

**MIND
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NESS...**
**REPORT
2010**



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We have known since ancient times that the way we think and the way we handle how we feel play a big part in mental health. Marcus Aurelius and Shakespeare both observed that the way we see something determines its impact on us. Cognitive Behavioural Therapy (CBT) has been seen for a long time as the leading way of dealing with this in mental health services and government has rightly been investing in this form of therapy. But in our daily lives many of us have been using other techniques to alter our thinking in positive ways, including exercise, meditation, contact with nature, music and philosophy or religion. The truth is all these methods — and others — can help with mental health and it depends on the individual.

Now there is new scientific evidence that meditation, especially when associated with some other mental disciplines derived from CBT, can improve our mental and physical health. This has given rise to a new group of psychological therapies called Mindfulness-based therapies. Despite the jargon this is a very exciting development — showing how ancient wisdom combined with modern science can improve mental health. In particular this new treatment can tackle recurrent depression but the principles have a much wider application to our lives. There is evidence for example that the use of Mindfulness in the workplace can improve productivity and decrease sickness absence.

This new approach is called Mindfulness and this report explains what it is and sets out the evidence that it works. We are calling for this potentially life changing approach to be more readily available and are launching a campaign and materials to help support this. The time has come to be mindful!

Dr Andrew McCulloch
Chief Executive
Mental Health Foundation



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INTRODUCTION

This report explores the theory, practice and potential of an approach to well-being called Mindfulness. Mindfulness has been the subject of growing attention and interest in recent years, thanks to a rapidly expanding evidence base suggesting it is helpful for many mental and physical health problems, as well as for improving well-being more generally.

Mindfulness is an integrative, mind-body based approach that helps people change the way they think and feel about their experiences, especially stressful experiences. This makes it particularly relevant in an age when some of our main health-care challenges are stress-related — mental health problems, psychological impacts of chronic long-term illness and stress-related physical conditions.

This report looks at Mindfulness from a number of different angles. It describes what Mindfulness is, the origins, and how it relates to well-being. It explores Mindfulness courses and surveys the evidence base for their effectiveness. It reports findings from new research into GPs’ attitudes towards and access to Mindfulness courses for their patients — especially MBCT, which is recommended by the National Institute For Health and Clinical Excellence (NICE) for the prevention of relapse in recurrent depression. It also reports survey findings that indicate likely public attitudes towards Mindfulness courses.

Based on these findings, the report presents arguments for expanding the use of Mindfulness interventions in the NHS and beyond, and offers recommendations for steps to bring this about.

Throughout, the report includes reflections from health professionals and researchers working in the Mindfulness field, service commissioners and providers, and accounts from people who have experienced and benefited from Mindfulness courses.

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EXECÜTIVE
SUMMARY

Mindfulness has been the subject of growing attention and interest in recent years, thanks to a rapidly expanding evidence base demonstrating that it can be helpful for many mental and physical health problems, as well as for improving well-being more generally.

Mindfulness is an integrative, mind-body based approach that helps people change the way they think and feel about their experiences, especially stressful experiences. It involves paying attention to our thoughts and feelings so we become more aware of them, less enmeshed in them, and better able to manage them.

Mindfulness interventions are often seen as situated within the cognitive behavioural tradition. However, they also have their roots in the ancient practice of meditation. They differ from traditional cognitive behavioural therapies in that they do not encourage people to challenge their thoughts, and they are not goal-directed. Rather, Mindfulness interventions aim to teach us how to accept our thoughts without unhelpfully identifying with them. When people practise Mindfulness, they are encouraged not to aim for a particular result but simply to 'do it, and see what happens'.

The first Mindfulness-based Stress Reduction (MBSR) programme, developed in the US, has inspired a number of variations, including Mindfulness-based Cognitive Therapy (MBCT); Acceptance and Commitment Therapy (ACT), a Mindfulness-based Psychotherapy; and Dialectical Behaviour Therapy (DBT), a Cognitive Behavioural and Mindfulness-based Therapy for borderline personality disorder.

EVIDENCE FOR MINDFULNESS

Mindfulness approaches have been proven to be effective in a wide range of mental and physical health applications. Mindfulness generally supports health promotion and prevention of ill health. Mindfulness programmes have achieved significant reductions in symptoms and relapse rates in mental ill health and there is evidence that Mindfulness interventions can directly benefit physical health by improving immune system response, speeding healing, and inducing a sense of physical well-being.

Mindfulness-based Cognitive Therapy (MBCT)

MBCT has achieved significant reduction in relapse rates among people with recurrent depression. MBCT has also been shown to reduce insomnia among patients with anxiety disorders, and improve anxiety and mood symptoms in people with generalised anxiety disorder (GAD). It has been found beneficial to people with bipolar disorder at high risk of suicide, and has achieved long-term reduction in depression in older people. MBCT has also shown potential for treating patients with chronic fatigue syndrome.

Our research carried out for this report suggests that few of the people who might benefit are currently being offered Mindfulness courses, despite the recommendation by the National Institute for Health and Clinical (NICE) of the use of MBCT for people at risk of repeated relapse into depression.

An expansion of MBCT services could be led through the existing Improving Access to Psychological Therapies (IAPT) programme. One of the major requirements for making Mindfulness courses more available is to train more clinicians to teach them. This will require an increase in access to teacher training courses, as well as the identification and preparation of suitable course leaders.

Mindfulness-based Stress Reduction (MBSR)

MBSR has been shown to reduce stress and mood disturbance, improve mood regulation, and increase perceptions of control in people with long-term anxiety disorders. MBSR participants with mood disorders have also shown reduced negative thinking and less stress and mood disturbance symptoms.

Participants in MBSR workplace programmes report being more engaged in their work, more energised and less anxious after the course, and also decreased medical symptoms and psychological distress. People who have taken an MBSR programme also show a greater ability to concentrate than do controls.

MBSR has also demonstrated reductions in the severity of psychiatric and medical symptoms, and a substantial reduction in use of GP services. Participants in MBSR have reported less depression, anxiety and over all psychological distress. Prison inmates in one study reported significantly reduced levels of hostility and mood disturbance after MBSR, and increased self-esteem.

Patients with chronic pain attending MBSR courses report less pain, reduced use of medication, and feeling less anxious and depressed. MBSR has also been shown to improve mood and reduce stress symptoms among people receiving treatment for cancer, as well as improve sleep and alleviate physiological and psychological symptoms of stress. It has also been found to reduce pain, lessen use of medication, and improve energy levels and quality of life in general.

HIV positive patients attending an MBSR programme reported significant improvements in quality of life and less psychological distress, as well as better immune system functioning, compared with controls. MBSR has also been associated with improvements in patients with psoriasis, fibromyalgia and chronic fatigue syndrome.

Acceptance and Commitment Therapy (ACT)

ACT has been found helpful for drug abuse, psychosis, chronic pain, depression and eating disorders. It can reduce hospital admissions among people with psychosis and self-harm, and improves emotional balance and mental health in people with borderline personality disorder. ACT has also been found to reduce use of medical services and sick leave among adults at risk of long-term disability. ACT training in the workplace can improve mental health, reduce depression and improve creativity.

Dialectical Behaviour Therapy (DBT)

DBT has been shown to improve behavioural self-management (less self-harm and drug abuse and fewer suicide attempts) among women with borderline personality disorder, and reduce hospital admissions. It can also reduce distress and anger among people with borderline personality disorder and improve social adjustment and overall mental health.

DBT trials for bulimia nervosa and for binge eating have also yielded promising results. DBT has also been found to reduce symptoms in depressed patients who were not helped by antidepressants, as well as in chronically depressed older adults.

Mindfulness and the brain

Neuroscientific studies have found differences in the areas of the brain associated with decision-making, attention and awareness in people who regularly practise Mindfulness meditation. People undertaking Mindfulness training have also shown an increase in activation in the left pre-frontal cortex, an area of the brain associated with positive emotions that is generally less active in people who are depressed.

Regular meditation also results in increased brain size in areas linked to emotion regulation, such as the hippocampus, the orbito-frontal cortex, the thalamus and the inferior temporal lobe.

Mindfulness and well-being

Research suggests that Mindfulness confers significant benefits for health and well-being and quality of life in general. People who are more mindful are less likely to experience psychological distress, including depression and anxiety. They are less neurotic, more extroverted and report greater well-being and life satisfaction.

People who are more mindful have greater awareness, understanding and acceptance of their emotions, and recover from bad moods more quickly. More mindful people have less frequent negative thoughts and are more able to let them go when they arise. They have higher, more stable self-esteem that is less dependent on external factors.

More mindful people enjoy more satisfying relationships, are better at communicating, and are less troubled by relationship conflict, as well as less likely to think negatively of their partners as a result of conflict. Mindfulness is correlated with emotional intelligence, which itself has been associated with good social skills, ability to co-operate and ability to see another person's perspective. People who are mindful are also less likely to react defensively or aggressively when they feel threatened. Mindfulness seems to increase self-awareness, and is associated with greater vitality.

Being more mindful is also linked with reaching academic and personal goals. Practising meditation has repeatedly been shown to improve people's attention, as well as improve job performance, productivity and satisfaction, and to enable better relationships with colleagues resulting in a reduction of work-related stress. People who are mindful feel more in control of their behaviour and are more able to override or change internal thoughts and feelings and resist acting on impulse.

Meditation practices more generally have been shown to increase blood flow, reduce blood pressure and protect people at risk of developing hypertension, as well as reduce the risk of developing and dying from cardiovascular disease, and to reduce its severity. People who meditate have fewer hospital admissions for heart disease, cancer and infectious diseases, and visit their doctor half as often compared to people who don't meditate.

Mindfulness can also reduce addictive behaviour, and meditation practices generally have been found to help reduce use of illegal drugs, prescribed medication, alcohol and caffeine.

PERCENTAGE OF GPs WHO THINK IT WOULD BE HELPFUL FOR THEIR PATIENTS WITH MENTAL HEALTH PROBLEMS TO LEARN MINDFULNESS MEDITATION SKILLS

72%

The Mental Health Foundation commissioned two pieces of original research to find out more about attitudes towards and practice of Mindfulness in health services, and to gauge wider public attitudes towards meditation as a way of promoting and protecting well-being.

We conducted a survey of GPs across the UK, to explore their attitudes towards, knowledge about and use of Mindfulness-based Cognitive Therapy (MBCT) for patients with recurrent depression.

A general public survey was also undertaken to explore wider public feeling about the pressures of life in UK society, and whether people might be receptive to Mindfulness courses.

GP survey

We commissioned ICM research to carry out an online survey of 250 GPs in early June 2009. The survey sample was nationally representative of the UK population in terms of age, region and gender. The survey found that:

- 72% — think it would be helpful for their patients with mental health problems to learn Mindfulness meditation skills
- 68% — think it would be very or quite helpful for their patients in general to learn Mindfulness meditation skills
- 52% — think that MBCT is very or quite effective
- 69% — say they rarely or never refer their patients with recurrent depression to MBCT. 5% refer to it very often. By comparison, 47% say they very often prescribe antidepressants to this patient group
- 75% — have prescribed antidepressants to patients with recurrent depression believing that an alternative approach might have been more appropriate. 67% did so because there was a waiting list for the suitable alternative treatment, 57% because they didn't have sufficient access to other suitable treatments, and 50% because it was the treatment option preferred by the patient
- 93% — surveyed agreed that it would be valuable to have more effective treatment options for patients with recurrent depression
- 20% — say they have access to MBCT courses for their patients
- 66% — say they would support a public information campaign to promote the potential health benefits of Mindfulness meditation
- 64% — think it would be helpful for them to receive training in Mindfulness skills themselves

The findings provide clear evidence that GPs are generally very positive towards Mindfulness as a health intervention, but rarely refer patients to MBCT courses — almost certainly because courses are not widely available. There is also evidently considerable scope for improving GP awareness of Mindfulness-based approaches.

The survey also suggests that GPs would welcome an effective, evidence-based, alternative treatment for recurrent depression. MBCT seems ideally placed to alleviate this situation — a simple, effective and economically viable intervention that can cater to many people at once, that requires relatively little staffing, and is already supported by many GPs.

General public survey

We commissioned Opinium Research to carry out a poll of 2,007 British adults over the period 16 — 19 June 2009 to explore their attitudes towards and practice of meditation, and their thoughts and feelings about the pace of life in UK society. Overall, the responses revealed that:

- 26% — of British adults say they practise meditation, although just under half (12%) of these do so rarely.
- 81% — agree that 'the fast pace of life and the number of things we have to do and worry about these days is a major cause of stress, unhappiness and illness in UK society'
- 86% — people agree that 'people would be much happier and healthier if they knew how to slow down and live in the moment'
- 53% — agree that 'I find it difficult to relax or switch off, and can't stop myself thinking about things I have to do or nagging worries'
- 51% — would be interested in attending free meditation classes to help them deal with stress and help them look after their health

The vast majority of people in our survey agreed that we live in a society where the speed of life and an overload of activity creates stress, illness and unhappiness, and that slowing down and appreciating the present moment would help people become happier and healthier.

A majority of the people surveyed would be interested in attending free meditation classes. This suggests there might be strong uptake of Mindfulness courses were they to be made more available. Interest might grow if more was known about these approaches.

CONCLUSION

Why we need more Mindfulness courses

From the clinical research and our own surveys, the benefits of Mindfulness could be helpful to a very wide mix of people, of all ages within health-care settings and more widely. They may be particularly appropriate for people with multiple mental health problems, and co-existing mental and physical health problems. As a mind-body intervention, Mindfulness is especially suited to dealing with such co-morbidity.

Mindfulness is a popular approach. Courses enjoy high completion rates and compliance with homework requirements. Mindfulness is a simple skill to learn and, because it requires the use of the mind, can be practised at any time and place.

There is increasing recognition that effective health care requires engaging patients in looking after their own well-being. Much, if not all, illness is influenced by stress, mental attitude, and behaviour choices. Mindfulness courses not only help people deal with illness; they are by nature a health promotion and illness prevention tool.

Mindfulness has potential cost advantages over many existing treatments, especially for mental health problems. Unlike most psychological therapies, interventions are delivered to groups rather than one-to-one, requiring less therapist time per patient. Mindfulness courses are time-limited: once the techniques have been taught, they can continue to be practised without further input from a therapist.

Depression, anxiety and stress are the cause of 13 million lost working days per year in the UK. One in six of us has a mental health problem at any one time. We live fast, complex, pressurised lives. Mindfulness practices are an easy-to-learn, inexpensive, portable and sustainable means to achieving 'headspace'.

The move to Mindfulness is not only more conducive to mental health and well-being; it appears to tap into a widespread yearning for a specific way of life.

Recommendations

The recommendations below reflect the known benefits that Mindfulness-based approaches can bring to a wide range of patients who experience recurrent depression and the current shortfall in awareness and capacity to deliver such approaches.

01 Implementation of NICE recommendation
The NICE guidance recommending Mindfulness-based Cognitive Therapy (MBCT) for people who are currently well but have experienced three or more previous episodes of depression should be implemented in full.

02 Service development
The expansion of MBCT training and services to meet the NICE recommendation should be driven by the Department of Health's Improving Access to Psychological Therapy (IAPT) programme. Primary Care Trust commissioners should consider how they can best build the capacity of Mindfulness services within their localities, using trained staff from statutory, independent and voluntary sector providers. Mindfulness-based approaches create the potential for patient self-management, reducing the use of scarce health resources.

03 Training and professional development
Mindfulness-based approaches should be taught during the early training of all doctors and offered as part of their continuing professional development. Few patients with recurrent depression who might benefit are currently being offered Mindfulness interventions. It is particularly important for GPs to increase their understanding of the potential benefits of MBCT for these patients, and to know what services are available locally.

Opportunities for professionals to develop Mindfulness-based skills are limited. There should be more opportunities for clinicians to train as Mindfulness teachers and practitioners themselves. This will require an increase in access to teacher training courses and more introductory courses for interested clinicians.

04 Research
Research on Mindfulness-based approaches should be prioritised within the government's mental health research and development strategy, and by other mental health research bodies, with an aim to:

- Understand better how specific Mindfulness-based approaches (such as MBCT) can be targeted even more effectively to existing patients with mental or physical health problems.
- Expand the evidence base for how such Mindfulness-based approaches can benefit different populations, such as adults who may be under stress at work or children who may lack attention skills at school.
- Understand better the neuroscience of how Mindfulness approaches actually work on the brain.

MIND
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AN
OVERVIEW

01.

WHAT IS
MINDFULNESS
AND WHY IS
IT RELEVANT?

16 – 17

Mindfulness is a way of paying attention to the present moment by using meditation, yoga and breathing techniques. It involves consciously bringing awareness to our thoughts and feelings, without making judgments about them. It is a method for observing what is happening right now, in our bodies, minds, and the world around us.

By paying attention to our thoughts and feelings in this way, we can become more aware of them, less wrapped up in them, and more able to manage them. Rather than struggling with our thoughts and feelings, or reacting impulsively to them, we can just notice them in a compassionate and interested way. This creates space for us to make more considered decisions about how to respond to the events in our lives.

How is this different from our usual way of operating? Often, rather than paying attention to our experience, we are swept away by it, carried along by thoughts and feelings, external events, interactions with other people, or memories of the past and hopes and fears about the future. Rather than staying consciously aware of what is happening in the present moment, we get caught up in our experience — especially when we are under pressure.

Our tendency then is to get stuck in ‘automatic pilot’: we identify strongly with our thoughts and feelings and react to them unquestioningly, with limited awareness. For example, rather than see and accept that we feel angry after a difficult interaction at work, we may fly off the handle at our partner when we get home, perhaps blaming them for putting us in a bad mood. Our impulsive reaction might then create another argument, and make us (and our partner) feel worse.

Mindfulness can be especially helpful for people with mental health problems such as depression, anxiety or chronic physical illness. Often people with these conditions struggle with or resist their experiences, especially when they are painful. They want things to be different. Unfortunately, this struggle can create more psychological suffering. Most of us have experienced this to some extent — a blistering headache, for example, can seem worse if we also get upset because it is preventing us enjoying a party we were looking forward to.

Mindfulness, then, is a way of experiencing things ‘as they are’. By paying careful attention to how things are in a non-judgmental way, we can see what is happening more accurately and respond more effectively in all areas of our lives. In this way, it enhances our quality of life and well-being.

‘MINDFULNESS IS AN ABC SKILL. THE A IS FOR AWARENESS – IF YOU WANT TO MAKE CHANGES THEN YOU’VE GOT TO KNOW WHAT YOU’RE DOING IN THE FIRST PLACE, AND THAT MEANS DEVELOPING A SPECIFIC AND SUBTLE SENSE OF WHAT IS GOING ON IN YOUR MIND AND BODY. THE B IS LEARNING TO ‘BE’ WITH EXPERIENCE.

OFTEN WE HAVE A THOUGHT, EMOTION OR PHYSICAL SENSATION AND THEN IMMEDIATELY GET INTO A STORY THAT ESCALATES IT AND CAUSES GRIEF – SUCH AS WHEN PEOPLE FALL INTO DEPRESSION AND RUMINATION, OR THEY HAVE PHYSICAL PAIN AND START THINKING ABOUT HOW TERRIBLE IT IS AND HOW ‘I CAN’T STAND IT’.

MINDFULNESS OFFERS AN OPPORTUNITY TO GET YOUR ATTENTION IN THERE BETWEEN THAT INITIAL THOUGHT, EMOTION OR SENSATION AND STAY THERE – WHAT WE SOMETIMES CALL DWELLING IN THE GAP. YOU DON’T FEED THE PROBLEM, AND BY NOT FEEDING IT, YOU DON’T MAKE IT WORSE. ACTUALLY, YOU CAN OFTEN MAKE THINGS BETTER BY MAKING ‘WISE CHOICES’ – THAT’S THE C.

YOU STOP, NOTICE WHAT’S GOING ON WITHOUT REACTING TO IT, AND THINK, ‘OK, THIS IS WHAT I NEED TO DO’. IT’S A CONSIDERED DECISION RATHER THAN A KNEE-JERK REACHING FOR THE BOTTLE OR THE RAZOR BLADE.’

Dr Paramabandhu Groves
Consultant Psychiatrist, Camden and Islington Mental Health
and Social Care Trust and Clinical Lead, Breathing Space

WHY IS MINDFULNESS HELPFUL?

18 – 19

‘IT’S REMARKABLE HOW LIBERATING IT FEELS TO BE ABLE TO SEE THAT YOUR THOUGHTS ARE JUST THOUGHTS AND THAT THEY ARE NOT ‘YOU’ OR ‘REALITY’. THE SIMPLE ACT OF RECOGNISING YOUR THOUGHTS AS THOUGHTS CAN FREE YOU FROM THE DISTORTED REALITY THEY OFTEN CREATE AND ALLOW FOR MORE CLEAR-SIGHTED-NESS AND A GREATER SENSE OF MANAGEABILITY IN YOUR LIFE.’

Professor Jon Kabat-Zinn
Founding Executive Director
Centre for Mindfulness in Medicine, Health Care and Society
University of Massachusetts Medical School)

Mindfulness may aid well-being through a number of mechanisms

Greater insight

By taking a mindful perspective, we observe our experience but don’t get caught up in it. Mindfulness helps us get greater clarity on what is happening in our minds, and in our lives.

Improved problem-solving

By slowing down and investigating our thoughts, feelings and experiences more carefully, we create space for coming up with wise responses to the difficulties in our lives. We create space between the urge to react and our actions themselves, and we can make considered and creative decisions about how to behave.

Better attention

We can concentrate better on tasks, maintain our focus and reach goals. We are less distracted. Experience can become fresher, lighter, clearer, richer and more vivid.

Less selfishness

We are less wrapped up in our own thoughts and feelings and so have greater ability to take others into account. We can be more considerate, empathic, compassionate, sensitive and flexible in our relationships.

Less neurosis

We experience the world in an open way that is not so weighed down by unhelpful psychological patterns. We are better attuned to ourselves, to others, and to the world, and able to act more skilfully, based on present need, rather than past conditioning.

More acceptance

Through Mindfulness, we see that events, thoughts and feelings always change, and we can learn to bear experiences more lightly, and let them go. We are more able to enjoy well-being that does not depend on things going ‘right’.

Greater enjoyment of life

We can become more aware of pleasant experiences that were previously unnoticed because of our mental focus on the past and the future.

Less ‘beating ourselves up’

Mindfulness reduces our identification with negative thinking patterns — we stop thinking we are our thoughts, and we can be kind to ourselves when we have negative thoughts about ourselves.

Better mind-body integration

Many of us have a tendency to live ‘in our heads’ and ignore what is happening in our bodies. Mindfulness makes us more aware of what is happening both in our bodies and in our minds, so we can experience and take into account the full range of our thoughts as well as our feelings.

The origins of Mindfulness

Mindfulness has its roots in meditative traditions that are thousands of years old. Mindfulness is most commonly linked with Buddhist practices, although similar ideas and techniques are found in ancient Greek philosophy, contemplative Christianity, Judaism and Islam, Gestalt and humanistic psychologies and today’s ‘slow’ movement.

In many of these traditions, Mindfulness is thought of as a quality that can be developed over time, through practices such as meditation. However, Mindfulness and meditation are not the same thing. ‘Mindfulness’ is a quality that we all possess to some degree or another — how much depends on our ability to pay attention to our experience.

‘Mindfulness meditation’ usually refers to a set of specific, very simple practices designed to cultivate the ability to be mindful.

The word ‘meditation’ can refer to a wide range of disciplines, some of which require different, or more elaborate, techniques to those involved in Mindfulness meditation, although they usually involve an ability to pay attention and develop insight in some way. For example, there are meditation practices that seek actively to harness the mind’s powers of concentration, contemplation or visualisation, not simply its capacity for observing thoughts, feelings and events.

In recent decades, clinicians and researchers working in psychological services have developed programmes based on Mindfulness meditation practices, with the aim to help people cope with health problems.

They have also begun to investigate the factors that make some people more or less mindful than others, and to conduct neuroscientific research to determine how Mindfulness disciplines affect the brain. Mindfulness-based therapies and courses have also been formally evaluated, resulting in an increasingly robust and comprehensive evidence base for their application in clinical practice.

CASE STUDY KATHY

Kathy Andrews, 47, attended a MBCT course two years ago, after hearing about the approach from a friend. I have a long history of depression and about 12 years ago I went on medication. As I started to get better we talked about trying some other ways of coping. I saw a cognitive behavioural therapist through my GP and also was talking to a friend in the US who said how much Mindfulness had helped her. So I asked my CBT therapist to refer me to the Oxford Mindfulness Centre.

I think Mindfulness is the piece that’s missing in other kinds of therapy. One of my kids asked me why I was going to this class and I said I was learning how to pay attention. They thought that was really stupid but it sums it up for me. Mindfulness means learning how to recognise what’s going on internally and externally. The biggest difference it has made is that I’m more connected — I’m able to more fully be with whatever I’m doing.

My depression comes from getting overwhelmed with hard feelings, whether it’s pain or frustration or irritability. Now I don’t feel overwhelmed by everything. I don’t get so sucked into old patterns of blaming and judging myself.

Not long after I’d finished the course, I was in a busy department store with my kids and started to have a panic attack. I was worried about losing one of them. So I thought: ‘Okay, my heart rate is going up, my blood pressure is going up, I’m feeling very tense, my shoulders are tightening up. ‘I did a Mindfulness practice called the three-minute breathing space and it helped me back up a bit. It shifted the perspective so that I didn’t go into a full panic attack.

I’ve got my medication down as low as it’s ever been, and I haven’t had a major depression since doing the course. It’s not that unpleasant feelings and stress don’t come, it’s that I’m not engaging with them the way I used to.

I’d recommend Mindfulness to everybody. I’ve done a lot of talk therapy over the last 20 years and that was useful, but this has made the bigger shift — I could feel something changing during the course.

MIND
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FOR
HEALTH
PROBLEMS

02.

MINDFULNESS COURSES FOR MENTAL AND PHYSICAL HEALTH PROBLEMS

22–23

Mindfulness-based Stress Reduction (MBSR)
Mindfulness-based Stress Reduction (MBSR), incorporates the teaching of traditional meditation techniques, some gentle yoga and stretching, and exercises such as the ‘body scan’ (in which participants lie down and are guided slowly through a process of directing their attention to different parts of their body). It is delivered in class format, so that participants can share their experiences, learning from and bonding with others who have similar problems. The aim is to help them cope with the stress associated with their conditions and manage symptoms better.

‘MINDFULNESS-BASED APPROACHES INTEGRATE ANCIENT PHILOSOPHIES, PRACTICES AND KNOWLEDGE WITH MODERN RIGOROUS SCIENTIFIC APPROACHES AND UNDERSTANDING.’²

Centre for Mindfulness Research and Practice, School of Psychology, Bangor University

The first major Mindfulness course for healthcare applications was developed in the late 1970s by Jon Kabat-Zinn at the University of Massachusetts Medical School. Kabat-Zinn wondered whether practices such as meditation and yoga could help people with chronic health problems such as high blood pressure, chronic pain and anxiety disorders.¹

Over 17,000 people have completed the MBSR programme at what is now the Umass Centre for Mindfulness in Medicine, Healthcare and Society. The model has been adapted by service providers across the US, with Mindfulness skills being taught as an aid to well-being in prisons, schools, workplaces and nursing homes, as well as to families and in community settings.

As interest in Mindfulness has grown, variations on the MBSR programmes have been developed. Most significantly, in the 1990s a group of psychologists were looking to create a group-based intervention for people prone to bouts of depression, for which there are few good treatments. They came across Kabat-Zinn’s work and — despite some resistance to an ‘alternative’ practice such as meditation — they realised it might be suitable. As experts in cognitive behavioural methods (CBT), they made some CBT-based adaptations to MBSR, and named their intervention Mindfulness-based Cognitive Therapy (MBCT).³

The MBSR programme has also been adapted for a range of other specific populations, including couples (Mindfulness-based relationship enhancement), people with generalised anxiety disorder (MBSR for GAD), children (MBSR-C), pregnant women and their partners (Mindfulness-based childbirth and parenting) and those with addiction issues (Mindfulness-based relapse prevention). It is also delivered in its original format to specific groups, such as people with cancer. Mindfulness is also a core element in a number of new psychological therapies, such as ACT (Acceptance and Commitment Therapy) and DBT (Dialectical Behaviour Therapy).

With the possible exception of MBSR, which has tended to be positioned within integrative medicine, Mindfulness interventions are often seen as situated within the cognitive behavioural tradition (indeed, they are sometimes referred to as the third wave of CBT). However, they differ from traditional cognitive behavioural therapies in that they do not encourage people to challenge their thoughts. Rather, Mindfulness interventions aim to alter our

relationship to our thoughts — to teach us how to accept them without unhelpfully identifying with them. Mindfulness interventions also differ from cognitive behavioural therapies in that they are not goal-directed. When people practise Mindfulness, they are encouraged not to aim for a particular result — not even alleviation of the problem for which they are seeking help. The attitude is more: ‘Do it, and see what happens.’

The Mindfulness-based Stress Reduction (MBSR) model has been described as psycho-education,³ ‘skills training’⁴ and even as a spiritual/existential therapy.⁵ Courses last between eight and 10 weeks, with sessions of between two and two-and-a-half hours per week, for groups of up to 30 participants.

The formal meditation practices involve giving attention to something (e.g. the breath, the body), while non-judgmentally observing thoughts and feelings (emotions and physical sensations). When the mind inevitably wanders, this is also noticed without judgment. Mindfulness is encouraged during everyday activities like eating and walking. The course includes discussions about the practices and other awareness exercises (such as keeping a ‘pleasant’ and ‘unpleasant’ events diary).

Each week, participants are given homework assignments (practising the exercises that have been taught, using guidance instructions on a CD) that take approximately 45 minutes a day. This ensures the learning is based on participants’ own experiences, and not just what they are told, and helps make the practices a habit, to be continued once the course ends.

While meditation is sometimes thought of as ‘mind training’, MBSR also pays a lot of attention to the body — it does not create an artificial separation between mind and body.

Mindfulness-based Cognitive Therapy (MBCT)
Mindfulness-based Cognitive Therapy (MBCT) was adapted from the MBSR model, adding tools and techniques from cognitive therapy specifically to help people prone to recurring depression. As Professor Mark Williams, one of the developers of MBCT, explains: ‘Depression is a recurrent problem, so we thought: ‘Is there any way you can help people in groups, so it could be economically efficient but also teach them the skills to stay well between episodes?’ That’s when we turned to Mindfulness, whose philosophy — seeing your thoughts as just thoughts — is very close to that of cognitive therapy.’

Why did Williams and his colleagues think Mindfulness might be especially helpful for people with a history of depression? First, when people who have experienced repeated episodes of depression experience difficulties in their life or become sad, they are more likely to start thinking negatively about what is happening. Typical negative thoughts might include: ‘I am useless’, ‘I am not strong enough to deal with this’ or ‘I always get depressed when this happens.’³ These negative thoughts can then tip them back into depression.

The more times someone becomes depressed, the more habitual these unhelpful patterns seem to become. Research suggests that early episodes of depression are more likely to be preceded by stressful events,³ whereas subsequent episodes are more likely to be triggered by depressive thinking itself.^{3 (p29)} Depression can then turn into a chronic relapsing condition. Research shows that people who have experienced one episode have a 50% chance of experiencing another one; someone who has had two episodes faces a 70% chance of relapsing; after three episodes the relapse rate is 90%.⁶

People who have been depressed are also more likely to switch into a ruminative style of thinking: they go over and over in their mind the reasons for their depression, worry about what might happen as a result of it and attempt to ‘think’ their way out of it. However, research suggests that trying to analyse one’s way out of it in this way can perpetuate the depression, rather than resolve it.^{6 (p33)} By focusing more on themselves and their depression, they feed it and get stuck in it. It is a recurring, vicious cycle.

Standard cognitive therapy attempts to deal with these issues by encouraging clients to examine their thoughts and question their accuracy. This has the effect of distancing them from their depressive thinking: the thoughts may still occur, but the person can see they are not the full picture, and can choose not to believe them (‘thoughts are not facts’). The developers of MBCT suggested that this ‘decentring’ aspect of CBT might be the key element.⁷

CBT also encourages people to challenge and replace negative thoughts with more positive interpretations, and to make goal-directed changes in behaviour. However, in MBCT negative thoughts are simply acknowledged and then let go, without judgment, and without making any attempt to change their content.

The developers of MBCT say that this kind of attention is associated with a ‘being’ mode of mind, as opposed to a ‘doing’ mode. Doing mode is the one in which we tend most to operate, especially in a culture that values goal-directed action. We deal with unpleasant events by trying to find solutions to the ‘problem’.

This approach is used in some elements of CBT and can work well when the problem is soluble, but may be less effective when the problem is more about emotional issues, or when nothing can be done to change the situation. In this case, attempts to solve the problem by ‘doing’ can lead to unproductive rumination: we turn the problem over and over in our mind, unsuccessfully seeking answers that may not exist. Unfortunately, the very process of thinking about the problem in this way can make us feel worse about it. In ‘being’ mode, on the other hand, we simply observe and accept the present moment.

Strengthening a person’s ability to operate in ‘being’ mode may help to short-circuit rumination. When we pay attention to the present moment there is little room for rumination on the past or future, and if rumination does occur, it can be seen more clearly for what it is — a seductive but ultimately unhelpful habit. When people are meditating, the neural response that is linked to conceptual processing is shorter than it is in people who are not meditating,⁸ suggesting that meditation may help people regulate the flow of automatic thinking.

Being mode is also associated with greater awareness of the body, which is where the signs of oncoming depression are often expressed. According to Mark Williams: ‘MBCT teaches people to become aware of warning signs in the body and to deal with them skilfully, rather than being caught up in the mind. So many of us live in our minds rather than our bodies.’In ‘doing’ mode, there is little space to consider new responses to situations. Switching into ‘being’ mode helps us hold back from reacting impulsively, and gives us time and space to consider new ways of acting (at which point we can return to ‘doing’). By nurturing the ability to operate ‘being’ mode, people prone to depression may become aware of approaching relapse and be able to forestall it.

MBCT largely follows the MBSR model (an eight-week course, two-hour sessions, between 12 and 30 participants, Mindfulness training plus discussion, presentations and exercises). However, it deviates from MBSR in several significant ways:

- The discussions, exercises and teaching framework emphasise how thinking processes contribute to depression. MBCT introduces a Mindfulness practice called the ‘three-minute breathing space’, which is designed to create a quick way of stepping out of automatic thinking, especially in difficult circumstances, such as stressful work situations, or during an argument
- There are a number of cognitive therapy exercises (e.g. playing out imagined scenarios) designed to help people decentre from their thoughts and feelings
- Participants prepare relapse prevention plans, including mood-lifting ‘pleasure and mastery’ activities that can be used to forestall depression

As Zindel Segal and colleagues say in their book *Mindfulness-Based Cognitive Therapy*: ‘The ultimate aim of the MBCT programme is to help individuals make a radical shift in their relationship to the thoughts, feelings, and bodily sensations that contribute to depressive relapse.’³ It also aims ‘to help participants be able to choose the most skilful response to any unpleasant thoughts, feelings or situations they meet’.³

Bring attention to and take an upright, confident posture to help step out of automatic thinking, then spend about one minute each on the following three steps.

01.

Ask yourself 'What is my experience right now?' and notice any body sensations, thoughts or feelings you are having, allowing them to be as they are without judging them.

02.

Place your attention on your breathing, following the in-and-out breath as it naturally occurs.

03.

Expand your awareness to the whole of your body, continuing to notice any thoughts, feelings or physical sensations that occur, without judgment.

'RESILIENCE IS BUILT UP BY TEACHING PEOPLE TO LOOK OUT FOR THE WARNING SIGNS OF DEPRESSION, TO SPOT THEM EARLIER AND DEAL WITH THEM SKILFULLY, WITH KINDNESS, CURIOSITY AND COMPASSION, RATHER THAN WITH JUDGMENT, HARSHNESS AND CRITICISM.'

Professor Mark Williams
Department of Psychiatry, University of Oxford, founder of the
Oxford Mindfulness Centre, and co-author of The Mindful Way
Through Depression and Mindfulness-Based Cognitive Therapy.

Acceptance and Commitment Therapy (ACT)

ACT is a Mindfulness-based psychotherapy. In ACT, patients are encouraged both to accept their current circumstances and, at the same time, move towards new behaviours (the commitment aspect). ACT draws strongly on a cognitive behavioural framework, but differs from traditional CBT in that it encourages adopting a mindful approach as a way of discovering deeply held values, and then making changes in accordance with those values. ACT makes use of a range of Mindfulness exercises (shorter and more informal than in MBSR and MBCT), and is usually (although not always) delivered on a one-to-one, time-limited basis.⁹

Dialectical Behaviour Therapy (DBT)

DBT is a cognitive behavioural and Mindfulness-based therapy for borderline personality disorder. It has also been adapted to work with other groups. The main dialectic (a set of opposing forces) is between acceptance and change. Clients are encouraged to come to terms with both processes, accepting their current circumstances while simultaneously working to improve them.⁹

Mindfulness is taught through techniques such as observing and counting the in-and-out breath, co-ordinating breathing with walking, and imaginative exercises (e.g. seeing the mind as a conveyor belt with thoughts and feelings passing through), rather than more formal or traditional meditation practices. The exercises are taught in a highly session-structured group which meets once a week for a year. DBT also teaches other skills for developing interpersonal effectiveness, emotional self-regulation and distress tolerance.

Mindfulness is presented as a way of developing attention and facilitating a state called ‘wise mind’, a healthy integration of ‘reasonable mind’ (our rational, logical side) and ‘emotional mind’ (the part led by our feelings). People diagnosed with borderline personality are often heavily identified with their emotions, and DBT aims to help them regulate emotions more effectively. Of course, other people may be overly rational and out of touch with their feelings (making them poor at empathising, for instance). In ‘wise mind’, the two complement each other.

Other Mindfulness-based courses

A number of other Mindfulness interventions have also been developed that adapt existing approaches for a range of specific populations. These include:

Mindfulness for Generalised Anxiety Disorder (GAD)

This incorporates elements of MBCT, ACT and DBT.¹⁰

Mindfulness-based treatments for eating disorders

DBT has been adapted for binge-eating disorder and bulimia nervosa, MBCT for binge-eating disorder, and ACT for anorexia nervosa. Mindfulness-based eating awareness training (MB—EAT),¹¹ a specific intervention for binge-eating disorder, includes guided meal meditations to address unhealthy eating patterns.

Mindfulness-based Cognitive Therapy for children (MBCT–C)

This is an adaptation of the MBCT programme, with shorter sessions (90 minutes a week, over 12 weeks) and practices, and a child-friendly approach to psycho-education, including games and stories.⁹

Mindfulness-based Relationship Enhancement (MBRE)

MBRE, delivered to couples, aims to help couples improve their relationships and deal more effectively with relationship stress. It places special emphasis on developing empathy, trust and closeness between partners, via mindful communication, touch and intimacy exercises.¹²

MBRP teaches participants to ‘ride’ relapse urges like waves, helping them to see that impulses to addictive behaviour naturally wax and wane and do not have to be acted out.¹³ It incorporates cognitive behavioural relapse prevention strategies.

Mindfulness-based Childbirth and Parenting (MBCP)

This approach, pioneered by Nancy Bardacke,¹⁴ teaches couples who are expecting a baby to deal with concerns about the upcoming birth, and trains them in wise attention that will form the basis of a good attachment relationship with the newborn child.¹⁵

CASE STUDY JANE

Jane Robinson, 46, is a Chief Executive of a social enterprise. She used a company training budget to attend a Mindfulness-based Cognitive Therapy course.

I had a professional coach who told me about MBCT. I was finding my job very difficult. I’d never run a business before. I was stressed — I’m also a single parent — and needed some support and a way to relax. I had also been really depressed for five years after my partner left me with a young child.

The course was fantastic — I loved it. I learned that you don’t have to go where your mind takes you. Instead of that whole conveyor belt of resentment and anger, which I could get caught up in forever when I was younger, I can recognise it and listen to it but not go down that road.

I couldn’t see the point of meditation before. I’d done it on yoga courses but my head would be all over the place. And I’d never heard of meditation to address pain or depression.

My parents died when I was very young and I can feel abandoned if I haven’t got someone to see or something to do. At the weekend that used to floor me completely. I used to feel like a baby in a cot with the parents not there. But I can go upstairs to meditate and the feeling of abandonment just disappears. It feels like a way of parenting yourself, rather than getting someone else to do it for you.

Now I don’t feel depressed and I’m managing things better. Mindfulness has added to all my previous work in therapy. I feel much calmer. My ex and I have become much better friends and been nicer to each other. And because I feel better, I can also help the people around me. I am also much calmer in the office, much more positive, even though my job can still be very stressful.

I think we live in quite a hostile world, and the course was like a kind of sanctuary.

MIND
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THE
EVIDENCE

03.

MINDFULNESS-BASED THERAPIES

30–31

Mindfulness-based Stress Reduction (MBSR)

A meta-analytic review of Mindfulness-based approaches concluded that the approaches yield ‘at least medium-sized effects, with some effect sizes falling within the large range’.¹³ These results have been found across a broad range of population types, ages and social groups. What follows is an overview of this evidence. More comprehensive systematic reviews can be found in the literature.^{13 16 17}

Trials of MBSR have shown it can reduce stress and mood disturbance, improve mood regulation and increase perceptions of control.¹⁶ In a study of people with long-term anxiety disorders, MBSR participants had less anxiety during and after completing the course, with improvements maintained at three-year follow-up.¹⁸ MBSR participants with mood disorders have also shown reduced negative thinking (rumination).¹⁹ The more MBSR participants practise Mindfulness in the group and at home, the more stress and mood disturbance symptoms appear to reduce.²⁰

Participants in a study of MBSR in the workplace said they were more engaged in their work, more energised and less anxious after the course. They were also given a flu vaccine, and had more antibodies when assessed at four and eight weeks than did a control group, suggesting their immune system functioning had improved.

Participants in another workplace MBSR programme reported a 31% decrease in medical symptoms, a 17% decrease in ‘daily hassles’ and a 31% decrease in psychological distress. The improvements were greater at three-month follow-up.²¹ Compared with controls, people who took an MBSR programme showed a greater ability to concentrate than did controls.²²

A growing evidence base indicates that Mindfulness-based approaches are effective in helping people manage stress, anxiety and depression, and other mental health problems. Research has found they can also improve people’s relationships, sharpen attention and improve emotional balance. Mindfulness interventions can help patients with physical health problems deal with their symptoms, and improve immune system functioning.

A study of MBSR in a US inner-city community setting reported a reduction in psychiatric symptoms (50%), anxiety (70%) and medical symptoms (44%), and a substantial reduction in number of GP visits.²³ Medical students who participated in MBSR became more empathic²⁴ compared with controls. They also reported less depression, anxiety and overall psychological distress. Inmates at six Massachusetts prisons reported significantly reduced levels of hostility and mood disturbance after MBSR, and increased self-esteem.²⁵

Compared with controls, patients with chronic pain attending an MBSR course reported less pain at the end of the course. They also said they were less restricted by pain, used less medication, and were less anxious and depressed, with most effects maintained at 15-month follow-up.²⁶ More than half (65%) of a group of patients with chronic pain who had failed to respond to standard medical care reported marked reductions in pain after MBSR.^{27 28} A pilot study of MBSR among women with binge-eating disorder found an average reduction in binges from four to 1.6 per week.²⁹

MBSR led to a 65% improvement in mood and a 35% reduction in stress symptoms in a group of people receiving treatment for cancer.²⁰ MBSR has also been found to reduce sleep disturbance and increase sleep time among people with cancer.⁵

Other studies of people with cancer using MBSR report fewer medical symptoms and fewer physiological signs of stress (lower cortisol levels). Psychological changes have included less tension, depression, anger, concentration problems and instability, fewer stress-related neurological and gastrointestinal symptoms, and increased energy and quality of life.⁵

A (small) study of HIV patients attending a MBSR programme found significant improvements in quality of life and less psychological distress, as well as better immune system functioning compared with controls.³⁰ MBSR has also been associated with improvements in patients with psoriasis, fibromyalgia and chronic fatigue syndrome.^{13 17 31 32}

Mindfulness-based Cognitive Therapy (MBCT)

Trials of MBCT with people with mental health problems have also shown promising results. In a study of 145 patients with recurrent depression who were currently in remission, only 37% cent of those who received MBCT relapsed in the following year, compared with 66% in a control group. Three-quarters of the MBCT participants had experienced more than two episodes of depression, and it was this group that benefited.¹⁹ A replication study of 75 patients also found that MBCT reduced relapse rates by more than a half over 12 months (36% for the MBCT group versus 78% for the controls).³³ It was on the basis of these studies that the National Institute For Health and Clinical Excellence (NICE) recommended MBCT to prevent relapse in patients who have experienced more than two episodes of depression and who are currently in remission.³⁴ The guidance, first published in 2004, confirms the recommendation in its 2007 and most recent 2009 revision.

Another trial with 123 participants with a history of recurrent depression found that MBCT (with or without antidepressants) was more effective in preventing relapse than maintenance antidepressant treatment alone, and better at improving quality of life. Over 15 months, 47% of the MBCT group relapsed, compared with 60% of those who were only given antidepressants (the MBCT group was encouraged to come off antidepressants, and 75% did so).³⁵ One study has found that MBCT leads to ‘significant improvement’ in insomnia symptoms among patients with anxiety disorders,³⁶ while another found MBCT reduces anxiety and mood symptoms in people with generalised anxiety disorder (GAD).³⁷ Another study has found that MBCT leads to reduced anxiety among people with bipolar disorder at high risk of suicide.³⁸ A pilot study of MBCT with older people reduced depression scores: 39 a year after the course, 62% of participants described the course as ‘extremely useful’, and most were continuing to use Mindfulness practices.

Several preliminary studies have found MBCT can help some people in the middle of a depressive episode. In one trial, MBCT reduced depressive symptoms from severe to mild, compared with no change in a control group,^{40 41} while another reported a remission rate of 33% after eight weeks of treatment,⁴² replicating an earlier trial.⁴¹ MBCT has also shown potential for treating patients with chronic fatigue syndrome.³²

Acceptance and Commitment Therapy (ACT)

ACT has been found helpful for drug abuse, psychosis, chronic pain, depression and eating disorders.⁴³ It reduces hospital admissions among people with psychosis, those who self-harm, and people with stress, and improves emotional balance and mental health in people with borderline personality disorder.¹⁶ ACT has also been found to reduce use of medical services and sick leave among adults at risk of long-term disability.⁴⁴ A study of ACT in workplace training found that, compared with a control group, participants had improved mental health, reduced depression and improved creativity.⁴⁵ A second study replicated these findings.⁴⁵

Dialectical Behaviour Therapy (DBT)

DBT has been shown to improve behavioural self-management (less self-harming and drug abuse and fewer suicide attempts) among women with borderline personality disorder, and to reduce hospital admissions. It has also reduced distress and anger among people with borderline personality disorder and improved social adjustment and overall mental health. These effects were maintained a year after treatment.^{16 46} On the basis of the evidence for DBT, the current clinical guidelines from the National Institute for Health and Clinical Excellence (NICE) recommend DBT programme for women with borderline personality disorder who self-harm.⁴⁷

A DBT trial for people with binge-eating disorder found that 89% of participants had stopped binge eating at end of treatment, compared with 12.5% of a control group, and 56% of participants were still not binge-eating at six-month follow-up.¹¹ A DBT trial for bulimia nervosa has also yielded promising results.¹¹ DBT also been found to reduce symptoms in depressed patients who were not helped by antidepressants,⁴⁸ as well as chronically depressed older adults (75% of whom were in remission six months after treatment, compared with 31% of a control group).⁴⁹

Other Mindfulness interventions

Couples who attended a Mindfulness-based Relationship Enhancement (MBRE) programme showed greater relationship satisfaction, autonomy, partner acceptance and closeness and lower personal and relationship distress compared with controls. Positive outcomes were associated with more daily Mindfulness practice.⁵⁰

A Mindfulness intervention for children (MBCT-C) was found to significantly reduce attention problems, anxiety and depression: 61% of parents reported that their children had fewer behavioural and anger management problems after the course.⁵¹ A Mindfulness-based intervention for pregnant women significantly reduced anxiety and negative mood compared with controls.⁵²

An adapted MBSR intervention for people with attention deficit hyperactivity disorder (ADHD) improved participants’ executive attention (associated with control, planning, decision-making, overcoming habitual patterns and self-regulation),⁵³ while a pilot study of a Mindfulness intervention for people with symptoms of obsessive-compulsive disorder found ‘a significant and large’ effect on symptoms.⁵⁴

A study involving 208 adults found that patients with chronic heart failure (CHF) attending a Mindfulness-based psycho-educational programme had less anxiety and depression and improved CHF symptoms after one year.⁵⁵

‘PATIENTS WHO HAVE HAD MORE THAN TWO EPISODES OF PREVIOUS DEPRESSION ARE BREAD-AND-BUTTER GP TERRITORY. MOST DEPRESSED PATIENTS HAVE HAD SEVERAL EPISODES AND ONCE THEY HAVE GONE THROUGH MENTAL HEALTH SERVICES THERE IS A FEELING OF ‘WHAT CAN YOU GIVE THESE PEOPLE?’ YOU CAN PUT THEM ON LONG-TERM ANTIDEPRESSANTS, BUT THEY DON’T WORK SO WELL FOR EVERYONE ... SO I THINK THERE’S A HUGE NEED FOR NON-PHARMACOLOGICAL INTERVENTIONS. THAT NEED HAS BEEN FILLED BY THE EVIDENCE FOR MBCT.’

Dr Stewart Mercer, GP and Professor of Primary Care Research, Glasgow University

Di Cowan, 53, has suffered from periods of depression since he was a teenager. He was referred by his GP for MBCT at the Mood Disorders Centre in Exeter. Eighteen months ago he was also diagnosed with bone cancer, and now also uses the ‘mental tools’ he has learned on the course to deal with the pain, disability and challenges of living with a serious physical illness. He has recently had major surgery to repair his spine, followed by chemotherapy and a stem cell transplant.

My depression really came to the fore in the 1980s after I’d had Q fever, which is like jaundice. From then on my health was never the same. I soldiered on working as a teacher but suffered depression and was pretty tired. Eventually I was diagnosed with chronic fatigue syndrome.

Four years ago, my GP suggested MBCT. If I had been asked about meditation before that I’d have remembered my youth and the Beatles and thought: ‘Yes, well that’s OK for a bunch of long-haired hippies, but not for me!’ But I thought: ‘Well, let’s give it a go. The worst that can happen is you go along a couple of times and if everyone’s burning joss sticks and wearing kaftans, you can walk away.’

But it wasn’t like that. It provides you with an understanding of your illness and the tools to deal with it. I learned a lot about depression, how it affects people like me and how to recognise the problems before they become serious. Being able to stop the mind wandering is a great tool to use against an illness like depression, because depression — at least for me — consists of the mind wandering into areas that it should not go, either reviewing painful or unpleasant things from the past or considering fears for the future. To get to the point where you can enjoy the ‘here and now’ is a wonderful thing. It’s a terrific weapon against depression. Once you have a regular practice, you can say ‘I’m in charge of my mind’.

The interaction with the rest of the group was also useful — sharing experiences, supporting and feeling supported by them. I go along to the reunions and there are people I’ll know there — it’s a community. You can have a feeling of being dreadfully isolated and lonely when you are depressed.

I think the most important thing was learning techniques that could help me deal with my other health problems. When I did the course, I had no inkling of the fact that I had other medical issues, but meditative techniques have helped a lot in coping with pain. Through meditation you examine the nature of pain and discomfort and get up close to it — you find out about it. Surprisingly, the closer you get, the more you are able to deal with it.

I’m also dealing with all the fears that go with a serious, long-term illness. Mindfulness helps me calm my mind and focus and make sure that I don’t panic or overreact. Then you’re dealing not with the fear about ‘What’s going to happen to my family?’ and all the other things that weigh you down, but ‘How are things right at this moment?’ That’s a lifeline, because it means I can summon up the courage to crack on with life. My son is 11 years old and he needs a dad who can take him to his football training and tell jokes — the course has given me the fortitude to do that. Depression makes people focus on themselves and their own problems to the point that they stop functioning. Mindfulness stops you from allowing your mind to tie you up.

MIND
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AND

WELL-BEING

04.

Mental well-being

People who more mindful are less likely to experience psychological distress, including depression and anxiety.¹⁶ They are less neurotic, more extrovert and report greater well-being and life satisfaction.¹⁶

People who are more mindful also have greater awareness, understanding and acceptance of their emotions (as well as being less reactive to them), and recover from bad moods more quickly.¹⁶ They do not get so stuck in repetitive thinking patterns (a process known as rumination), are less likely to shy away from difficult experiences, and are less perfectionist.⁵⁷ More mindful people have less frequent negative thoughts and are more able to let them go.⁵⁸

They have higher, more stable self-esteem that is less dependent on external factors.⁵⁹ In developmental studies, Mindfulness is associated with the ‘secure attachment’ that comes from ‘attentive, responsive and sensitive care-giving’ and which has been shown to be conducive to well-being.⁶⁰ Daniel Siegel notes that many of the qualities associated with secure attachment — ‘regulation of body systems, balancing emotions, attuning to others, modulating fear, responding flexibly and exhibiting insight and empathy’ — are linked to Mindfulness.⁵⁶

Greater Mindfulness is not only helpful for addressing mental and physical health problems, it may also benefit well-being generally. This section documents some of the evidence that suggests being mindful can support well-being.

Physical well-being

Mental and physical health are inextricably linked,⁶¹ and so we might expect Mindfulness to boost physical as well as mental health. As we have seen, Mindfulness can certainly help people cope with the psychological challenges of physical illness, and there is evidence that Mindfulness interventions can directly benefit physical health by improving immune system response, speeding healing, and inducing a sense of physical well-being.¹⁶

Meditation practices more generally have been shown to increase blood flow, reduce blood pressure and protect people at risk of developing hypertension, as well as reduce the risk of developing and dying from cardiovascular disease, and reducing its severity.^{62 63 64} US health insurance statistics have shown that people who meditate have fewer hospital admissions for heart disease, cancer and infectious diseases, and visit their doctor half as often.⁶⁵

Behaviour

People who are mindful feel more in control of their behaviour and are more able to override or change internal thoughts and feelings and resist acting on unwanted urges.^{16 66} They are less likely to report feeling aggressive and to respond aggressively to unpleasant situations.⁶⁷

Mindfulness can reduce addictive behaviour. In a study of gamblers, it was found that more mindful people were less likely to become addicted (they were also more successful, as they were better able to read the game more accurately!).¹⁶ Meditation practices more generally have been found to help reduce use of illegal drugs, prescribed medication, alcohol and caffeine.⁶³

Life skills

Being mindful helps us relate to others.²¹ One study found that Mindfulness is positively associated with better ability to express oneself in social situations, greater empathy, better identification and description of feelings, lower social anxiety and less distress contagion.⁶⁸

More mindful people enjoy more satisfying relationships, are better at communicating, and are less troubled by relationship conflict, as well as less likely to think negatively of their partners as a result of conflict.¹⁶

There are correlations between Mindfulness and emotional intelligence, which itself has been associated with good social skills, ability to co-operate and ability to see another person’s perspective.¹⁶ People who are more mindful seem to be more compassionate towards themselves, and show greater empathy — they feel closer to and more connected with others.¹⁶

Mindfulness seems to promote secure attachment, which has also been associated with compassion, altruism and tolerance.⁶⁰ People who are mindful are also less likely to react defensively when threatened.¹⁶ Mindfulness seems to increase self-awareness, and is associated with greater vitality.⁶⁹

Being more mindful is also linked to reaching academic and personal goals.¹⁶ Practising meditation has repeatedly been shown to improve people’s attention,^{16 70 71 73} as well as improve job performance, productivity and satisfaction, and enable better relationships with colleagues, resulting in the reduction of work-related stress.⁷⁴

Mindfulness and the brain

Neuroscientists have studied the effects of meditation on the brain, and some suggest that Mindfulness practices can foster sustained neural changes. Says Richard Davidson, Director of the Laboratory for Affective Neuroscience at the University of Wisconsin and one of the world’s leading experts on the neuroscience of meditation: ‘We’ve come to appreciate the value of physical training but we have not given the same kind of attention to the mind. In our work, we now view happiness and compassion as skills that can be trained.’⁷²

This is a significant shift in the prevailing view — it used to be thought that traits such as attention span and emotion regulation were fixed properties that could not be greatly altered.⁷⁵ Now, studies in neuroplasticity suggest that the adult brain is much more malleable than previously thought.⁷⁶

Compared with non-meditators, it has been shown that people who practise Mindfulness meditation for 40 minutes a day have greater cortical thickening in areas of the right prefrontal cortex and right anterior insula. These areas have been associated with decision-making, attention and awareness.⁷⁷

There is a proportionate relationship between the increase in cortical thickness and the relative meditation experience of the subjects. People undertaking Mindfulness training have also shown an increase in activation of the left pre-frontal cortex, an area of the brain associated with positive emotions that is generally less active in people who are depressed.⁷⁸

People who have meditated regularly for more than five years seem to have increased brain size in areas linked to emotion regulation, such as the hippocampus, the orbito-frontal cortex, the thalamus and the inferior temporal lobe.⁷⁹ When presented with threatening emotional stimuli, more mindful people seem to show less reactivity, as measured by reduced activity in the amygdala and more activity in the pre-frontal cortex.⁸⁰

Perhaps it is not so surprising that regular Mindfulness practice can lead to significant brain changes. These have been observed in people who dedicate themselves wholeheartedly to other skills too. Taxi drivers, for example, have been found to have a larger hippocampus than non-taxi drivers, with the length of time in the job predicting the size differential.⁸¹

Brain changes have also been seen in people who undergo significant stress, neglect and abuse. Structural differences have been observed in the brains of people prone to depression, and some are associated with the length of time they have been depressed.⁸¹ It seems that experience — positive and negative — may mould the brain, just as the brain influences experience.

There have also been more than 100 studies of changes in brain wave activity during meditation.⁸¹ Findings include more synchronicity of alpha waves, which has been linked to a state of being relaxed and alert. Meditation has also been associated with an increase in the waves, which have been linked to positive emotions,⁶³ as well as increased cortical coherence and left-right hemisphere interaction.⁶⁴

More experienced meditators produce stronger and more synchronised gamma waves, which have been linked to awareness, attention and learning.^{64 82} Compared with beginner meditators, experienced meditators show more activation in areas of the brain associated with attention.⁸¹

In *The Blissful Brain: Neuroscience and Proof of the Power of Meditation*, Dr Shanida Nataraja argues that meditation shifts the balance from what might crudely be described as ‘left-brained’ thinking, which is more analytical, rational, logical and ego-centred, to more ‘right-brained’ thinking, which is associated with attention, non-verbal awareness, visual and spacial perception, and the expression and regulation of emotions. Dr Nataraja says that people from western industrialised cultures have a tendency to be dominated by the more left-brained mode of operation.

By cultivating the right-brained mode through practices such as Mindfulness meditation, we may be able to facilitate a more balanced way of being.⁸³ Neuroscientist Daniel Siegel suggests that Mindfulness practices may enable the mind to attune to its own mental state, promoting neural integration (linkage, co-ordination and balance between different areas of the brain), which then may help us become more mentally healthy.⁵⁶

Pascale Malardier, 35, referred herself to a MBCT course following a period off work with anxiety.

I’m quite an anxious person, and a couple of years ago I had some time off work with stress. When I was off sick I became interested in how to cope with anxiety. I looked into talking therapies, but I was also interested in finding something where I could be more active.

I found the Mindfulness-based Cognitive Therapy course on the Breathing Space website [Breathing Space is run by the London Buddhist Centre and offers Mindfulness based courses for people with addictions and depression]. We were told there would be quite a lot of homework and I was happy about that — I knew there would be eight weeks where I was going to be focused on it.

My experience was very positive. It has helped me a lot. The most useful thing was learning to be mindful of the present. The course doesn’t try to change anything. You are not trying to create a different sensation in your body; you just have to be aware of what is happening in your mind. It’s as simple or as complicated as that!

It helps because you can see that your reaction to sensations is a perception. So now, when somebody says something to me, I’m conscious of how my body is reacting and I can put a different perspective on it in my own mind, rather than creating anxiety. I’m more able to be with the sensation, whereas before there would have been an automatic response. I respond in a less anxious way, or even if I don’t then I’m aware of that, and just being aware of it makes me feel less anxious. It has allowed me to experiment and explore different ways of behaving. I can cope much better — I can see anxiety coming.

‘BEING MINDFULLY AWARE, ATTENDING TO THE RICHNESS OF OUR HERE-AND-NOW EXPERIENCES, CREATES SCIENTIFICALLY RECOGNISED ENHANCEMENTS IN OUR PHYSIOLOGY, OUR MENTAL FUNCTIONS, AND OUR INTERPERSONAL RELATIONSHIPS.’⁵⁶

Dr Daniel Siegel
The Mindful Brain

MIND
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OUR
RESEARCH

05.

The Mental Health Foundation wanted to find out more about attitudes towards and practice of Mindfulness in health services, and to test the temperature of wider public attitudes towards meditation as a way of promoting and protecting well-being.

First we commissioned a survey of GPs across the UK, to explore their attitudes towards, knowledge about and use of MBCT for patients with recurrent depression. We did this because MBCT is the best developed Mindfulness intervention in this country. It targets a specific population, and is recommended in the NICE guidelines for depression,³⁴ which determine the treatments that should be provided by the National Health Service. We wanted to find out how far the NICE recommendation is filtering through into practice. MBCT ought to be particularly welcome to GPs because it is effective with a large group of patients who present mainly in primary care and for whom there are few effective treatments. Around one in ten people experience depression in any one year, and for one in five of these, the condition is chronic.⁸⁴ We also surveyed GPs about their attitudes towards Mindfulness as a treatment for other mental health problems, and for health generally.

We then commissioned a general public survey. This aimed to explore wider public feeling about the pressures of life in UK society, and whether people might be receptive to Mindfulness courses.

GP SURVEY AN OVERVIEW

We commissioned ICM research to carry out an online survey of 250 GPs in early June 2009. The survey sample was nationally representative of the UK population in terms of age, region and gender.

The survey found that

- 72% — think it would be helpful for their patients with mental health problems to learn Mindfulness meditation skills (21% don't know if it would be helpful; 7% say it would not be helpful)
- 68% — think it would be very or quite helpful for their patients in general to learn Mindfulness meditation skills
- 52% — think that MBCT is very or quite effective (28% say they don't know how effective MBCT is; 3% say it is not at all effective)
- 69% — say they rarely or never refer their patients with recurrent depression to MBCT. Five per cent refer to it very often. By comparison, 47% say they very often prescribe antidepressants to this patient group
- 75% — have prescribed antidepressants to patients with recurrent depression believing that an alternative approach might have been more appropriate. Two-thirds (67%) did so because there was a waiting list for the suitable alternative treatment, 57% because they didn't have sufficient access to other suitable treatments, and 50% because it was the treatment option preferred by the patient. Nearly all (93%) the GPs surveyed agreed that it would be valuable to have more effective treatment options for patients with recurrent depression
- 20% — say they have access to MBCT courses for their patients (48% say they do not, and 32% don't know if they have access or not); consider themselves very well-informed about MBCT (27% say they are quite well-informed about it, 47% say they are not very well informed, and 22% have never heard of it). More than a third (37%) of GPs say they sometimes

suggest to patients they might benefit from learning to meditate. Of those who don't, 45% cite insufficient evidence for the benefits of meditation, 41% think their patients are likely to think meditation a 'strange' thing to do and are unlikely to be interested; 25% think it is inappropriate for them to recommend 'spiritual' practices to their patients, and 13% say they don't suggest meditation to their patients because it wouldn't be helpful for them

- 66% — say they would support a public information campaign to promote the potential health benefits of Mindfulness meditation
- 64% — think it would be helpful to receive training in Mindfulness skills themselves

A number of themes emerge from these figures. First, GPs are generally very positive towards Mindfulness as a health intervention. Almost three-quarters (72%) believe learning Mindfulness meditation skills would be useful for their patients with mental health problems, and almost as many (68%) think it would be helpful for their patients in general. More than half (52%) believe MBCT is effective for patients with recurrent depression. Most of the rest say they don't know if Mindfulness (or MBCT) would be helpful – very few GPs who are aware of Mindfulness courses are hostile to them.

Two-thirds would like to be trained in Mindfulness themselves (64%) and a similar proportion would support a public information campaign promoting its potential health benefits (66%). Again, bearing in mind that some GPs probably would not lend their support to such a campaign because they know very little about Mindfulness (there was no 'don't know' option for this question), this degree of enthusiasm is striking.

GP opinion carries great weight with policymakers and patients. As the gatekeepers to services, their support is vital if a new approach is to succeed. The fact

that they are favourable to Mindfulness-based approaches smoothes the way for rolling them out more widely.

However, positive sentiment is not being matched by practice. The majority of GPs (69%) rarely or never refer patients to MBCT courses, and only one in 20 (5%) refer patients to them very often. This is almost certainly because courses are not widely available: only one in five (20%) GPs say they have access to them for their patients. Indeed, more GPs say they sometimes refer patients to MBCT (31%) than say they have access to courses (20%).

GPs say they need alternative means to deal with recurrent depression: three-quarters (75%) in this survey have prescribed their patients antidepressants despite thinking an alternative approach might have been more appropriate, most often because of long waiting lists or lack of availability of alternatives. MBCT seems ideally placed to alleviate this situation – a simple, effective and economically viable intervention that can cater to many people at once, that requires relatively little staffing, and is already supported by many GPs.

There is considerable scope for improving GP awareness: 22% of GPs have never heard of MBCT, and only four per cent consider themselves very well-informed about it. Only a third (37%) have discussed the potential benefits of meditation with their patients; the majority are reluctant to do so, but very few (13%) because they don't believe it would be helpful. More often GPs cite lack of evidence (45%), likely patient resistance (41%) and it being inappropriate (25%) as their reason for not recommending it to patients. Giving GPs the confidence to recommend Mindfulness practices more often might have considerable health benefits for our society.

GP SURVEY DETAILED RESULTS

44–45

This section reports in detail the responses from GPs to our questions.

We asked how GPs usually responded to patients with recurrent depression

94% — very often or quite often prescribe maintenance doses of antidepressants (47% very often)

79% — very often or quite often refer to psychological therapies (17% very often)

64% — often use ‘watchful waiting’ and offer no treatment until the patient actually becomes depressed (8% do this very often)

31% — very often or quite often refer patients to MBCT (5% very often); 40% rarely and 29% never refer patients to MBCT

29% — very often or quite often refer patients to exercise therapy schemes (5% very often)

Prescription of antidepressant medication on a maintenance basis is by far the most common GP treatment response to patients with recurrent depression. Maintenance prescribing means that patients continue to take antidepressants even when they are not depressed, as a prophylactic against relapse. In recent years, there has been a growing debate about the effectiveness of antidepressants, as well as concerns about their side effects.⁸⁵ Frequently, they are not popular with patients.⁸⁵

Recent years have also seen more emphasis on the provision of psychological therapies for common mental health problems. They are recommended as a first-line treatment in NICE guidelines for many conditions, and the government has invested new funding to increase the availability of some types of talking treatments. However, this shift towards talking treatments remains at an embryonic stage; referral to these services is still far from the norm,⁸⁶ and only 17% of GPs in our survey refer patients with recurrent depression to them very often.

Also, while approaches such as cognitive behavioural therapy help many patients with recurrent depression, many will already have been prescribed courses of CBT during earlier episodes. Top-up sessions, while useful, may not be available, and it may be more appropriate to try an approach that is specifically targeted at this group.

The third most common strategy GPs use for this group is ‘watchful waiting’ (64% of GPs in our survey say they use it often). This means that no treatment is offered while depression is in remission. However, this may be a missed opportunity. If we are to shift more towards a health promotion model, measures that help prevent future episodes of illness should be taken while people are well. MBCT is a prime example of an intervention that works in this way.

The fact that 31% of GPs say they sometimes refer patients to MBCT is encouraging, given that it is a relatively new approach. However, only five per cent do so very often, and two-thirds rarely or never use it. Almost ten times as many GPs very often prescribe maintenance antidepressants to this group as very often refer them to MBCT. The fact that more GPs say they refer patients to MBCT than have access to courses reflects their enthusiasm for this approach.

‘THERE IS A LARGE NUMBER OF PATIENTS IN GENERAL PRACTICE WHO STAY ON LONG-TERM ANTIDEPRESSANTS, EITHER BECAUSE THEY’RE NOT QUITE BETTER OR SCARED OF COMING OFF. FOR THAT GROUP MINDFULNESS IS A CONSIDERABLE SUPPORT.

IT IS EVIDENCE-BASED AND CAN PROVIDE A KIND OF SECURITY FOR THE PATIENT IN THEIR AMBIVALENCE ABOUT WHETHER TO BE ON ANTIDEPRESSANTS. IT PROVIDES A REPLACEMENT – AN ACTIVE SET OF MECHANISMS TO EMPOWER PEOPLE. YOU REPLACE AN EXTERNAL DRUG SUPPORT WITH A FORM OF SELF-MANAGEMENT.

IT HELPS GPs WHO MAY THINK A PERSON SHOULDN’T BE ON ANTIDEPRESSANTS TO HAVE SOMETHING VERY POSITIVE TO OFFER – EVEN CBT HAS NOT BEEN USED IN THIS WAY. IT’S THE ONLY EVIDENCE-BASED STRATEGY WE HAVE FOR PEOPLE WHO HAVE HAD A HISTORY OF RECURRENT DEPRESSION AND NEED AN ALTERNATIVE APPROACH.’

Richard Byng
GP and lecturer at the Peninsula Medical School
University of Plymouth

We asked for GPs’ views about the effectiveness of treatments for recurrent depression

- 94% — think that maintenance prescription of antidepressants is very or quite effective (28% very effective)
- 75% — have prescribed antidepressants to patients with recurrent depression even though they believed that an alternative approach might have been more appropriate. Of these, 67% did so because there was a waiting list for the suitable alternative treatment, 57% because they didn’t have sufficient access to other suitable treatments, and 50% because it was the treatment option preferred by the patient
- 82% — think that psychological therapies are very or quite effective (10% very effective)
- 52% — think that MBCT is very or quite effective (9% very effective); 17% think it is not very effective, and 3% consider it not at all effective
- 28% — say they don’t know if MBCT is effective; 13% say they don’t know if exercise therapy is effective; 2% say they don’t know if psychological therapies are effective and 1% say they don’t know if antidepressant medication is effective
- 49% — think that exercise therapy is very or quite effective (8% very effective)
- 93% — agree that it would be valuable to have more effective treatment options for their patients with recurrent depression (58% strongly agree)

The vast majority of GPs think that maintenance antidepressants work for patients at risk of depressive relapse, although less than a third (28%) think that they are very effective. Three-quarters have prescribed antidepressants when they think an alternative might have been more appropriate, most often because of poor availability of alternatives. GPs are warm towards psychological therapies (82% think them effective for patients with recurrent depression, although only 10% think them very effective).

More than half think that MBCT is effective (52%), and almost as many as those who consider it very effective (9%) think the same about psychological therapies (10%). However, the number of GPs who say they don’t know if MBCT is effective (29%) is much higher than for other approaches (13% for exercise therapy, two per cent for psychological therapies and one per cent for antidepressants).

The low faith in any treatment being ‘very effective’ indicates GPs’ poor recovery expectations for this group of patients – recurrent depression is widely acknowledged to be difficult to treat.

We asked how much GPs know about MBCT

- 4% — consider themselves to be very well informed about MBCT
- 27% — consider themselves to be quite well informed about MBCT
- 47% — consider themselves to be not very well informed about MBCT
- 22% — have never heard of MBCT

Over a fifth of GPs have never heard of MBCT and of those who have, the majority consider themselves not very well informed about it.

We asked how many GPs have access to MBCT courses for their patients

- 20% — say they have access to MBCT courses for their patients;
- 48% — say they do not have access to MBCT courses; and
- 32% — don’t know if they have access to MBCT courses or not.

Given that MBCT is a relatively new approach, the fact that one in five GPs say they have access to courses is encouraging. However, the anecdotal evidence from interviews carried out for this report suggests that few areas have established formal and structured MBCT treatment pathways, so it seems unlikely that many GPs are directly referring patients to MBCT courses. It may be that, by referral, GPs mean directing patients towards services that use Mindfulness as part of their work.

We asked those GPs who said they don’t have access to MBCT courses (or don’t know) if they think they would be useful

- 57% — of these GPs say that having access to MBCT courses would be helpful (17% think it would be very helpful, and 41% quite helpful); 41% don’t know but only 1% think it would not be helpful.

A majority of GPs who say they don’t have access to MBCT courses (or don’t know if they have) believe they would be helpful. However, a high percentage don’t know if they would be helpful and a very small number think they would not be helpful.

We asked GPs if they think it would be helpful for their patients with mental health problems to Mindfulness (meditation) skills

- 72% — think it would be very or quite helpful (16% very helpful, 55% quite helpful) for their patients with mental health problems to learn Mindfulness skills. A very few (7%) say it would be not very or not at all helpful and 21% don’t know

Most GPs believe that Mindfulness meditation is a helpful approach for people with mental health problems. Very few think it would be either not very helpful (4%) or not at all helpful (3%). This suggests that GPs could be strong advocates for Mindfulness-based approaches for people with mental health problems.

We asked if GPs think it would be helpful for their patients in general to learn Mindfulness skills

- 68% — think it would be very or quite helpful (12% very helpful, 56% quite helpful) for their patients in general to learn Mindfulness skills. Ten per cent say it would not be very helpful, three per cent not at all helpful and 19% don’t know.

Most GPs (almost as many as those who think Mindfulness skills may be helpful for people with mental health problems) say Mindfulness skills would be useful to their patients in general (e.g. those with physical problems). This suggests that GPs would be receptive to the idea of offering Mindfulness more widely. In the US, Mindfulness courses are better known as treatments for helping people with chronic physical ill health.

We asked if GPs ever suggest to their patients that they might benefit from learning to meditate

- 37% — say they sometimes suggest to patients that they might benefit from learning to meditate; and of those who don’t ever suggest it to their patients, 45% say there is not enough evidence for the benefits of meditation, 41% say their patients are likely to think it a ‘strange’ thing to do and are unlikely to be interested, 25% think it is inappropriate for them to recommend ‘spiritual’ practices to their patients, and 13% say they don’t think meditation would be helpful for their patients.

More than a third of GPs sometimes suggest to patients that meditation might be helpful for them. Most of the rest don’t, not because they don’t think meditation would be helpful (13%), but because they lack confidence in it as an evidence-based intervention (45%), because they are concerned about how their patients might respond (41%), or because they are worried that they might be going beyond their remit (25%).

We asked if GPs practise meditation themselves

- 12% — say they practise meditation
- We asked if GPs think it would be helpful to be trained in Mindfulness skills themselves
- 64% — think such training would be helpful, 19% say it would be very helpful and 45% would find it quite helpful. Only 8% say it would not be at all helpful

Despite their enthusiasm about Mindfulness courses, most GPs do not practise meditation themselves. However, they would welcome opportunities to receive Mindfulness training. There could be several advantages to this. The approach can only really be understood from experiencing and practising it; reading about Mindfulness will not give the same depth of comprehension. Giving GPs the opportunity to develop Mindfulness skills might help them explain their potential benefits to patients.

It might also help GPs deal more effectively with their patients. A mindful doctor/patient relationship could improve health outcomes and lead to more humane, patient-centred care. Training in Mindfulness might also help GPs deal better with the very considerable stresses and pressures of their job, which in turn might benefit patients.

We asked if GPs would support a public information campaign to promote the potential health benefits of Mindfulness meditation

- 66% — would support such a campaign
- Two-thirds of GPs would support a campaign to promote the potential health benefits of Mindfulness meditation. Again, given that around one in five GPs seems to know very little about Mindfulness, this level of support is striking.

Variations according to GP experience, age, gender and location

More experienced GPs are more likely to refer patients to MBCT

- 37% — of the GPs in this survey who qualified before 1970 say they refer to it very or quite often, compared with 15% of those who qualified after 2000

More experienced GPs are also more likely to consider themselves well-informed about MBCT (34% of those who qualified before 1970, compared with 20% of those who qualified after 2000) and to say they have access to courses (22% of those who qualified before 1970, compared with 5% of those who qualified after 2000).

However, less experienced and younger GPs are more likely to meditate themselves (20% of those who qualified after 2000, compared with 12% of those who qualified before 1970) and to support a public information campaign to promote the potential health benefits of Mindfulness meditation (80% of those who qualified after 2000, compared with 59% of those who qualified before 1970).

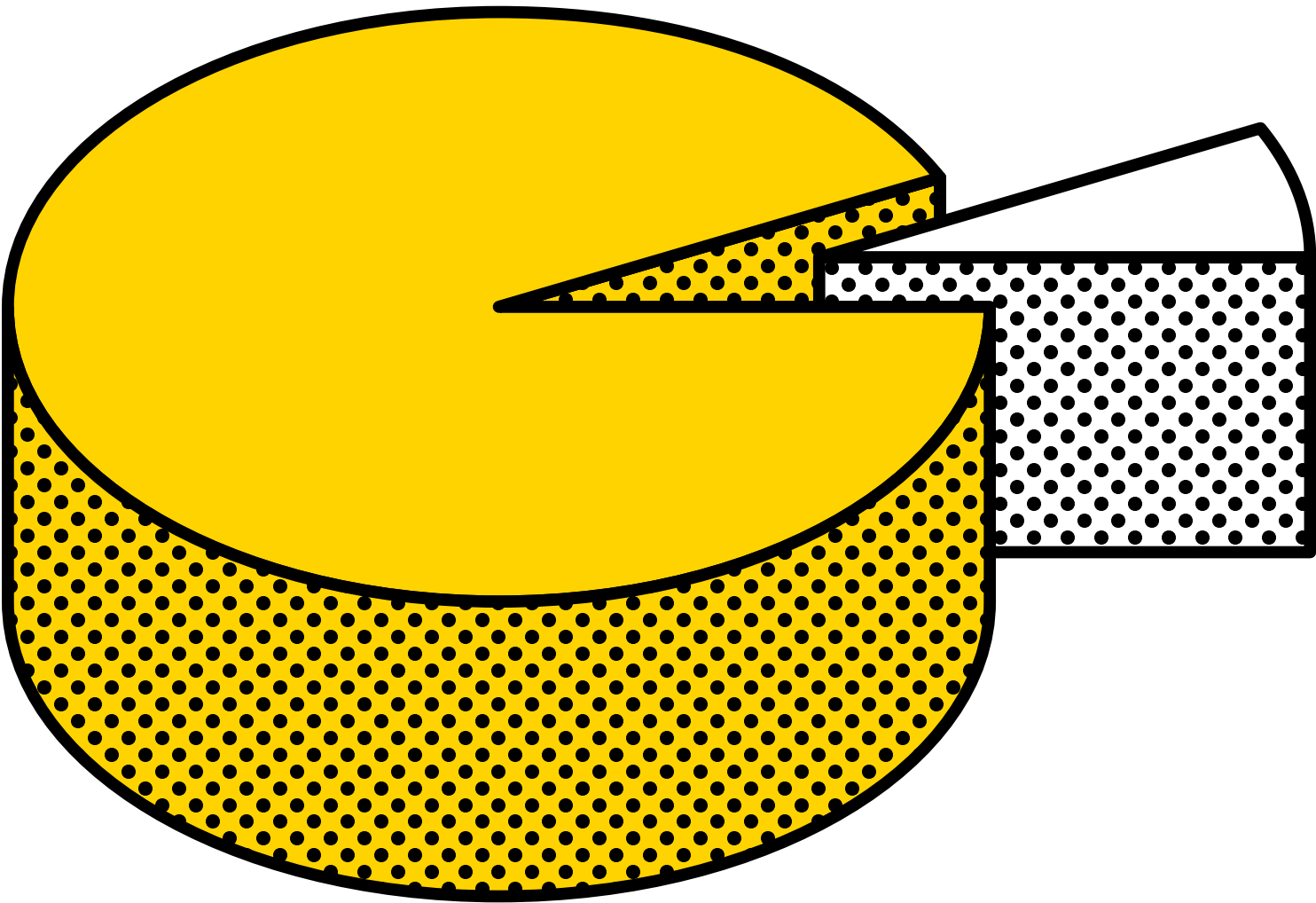
Urban GPs are more likely to refer to MBCT very or quite often than are rural GPs (35%, compared with 20%). They are also more likely to consider themselves well-informed about MBCT (41% compared with 26%), to think it would be useful to have access to courses (68%, compared with 56% in rural areas and 49% in suburban areas) and to support a public information campaign to promote the potential health benefits of Mindfulness meditation (71%, compared with 58% of rural GPs).

Female GPs are more likely to think MBCT courses would be helpful for their patients at risk of depressive relapse (70%, compared with 53% of male GPs), those with mental health problems (85%, compared with 68%), and their patients in general (85%, compared with 63%). They are also more likely to suggest to their patients that learning to meditate might be helpful (47%, compared with 34% of male GPs) and to support a public information campaign to promote the potential health benefits of Mindfulness meditation (78%, compared with 62% of male GPs).

93% OF GPs AGREE THAT IT WOULD BE VALUABLE TO HAVE MORE EFFECTIVE TREATMENTS FOR PATIENTS WITH RECURRENT DEPRESSION

THE GENERAL PUBLIC SURVEY

We commissioned Opinium Research to carry out a poll of 2,007 British adults over the period 16—19 June 2009 to explore their attitudes towards and practice of meditation, and their thoughts and feelings about the pace of life in UK society. For this survey we decided to use the term ‘meditation’ rather than ‘Mindfulness’, because we felt that the latter was unlikely to be recognised by many people who did not have experience or knowledge of either meditative practices or psychological interventions.



Overall, we found the following

- 26% — of British adults say they practise meditation, although just under half (12%) of these do so rarely
- 81% — of people agree that ‘the fast pace of life and the number of things we have to do and worry about these days is a major cause of stress, unhappiness and illness in UK society’
- 86% — of people agree that ‘people would be much happier and healthier if they knew how to slow down and live in the moment’
- 53% — of people agree that ‘I find it difficult to relax or switch off, and can’t stop myself thinking about things I have to do or nagging worries’
- 51% — of people would be interested in attending free meditation classes to help them deal with stress and help them look after their health

According to our survey, a quarter of us say we practise meditation, although nearly half of these (12%) do so rarely. It also shows that more than half of us never practise meditation, and 21% say we don’t know how to.

It is worth noting that people may have very different ideas about what meditation is, so we do not know exactly what they are doing when they say they meditate.

The vast majority of people in our survey agree that we live in a society where the speed of life and an overload of activity creates stress, illness and unhappiness, and that slowing down and appreciating the present moment would help people become happier and healthier. Only 9% disagree and 10% don’t know. More than half say they find it difficult to relax, with only a quarter disagreeing. This suggests that the benefits of promoting Mindfulness practices may well reach beyond people who are in contact with health services, and Mindfulness approaches may be able to help the wider population cope with the pressures of modern life.

About half of the people surveyed would be interested in attending free meditation classes. This suggests there might be strong uptake of Mindfulness courses were they to be made more available. Interest might grow if more was known about these approaches.

Variations in gender, age and location

Among the general public, women are more likely to practise meditation than men (29%, compared with 23%). They are also more likely to be interested in attending free meditation classes (59%, compared with 44% of men).

People living in the East Midlands (34%) are most likely to practise meditation, followed by Londoners (31%). Those living in Yorkshire and Humberside are much less likely to practise meditation (16%), and are also among the most likely to find it difficult to relax (61%), along with those living in the Midlands (West Midlands 61%, East Midlands 59%).

People living in Northern Ireland are least likely to find it difficult to relax (45%), followed by Londoners (46%). Young people aged 18–34 (60%) are more likely to find it difficult to relax than older people aged 55 or over (43%).

However, young people are less likely to agree that people would be healthier and happier if they knew how to slow down and live in the moment (77%, compared with 91% of people aged over 55).

MIND
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ARGUMENTS
FOR
PROMOTION

06.

APPLICATION POTENTIAL

52—53

The benefits of Mindfulness can be experienced by a very wide mix of people, in an equally wide range of contexts. They include people being treated for cancer and looking for ways to manage pain and anxiety, schoolchildren needing to develop their attention skills, people with depression seeking to break the cycle of negative thinking, and people who want to feel less stressed in their jobs and to work more productively.

In this section we suggest a number of reasons for developing the use of Mindfulness courses, and Mindfulness more generally.

Mindfulness courses have especially strong potential for people with chronic or hard-to-treat conditions. While modern medicine has been extremely effective at treating acute illness, it has been less successful at dealing with mental health problems, illnesses that are ‘medically unexplained’ or strongly stress-related (e.g. irritable bowel syndrome or psoriasis), and chronic physical diseases.

These illnesses put great strain on the health system: around 30% of GP consultations relate to a mental health problem,⁸⁴ and around 20% relate to chronic pain.⁸⁷ These conditions create unresolved suffering for many people — depression, for example, is predicted to create the world’s second greatest burden of disability by 2020 — as well as exacting a huge toll on our social and economic resources (not just health and social care costs, but costs of lost productivity, welfare payments, and other wider social issues).

The cost to UK society of mental health problems has been estimated at £98 million a year, greater than that of crime.⁸⁷ Mindfulness may not cure these conditions, but it offers a way of managing them that reduces suffering. Many hard-to-treat conditions occur together — people with mental health problems often have several overlapping issues (people with depression are 19 times more likely to be diagnosed with panic disorder,³ for example), and are likely also to have physical health-care needs. Similarly, people with physical health problems often experience poor mental health.

As a mind-body intervention, Mindfulness is especially suited to dealing with such co-morbidity. As Grossman and colleagues put it in their 2004 review of Mindfulness based approaches: ‘A single, relatively brief and cost-effective programme that can potentially be applied to a wide range of chronic illnesses and is able to effect a positive shift in fundamental perspectives toward health and disease should be of great interest.’¹⁷

‘IT’S VERY TRANSPORTABLE. PEOPLE CAN DO IT IN THEIR CARS, AND TURN ORDINARY, DULL MOMENTS LIKE STANDING IN A SUPERMARKET QUEUE INTO A MINDFULNESS EXERCISE, INSTEAD OF GETTING ANGRY WITH THE PERSON IN FRONT OF YOU BECAUSE THEY’RE NOT MOVING FAST ENOUGH. PEOPLE USE THE THREE MINUTE ‘BREATHING SPACE’ EXERCISE FOR YEARS AFTER THE COURSE.’

Professor Mark Williams
Director of the Oxford Mindfulness Centre
Oxford University

EMPOWERMENT

Mindfulness courses are not ‘done to’ people; they teach people skills that they can develop and continue to practise over a lifetime as a way of managing their own health, rather than being dependent on medicine. This may help the patient feel they are more in charge of their condition, conferring a sense of mastery as well as active engagement with recovery. In a follow-up of former MBSR participants, Jon Kabat-Zinn reported that 86% of participants ‘got something of lasting value’ out of the course, with the most commonly reported changes including ‘a new outlook on life’.¹³ Sometimes it is this ‘reframing’ — the change in our perception of or response to symptoms, rather than a change in symptoms themselves — that alleviates a chronic health problem.

Mindfulness is a popular approach. Despite making significant demands on participants, courses enjoy high completion rates (an average of around 85%) and compliance with homework requirements (57% of participants practise nearly every day, according to one study).¹³ Another study found that 75% of participants were still meditating between six and 48 months after the course.¹³

By comparison, only a third of patients taking maintenance antidepressants are satisfied with the quality of their treatment,³ and almost half of people prescribed antidepressants have stopped taking them after three months.³ With Mindfulness courses, maintenance treatment or therapy may not have to be prescribed — after the initial intervention, patients can continue to practise by themselves the skills they have learned (although follow-up refresher courses are available and may be helpful).

Mindfulness is a simple skill to learn and, because it requires the use of the mind, can be practised at any time and place. A recent investigation of MBSR delivered to residents in a therapeutic community reported that residents liked its ‘utility, portability and sustainability’.⁸⁸

There is increasing recognition that effective health care requires engaging patients in looking after their own well-being. Much, if not all, illness is influenced by stress, mental attitude, and behaviour choices. If we are to lighten the load on overstretched health services ill-equipped to deal with chronic, stress-related conditions, we need new approaches that can help people manage their well-being. Increasingly, the focus in health care generally, and mental health care especially, is on strategies that can prevent illness occurring or re-occurring and promote health and well-being.

Mindfulness courses are entirely in tune with this approach. While they can help people deal with illness, they are by nature a health promotion (and illness prevention) tool. They encourage people to be psychological masters of their own mind and body states, however well or ill they are.

Mindfulness interventions are founded on practices that have survived for thousands of years, presumably because people find them helpful. Some people are strongly attracted to Mindfulness precisely because it appears to offer an ‘alternative’ approach to healing. Holistic, person-centred, ‘heart-felt’ treatments help them feel respected, listened to and cared for in a way that is not always the case in standard medical care.

A bonus of Mindfulness courses is that they can be presented and experienced in many different ways, depending on the worldview of the participant. Some people may prefer to regard the practices as techniques that sharpen and calm their minds; others may see Mindfulness as enabling them to reach a level of awareness and meaning that might be thought of as spiritual.

‘THERE’S A MUCH GREATER ACCEPTANCE [AMONG PARTICIPANTS] THAN I WOULD HAVE PREDICTED. [WHEN I FIRST CAME ACROSS IT] I DIDN’T WANT TO GO THERE, IT FELT TOO RELIGIOUS AND WIFFLY WAFFLY. BUT THEN I REALISED THE BENEFITS FOR MYSELF, AND ALSO THE SCIENCE IS PRETTY INCONTROVERTIBLE. SOME PEOPLE LIKE THE MEDITATIVE ASPECT, BUT I THINK THEY ALSO LIKE THE SENSE OF WARM WELCOMING ATTITUDE THAT THE HEALTH SERVICE IS PROVIDING – SOMETHING WHERE THEY ARE TREATED MORE LIKE GUESTS THAN PATIENTS.’

Professor Mark Williams
Director of the Oxford Mindfulness Centre
Oxford University

Dr Shanida Nataraja
Author of The Blissful Brain:
Neuroscience and Proof of The Power of Meditation

COST EFFECTIVENESS

54—55

Mindfulness has potential cost advantages over many existing treatments, especially for mental health problems. Unlike most psychological therapies, interventions are delivered to groups rather than one-to-one, and thus require less therapist time per patient. Unlike much medication, which may require continued prescription, Mindfulness courses are time-limited: once the techniques have been taught, they can continue to be practised without further input from a therapist (although follow-up booster sessions may be useful).

The first analysis of MBCT’s cost-effectiveness compared with maintenance antidepressant treatment was published last year. It found that MBCT was as cost-effective as maintenance antidepressant prescription over the 15-month period during and after delivery of the course, but that MBCT became more cost-effective over the final three months. The authors point out: ‘If this trend were to continue, the relative cost-effectiveness of MBCT may increase over time.’³⁵

The group format may also have a salutary effect, especially among patients with conditions that leave them feeling isolated. As Willem Kuyken, Professor of Clinical Psychology at The Mood Disorders Centre, Exeter University, points out: ‘We know that people find being in a group helpful. They find it reassuring to meet people with similar problems and helpful to be able to compare themselves with others. The social processes that happen in groups are part of the treatment.’

‘LORD LAYARD’S JUSTIFICATION FOR THE IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES PROGRAMME WAS THAT, EVEN WITH A 50% RESPONSE RATE, IT PAYS OFF FOR THE DEPARTMENT OF WORK AND PENSIONS. THAT’S BECAUSE THOSE PEOPLE WILL WORK FOR ONE OR TWO MORE MONTHS MORE, SO THE COST OF THE THERAPY IS MORE THAN COVERED BY ITS ECONOMIC BENEFITS.

SO IF YOU THEN COMPARE THE COST OF MBCT WITH THE BENEFITS OF HALVING THE RATE OF RELAPSE OVER 12 MONTHS, THAT COULD BE ENORMOUSLY IMPORTANT FOR AN ECONOMY WHERE DEPRESSION IS ONE OF THE BIGGEST CAUSES OF SICK LEAVE.’

Professor Mark Williams
Director of the Oxford Mindfulness Centre
Oxford University

A WIDER SOCIAL NEED

‘WE HAVE A CULTURAL MODEL BASED ON INDIVIDUALISM AND GREED, AND WHILE TECHNOLOGICAL ADVANCES HAVE IMPROVED PEOPLE’S WELL-BEING IN MANY WAYS, THIS MODEL OF OPEN-ENDED ECONOMIC GROWTH IS NOT REALLY SUSTAINABLE FOR THE PLANET. MINDFULNESS CAN OFFER A WAY NOT TO GET CAUGHT UP IN THE CONDITIONING THAT COMES FROM OUR CULTURE, AND PERHAPS ALSO [A WAY TO] LEAD A HAPPIER, MORE CONTENTED LIFE – NOT BEING CAUGHT UP IN COMPARING OURSELVES WITH OTHERS AND WANTING THE LATEST GIZMO. IN MBCT YOU LEARN TO JUST PAY ATTENTION TO SIMPLE EXPERIENCE, AND THAT CAN BE QUITE PLEASURABLE. IT CAN OFFER A GREAT SENSE OF SATISFACTION AND HAPPINESS. IF WE ALL DID IT, IT MIGHT HAVE A BIG IMPACT IN TERMS OF NATIONAL WELL-BEING AND HAPPINESS.’

Dr Paramabandhu Groves
Consultant Psychiatrist
Camden and Islington Mental Health and Social Care Trust
and Clinical Lead, Breathing Space

We live in an age of stress. A recent survey by the Mental Health Foundation found that 77% of people believe the world has become a more frightening place in the last decade, and that there has been a rise in anxiety-related mental health problems — the numbers of people with an anxiety disorder rose by 800,00 between 1993 and 2007.⁸⁶ Depression, anxiety and stress are the cause of 13 million lost working days per year in the UK,⁴⁵ and one in six of us has a mental health problem at any one time.⁸⁴ Some commentators also point to a rise in incidence of depression and average earlier onset over recent decades.^{89 90}

There are many reasons for this. There has been rapid technological, social and economic change for which we are not biologically well-adapted. Our brains can struggle to cope with the vast range of information available to us and the unfamiliar nature of the threats we face, from job and financial insecurity to fear of crime. This can create difficult emotions with which we may attempt to deal by using maladaptive quick fixes such as drinking, smoking, overeating, workaholism or compulsive shopping. These can contribute to further stress and ill-health, fuelling a vicious cycle.

At the same time, social bonds have fragmented, and many of us are left to deal with overwhelming pressures without the family and community support on which previous generations may have counted.⁸⁶ The importance of social capital was highlighted in the government’s recent Foresight report,⁹¹ which suggested a five-a-day prescription for mental health and well-being (Connect, Be Active, Take Notice, Keep Learning, Give⁹²). As the evidence cited in our report suggests, much of this ‘five-a-day’ prescription could be achieved through the use of Mindfulness skills. Indeed, one of the five recommendations (‘take notice’) is derived from the research on Mindfulness.

Our culture focuses on the acquisition of material wealth, but this does not increase happiness after we reach a certain level of income.⁹³ It is interesting to note that speed, wealth acquisition and consumption of information are all manifestations of the ‘doing’ mode in which many of us tend to operate by default.

The effects of this speed and social fragmentation appear to be recognised by the general public, who cite ‘a loss of solidarity and community’ and ‘an increase in the availability of information’ as prime reasons why the world has come to seem more frightening.⁸⁶

Many people are actively engaged in trying to counter this trend. In the last few years we have seen the emergence of a ‘slow’ movement that promotes a more mindful approach to activities such as eating, travel and urban living. In spring 2009 a 10-day festival, Slow Down London, was held in the UK capital to try to get residents to take a more measured approach to life. Its slogan was ‘Live Life in Real Time’, which encapsulates precisely the philosophy of Mindfulness.

Of course, many people already practise disciplines such as meditation and yoga as part of their own self-directed stress reduction programmes that they have developed through personal experience of what works for them. The promotion of Mindfulness would simply be an evidence-based expansion of what these people have discovered for themselves — practices that foster the development of attention skills are especially suited to an age of speed, distraction and information overload.

A frequently heard cry among time-pressured early 21st century UK citizens is for some ‘headspace’. Many of us are required to multi-task, at speed, processing large amounts of information thrown at us from many different media. We live fast, complex, pressurised lives, making it ever more salient that we manage our minds as we try to deal with this onslaught. Mindfulness practices are an easy-to-learn, inexpensive, portable and sustainable means to achieving that ‘headspace’. The move to Mindfulness is not only more conducive to mental health and well-being; it appears to tap into a widespread yearning for that way of life.

MIND
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FUTURE
DIRECTIONS

07.

CURRENT PROVISION OF MINDFULNESS COURSES

58—59

Anecdotal evidence suggests that access to Mindfulness training is most likely when a patient is referred to a service where a health professional has shown a particular interest in the approach, and has chosen to train in it as part of their continuing professional development. However, very few areas have structured, targeted access to courses so, from the patient’s point of view, access is likely to be as much a matter of chance as design.

Interest is growing. According to Paramabandhu Groves: ‘Mindfulness is not as mainstream as CBT, but it is something most people in psychology circles have heard about.’ Mark Williams says his own informal research suggests there is ‘something’ Mindfulness-related available in most areas of the UK, although ‘we are some way away from having a universal service, with more places like Oxford and Devon that have set up services through the NHS’.

Some people may receive Mindfulness training as part of attempts to take the approach beyond health-care settings, such as in schools, or as part of a workplace well-being programmes. However, this seems fairly unusual.

Otherwise, people will encounter Mindfulness training only if they seek it out themselves: by reading books or hearing about it in the media, from family, friends and colleagues, through the practice of similar disciplines such as yoga, through their religious or spiritual traditions, or by attending classes at a health centre or other venue that offers meditation instruction. Increasingly some Mindfulness teachers are offering MBSR and MBCT privately, or in local community centres.

‘IT IS UP TO THE STRATEGIC HEALTH AUTHORITIES AND PRIMARY CARE TRUSTS TO COMMISSION THE SERVICES THAT ARE RECOMMENDED BY NICE, BUT PROVISION OF MBCT AROUND THE COUNTRY IS SPARSE AND PATCHY.’

Professor Willem Kuyken
Professor of Clinical Psychology and Co-founder
Mood Disorders Centre, Exeter University

EXPANDING DELIVERY OF MINDFULNESS COURSES IN THE UK

Fulfilling NICE guideline recommendations
The first step is to meet the NICE guideline recommendations and expand provision of MBCT courses for patients at risk of relapse who have experienced more than two episodes of depression and who are currently in remission. If the results of the trials so far conducted were replicated, this would halve the incidence of depressive relapse among these patients over the following 12-month period, offering potentially significant economic, social and health benefits to them and to society.

The expansion of MBCT services could be usefully led through the existing Improving Access to Psychological Therapies (IAPT) programme, whose stated principal aim is ‘to support Primary Care Trusts in implementing NICE guidelines for people suffering from depression and anxiety disorders’.⁹⁴ While the IAPT programme was set up specifically to improve the current lack of access to treatment for this group — only a quarter of the six million people in the UK with depression and anxiety receive any kind of treatment — IAPT appears to be paying little attention to Mindfulness as an approach. A search of the IAPT website in September 2009 brought up no results for ‘Mindfulness’ or ‘MBCT’.⁹⁴

Increasing access to Mindfulness teacher training
One of the major requirements for making Mindfulness courses more available is to train more clinicians to teach them. This will require an increase in access to teacher training courses, as well as the identification and preparation of suitable course leaders. Mindfulness practices can only be transmitted by teachers who are experienced in the practices themselves — inexperienced teachers are liable to be ineffective (indeed, early US trials with such teachers were unsuccessful)⁹⁵. Therefore, potential candidates are usually only accepted for training if they have themselves undergone an eight-week MBCT or similar course as a participant and have maintained regular practice for at least a year.

So far, suitable teachers have been mostly self-selecting, having sought out training following personal experience of the benefits of Mindfulness practices. However, this may not produce enough teachers to meet potential demand. Developing more introductory courses for interested clinicians might be a way to discover if they want or are suitable to train further.

Promoting Mindfulness
While Mindfulness is becoming fairly well-known in psychology circles, it is not so well known generally. This report is a step in the process of raising awareness of Mindfulness-based approaches among health-care professionals and commissioners, policy-makers, business leaders, government, the media and the general public.

The next step would be to turn this awareness into action, in the form of education and training programmes, media and communications campaigns, and sharing of knowledge and best practice. Introductory courses in Mindfulness, led by qualified teachers, would allow people to experience the process for themselves.

Refining Mindfulness courses
Mindfulness-based approaches are being developed to suit a wide range of clinical and non-clinical populations. There has been an especially creative fusion with techniques from the cognitive behavioural tradition. Packaging Mindfulness skills with other therapeutic approaches — especially those tailor-made for specific clinical populations — is likely to make them more effective.

Existing Mindfulness-based approaches would benefit from further development. As Willem Kuyken says of MBCT: ‘Within depression we have an intervention that seems to prevent recurrent depression. But we still have nearly half the people relapsing over the course of a year. We can probably do a lot better.’

Mindfulness-based approaches might also be refined to apply both to other mental and physical health problems, and to the wider general public. Some people may not feel inspired to attend a ‘stress reduction’

or ‘Mindfulness for depression’ course. The next phase of development might involve finding ways to offer healthy populations the opportunity to undertake Mindfulness training, as a health promotion tool, rather than a treatment for illness.

Courses might be presented, for example, as a way to develop attention or performance. In the US, Mindfulness practices are sometimes used in this way by elite sportsmen and women. Mindfulness training might also have great value in schools, both to reduce educational stress levels for children and to teach them ways of managing their thoughts, emotions, and stressful life experiences at an early age.

Research
Scientific research into ‘meditation’ has been ongoing for half a century or more. However, building on the often positive results has sometimes been hampered by an inability to agree on what meditation actually is. One of the great advances of Mindfulness-based approaches has been to develop a clearly structured, replicable format that lends itself to high quality scientific investigation.

In the UK, bodies such as the Wellcome Trust and the Medical Research Council have already funded research into Mindfulness-based cognitive therapy. However, we need to understand more about how Mindfulness interventions work. Further neuroscientific research would enable us to examine what is happening — and perhaps changing — in the brains of people who attend Mindfulness courses. We need to know which elements of the courses produce beneficial effects, and we need to track course participants (and controls) over longer periods of time, to discover how consistently changes are maintained.

We need more trials of Mindfulness-based approaches with different populations, to discover if there are people for whom they are more or less helpful. This might lead to further targeting for optimal effectiveness. We also need to assess and research the most effective ways of teaching Mindfulness courses, and the best ways to train people to teach them.

In summary the Mental Health Foundation would like to recommend the following actions based on the known benefits that Mindfulness-based approaches can bring to a wide range of patients who experience recurrent depression and the current shortfall in awareness and capacity to deliver such approaches.

01 Implementation of NICE recommendation

The NICE guidance recommending Mindfulness-based Cognitive Therapy (MBCT) for people who are currently well but have experienced three or more previous episodes of depression should be implemented in full.

02 Service development

The expansion of MBCT training and services to meet the NICE recommendation should be driven by the Department of Health's Improving Access to Psychological Therapy (IAPT) programme.

Primary Care Trust commissioners should consider how they can best build the capacity of Mindfulness services within their localities, using trained staff from statutory, independent and voluntary sector providers. Mindfulness-based approaches create the potential for patient self-management, reducing the use of scarce health resources.

03 Training and professional development

Mindfulness-based approaches should be taught during the early training of all doctors and offered as part of their continuing professional development.

Few patients with recurrent depression who might benefit are currently being offered Mindfulness interventions. It is particularly important for GPs to increase their understanding of the potential benefits of MBCT for these patients, and to know what services are available locally.

Opportunities for professionals to develop Mindfulness-based skills are limited. There should be more opportunities for clinicians to train as Mindfulness teachers and practitioners themselves. This will require an increase in access to teacher training courses and more introductory courses for interested clinicians.

04 Research

Research on Mindfulness-based approaches should be prioritised within the government's mental health research and development strategy, and by other mental health research bodies, with an aim to:

- Understand better how specific Mindfulness-based approaches (such as MBCT) can be targeted even more effectively to existing patients with mental or physical health problems;
- Expand the evidence base for how such Mindfulness-based approaches can benefit different populations, such as adults who may be under stress at work or children who may lack attention skills at school; and
- Understand better the neuroscience of how Mindfulness approaches actually work on the brain.

IT IS ON THE BASIS OF THE CLINICAL RESEARCH THAT THE NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (NICE) RECOMMENDS MINDFULNESS AS A TREATMENT FOR RECURRENT DEPRESSION

Carla Linley, 40, attended a Mindfulness-based relapse prevention course at while in daycare rehabilitation from alcohol addiction.

I had been in a difficult relationship for 20 years and basically lost myself in alcohol. I self-medicated to deal with emotions, in a sense trying to kill myself by drinking heavily. I went into detox in January 2007.

About six months into treatment I was really struggling with stress and cravings, and especially my negative thinking processes. We were invited for an open day at the Breathing Space programme and I went along with my key worker. I really liked it so had a chat with one of the people there, and he recommended the Mindfulness for addiction course. He said it might help me deal with my thoughts, and some of my overwhelming feelings.

My mum used to practise meditation when I was younger. She was a single parent and said that it was very good for stress. I don't deal well with stress — I suffered panic attacks quite frequently and was signed off sick seven years ago for a stress-related illness.

Initially, I found the course quite hard because of my anxiety about being around people I didn't know. But we all had something in common so that made me feel safe. I soon found it incredibly relaxing and helpful. I couldn't believe it — something in me changed very dramatically and I was able to focus on things more. I became a lot more confident, more comfortable in my skin. I started to accept myself.

The meditation helps with allowing things to pass rather than thinking about them too much. It's helpful because my mind was constantly working — I couldn't shut it off, which is typical of people suffering an addiction. I used to have problems sleeping but now I'm able to go to sleep quite easily. It also helps with being able to sit with cravings. You can stay with that feeling rather than avoiding it. Ultimately the craving moves into another feeling.

I use the practices if my mind starts to race, or analyse and think too much. I can bring myself into the moment and focus on what I'm doing. When I have a panicky feeling I can calm myself down and relax with the breathing, bringing myself back into my body, or asking how the ground feels under my feet or what emotion I'm having, rather than my mind wandering off in a negative way. I use it when I'm brushing my teeth, having a shower, or on the tube, and you can also do it when you're walking or eating. We also learned some Tai Chi type movements and I find it useful to put those together with the Mindfulness and awareness practices. I use it with the CBT we learned — there were specific tasks on how to challenge thoughts and that helps deal with my negative talk processes, which can stimulate panic attacks.

It was all part of getting me back on track. I almost think if I hadn't done it I'd be drinking again. It has helped me focus on what I want, and I can be comfortable and real with myself. It feels like something special that is a part of me. I think I will be able to continue with it for as long as I remember.

I'm now attending after-care and studying counselling skills, and I'm going to do an NVQ in health and social care for alcohol and drug addiction. Whenever I come across somebody who's really struggling with anxiety, thinking processes and craving, I recommend Mindfulness to them.

MIND
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GOOD
PRACTICE
MODELS

08.

The Oxford Mindfulness Centre

The Oxford Mindfulness Centre was set up in 2007, supported by a charity (the Society for the Wider Understanding of the Buddhist Tradition, whose patron is the Dalai Lama) and led by Professor Mark Williams, one of the pioneers of Mindfulness-based Cognitive Therapy (MBCT).

Its mission is ‘to realise the potential of Mindfulness-based approaches in mental and physical health and to promote the well-being of people in their world of work, home and family life’. It conducts research, trains therapists and offers classes to NHS patients in the Oxford area. It runs around half a dozen MBCT courses a year for patients with a range of conditions, including depression, anxiety and chronic fatigue. It is based in the Department of Psychiatry at Oxford University and works closely with the Oxford and Buckinghamshire Mental Healthcare NHS Trust and the mental health charity SANE.

GP referral capacity has been quite limited; the centre aims to facilitate its expansion. An obstacle has been the small number of health professionals trained to deliver courses, so the centre has developed teacher training pathways, ranging from a one-day introduction to Mindfulness through to a two-year Master of Studies programme.

Research in progress includes a ‘dismantling trial’, funded by the Wellcome Trust, in which MBCT is compared with an active placebo treatment (an instruction based MBCT course that does not teach any Mindfulness practices). This aims to discover to what extent the meditation practice component is an active ingredient in the courses. The recently published results of a small randomised controlled trial showing that MBCT can be effective for currently depressed people.⁴⁰ Staff at the centre have produced work on Mindfulness for patients with chronic fatigue syndrome,³² and are developing projects to test its effectiveness with eating disorders and health anxiety. With the help of nurse-midwife Nancy Bardacke, they are also looking at the potential for Mindfulness to help pregnant women and their partners cope with childbirth and parenting.

The centre is carrying out neuroscientific research using EEG to look at the relationship between Mindfulness practices and pre-frontal brain asymmetry, as a measure of ‘approach’ versus ‘avoidant’ styles of relating. These different styles, and the brain activity related to them, have been associated respectively with positive and negative mood states.

Williams is keen to develop projects that take Mindfulness courses into new arenas. The centre has developed a Mindfulness for schools programme, drawing on existing work with children and adolescents in the US and Australia. It has developed a syllabus that is being piloted in a dozen schools around Oxford as part of the SEAL (social and emotional aspects of learning) curriculum. Interested teachers are given several days’ training and ongoing supervision. Williams says that pupils are ‘surprisingly open’ to Mindfulness instruction. ‘As soon as they try to meditate they realise it’s hard, so it’s a challenge. With a good teacher they can become quite curious as to why it’s so difficult to keep your mind focused.’

Williams also advocates making ‘small changes to large populations’. ‘If you just target high-risk groups, you’ll catch some people, but if everyone in the population lost half a kilo, you’d prevent more heart attacks than by targeting high-risk groups.’ He suggests pregnancy classes as a good opportunity for Mindfulness training, because ‘when you’re about to have a baby it’s the one time you will accept class-based education without feeling pathologised. You turn up because you’re scared! You want to get information and do the best by your child. Based on current evidence of how Mindfulness works in other contexts, we believe it will not only help women cope with fear and pain but also prevent post-partum depression and promote good attachments for both parents. This is an extraordinary prospect.’¹⁵

The Mood Disorders Centre
Exeter University

The Mood Disorders Centre is a partnership between the NHS and Exeter University. It supports ‘the development and evaluation of novel, innovative, non-traditional, and more widely available treatments ... accessible to the large numbers of people who suffer depression [and] do not respond to standard treatments.’⁹⁶

The centre uses a range of cognitive behavioural methods, including individual and group CBT, MBCT, and Mindfulness based parent training (a new MBCT-based course aimed at helping people with a history of depression to develop parenting skills). Patients are referred through their GP or through the local well-being and access service.

Research includes studies of MBCT to prevent relapse in patients with recurrent depression and DBT for depression with personality disorder. Led by Professor Willem Kuyken, the centre recently carried out a randomised-controlled trial of MBCT, evaluating its efficacy and cost effectiveness in comparison with maintenance antidepressant prescription. The research was funded by the Medical Research Council and published at the end of 2008.³⁶ According to Kuyken, the results ‘suggest that MBCT is as effective as maintenance antidepressants at keeping people well and it is certainly not more expensive’. Kuyken now plans to conduct a larger trial with around 420 patients and follow-up over a longer (two-year) period to see if the findings are confirmed.

The centre runs a part-time postgraduate training in MBCT for therapists who want to teach the approach. The first course began in 2008, with 13 students enrolled.

The centre’s activities are supported by the Devon Primary Care Trust, which is working to expand the use of MBCT across the county. ‘The cost-effectiveness point that we made in the 2008 paper is already coming through,’ says Kuyken. ‘Once you’ve got a set of groups running you can see an awful lot of people, many more than with individual therapy.’

Ian Pearson is joint commissioning manager for adult mental health for the Devon Primary Care Trust and Devon County Council. Here he talks about Mindfulness services from a commissioning perspective.

I’ve got good confidence that MBCT is effective and that I need to roll it out across the county — at the moment it is available in parts of Devon. The feedback I’ve had from people using the service is positive. I also think it has resonated with GPs who have referred patients with long histories [of depression] and seen a difference.

As a commissioner I try to take a values based approach. The values are about people having an expertise in their own mental health, being able to direct their recovery, and earlier intervention producing better outcomes and being a better use of the public purse. Doing things once with people is better than them accessing different services in a scatter-gun approach.

Moving Mindfulness upstream so people can access it earlier in the lifespan is also part of our agenda — early intervention for children so they don’t become tomorrow’s patients and prisoners. Not only are depression rates going up but the average age of onset has moved from about 40 years to people in their teens. On that basis, we need to get in earlier.

Breathing Space London

Based in Bethnal Green, the Breathing Space programme is run by the London Buddhist Centre. It uses Mindfulness-based approaches to help people look after their mental health, especially MBCT and MBRP (Mindfulness-based Relapse Prevention) for preventing depression and addiction, and MBSR to help carers manage stress and anxiety. It runs follow-up courses based on Acceptance and Commitment Therapy, as well as countryside retreats for carers, 'to give them a break and enable them to learn relaxation tools'.

The centre has a 10-strong teaching team, supervised by Dr Paramabandhu Groves, an NHS consultant psychiatrist specialising in addiction. The programme takes a secular approach to Mindfulness — it has recently created a dedicated space for the courses using loans and grants from Futurebuilders and the City Bridge Trust.

Breathing Space accepts referrals from health professionals and from participants directly. London Borough of Tower Hamlets pays for a number of free places for people on a low wage, and the programme has contracts with Tower Hamlets, Hackney, Waltham Forest and Newham to provide Mindfulness-based services to carers. It works with local stakeholders, including NHS and voluntary sector mental health and addiction services, black and Asian groups, carer service providers, disability organisations and housing and community associations. Costs for its courses are kept low.

Dr Groves says the courses appeal to a wide range of people, often for different reasons. 'Some like the fact that they're learning a set of skills — they want an approach where it's them doing the work. Some also like taking a more spiritual approach to their problems it makes it a bit more attractive and different from cognitive behavioural therapy. But of course, you don't have to be spiritual or have those inclinations to find it useful. Some people are pleased that we don't use Buddhist terminology — we 'stick to realities' as one person put it.'

Dr Groves sees Mindfulness as 'a basic life skill' that could have a wide application. Breathing Space staff are now considering how to expand the programme's activities further — possibilities include developing courses to work with people with eating disorders, offenders, and young people. Further collaborations with other organisations are also planned.

The Centre for Mindfulness Research and Practice, Bangor University

The Centre for Mindfulness Research and Practice, founded in 2001, is based in Bangor University School of Psychology. With 13 full and part-time staff and 11 freelance Mindfulness teachers, the centre is the UK's biggest training organisation for Mindfulness teachers. It offers courses ranging from introductory and continuing professional development training to flexible part-time Masters programmes.

There are currently 90 Masters students, and around 60 people a year enrol on the centre's week-long level 1 teacher training retreats. There are also courses for the growing number of psychological therapists who want to include a Mindfulness element in, or adopt a mindful approach to, their one-to-one work with clients.

Judith Soulsby has worked at the centre since its inception, and now heads up the Masters programmes. She says that training not only empowers clinicians to teach Mindfulness to their clients, but also helps 'those who work in difficult settings to ground themselves and deal with their own distress levels'.

She says that most people who register for the courses do so on their own initiative (although some are funded by their health trusts or employers), often because they have had personal experience of Mindfulness practices and want to share them with clients. They include clinical and other psychologists, psychotherapists and counsellors, GPs and psychiatrists, occupational therapists, nurses, hospice workers, health visitors, social workers, and many other professions.

The centre offers Mindfulness courses to the public, including people with depression and anxiety, chronic pain, cancer, and chronic fatigue syndrome, as well as new mothers from deprived areas. The centre is self-funding, and so has to charge for these courses. Soulsby suggests that greater availability through the NHS would enable them to meet demand. 'A lot of people are desperate to do a course but can't afford to pay.'

The centre is working with the Oxford Mindfulness Centre on the Wellcome Trust 'dismantling' research. Another research and teaching specialty offered through the local health trust is Mindfulness for people with cancer, who often face considerable mental health challenges as a result of their diagnosis.

As part of new developments for Bangor, Mindfulness is being built into the doctoral training curriculum for clinical psychologists in North Wales. The centre, as part of the School of Psychology, is also involved in strategic working groups with the new North Wales regional NHS organisation, focusing broadly on psychological therapies including elements of Mindfulness.

MINDFULNESS SCOTLAND

Mindfulness training is enjoying a relatively strong presence in Scotland. This is partly due to the Scottish Government responding to the NICE guidelines recommending MBCT. It has provided ongoing funding to train mental health professionals (clinical psychologists, mental health nurses, occupational therapists) to deliver MBCT courses in psychological therapy services.

More than 200 people have been trained through this initiative. However, according to Stewart Mercer, Professor of Primary Care at Glasgow University, the delivery is 'patchwork'. 'It's certainly not the case that every GP can refer patients to MBCT,' he says. 'But in some places they can refer people to mental health services where staff have enough experience to run an MBCT course.'

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A charity, Mindfulness Scotland, is being set up by local businessman (and Mindfulness trainer) Martin Stepek. It aims to give strategic direction to the various strands of Mindfulness work being carried out. 'I had run sessions in prisons, schools and charities, as well as in the public and private sector,' says Stepek. 'I thought it was a pity that something with such a strong evidence base wasn't generally promulgated. The research suggested that it could help with some of the social issues we face in Scotland.' Stepek has recruited GPs, psychiatrists, psychologists, academics and voluntary sector leaders to act as trustees, as well as 14 trainers and an administration and management team.

Mindfulness Scotland will act as an umbrella group to share knowledge and expertise and deliver courses to organisations and individuals, train teachers, help raise awareness through the media and in government, and initiate and encourage Scottish-based research. Already in the pipeline is a qualitative study to test the delivery of distance-learning courses to people in Scotland's many remote areas.

It hopes to help grow Mindfulness courses in the NHS, but also to promote them in a range of other contexts: workplace well-being programmes, for example. Several voluntary sector organisations in Scotland (e.g. Breakthrough Breast Cancer) are interested in exploring how Mindfulness-based approaches might help particular groups in the community.

Stepek hopes that, by promoting Mindfulness at grassroots level, they can reach more people. 'If I teach 20 people to offer Mindfulness training to their colleagues, then you can get exponential growth very quickly. There will be people in the workplace who are qualified to teach — a bit like with first aid.'

‘THE COURSE HAS BEEN
FANTASTIC AND HAS
PROBABLY SAVED MY
LIFE! NO EXAGGERATION!’

The Health and Safety Executive has reported that one in five employees report feeling very or extremely stressed at work (equivalent to five million people in the UK). Across the UK, stress, depression and anxiety are the cause of 13 million lost working days each year.^{97 98 99} Stress is now the most common reason for long-term sickness absence, with — since the mid 1990s — a doubling of the numbers who say their stress was caused or made worse by work.¹⁰⁰ The cost to society has been estimated at £3.7 billion a year.⁹⁹

Most employers are well aware of the cost of stress-related absences, and some have put in place stress-management programmes to help their workers. Mindfulness may have much to offer as a workplace strategy for reducing stress, and some employers are already beginning to realise the benefits.

A internal review conducted by Transport for London (TfL) in 2003 found that mental health was one of the top two health issues affecting company employees (along with muscular-skeletal problems). As part of a strategy to help staff deal more effectively with stress, TfL offers a six-week group stress reduction workshop, open to any of its 20,000 employees who meet the referral criteria.

The course teaches Mindfulness techniques alongside more traditional psycho-education and cognitive behavioural therapy. ‘The workshops marked a real change in direction because they are aimed at teaching people life skills rather than purely being a quick fix,’ says Alison Dunn, TfL’s head of treatment services. ‘We have also been able to reach people who wouldn’t want to come to counselling — this has more of a training feel to it.’

The course has paid dividends: among employees who have attended the course, the number of days off for stress, anxiety and depression have fallen by 71% over the following three years. Absences for all conditions dropped by 50% over that time. Dunn says there are also qualitative improvements, with 80% of participants reporting improvements in their relationships, 79% improvements in their ability to relax, 64% improvements in sleep patterns and 53% improvements in happiness at work.

‘Participants learn that they have some control over their responses even if they can’t control the events themselves — what a customer says to them, for example,’ says Emerald-Jane Turner, who developed the course. ‘They start to realise that their thinking processes have an impact and that they can become more resilient. People take it home with them. They’ll says things like: ‘When I’m on the phone with my ex-wife I can step back instead of having a go at them.’ It’s not that we’re telling them to be more mindful — they just seem to become more mindful as a result of doing the practices. The breakthroughs people have are sometimes quite extraordinary.’

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CASE STUDY
DEBBIE

Debbie May, 42, a TfL physiotherapist, had encephalitis three years ago. She now has to take special care of her stress levels. She suffered a seizure while travelling home from work last October, and was referred to the workshop.

‘I was getting wound up, and the seizure may have been my brain telling me to calm down and not overdo things.’ The course helped her to ‘switch off and unwind’, and developed her confidence. ‘I learned to slow down and take things as they come,’ she says. ‘There was quite an interesting session where the leader handed out satsumas and we had to take the time to peel them and taste them slowly. Normally everything is just rush, rush, rush. I look back at that sometimes and think: ‘I’m not going to rush my food’.’ She also continues to use the stretching and ‘body scan’ practices.

Mindfulness may have a particular role in the workplace at executive level, not only in terms of stress management (three-quarters of executives say that stress affects their health, happiness and home life, as well as their work performance⁹⁷) but also to promote ‘mindful leadership’. Research by business school INSEAD found that meditation-based coaching programmes increase the likelihood of managers behaving in a socially responsible way.¹⁰¹

Executive coach Michael Chaskalson has led ‘mindful leadership’ training in the Cabinet Office and Home Office, as well as at KPMG, PricewaterhouseCoopers, the Prudential and the London Business School. He trains and coaches NHS managers and clinicians, and is an honorary research fellow at Bangor University, where he teaches at the Centre for Mindfulness Research and Practice. He says the benefits of Mindfulness at work include ‘greater awareness of ourselves, others and the world around us, a greater capacity to manage stress and a greater capacity to manage attention’.

According to Christopher Smith of the Bath Consultancy Group, working with Chaskalson has ‘increased my ability to focus in my work, so that I tackle things more effectively’. He also says he is ‘better able to quickly re-charge my energy in the midst of a challenging schedule, so I stay at my best and am less weary at the end of the day’. According to another client, Joy McKeith of Triangle Consulting, Mindfulness training gave her ‘new ways of seeing things — the practices have helped me to develop skills and strategies for responding to stress’.¹⁰²

Chaskalson points out that being mindful at work, or being a ‘mindful leader’, does not mean going slow, being less productive or losing competitive edge. Indeed, attention training can help people be sharper and more effective. ‘Lewis Hamilton and Roger Federer are mindful,’ he says. ‘They are fast and competitive and mindful. And by developing greater awareness, you can develop better relations with your colleagues and be more able to renew yourself from stress and develop your attention. You can’t have too much Mindfulness. Whatever the problem is, if you’re better able to work with the content of your mind then things will go better for you.’

In this report, we have tried to lay the groundwork for further developing the use of Mindfulness-based approaches in the NHS and beyond. We have explored the benefits that Mindfulness can bring to people’s lives, and the potential for cultivating Mindfulness through short, structured, cost-effective, well-established and acceptable therapeutic interventions. We have surveyed current practice and opinion among stakeholders and found widespread receptiveness to Mindfulness-based ideas and approaches.

There is scope for expanding the careful and steady development work that is already taking place. However, this would mean funding more research to develop and consolidate the evidence base, continuing to develop and refine the approaches for best effectiveness, building the capacity to deliver the approaches, and promoting greater understanding of how Mindfulness training and practice might be helpful to patients and clinicians in health services and in other social and institutional settings, and to other individuals and groups in society generally.

The growing recognition of Mindfulness approaches is remarkable. An EBSCO database search for scientific articles with the word ‘Mindfulness’ in the title in July 2009 brought up almost 1,300 results, with 300 of these published since the beginning of 2008. In 1999, the US National Institute for Health funded three studies on Mindfulness; by 2008 that had risen to 44.¹⁰³ This impetus is apparent from our own research. The finding that so many GPs think Mindfulness would be a helpful approach not only for their patients with mental health problems but also for their patients in general, and for themselves, is remarkable, given that these approaches have so far received little promotion within the health service. Perhaps even more remarkable is the fact that Mindfulness approaches are based on ‘alternative’ practices that are thousands of years old and that teach nothing more complex than a way of paying attention.

There are grounds for enthusiasm, but also for caution. The enthusiasm is based on the likelihood that Mindfulness-based approaches have much to offer in a very wide range of settings. The caution is based on the knowledge that this is not a top-down approach that can be thrown at any problem. To be effective, Mindfulness practices must be learned and transmitted experientially,

and taught by people who have made a substantial and enduring commitment to maintaining their own Mindfulness practice. Mindfulness needs to be grown carefully. Bureaucratic attempts to introduce it are likely to make no difference or, worse, cause frustration and confusion.

If Mindfulness-based approaches are to fulfil the promise they have shown, we will need careful and sustained engagement from key stakeholders – researchers, clinicians, service commissioners and providers, policy-makers, public, private and voluntary sector institutions, as well as individuals and communities. Ideally those involved at these levels would also have a good grounding in the practice of Mindfulness disciplines.

Of course, Mindfulness approaches may not be suitable for everyone. Some people may not want to learn Mindfulness skills. Attempts to browbeat or in any way pressurise anyone into Mindfulness training would be wholly contrary to its spirit. Mindfulness training can be offered, but should not be imposed.

Fortunately, it seems that a growing number of people are encountering genuine introductions to Mindfulness, finding it useful in their own lives, and becoming enthusiastic about transmitting what they have learned. That, we believe, is the foundation for implementing Mindfulness-based approaches.

We live in a world where much suffering is created by mental health problems, the psychological impact of long-term physical health problems, and the speedy, stressful elements in our culture that help perpetuate these and many other social, economic and environmental problems. Mindfulness and Mindfulness-based approaches could offer much, not just as a tool for developing our health and well-being, but also as a way to foster qualities such as insight, empathy, tolerance and discernment. This could result in greater expression of what dialectical behaviour therapy calls ‘Wise Mind’.

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