesting to determine from future research which perspective has greater

therapeutic validity, and whether there is a fundamental difference amongst these therapies which requires experienced practitioners in MBSR and MBCT, but not in DBT and ACT.

3. Assuming that therapists must be practitioners themselves, what level of proficiency must they achieve before teaching it professionally?

Many therapists who learn mindfulness for use in clinical practice will be doing so based on years and even decades of personal practice and reflection. However, now that more practitioners are receiving training in mindfulness, many will be coming to mindfulness for the first time and, like patients, will have an enormously variable rate of progress and connection with the practices. Current programs for training mindfulness teachers vary widely in their training requirements. As mentioned above, neither ACT nor DBT require specific periods of mindfulness practice before therapists utilise it with patients. On the other hand, accreditation as an MBSR teacher requires at least one five or ten-day silent residential retreat, as well as 24 days of MBSR-accredited courses, generally run similarly to silent retreats. MBCT training to date has involved a seven-day residential retreat. However individual differences between trainee therapists may prejudice the question as to whether a 6-week, 12-week or a one-year

course is sufficient. Six weeks may be sufficient for some, whereas a year may be insufficient for others.

A question is raised as to whether a practitioner needs supervision by an experienced teacher before receiving their credentials as a mindfulness teacher. Many would suggest that to gauge proficiency by merely measuring theoretical knowledge is not sufficient to determine whether the practitioner can apply that knowledge correctly and deal with the many and varied questions raised by clients. Many therapists may find that the training they receive does not require ongoing supervision, but nevertheless may find it prudent to receive it.

4. Does a practitioner need to adopt a 'philosophy' in order to use mindfulness professionally?

New teachers and students of mindfulness often raise the question as to what extent they need to adopt a particular philosophy or way of life. Although the threads of mindfulness are woven into many Eastern and Western cultural and philosophical traditions, it is most commonly associated with Buddhism. Hence some people from non-Buddhist backgrounds may have concerns as to the religious, philosophical or cultural congruence of taking up or teaching the practice. Most teachers of mindfulness in clinical settings do not come from Buddhist backgrounds.



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Instead they find it is best taught in a pragmatic and non-religious way, with an emphasis on the practical application of mindfulness to particular issues that are relevant for the individual who is learning mindfulness. This approach has been seen as crucial to the integration of mindfulness into health-related undergraduate core-curricula with audiences characterised by cultural and philosophical diversity (Hassed, 2004). The medical course at Monash University (in Melbourne, Australia) has a 6-week mindfulness-based stress management program as core curriculum as a part of the personal and professional development of the students. Undoubtedly many people find that as they become more aware they often consider deeper philosophical questions and may experience philosophical shifts in their thinking. Such shifts, however, represent a deepening in the practitioner's understanding of the nature of their intra- and interpersonal processes, rather than an alignment with any philosophy or religious tradition. Furthermore, this process is client-centred, in that it comes from the patient in their own time and not from the teacher's agenda. Each person will then explore such issues in a way that is culturally and philosophically congruent for them.

5. Is mindfulness a discipline which can be easily combined with other psychological approaches?

The combination of mindfulness with cognitive therapy, as in MBCT, has attracted a significant amount of attention. However, for a number of reasons, MM may not work so well with some other forms of psychotherapy. MM, for example, seeks to take one beyond thought, emotion and identification with mental and physical processes. Furthermore, MM takes a firm stance in the present moment and only ever looks at what is going on now. Some might argue that some forms of psychotherapy and psychoanalysis, and even some meditative practices such as visualization, may lack theoretical and practical consistency with mindfulness in that they may rely on taking a person deeper into thoughts, emotions

or dreams, or encouraging them to go over the past and project into the future (c.f. Epstein, 1995). However, mindfulness refers to a decentred, nonjudgmental quality of attention, which could be applied in theory to most if not all psychotherapies. Simply getting patients to 'take their thoughts less personally and seriously' should not conflict with most psychotherapeutic approaches. Furthermore, while the initial training phase in MBCT encourages participants to observe their thoughts and emotions dispassionately, rather than attempting to change or even understand them, the ultimate aim is to allow participants to cease habitual rumination, and learn to deal effectively with their thoughts and emotions. That is, they learn to disengage their 'automatic pilot'—which has, for whatever reason, become maladaptive—which then allows them to make conscious, informed decisions about how to respond to their internal and external experiences. Whether mindfulness is antagonistic or complementary to a range of other forms of psychotherapy is not entirely certain and perhaps further research and experience will help to provide an answer to that question.

6. Is mindfulness best taught in a group setting or as individual therapy?

Most mental health clinicians will be accustomed to implementing therapy on an individual basis. Traditionally, mindfulness has been taught in groups, but often with individual follow-up when needed. Group delivery has the potential to be more therapeutic and cost-effective than individual instruction alone, not just for mindfulness but for other forms of psychotherapy as well. Group delivery of mindfulness teaching provides participants with advantages such as learning from others' insights, increases motivation to practice through peer support, and assists with the isolation common with many mental illnesses. For the practitioner, however, working with groups makes therapy training more complex in that two skill-sets may have to be learned, mindfulness therapy and the relevant group-work skills. The prospective mindfulness teacher may learn

much on both counts by modeling their teacher's way of running the group. Some relevant background in group-work will probably assist the development of the relevant skills, although sometimes the ground-rules for delivery of these therapies, with their emphasis on modeling of mindfulness and acceptance in the group, may mean that previously learned group-work skills have to be modified or unlearned for this new model of practice.

Conclusion

Mindfulness represents a particular way of relating to thoughts, emotions, and experiences. On this basis mediation practices designed to enhance the capacity for mindfulness represent a potential new dimension that may be added to existing psychotherapeutic approaches. The demonstrated utility of mindfulness mediation within a wide range of physical and mental health contexts has resulted recently in it being an area of significant growth in psychological research. Of particular interest to researchers and practitioners is the possibility that mindfulness represents a unique way of going about the process of psychotherapy, and a new framework for understanding the operation of the mind. While cognitive therapy aims to challenge and change the content of thoughts, mindfulness-based therapies such as MBCT aim to change our relationship to our thoughts. This is new ground in psychology and psychiatry, and denotes an exciting new direction in both fields. While it is premature to talk about a paradigm shift, it has spawned a number of new, apparently very effective therapies, with demonstrated utility for a number of psychological and physical concerns, and represents a new conceptualisation of the active ingredient in psychotherapy and psychological change.

Further investigation is required to understand the psychological mechanisms and processes underlying the apparent effectiveness of mindfulness-based interventions. There is a need for larger-scale RCTs to explore the validity of different mindfulness-based interventions

and to determine whether they are in fact more effective than current psychotherapeutic approaches.

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