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Mindfulness-based approaches:

A guide for psychologists

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Note

The terms 'client' and 'service user' are both commonly used by psychologists working with mindfulness-based approaches. We generally opt for 'service user' when discussing people in the context of services and 'client' when talking about work done that requires someone's active engagement with us, for example, in therapy and care planning. For individuals who are receiving hospital care, the term 'patient' is generally used. There might be something different about mindfulness training in that the person is now a student of mindfulness (rather than a service user) and can be considered a course participant and on completion a course graduate. The two latter terms would be appropriate with community work.

Contents

EXECUTIVE SUMMARY

Mindfulness-based approaches have a growing body of clinical and research evidence for their use and are a way of working that psychologists need to be aware of and may consider offering.

Mindfulness-based approaches teach people present moment awareness, and cultivate attention, awareness, a non-judgemental stance and purposeful intent. Such a state of being can be beneficial for both a therapist and the person in therapy.

Mindfulness is linked to Eastern spiritual traditions but can be used separately from these without fear of converting someone to a faith path or being disrespectful to spiritual traditions.

Mindfulness is a *core* element of two group interventions that have been demonstrated to be clinically effective, Mindfulness-based Stress Reduction and Mindfulness-based Cognitive Therapy.

Mindfulness is an *important* element of two multi-component psychological models of understanding, formulating and intervening with psychological problems: Dialectic Behavioural Therapy (DBT), Acceptance and Commitment Therapy (ACT), Compassion Focused Therapy (CFT) and Mindful Self Compassion (MSC).

It is important for psychologists to have the appropriate training for the mindfulness-based approach that they share or teach, and for them to have their own regular personal practice.

Care is required when introducing mindfulness into individual work; it should not be introduced as a 'bolt on' skill or a technique for clients to learn. This area has been less well researched than group interventions, MBSR and MBCT, and mindfulness skills situated within specific models (e.g. DBT, ACT, CFT, MSC).

Psychologists introducing mindfulness-based approaches need to be open to unusual and unexpected effects, and these must be approached in a mindful way to help people through them. Afterwards, reflection without judgement through supervision is recommended to discover what can be learned from the experience.

It is strongly recommended that readers consider this document from three perspectives: the strength of the evidence base, their own experience as a mindfulness practitioner/teacher and the mindfulness readiness of the client.

The evidence for mindfulness-based approaches varies with different clinical populations, but important elements include the experience of the psychologist with the mindfulness approach, their experience of working with the psychological problem and the overall psychological wellbeing of the client at that time.

Mindfulness-based approaches have been demonstrated to be potentially beneficial for children and adolescents, people with intellectual disabilities and older adults, as well as adults.

Mindfulness-based approaches have demonstrated benefits for people with long-term conditions (e.g. chronic pain and cancer) but care needs to be taken to adapt the approach to encompass physical health needs.

In Sports psychology mindfulness-based approaches have been used to help athletes cope with stress, however the sporting environment offers unique challenges for both athlete and mindfulness teacher, particularly distinguishing mindfulness from flow states.

In Occupational psychology mindfulness-based approaches have been used to tackle stress, relationships, the emotional tone of teams and leadership. In all of these adaptations are needed to how mindfulness is delivered because of the organisation and employee factors.

HOW TO USE THIS DOCUMENT

This document is for all psychologists, clinical and academic, who like almost everyone, have heard about mindfulness and want to know more. This is a read from a psychological perspective that is sympathetic to mindfulness but not eulogistic. We hope it will prompt people to think about where mindfulness could potentially offer support in their area of work. We hope that it will stimulate research in the many areas that the document highlights where there are promising exploratory and feasibility studies. In most areas there is still a need for better controlled trials, and yet at the same time, a huge richness in the qualitative and case study reports which may provide deeper insights into what actually happens when mindfulness is introduced into the therapeutic setting.

This document is thus a guideline for practitioner psychologists. Experts in different specialties share their knowledge and views on the use of mindfulness-based approaches with some degree of scholastic rigour rather than just advocacy for mindfulness. Each highlights the evidence and is a reference for psychologists to orientate themselves to mindfulness in general and its application with their client groups. The guidance is a resource to 'dip' into and find out what clinicians are doing with different client groups. This document aims to increase the quality of service delivery and safety for clients, and point psychologists in some interesting new directions.

This document is organised in two parts. Part 1 offers background information and contextualisation. This may be a good starting point for those new to mindfulness-based approaches. Part 2 offers summaries for mindfulness as applied to different populations.

Psychologists work with individuals, groups and organisations. It is hoped that this set of guidance reflects this. There are also sections covering organisational (workplace) mindfulness, mindfulness in education, and mindfulness in sport.

The document features various boxes that include summaries, overviews, things to consider and short illustrative clinical vignettes and best practice tips.

References are organised by Section to allow readers to easily follow up key references.

Individual psychologists are faced with a choice between having what can be an expensive training in mindfulness to be a certified practitioner of mindfulness or to make the best from the available literature and shorter courses. It is hoped that this document will help psychologists make informed choices about safe practice without being dogmatically prescriptive. The Governance section provides what you need to know about best practice.

Please be aware that NICE guidance currently supports MBCT as a relapse prevention intervention for those with chronic depressive illness, ACT for the management of chronic pain, and DBT in the management of suicidal behaviours in those with emotion regulation difficulties (e.g. emotionally unstable personality disorder). Mindfulness was indicated by NICE as an area for future research in the management of chronic pain.

As with any psychological intervention, when making choices about mindfulness being involved in a piece of clinical work, an individual formulation is vital to the understanding, organisation and delivery of care to any client. How mindfulness is to be offered to any client needs to be part of a formulation rather than mindfulness as a prescribed global panacea. The formulation may suggest for the client that a publicly available mindfulness source (book or app) might be a good starting point for them before individual therapy in other cases, this might be totally inappropriate and even cause harm.

CHAPTER 1

Mindfulness explained

Part 1: Mindfulness explained

MINDFULNESS AND PSYCHOLOGY

Psychologists are using mindfulness-based approaches (courses and techniques) with their clients in many settings and for many different presenting problems. Alongside this professional work, there is a mass of literature, books, and websites in the public domain that advocate for the benefits of mindfulness across a spectrum of contexts.

It is beyond the scope of this document to review all of the current literature. The interested reader is referred to the website of the American Mindfulness Research Association which regularly collates reviews and meta-analyses in this rapidly expanding field (https://goamra.org/). Practitioners are strongly encouraged to engage with current critiques of the field (Davidson & Kaszniak, 2015; Farais, et al., 2016; Purser, 2019; Van Dam et al., 2020), and to ensure they read the section on Clinical Governance (see also Baer et al., 2019).

GENERAL BACKGROUND ON MINDFULNESS IN HEALTH

In the last few decades there has been a proliferation of mindfulness-based interventions in both the physical and mental healthcare settings. Part of the impetus and growth of mindfulness in healthcare stems largely from the development of a standardised eight-week group protocol called Mindfulness-based Stress Reduction (MBSR) developed in the United States healthcare setting in the 1980s. MBSR was designed to help individuals with chronic physical health conditions known to be exacerbated by stress (e.g. pain, eczema, irritable bowel syndrome; Kabat-Zinn, 2003). Its standardisation made it amenable to research evaluation in a variety of settings. From this, the evidence base grew.

Various meta-analyses indicate MBSR can mitigate the distress of physical health symptoms and offer improvements in quality of life (Goldberg et al., 2021; Grossman et al., 2004). The mechanism of change centres on developing a more flexible mental and cognitive relationship to pain and stress. It encourages an exploration of how responding kindly, rather than reacting, can modify and reduce the additional mental layer of suffering that comes with pain, and through this, improve wellbeing (Gu et al., 2015; Reibel et al. 2001; Shapiro et al., 2008). Recent NICE guidelines for chronic pain (NICE, 2021) do not currently recommend mindfulness as a primary psychological intervention but do point to this as an area requiring more research.

More recently, Mindfulness-based Cognitive Therapy (MBCT) has been developed through the work of the Oxford Mindfulness Centre as a relapse prevention approach for those with long-standing (recurrent) depression (Kuyken et al., 2016; Piet & Hougaard, 2011). MBCT combines elements of mindfulness meditation practice alongside cognitive restructuring to allow individuals to work with, and see more clearly, patterns of thinking that may be unhelpful. MBCT comprises approximately 80 per cent mindfulness meditation training and 20 per cent cognitive techniques. MBCT is cited in the NICE Guidance as recommended treatment for recurrent depression (NICE, 2009). A recommended paper by Crane et al. (2017) provides insights on the key features of mindfulness-based interventions that arise from this pathway of MBSR and MBCT. Appendix 1 details the most up to date meta analyses for MBSR and MBCT and would be a good starting point for an overview of the literature.

There are also a variety of other therapeutic models with mindfulness elements as part of a multi-component approach (Acceptance and Commitment Therapy, ACT; Dialectical Behaviour Therapy, DBT; Mindful Self Compassion, MSC; and Compassion Focused Therapy, CFT).

The core distinction between these interventions and MBSR/MBCT are as follows: (i) whether the intervention is conducted in a group, individually or a combination of both; (ii) the amount of formal training in mindfulness completed by participants; (iii) the reliance on the mindful component as the core mechanism of change; and (iv) the requirements for the embodiment of mindfulness in the person delivering the intervention. Necessarily, this latter component has implications for the personal and professional training required to deliver standardised protocols (e.g. MBSR/MBCT; see also the section on Clinical Governance).

Table 1: An overview of the development of mindfulness – from the monastery to the mainstream. The dark blue section contains protocols that have been developed and evaluated in the clinical setting (illustrative examples). Note that these arise from a blend of contemplative traditions (e.g. Zen Buddhism) as well as psychological frameworks.

A VARIETY OF CONTEMPLATIVE AND SPIRITUAL TRADITIONS	
Mindfulness-based Stress Reduction (MBSR) Mindfulness-based Cognitive Therapy (MBCT) Programmes adapted from MBSR/MBCT for specific presentations and contexts: e.g.: Mindfulness-based Relapse Prevention (addictions); Mindfulness-based Eating Awareness Training (eating and body image); Mindfulness Awareness Practices (ADHD); Mindfulness in Schools (MiSP); Breathworks	Dialectical Behavioural Therapy (DBT) Acceptance and Commitment Therapy (ACT) Compassion Focused Therapy (CFT) Mindful Self Compassion (MSC)
There is additionally a huge variety of adaptations and modified practiced based on the above e.g: Soles of the Feet (intellectual difficulties) and various online programmes and apps.	

DEFINING AND EXPLAINING MINDFULNESS

The term mindfulness as used in the healthcare setting broadly refers to the development (through formal and informal training) of a deliberate, engaged and non-judgemental relationship to mental or physical suffering. Although often referred to as 'mindfulness meditation' the term is distinct from meditation. The latter more broadly represents a larger group of mental training that tends to be linked to spiritual and faith practice, and can involve a huge variety of practices.

Across disciplines, confusion abounds as to the 'correct' definition of mindfulness (Chiesa, 2012; Grossman, 2011; Shaw, 2020). In part, this confusion stems from the multiple origins of the word, problems with translation, and attempts to cross-reference more modern psychological and cognitive science constructs situated in a bio medical model, with ideas from Eastern contemplative traditions (Grossman, 2019). In this section we explore some of these issues and suggest how these might be thought through and framed in clinical practice.

CURRENT RECOMMENDED WORKING DEFINITIONS

Kabat-Zinn's definition of mindfulness is one of the most commonly used in academic and clinical literature. After expert debate, this was the definition adopted by the UK's Mindfulness Initiative. Kabat-Zinn defines mindfulness as a type of awareness that arises from:

'paying attention …… on purpose, in the present moment, non-judgmentally' (Kabat-Zinn, 1994).

Another oft-used definition is provided by Bishop:

'Present moment awareness and the non-judgemental and dispassionate quality of this awareness' (Bishop et al., 2004).

From these definitions it can be seen that both cognitive (attention and intention) and relational (non-judgmental, dispassionate) elements are integral to 'being mindful'.

Different client groups may have more or less capabilities in these different 'sub-components' that facilitate a moment of mindfulness. For example, an individual with high perfectionism in a competitive environment (e.g. medical students) may be very good at paying attention, but less able to use this cognitive ability in relation to bodily sensations of emotion, and may need extra support to develop a non-judgemental stance. Another individual may be very kind and compassionate towards themselves, but could struggle to focus attention or maintain intention when required. Mindfulness is the combination of these skills, and requires cultivation of all these different elements. Attentional and metacognitive elements are important, but certainly not the whole story. What you attend to, and how you attend are considered in tandem.

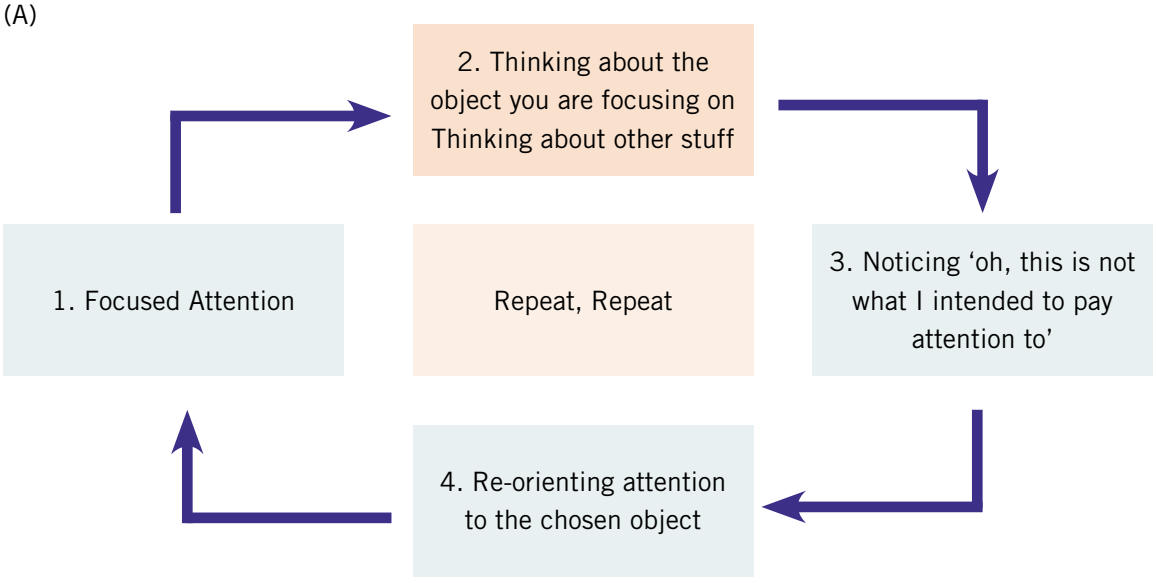
While it is possible to understand these definitions at a conceptual level, it is important that those supporting or offering mindfulness practice and training in the clinical setting have a personal experience of what it really means to be mindful. This can be drawn upon when clients, colleagues and carers ask about any mindfulness intervention being offered, including the benefits and often very real challenges. An appropriate personal vignette of how being mindful in everyday moments of challenge helps you as a therapist to cope (or at least mitigate prolonged distress), can be a powerful tool to model mindfulness (and reduce idealisation of the therapist at the same time).

KEY ELEMENTS OF MINDFULNESS BRIEFLY EXPLAINED

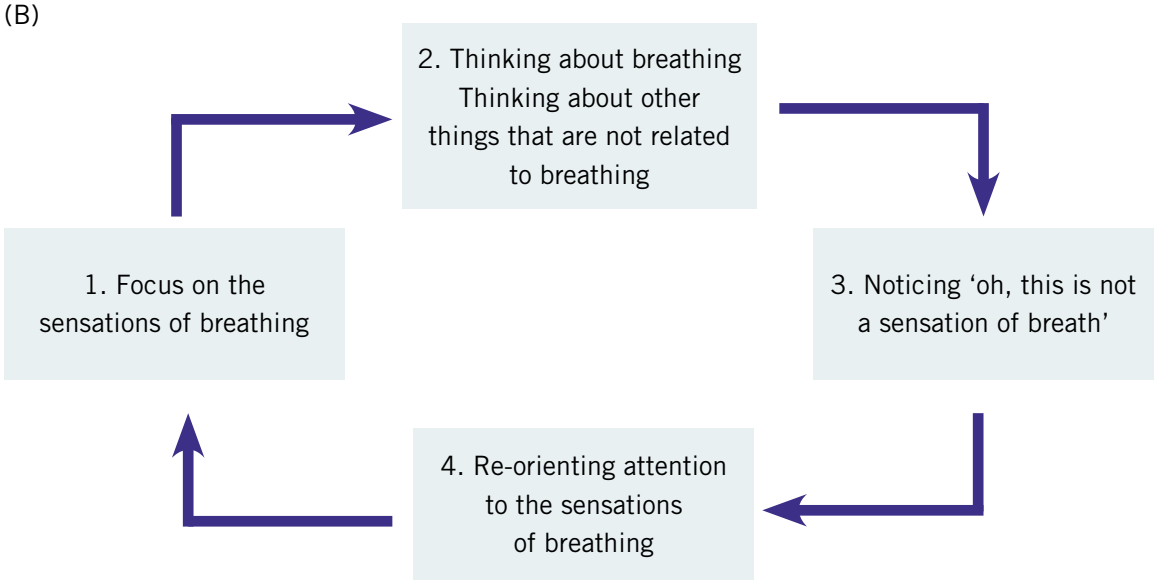
In the section below we will cover some of the key elements of what is involved in mindfulness training. Necessarily this is a brief synopsis, oriented towards a cognitive sciences framework. Figure 2 below is offered as a useful heuristic to orient the reader, with a particular intention to support those new to mindfulness (Russell et al., 2017; elaborated from Hasenkamp et al., 2012).

Figure 2: The Four Stage Neurocognitive Model of Mindfulness (adapted from Russell, 2017). (A) showing in a simplistic form, the four elements of a mindful moment. (B) showing as might be applied to a classical training object, the sensations of breathing.

(A)



(B)



FINDING THE PRESENT MOMENT

Although there are individual differences in dispositional mindfulness (Tomlinson et al., 2018), current thinking suggests that this is a faculty we can all train and enhance. The process typically starts by learning to focus and sustain attention on a single object referred to as a present moment anchor. This anchor is often bodily sensations, the experience of breathing, sounds, or other of the five senses.

These particular training objects all have a 'present moment' quality, insofar as they offer sensory information that unfolds over time. They have necessarily been experienced before (in the past), and we might anticipate experiencing them again (in the future). However, by tuning into them directly in the here and now, as they are unfolding, attention is anchored in the present moment. Bringing awareness to present moment anchors can provide a momentary sense of relief. However, this can also be harder than it sounds, especially if physical or emotional distress is also a feature of the present moment. Hence practice, patience and persistence are required.

NORMALISING MIND WANDERING

It is to be expected that the mind will wander, often unknowingly and repeatedly (Smallwood & Schooler, 2015). Frequently, the mind wanders to the past or the future (remembering or reflecting; planning or anticipating). Rumination on past events is a common mind wandering pattern observed in depressive illness and a key target in one of the main mindfulness interventions (MBCT).

Anticipation, planning and rehearsal are mind wandering patterns exacerbated in anxiety states. When the mind wanders, this mental activity captures our awareness, and attention to the present moment diminishes. Excessive automatic activation and proliferation of these patterns can result in the amplification and maintenance of unpleasant emotions (e.g. sadness or anxiety) and increased psychological distress. It is important to be aware that reflecting and anticipation are not 'bad' or 'wrong'. They are part of our human repertoire of mental activity. However, when they are activated in the service of managing emotions, and become automatic patterns, this can escalate and maintain distress (rather than help to manage these moments wisely).

A key aspect to developing mindfulness is learning to increase awareness of when the mind has wandered, and to gently, kindly and self-compassionately bring attention back to

the present moment (the chosen anchor or what is happening right now). The moment of awareness of mind-wandering is a cause for celebration! Here, you gain mindfulness of your mental activity – being present to what is unfolding in the mental realm. Responding kindly and with self-compassion when you meet this mental activity is one of the tasks honed with mindfulness practice.

It can help to label this activity as 'Thinking', 'Planning' or 'Remembering', This can facilitate 'de-coupling' (Levin et al., 2015) from mental activity and provides the opportunity to choose to shift attention back to the chosen anchor, for example, breathing. The analysis or modification of thoughts is not required in this process oriented approach. Rather, noticing, releasing, letting go and getting back to what you were doing (focusing on the breath or bodily sensations) is encouraged. Repetition is crucial to gain the benefits of mindfulness (hence the requirement for formal practice in MBSR and MBCT protocols). Practice helps to finesse the ability to be fully present and non-judgemental even when things are difficult or not as you wish them to be. With repetition, slowly but surely, the ability to focus, to manage mind-wandering (of any sort), and to be patient with oneself and one's mind is developed.

HELPFUL AND UNHELPFUL MIND WANDERING

Every person, whether they are experiencing mild, moderate or intense distress in the moment, has the potential to benefit from being able to gain awareness of the types of mind wandering that either support or exacerbate challenges. While reflection and planning can be helpful in the short term, excessive rumination and anticipation often makes things worse, and rarely addresses the real difficulty (feeling sad or anxious). Mindfulness training offers the possibility to become empowered to make informed choices about when to be willing to experience and engage with unpleasant emotions, and when to shift awareness instead onto anchors associated with calm, so as to gain conscious control over this process.

There is also an opportunity to make an informed choice as to where to place attention – in the realm of mind, or in the realm of here and now. Mindfulness training allows more control over the brain's attentional networks (Lutz et al., 2009), and the possibility to cultivate a healthier and more flexible use of the attentional focus (Keng et al., 2011). This capacity may be increasingly important in our highly distracted and reactive Western culture.

ACCESSING DEEPER HABITS OF MIND

Although mindfulness typically starts with the body, gaining some ability to monitor mind-wandering (mental sensations) makes it possible to uncover and explore deeper habits of mind, and the links between thinking and feeling. Getting familiar with the variety of mental sensations (thoughts, images, memories, patterns of mind wandering) is where deeper healing can take place (but necessarily requires more practice). By observing closely (without judgement) mental reactions to different scenarios, it is possible to become increasingly familiar with these conditioned responses. With continued practice focusing on present moment anchors (breath, hands, feet, sounds, etc.) it is possible to learn to do something different in these moments and reduce the distress that comes from the mental struggle to make things different.

As a specific example, whenever present moment awareness illuminates the presence of a thought, perhaps about not liking a part of ourselves (self judgement), in mindfulness we would not engage in the *content* of the thought. Instead, once we have celebrated our moment of awareness (that the mind has wandered), perhaps labelling this experience as 'thinking', noticing what is happening in the body and then kindly, gently and self-compassionately choosing to focus on one of the present moment anchors – breath, body or senses.

THE IMPORTANCE OF ACCEPTANCE AND CURIOSITY

Developing a non-judgemental relationship to the experience of thoughts and feelings, and not seeing them as either 'good or bad' can be freeing. If we can reduce judgement when experiencing an unpleasant or distressing emotion, this can lessen the impact of the experience. There is still something unpleasant, but the draining reactivity to this experience can be reduced with mindfulness. It is healthy for all of us to experience the full range of emotions, and entirely unrealistic to expect to feel 'happy' or 'content' all the time.

In a mindfulness practice, it can be helpful to label any emotion noticed, in a similar way to the labelling of thinking above, by saying '*This is a feeling of…*' and ending this sentence with the name of the feeling, for example, boredom, distress, or a description of the feeling of the movement in the body (tightening, squeezing, contraction, etc.). Similar to before, celebrate your moment of mindfulness. This is the moment where you are empowered to make a choice to reduce the impact of old (likely unhelpful) patterns, and shift awareness to the present moment anchor of your choice. With practice, it is possible to become more rapidly aware of such moments, and to become increasingly deliberate about making choices in how to respond when feelings of any intensity arise.

For example, the experience of 'pain + mental struggle against pain' is very different from the experience of 'pain' alone. The mental struggle of wishing things were different adds to, and amplifies the experience of pain, in ways that mindfulness shows us it's possible to mitigate. More on pain can be found in Part 2, with insights from an expert by experience in the section on Illustrative Extensions (Breathworks).

Mindfulness develops curiosity about our experiences, inviting a continual exploration of how things are 'now'. This is distinct from how we might imagine them to be, or believing that we 'already know' what the experience will be like (e.g. 'my feet are always cold'). This mental orientation is often captured in phrases such as 'seeing as if for the first time' or 'seeing with the eyes of a child' (who has less assumptions and prejudices wired into their perception). This feature may be particularly important to reduce the distress of remembered or anticipated mental or physical pain as experienced in chronic or relapsing conditions.

A SEEMINGLY PARADOXICAL APPROACH

The mindful approach, with its ultimate aim of acceptance of experience, may sit at odds with some client's beliefs that psychological therapy is about 'getting rid' of negative experiences or 'fixing' negative emotions. As such, the embodiment of the therapist offering this approach (and their own experience and confidence in the benefits of such a seemingly paradoxical approach) is critical (Crane, 2013). The shift in mindset from a judging to compassionate relationship to mental and physical distress seems to be a vital component for change (Shapiro et al., 2005, Lee et al., 2021), and may be particularly valuable for those with adverse childhood experiences (where healthy attachments were not cultivated; Kuyken et al., 2010).

Given the necessary requirement to engage with the body and emotions in a direct way, those with sensitivities (body image, dysmorphia, eating disorders, complex trauma, avoidance, etc.) may require a scaffolded learning approach to more gently bring them into body awareness. Even a seemingly 'simplistic' technique of mindfulness of the breath may be challenging at first for those with asthma, COPD or in the aftermath of the covid pandemic.

SUMMARY

- Mindfulness is a term which refers to the state of awareness that arises when all the above conditions are met – paying attention, to the present moment, on purpose (with intention), dispassionately and without judgement.
- Ideally the practitioner is doing all of these things at once, but these may be broken down into steps in the early phases as awareness of the subtleties of the workings of the mind/body/heart develops.
- Mindfulness is not a place or state to be 'reached' – even experienced practitioners will continually develop and refine their ability to engage with their own mental phenomena.
- Mindfulness is not about creating a life of happiness with no distress. It is about increasing the ability to be present no matter what is arising.

The notion of changing our relationship to suffering via mental training is not new. Humans throughout history have sought to minimise the suffering inherent in the human condition. The use of mindfulness (or variants thereof) to find 'peace in a frantic world' (the title of Willams & Penman's highly recommended 2011 book *Mindfulness: A practical guide to finding peace in a frantic world* – see Appendix 2 for book recommendations) can be found in a variety of spiritual, faith, philosophical and other traditions. There are many ways to learn to deal with suffering in a way that is compassionate and kind. Some require turning inwards, examining the self, while others turn outwards, evoking benign deities or sources of unconditional love. We turn now to explore mindfulness in religion, faith and spirituality.

MINDFULNESS IN RELIGION, FAITH AND SPIRITUALITY

The mindfulness training of MBSR/MBCT (as well as the mindful elements of DBT) draw on the Zen Buddhist tradition (Kabat-Zinn, 2011). These programmes were designed as a secular variant of traditionally Buddhist teachings with the intention of allowing everyone (including those with no interest in Buddhism) to benefit from the techniques (see also Wallace & Shapiro, 2006). As a result of the link between these secular programmes and Eastern contemplative traditions, there are often questions asked such as 'Where does mindfulness come from?', 'Is this a spiritual path?' and 'Is mindfulness suitable for those with other faith orientations?' This section gives some suggestions for how we might think about these questions in the context of our clinical work.

WHERE DOES MINDFULNESS COME FROM?

The term mindfulness meditation, does have origins in Eastern contemplative practice and Zen Buddhism is a cited source that inspired the ethos and approach of both MBSR/MBCT and DBT. This must be acknowledged. However, Thupten has argued that **it would be wise to recognise modern mindfulness as a new phenomenon to avoid the confusions that arise** when trying to map it to Bhuddhist concepts (Thupten, 2019).

For example, the Pali word 'sati' is often cited as the source for the word 'mindfulness' as used in English. Yet the Western application of mindfulness drawn from this source substantially fails to capture the full scope and meaning of the word in Pali. To add more confusion, 'sati' is also used in historical Hindu practice, where it refers to the ritual of a widow sacrificing herself by sitting atop her deceased husband's funeral pyre. So it would be a mistake to cling too tightly to Bhuddhist (or other contemplative) concepts as we attempt to understand the use of the term 'mindfulness' in Western secular applications.

Another translation from Sanskrit (स्मृति smṛti), is 念(*nian*) in the Chinese language. The latter is composed of two Chinese characters jin 今 'now; this' and xin 心 'heart; mind'; together it means 'to think of, reflect, learn by heart, to have 今 present to 心 the heart or mind'. These definitions capture the essence of the more holistic mind/body/heart interactions that come to awareness as we develop and train mindfulness skills. The explicit inclusion of awareness of the body and heart in the work of mindfulness starts to extend the more 'cognocentric' (Thompson, 2001) approaches to psychotherapy.

A number of emerging mindfulness-based interventions are referred to as heart based therapies (e.g. Dent, 2021). Compassion focused therapy (CFT; Leaviss & Uttley, 2015) and Mindful Self Compassion (MSC; Germer & Neff, 2013) also bring the heart/compassionate mind element to the forefront of their approaches, drawing on both scientific Western principles (such as evolutionary and polyvagal theory; Gilbert, 2019) as well as practises of compassion from contemplative traditions. The development of a compassionate, non-judgemental, and kindly attitude is a central axiom of mindfulness, as well as an important contributor to outcomes in many MBIs (see Kuyken et al. 2010, Shapiro et al., 2006).

This move towards 'heart' in the therapy work (particularly in settings dominated by the Cognitive Behaviour Therapy and medical models) may point to the need for practitioners to be more aware of Somatic, Holistic or Transpersonal therapeutic approaches, where inclusion of this domain of experience is more thoroughly elaborated.

MINDFULNESS ELSEWHERE

It may also be helpful for clinicians and clients to be aware that variants of 'mindfulness' appear in many other religious, spiritual and philosophical traditions. The monk Evagrius Ponticus, a Christian Desert Father (Bradford, 2011), taught a form of quieting the mind (*hesychasm*) which led to the illumination of the conditioned links between thoughts and emotions. Identification and management of these links facilitated deeper states of meditation and prayer. Jesuits (see deMello, 1998) and Quakers also offer teaching along broadly similar lines.

We might also look to the philosophical teachings of the Stoics and others to find mental training techniques adopted to increase resilience, manage strong emotions, and act in ways that are healthy for ourselves and the societies we live in. 'Attention (prosochê) is the fundamental Stoic spiritual attitude. It is a continuous vigilance and presence of mind, self-consciousness which never sleeps, and a constant tension of the spirit. Thanks to this attitude, the philosopher is fully aware of what he does at each instant, and he wills his actions fully.' (Hadot, 1995, p.84). We are thus advised to be mindful of mindfulness (Grossman, 2010; Kirmayer, 2015).

SECULAR MINDFULNESS

Mindfulness as a term in psychology has been present since the late 1970s in the work of Ellen Langer (reviewed in Langer & Moldoveanu, 2000). Her particular emphasis on the study of 'mindlessness' from a Western scientific orientation further extends our understanding of how mindfulness can be understood within the 'culture' of psychotherapy and outside of a necessarily Buddhist orientation (Fox, 2019).

Working from the evidence base and the growing neuroimaging data around mindfulness and meditation more generally (Davidson et al., 2003; Holzel et al., 2011), it is possible to present a secular argument for the use of mindfulness. These studies demonstrate that mindfulness training strengthens the attention network (Malinkowski, 2013), which is helpful, as this network is easily hijacked by distressing thoughts and intense emotions (Pessoa, 2008). Mindfulness training helps us to get more in touch with bodily sensations and regulate our emotions in

more flexible ways. Western cognitive neuroscience has much to say about what happens when we cultivate mindfulness using language that does not need to alarm or confuse service users (Wielgosz et al., 2019).

It can be helpful for the psychologist to be explicit about their own relationship with Buddhist (or other faith) approaches at the outset. For example saying 'I have training in secular mindfulness but am not a Buddhist. As a psychologist, I am interested in the mind and this particular orientation has a lot to say about the nature of the mind. Approaches based on these insights may be useful to help us better understand our responses to distress, particularly when other therapies have not been helpful'.

For those worried that teaching MBSR or other MBIs with links to Buddhism in their service, Table 1 below provides some insights and distinctions that may help to allay fears that teaching mindfulness in the clinical setting is 'Buddhism by stealth'.

Table 1: What, Why, When, Where, How, With Whom: Key Distinctions between secular mindfulness and mindfulness taught in a Buddhist contemplative tradition.

What	The basic mindfulness training principles and practises (e.g. Mindfulness of the Body, Breath and Thoughts) as taught in healthcare MBIs do relate to some of the very first foundational training offered in various Buddhist traditions. However there is much more required by those on a formal Buddhist path. A typical outcome from a eight-week course is that individuals use one or two short mindfulness tools (such as the Three-Minute Breathing space) in their lives following the intervention. The acquisition of a set of skills and techniques, or coping strategies based on mindfulness, is very different from a full integration of mindfulness principles and ethics into daily life. The impact of an eight-week course MBI, while clinically effective and often profoundly transformative, is very different to the impact of a life-long commitment to mindfulness, held in an intentional community and guided by an expert in meditation.
Why	The intentions for practice are very different. In healthcare, clients are interested in reducing their own suffering. In Buddhism, practitioners are committed to reducing the suffering of all beings.
When	Mindfulness as delivered in the healthcare setting is mostly done so in response to a cry for help. As such, the training is in the context of a specific moment of suffering (depression, anxiety, etc.). While many turn to faith and spirituality in a crisis, the activities of mindfulness in the Buddhist setting are not usually taught to people in crisis.
How	Buddhism situates mindfulness within a strong container of ethics and moral behaviour. Secular mindfulness as delivered in healthcare settings may have some of these features, but mindfulness offered more widely, may not (e.g. the case of training mindful snipers in the military, or mindfulness in the corporate setting).
With Whom	In healthcare the teacher is most likely a therapist or allied health professional who has had some training and practice of secular mindfulness. While the embodiment of mindfulness is an important factor, this is not the same as having a dedicated guru, lama or spiritual guide as your teacher.

VIGNETTE: CLASSICAL CONTEMPLATIVE PRACTICE

Alan Wallace's 2006 book *The Attention Revolution* gives a flavour of what is possible with sustained, precise and guided training of the attentional faculty held in the context of spiritual development. He describes the nine stages of attention training from a set of attention training techniques called 'Shamatha'.

Wallace proposes that with the best will in the world, a secular practitioner living in the modern world is unlikely to progress beyond stage three, even if spending a long time in retreat (see Jacobs et al., 2011, for some of the experimental work on intensive training in this method).

This contextualisation may be helpful to manage expectations about what is possible in a short duration mindfulness training as offered in healthcare and other settings, as well as reassure clients that this training is not, in fact, Buddhism in disguise.

IS THIS A PATH (AND WHERE DOES IT GO?)

From this section and table, it is hopefully clear that secular mindfulness offers a 'light touch' variant of what are core elements in many contemplative and spiritual traditions. From this we might infer that there is some overlap, but little danger of 'accidentally' becoming a Buddhist or that NHS services are promoting spirituality. However, the reader is alerted to the fact that including mindfulness as an intervention does open the opportunity to extend the work of psychological enquiry into a bio-psycho-social-spiritual model.

What is known, however, is that consistent mindfulness practice (even over eight weeks) modifies mental habits and conditioning and changes neural pathways (Farb et al., 2007). The relationship to thoughts, feelings and the body evolves with repeated practice. There is evidence from the depression literature that formal home practice impacts positively on relapse prevention (Crane et al., 2014; Hawley et al., 2014) and that time spent in formal practice impacts on symptoms and wellbeing (Carmody & Baer, 2008). As such, individuals will develop insights and experience change at different speeds, determined by their motivation for change, commitment to practice, and influenced by the level of embodiment of the teacher/therapist. This could be the start of a lifelong journey with mindfulness for some, or a set of coping strategies on which the client can draw upon in times of challenges.

Some healthcare settings do support ongoing secular practice through monthly drop-ins, booster workshops or peer supported programmes (see Vignette Peer Led Groups). There is evidence that booster sessions may support the maintenance of benefits from group interventions (McCartney et al., 2020). NICE currently recommends four booster sessions over a 12-month period post treatment for individuals with recurrent depression (NICE, 2009).

Finding the right 'follow-up' group can be a challenge. Often the only option for regular community practice groups outside of NHS services may well be a Buddhist (or other contemplative or spiritual) setting. Clinicians might also explore the use of apps or audios as another option to support ongoing engagement with mindfulness.

VIGNETTE: PEER LED FOLLOW UP GROUPS

One author (TR) has been offering supervision to peer supporters employed by NHS services to deliver mindfulness 'drop in' groups. These groups are for service users who have completed a set duration intervention such as MBCT, but are asking for continued opportunities to practice. Likely cost-saving, asking peer trainers (experts by experience/ service users) to facilitate these groups is one possibility. Peer trainers are often perceived as more approachable and empathic. Their embodiment of mindfulness (the experience of using mindfulness to help respond wisely to difficulties) can also be a powerful source of motivation for others.

Several themes arose in supervision. For example, one peer trainer was told she could facilitate the group and offer practice space but was 'not allowed to teach mindfulness' as she did not have the relevant qualifications. This left her confused and anxious as to what she was actually doing and asking questions such as 'Can I give guidance on posture or does that count as teaching?'.

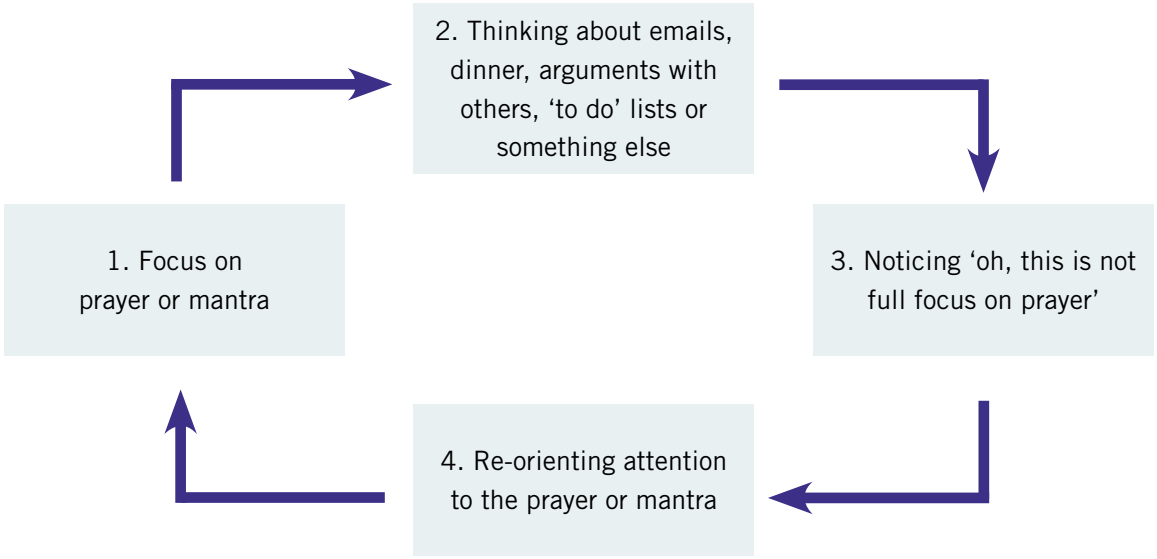
There were also discussions about hierarchies and power dynamics in the room – was she a member of the team offering a part of the service, or a service user? She occupied a 'middle ground' that at times required help to hold (especially if she noticed anyone in the group who was struggling and might need extra help). Supervision by a clinician formally trained in mindfulness-based approaches is a safeguard to help hold such dilemmas.

It is possible that clients who really commit to practice may begin to ask questions that relate to experiences of mind/body that lie beyond the standard training protocol (or even the Western framework for understanding 'mind'). If clients do begin to have questions about mental phenomena that are beyond the mindfulness experience of the psychologist, the practitioner is advised to humbly recognise the boundaries of their own experience and seek supervision. This may be from a more experienced secular teacher, a contemplative scholar, or a practitioner from a holistic or transpersonal orientation. It may require a referral to a spiritual advisor or appropriate faith practitioner. The same applies if client's report unusual or unexpected events (see Governance section for more on the latter). In addition to seeking supervision, psychologists, independent of their faith, spirituality or not, need to observe the BPS/HCPC *Code of Ethics and Conduct* (BPS, 2021), and BPS *Practice Guidelines* (BPS, 2017; Section 3.12).

IS MINDFULNESS SUITABLE FOR THOSE WITH OTHER FAITH ORIENTATIONS?

Understanding that a key element of mindfulness is about learning to focus with intent (and manage the wandering mind), the benefits of secular mindfulness training may actually support and augment faith practices. Prayer may be made more intentional, focused and embodied with mindfulness. For example, if someone is praying, but in the middle of the prayer they begin thinking about what they are going to make for dinner, or an email they need to send, mindfulness skills can be used to help bring the mind promptly and gently back to the task at hand (prayer/recitation/worship). See Figure 2 for an illustration of this. In this example, it could be construed that the attentional object used in the mindful practice is the recitation of the prayer, or maintenance of the intention to stay in relationship to a 'God' or deity. Other variants of this might include the use of mantras, chanting or physical movements (the latter present in Sufi worship), where the ability to intentionally maintain focus on the activity is enhanced by mindfulness training.

Figure 3: How mindfulness might support focused attention and presence with the divine through prayer or mantras referenced to the Four Stage Neurocognitive model of mindfulness.



When working with individuals who bring a strong faith practice into therapy (and who might benefit from mindfulness as an intervention), it may be helpful to find out more about how they practice their faith. This may uncover overlaps that could be mutually beneficial and reinforce mindfulness practice. For example the book *Sadhana – A way to God: Christian Exercises in Eastern Form* by Anthony de Mello (1998) details how techniques offered in MBSR and MBCT might be integrated into Christian contemplation.

REAL WORLD EXAMPLES

When teaching mindfulness to medical students from Islamic backgrounds, one student commented that although she approached the training with reservations, the understanding of what it means to be mindful helped her to more fully connect to Allah. She noticed she was automatic in her physical movements of prayer and used mindfulness to help her fully engage with intention as she moved her body into the prayer posture.

Working with clients from the Catholic faith, challenges arose when trying to work with the 'non judging' component of mindfulness. The client asked '*Have I been practising judging?*' which opened up a discussion about judgement and discernment in the service of wellbeing, whilst maintaining contact with the tenants of her faith.

Those using yoga as a spiritual practice have commented that mindfulness training helps them to recognise when the movements and postures they are making have become automatic. They are also better able to recognise when their body is in the yoga studio (but their mind is elsewhere on tasks, plans, memories or other mind wandering experiences).

AN IMPORTANT CAVEAT

What might be different when working using mindfulness with someone from a very orthodox faith practice is the type of reactivity arising from thoughts construed as 'sinful'. Curiosity, gentleness and flexibility are required in this situation. It would be important for the psychologist to draw out exactly what the individual is doing (mentally and emotionally) with such thoughts (the process orientation of mindfulness), and what it would mean to accept such a thought if their faith dictates it is 'sinful'. Research showing the links between religion and thought-action fusion (Berman et al., 2010) might be borne in mind in such cases, as the thought itself may carry the same implications as the actual act (e.g. how to respond thoughts of masturbation or a sexual or taboo act).

From a strict mindfulness point of view, any thought that arises is a transitory experience in the mind that is ideally allowed to arise and dissipate without judgement. Furthermore, the sensation itself (the thought and emotional tone around it) is explored with the same kindness and acceptance, allowing the opportunity for working differently with these emotional and feeling states. To do this work without harm, requires a skilled practitioner with supervision and possibly advice from faith leaders.

OVERVIEW:

- With skill and sensitivity, mindfulness practice can be integrated with most other faiths to allow *all* clients to benefit from this approach.
- It is important to address any fears as early on in the teaching of the practice as possible.
- The psychologist needs to be aware of their own stance and limitations at all times, seeking supervision where required.

THE DEVELOPMENT OF MINDFULNESS-BASED APPROACHES IN APPLIED SETTINGS

In this section we consider in more detail the psychological approaches that have reached an advanced level of development with a reliable research base and that incorporate mindfulness practice. The core elements of each are briefly described, with the distinguishing features of the mindfulness elements highlighted. A high level overview of the relevant evidence base is offered (noting that more detail may be found in the condition specific sections in Part 2). Information about training pathways can be found in the Governance Section.

These approaches include:

- Mindfulness-based Stress Reduction (MBSR)
- Mindfulness-based Cognitive Therapy (MBCT)
- Dialectic Behavioural Therapy (DBT)
- Acceptance and Commitment Therapy (ACT)
- Compassion based interventions (CFT, MSC)

Table 2: Mindfulness-based Interventions at a Glance (references/citations can be found within text).

	ORIGINATORS	DELIVERY	MINDFULNESS ELEMENTS
Mindfulness-based Stress Reduction (MBSR)	Kabat Zinn	Group based	Formal Training in Mindfulness Focus on stress reduction
Mindfulness-based Cognitive Therapy (MBCT)	Williams & Teasedale	Group based Individual (emerging)	Formal Training in Mindfulness Augmented with (condition specific) CBT principles
Dialectical Behavioural Therapy (DBT)	Linehan	Group based Individual	Mindfulness is one component of a multi-component intervention
Acceptance and Commitment Therapy (ACT)	Hayes	Group based Individual	Mindfulness is one component of a multi-component intervention
Compassion Focused Therapy (CFT)	Gilbert	Group Based Individual	Compassion forefronted Mindfulness is a component that supports this aim
Mindfulness Self Compassion (MSC)	Neff & Germer	Group Based	Compassion forefronted. Mindfulness is a component that supports this aim

Different programmes place more or less emphasis on the mindfulness *training* element, with variability in the requirement for formal *practice* of mindfulness (as opposed to informal day to day engagement with mindfulness). Necessarily, this means there are different requirements for the training of therapists to deliver these different types of MBIs.

Elements of mindfulness can also be found within Mindful Self-Compassion (Germer & Neff, 2013; Neff & Germer, 2012) and Compassion Focused Therapy (Gilbert, 2014). In these interventions, the mindful element is relevant, helpful and certainly augments the process, but is not a core feature of the intervention. Certainly mindfulness has elements of compassion and self-compassion within it, and compassion can be more easily accessed and amplified if mindfulness is present. The two are interwoven. What distinguishes programmes is where the emphasis is placed, and the order in which different elements are presented/explored.

IN BRIEF

- MBSR and MBCT are standardised group mindfulness training protocols taught over eight weeks that specifically teach and train mindfulness as the primary active ingredient in the therapeutic process.
- DBT and ACT utilise mindfulness skills and tools included within a broader spectrum of multifaceted therapeutic approach. In these models, mindfulness skills augment other elements trained concurrently. Both individual and group work are offered as part of these interventions.
- Programmes forefronting the development of compassion have elements of mindfulness that are related to and augment compassion training, but are not necessarily the main component.
- Delivering any of these interventions requires additional personal as well as professional development training and supervision.

MBSR AND MBCT

Kabat-Zinn created the MBSR programme in the 1980s as a way to help reduce the stress that exacerbated long term physical health problems. It was primarily for individuals who had reached the limits of the medical model with respect to treatment, but whose conditions were impacted by stress (e.g. psoriasis, irritable bowel syndrome and chronic pain). Kabat-Zinn, a biologist and meditation practitioner from the Zen tradition, developed a standardised eight-week protocol, based on the principles of mindfulness of the breath, body, thoughts and feeling. MBSR training typically consists of eight, two-hour weekly sessions and a whole day of silent retreat practice after week six. A large number of studies have been conducted looking at the efficacy of MBSR across a variety of physical and mental health conditions, ranging from cancer to back pain (Zhang et al., 2021; see Appendix 1 for papers that have conducted meta-analysis of MBSR).

Practitioners (psychologists, educators, coaches, etc.) working in many different parts of healthcare and wider society have subsequently used either the standardised or modified variants of the MBSR programme in their work with young people, in educational settings, the workplace, with offenders, GPs and ‘blue light’ emergency services and the military. See The (UK) Mindfulness Initative’s (2019) publications for a robust overview of the wider application of mindfulness in society and specific reports for education, the workplace, criminal justice system and public policy.

CORE ELEMENTS OF MBSR

1. Body-scan exercises (suggested 45 minutes duration daily lying down scanning attention through the body).
2. Mental exercises focusing one’s attention on the breath.
3. Physical exercises with focus on being aware of bodily sensations.
4. Practise in being fully aware during everyday activities.

The Oxford Mindfulness Centre has adapted the MBSR programme for use with people who experience long term depressive illness (MBCT). This work emerged from a specific theoretical formulation (Crane, 2017; Teasedale et al., 2006) designed to prevent the recurrence of depressive relapse. Mixing MBSR with CBT and targeting ruminations, MBCT is an eight week

(90 minutes or two hours per week) programme. A half-day silent retreat is included after session six to help consolidate the learning. There is variability across services in the ability to accommodate the day of silence, and variance across the UK in protocol adherence (Crane & Kuyken, 2013). A number of research studies have shown the efficacy of this approach and this treatment is recommended by NICE guidance as a suitable intervention for individuals with more than three episodes of depression who are currently in remission. Key references detailing the theoretical and clinical work for MBCT's efficacy in depression in the UK are Kuyken et al. (2008, 2010, 2012, 2015) and Williams & Kuyken (2012) and Williams et al. (2014).

CORE ELEMENTS (EIGHT SESSIONS) OF MBCT (from Mindfulness-based Cognitive Therapy for Depression: A New Approach to Preventing Relapse, Segal et al., 2018)

1. Automatic Pilot
2. Dealing with Barriers
3. Mindfulness of the Breath
4. Staying Present
5. Allowing/Letting Be
6. Thoughts are Not Facts
7. How can I best take care of myself?
8. Using what has been learnt to deal with future moods

HOW LONG DOES THE TRAINING NEED TO BE?

Although the original MBSR programme is of eight weeks duration, positive results have been demonstrated with much briefer training, and there are significant modifications to the standardised programme in the published literature. Most notable is the absence of a full day retreat in MBCT and shorter class length (usually 90 minutes). Increasingly, shorter duration courses, workshops, and self-paced learning options (books, apps and online variants) draw on this evidence base in their more accessible offerings of mindfulness training to promote psychological wellbeing.

HOW MUCH PRACTICE IS REQUIRED?

The question of the precise amount of training and practice required to benefit from mindfulness training remains an active research question. Many studies show correlations between outcomes and self-reported formal practice (Parsons et al., 2017). The systematic review of Lloyd et al. (2018) found that in four out of seven studies, home practice predicted clinical outcomes. Conversely, some research shows that it is not the duration of practice but rather the *frequency* of practice that is most important (Pradhan et al., 2007). The *quality* of the practice has also been evaluated (Del Re et al., 2013). Quality is important as in the early stages of the practice. It may be that individuals (especially those without professional guidance) are in fact practising mind wandering and judging, with very little 'mindfulness' happening at all.

The general rule is that significant repetition and formal practice under the guidance of a practitioner who embodies the principle of mindfulness is required to see lasting benefits. It is likely the amount of practice dictates whether the individual uses what is offered on a course to hone enough skills to be mindful as a coping strategy, or engages in sufficient dedicated practice (including beyond the course) to facilitate more lasting changes. See Masheder et al. (2020) for some ideas on how to support personal practice.

Having said that, even brief training (Schumer et al., 2018) and mindfulness workshops and seminars (Manoch et al., 2009) can be of benefit. The latter may be more accessible for certain groups, for example, healthcare professionals (see Part 2).

THE EMBODIMENT OF THE THERAPIST

The role of embodiment in the mindfulness teacher and the impact of group dynamics has been harder to evaluate empirically, yet both are likely strong contributors to the effects. Therapist competency is often mentioned in the literature (Crane et al., 2010) although is not an issue solely related to mindfulness-based approaches (Shafran et al., 2009). Crane emphasises the importance of embodiment of mindfulness by the teacher, which not only requires adequate training but also an intensive personal practice in daily life (Crane, 2016; Crane et al. 2020). How our clients see us as therapists respond mindfully and compassionately to emotional distress (theirs and our own) is a key element of modelling mindfulness in the room. Several studies indicate that therapist mindfulness *alone* already has positive impacts on the therapeutic encounter (Dunn et al., 2012; Grepmair et al., 2007). See also the section on Mindfulness in Individual work for more on this.

THE NEED FOR FORMULATION

Studies are on-going evaluating the use of MBCT for a range of psychological problems and are detailed in the following sections of this document. Key to these applications is a well-developed theoretical formulation as to why mindfulness training is suitable for a particular group. For example, Chadwick focused specifically on the distress associated with voices as a target for mindfulness practice for people who experience psychosis. For people with a diagnosis of Bipolar Disorder the focus has been on the reduction of the long-standing and chronic anxiety associated with the condition and increased psychoeducation about bodily states related to mania. Kristeller and colleagues have developed the MB-EAT programme for people with problems with eating and body image (and 'binge eating' specifically), using a curriculum that has a greater emphasis on mindful eating and mindful food selection. The reader is referred to the presenting problem specific sections in Part 2 for further details on these formulated approaches.

THINGS TO CONSIDER: THREE WAYS TO 'FORMULATE' MINDFULNESS

1. Take a standardised approach and replace the condition specific information aligned to the presenting problem.
2. Consider how a mindfulness-based approach might be suitable for different aspects of a presenting problem (particularly as relate to the benefits of more generic stress reduction or being more targeted to condition specific behaviours).
3. Tightly targeting a formulated understanding of the cognitive profile of a presenting problem to mindfulness theory in order to adapt what is taught.

Rather than seeing mindfulness as a 'cure all' for every condition, these researchers have tightly coupled the intervention to specific aspects of the psychological problem as a way to ensure the scientific integrity of the approach. **It would be inappropriate simply to take the MBCT approach of Williams and colleagues and apply it to any psychological problem, as this is specifically designed for people with recurrent depression.**

METHODOLOGICAL ISSUES WITH THIS WORK PRACTITIONERS MIGHT CONSIDER

Many of the studies, particularly in more 'niche' areas of mental and physical health are still at the feasibility and acceptability stage of research, with large scale randomised controlled trials still required.

While there is benefit to be obtained from the generic effects of standardised protocols, in the UK, more tightly formulated interventions are resulting in bespoke adaptations that may ultimately bear more fruit.

The design of appropriate control conditions (e.g. placebo, medication only, treatment as usual including medication and/or psychological interventions) or the use of a tightly matched (non-mindful) trial arm, has been a challenge in this field of research.

Several high quality studies that have included active control groups have shown limited and very specific effects from the mindfulness practice group as compared to the active control (Maccoon et al., 2012; McCartney et al., 2021; Shallcross et al., 2018; Williams et al., 2014). Maccoon et al. (2012) contrasted MBSR with an active control group and found no significant difference on questionnaire measures of anxiety, distress, medical symptoms and hostility, but some quite specific effects on thermal pain ratings.

Similarly, Williams et al. (2014) contrasted MBCT with an active control group and found no significant effect of mindfulness practice across the whole group of individuals considered to be experiencing a major depression (but specific effects for those with adverse childhood events). A recent systematic review and meta-analysis (McCartney et al., 2021) concluded that while there was good evidence for MBCT's efficacy when compared to treatment as usual, its comparison to other active treatments was non significant.

Finally, Shallcross et al. (2018) report equivalence between MBCT and an active control condition at 26-month follow-up for relapse to depression. **As such, MBCT may be an alternative treatment, rather than a superior treatment.**

Which outcomes to measure is also hotly debated (Baer, 2011; Davidson & Kasniak, 2015). The quantification of mindfulness via questionnaire measure is difficult, and there are some cases where symptom rating scales can increase post mindfulness as avoidance strategies have been dropped. Changes in wellbeing may be useful and supportive (especially in those managing chronic conditions), but these metrics are not the same as directly targeting 'clinical' outcomes. Underlying cognitive neuropsychological changes (e.g. Lao et al., 2016; Moore & Malinkowski., 2009, Sumantry et al., 2021) may also be considered as target outcome metrics contributing to therapeutic effects.

Qualitative and narrative data is often extremely rich in this field, but does not lend itself to the RCT methodology design favoured by healthcare service providers.

DIALECTICAL BEHAVIOUR THERAPY (DBT)

Dialectical Behaviour Therapy (DBT) was developed by Marsha Linehan and colleagues as a psychotherapeutic approach for people with problems with interpersonal relationships, emotional dysregulation, and self-harm behaviours living in the community. It is offered to those who (at that time) were recipients of the psychiatric diagnosis of Borderline Personality Disorder (BPD) (Linehan, 1993a, 1993b). Linehan asserts the centrality of mindfulness to DBT by naming it as a 'core' skill. She defines the mindfulness used in DBT as 'psychological and behavioural versions

of meditation practises from Eastern Spiritual training'. Although the evidence base is still small, DBT is a recommended treatment for people who self-harm (NICE, 2009).

Mindfulness, distress tolerance, emotional regulation and interpersonal skills are trained in DBT. Mindfulness supports the latter three – helping clients to tolerate and accept distressing and painful emotional experiences, learning how to choose how to respond, and practising boundary setting and communication in order to enhance relationship skills.

The core foundations of DBT include:

- A Cognitive Behavioural approach;
- The integration of Eastern Meditative Practice, in particular Zen Buddhism, including mindfulness;
- A dialectical philosophical framework with the most important dialectic being the discourse between acceptance and change.

As stated earlier, mindfulness is the process of paying attention intentionally and without judgement to what unfolds in the present moment. In DBT this skill is practised in each therapy session and before each skill group module. Mindfulness is a skill both therapist and client are expected to practice. The aim is to teach the ability to use attention flexibly so that the individual has a choice about what to attend to. This allows the possibility of reducing rumination, increasing emotional tolerance and choosing not to respond in a habitual manner to stimuli that previously led to impulsive action.

Though Linehan's application of mindfulness to therapy comes via a similar route to Kabat-Zinn's (1994) MBSR/MBCT (Segal et al., 2012), there are differences in the way it is approached. MBSR and MBCT are closer to the Buddhist practice model where a period of silent practice may last 40-45 minutes and consist of mentally scanning the body bit by bit with rigorous daily practice regimes. As DBT is designed for a client group with challenges to emotional regulation, practice is for shorter periods and more integrated into normal life. There is less of a feeling of adopting a practice, and more of learning an approach to life.

DBT CORE SKILLS AND THEIR RELATIONSHIP TO MINDFULNESS

DBT introduces clients to seven skills to assist in developing Mindfulness. They are the three 'What Skills', the three 'How Skills', and 'Wise Mind'. The 'What Skills' are 'observing', 'describing' and 'participating'. The 'How Skills' are 'without judgement', 'one mindfully' and 'effectively'. 'Wise Mind' is learning to integrate the emotions (Emotion Mind) with logical rational thought (Reasonable Mind).

As with all mindfulness, 'observing' is a very important skill. However, Linehan introduced 'describing' as a distinct skill. The rationale for this client group is their particular challenge to be aware in the present moment. Learning to describe thoughts, feelings and experiences in a factual way, as they happen, helps to develop their skills without getting caught up in their internal or external experience.

Observing, describing, non-reactivity, non-judgement and acting with awareness are all facets of mindfulness assessed by one of the more common mindfulness questionnaires, The Five Facet Mindfulness Questionnaire (Baer et al., 2006). See Gu et al. (2016) and Williams et al. (2014) for the issues related to using this scale pre- and post-treatment in various samples.

In DBT mindfulness practice, 'participating' is the ability to be totally absorbed and aware of what you are doing in the present, perhaps closest to Kabat-Zinn's description of mindfulness as being present in one's own life, moment by moment.

The DBT 'How Skills' stress practising letting go of judgement as part of being mindful, to help the person see things as they are rather than reacting to their constructs about the situation. For example, Linehan describes using mindfulness to observe internal and external events without trying to stop them if distressing, or prolong them, if positive.

'One mindfully' reinforces the importance of focusing on the present rather than ruminating about the past or becoming worried about the future. 'Doing things effectively' is defined as doing what works to achieve the desired outcome.

The experience of 'wise mind' combines intellectual knowledge with intuitive wisdom. DBT suggests that 'wise mind' needs to be developed and used, as it is the most effective way to solve problems and deal with difficulties.

This mindfulness practice is enhanced by seeking feedback from the participants on what difficulties they experienced in employing the 'What' and 'How' skills to achieve a 'wise mind' and noticing the effect this had on their mood and ability to function.

EVIDENCE BASE FOR DBT

Whilst the evidence base is still small, there is emerging evidence that DBT has some efficacy with a range of clients, settings and difficulties (Lynch et al., 2008). For example: women with a diagnosis of Borderline Personality Disorder and substance misuse (Linehan et al., 1999); women with binge eating difficulties (Telch et al., 2001); older adults with a diagnosis of both depression and personality disorder (Lynch et al., 2007); adults who had experienced sexual abuse in childhood (Decker & Naugle, 2008); suicidal young people (Miller et al., 2006); male offenders in a high secure setting (Morrissey & Ingamells, 2011); male forensic inpatients (Sakdalan et al., 2010); adapted and used in Community Intellectual Disabilities services (Thomas et al., 2007; Lew et al., 2006; Baillie et al., 2010).

ACCEPTANCE AND COMMITMENT THERAPY AND MINDFULNESS

Acceptance and Commitment Therapy (ACT) developed by Steven Hayes is a behavioural therapy focused on committing to values-guided action; identifying individual core values and using these to guide, motivate and inspire behavioural change (Harris, 2009). ACT has developed in parallel with a basic behaviour-analytic account of human language and cognition called Relational Frame Theory (RFT). These basic theory accounts and clinical models have each informed the other as they have progressed.

ACT CORE SKILLS AND THEIR RELATIONSHIP TO MINDFULNESS

There are six core therapeutic processes in ACT which are as follows:

- Contacting the Present Moment (Be Here Now). To be psychologically present and consciously connecting with and engaging in what is happening in this moment.
- Cognitive Defusion (Watch Your Thinking). To step back and detach from thoughts, images and memories.
- Acceptance (Open Up). To make room for painful feelings, urges and emotions instead of fighting them or running away from them.
- Self-as-Context (Pure Awareness). Understand the 'observing self' and become aware of what we are thinking, sensing, feeling or doing in the moment.
- Values (Know What Matters). What truly matters to you in the big picture? Clarifying values to guide our actions.
- Committed Action (Do What It Takes). Taking effective value-guided action to create a meaningful life.

These are not separate processes; however, when first engaging with ACT it can be helpful to work through them separately before putting them all together. When the core processes are seen as working together they support the development of psychological flexibility, a core aim in ACT. Psychological flexibility is the ability to fully contact the present moment and the psychological reactions it produces as a conscious person and to modify behaviour in the situation in the service of chosen values.

ACT further recognises multi-layered complexity in the experience 'self'. Mindfulness is the tool to reach what they see as a transcendent sense of self where thoughts and feelings are experienced as just that, and a person does not identify with a conceptual self such as 'I am bad' or 'I am worthless', (Fletcher & Hayes, 2005).

ACT has a different attitude, compared with the other third wave therapies, to the mindfulness traditions that they all draw on, and so a different position with regard to mindfulness skills acquisition and practice. It does not follow a manualised protocol for its mindfulness; instead the therapist creates them or co-creates them with the client. In practice this means less formal mindfulness practice and greater collaborative experimentation with individualised, informal mindfulness practice with a clear value link.

ACT is not focussed on symptom reduction. Mindfulness skills are taught as a way to facilitate a change in the relationship a client has with their symptoms so that these no longer hold them back from valued-guided action. Quality of life is improved in part through the re-engagement with positive actions and a reduction in reactivity to symptoms through mindfulness.

Practitioners used to working from models focussed on symptom reduction may be challenged in the process of learning and using ACT tools. However, utilising ACT techniques for themselves will enrich the therapist's own experience of life as well as greatly improve their effectiveness in applying it with their clients.

In summary, although ACT does not prescribe exacting mindfulness practice for either its therapists or its clients, the whole enterprise is transfused with the spirit of mindfulness, and mindfulness is central to the crucial ACT aims of defusing thought and language, attaining acceptance and reaching a transcendent sense of self. For this reason, ACT is included in Baer's (2003) review of mindfulness training as a clinical intervention. Although ACT does not describe its interventions in terms of mindfulness or meditation, it is included here because several of its strategies are consistent with the mindfulness approaches described. Clients in ACT are taught to recognise an observing self who is capable of watching his or her own bodily sensations, thoughts, and emotions. They are encouraged to see these phenomena as separate from the person having them.

ACT EVIDENCE BASE

Like all third generation behavioural therapies, successful use of ACT is dependent on the training levels and experience of the practitioner as well as the interest and motivation of the client. In the right setting, ACT has been shown to be effective with a range of conditions including the following: anxiety (Eifert & Forsyth, 2005); depression (Zettle, 2007); obsessive-compulsive disorder (Twohig et al., 2006); social phobia (Ossman et al., 2006); generalised anxiety disorder (Dalrymple & Herbert, 2007); psychosis (Bloy et al., 2011; Gaudiano & Herbert, 2006), borderline personality disorder (Brann, et al., 2007–2009); workplace stress (Bond & Bunce, 2000); chronic pain (Dahl, Wilson & Nilsson, 2004; NICE, 2021); psychological adjustment to cancer (Branstetter et al., 2004); epilepsy (Lundgren et al., 2008); weight control (Tapper et al., 2009); smoking cessation (Brown et al., 2008; Gifford et al., 2004); and self-management of diabetes (Gregg et al., 2007).

In a review of meta-analysis of empirical studies of the effectiveness of ACT Gloster et al. (2020), 20 meta-analyses, 133 studies, and 12,477 participants, found ACT to be effective for a range of presenting problems. What was not ascertained in these studies was the role of mindfulness within the ACT interventions. Hacker et al. (2016) conducted a more nuanced type of meta-analysis to explore the effectiveness of ACT for anxiety and depression. Using a sequential meta-analysis method, they concluded that there was insufficient evidence for ACT when compared to an active control condition in the management of anxiety. A similar result was found for depression.

COMPASSION FOCUSED THERAPY AND MINDFUL SELF COMPASSION

Compassion and mindfulness go hand in hand and support each other. Both have links (and are linked) in many contemplative traditions. Recently psychologists have become interested in how the two can be combined in therapeutic approaches to bring added benefits to therapeutic goals and performance (Dorjee, 2016; Van Gordon et al., 2022)

Compassion involves an appreciation of suffering and a wish to alleviate it. Self-compassion involves including yourself in the suffering you appreciate and wish to alleviate. According to Neff (2003) there are three components to self-compassion:

1. Self-kindness – which is generated when our inner dialogue becomes more supportive and our self-talk soothes us in the face of a hostile environment.
2. Common humanity – which is the insight that all humans experience failure and suffering which helps to contexualise our experience more broadly.
3. Mindfulness – used as a means to support our ability to recognise our thoughts and feelings as just that, thoughts and feelings, and not overly identify with them. Thus we are able to observe with greater clarity the pain we may be in without being overwhelmed by it or creating defences to protect ourselves.

Gilbert (2009) proposed that self-compassion has its basis in human evolution, that as mammals we are shaped by attachment and affiliation and a propensity to tend and to befriend. It is suggested that people who grow up in safe and secure environments with validating and supportive caregivers internalise this and so develop the ability to show compassion to themselves. In contrast, it is suggested that those who grow up in environments that were hostile, insecure and lacked validation do not develop the internalised resource of compassion that they can use to soothe themselves in times of trouble.

It has been proposed that those who have been unfortunate in the environment in which they grew up in can still be taught the skills of compassion. Gilbert and Proctor (2006) developed a group based approach called compassionate mind training (CMT). This training was developed with clinical populations with high shame and self-criticism. It aims to help them gain those skills that their developmental environment did not positively assist them in developing.

This approach has been further developed by Gilbert into a model of working called Compassion Focused Therapy (CFT) which could be used in individual and group work. This approach is considered to be a form of Third Wave CBT. The approach has at its centre compassionate mind training. It aims to integrate ideas from standard CBT with attachment theory, evolutionary psychology, developmental psychology, neuroscience and Buddhist psychology.

Germer and Neff (2013) have developed their approach which combines self-compassion and mindfulness to create a group therapy that they call Mindfulness Self Compassion (MSC). It takes as its basis the structure of Kabat-Zinn's MBSR course but adds in self-compassion as a dual

theme throughout the course. Neff (2012) stresses that Self-compassion is not to be confused with Self-pity, Self-indulgence or Self-esteem.

In terms of evidence base for these approaches Leaviss and Uttley (2015) conducted a systematic review of the research evidence for CFT finding 14 studies, three of which were RCTs. Their conclusions were that whilst the studies showed promise for CFT there was a need for larger high quality studies. Craig et al. (2020) in a systematic review of CFT studies for effectiveness and acceptance with clinical populations note the holistic, integrative and transdiagnostic elements of the approach. They consider that CFT has much promise when delivered in a group format for at least 12 hours. They suggest that CFT needs a universal updated manual to direct the type of research needed to justify the provision of CFT in health services.

CFT has also been evaluated in the general population (*N*=55) using a pre-post design with three month follow-up (Irons & Heriot-Maitland, 2021). The eight-week intervention showed significant increases in compassion, self-reassurance, social rank, positive emotions and wellbeing. There were reductions in self-criticism, attachment anxiety and distress.

Neff and Germer (2013) carried out a pilot study and a randomised control trial on their MSC approach. This produced positive results finding gains in mindfulness, self-compassion and wellbeing that were maintained in a six-month follow-up. However, there was no active control in this study and there is a need for more research.

The importance of self-compassion in mental health and resilience is beginning to be understood more thoroughly (c.f. the findings of the meta-analysis conducted by MacBeth & Gumley, 2012). While mindfulness and self-compassion seemingly have developed separate trajectories in terms of the different protocols developed, elements of mindfulness and self-compassion are involved in both types of approaches with varying degrees of emphasis. Delineating the specific contributions of each will require more research. It may be helpful to understand that mindfulness and compassion are considered to be two wings of the same bird in Buddhist traditions (Kraue & Sears, 2009).

MINDFULNESS IN INDIVIDUAL WORK

The majority of the research concerns group based mindfulness training (MBSR/MBCT/DBT/MSC), with some MBIs also including individual work or a blend of group and individual sessions (ACT/DBT/CFT). This section explores how the clinician might approach using mindfulness in the context of individual work and points to a number of considerations to be held in mind. What we are keen to avoid, is the ad hoc addition of 'mindfulness techniques' to sessions or interventions. Where the formulation indicates mindfulness training might be a suitable addition to the work, the practitioner might consider where this training is best accessed (which may not necessarily be with the therapist in session).

This section covers:

- the benefits of the therapist themselves practising mindfulness;
- the sharing of mindfulness biblio and digital self help materials to support psychological work;
- and the delivery of standardised protocols in the one-to-one setting.

THERAPIST MINDFULNESS

Therapists themselves can also enjoy the benefits of mindfulness on emotion regulation and wellbeing, yet this training can also enhance therapeutic alliance and the efficacy of our work (Davis & Hayes, 2011). Mindfulness and self compassion skills may be particularly helpful when working with challenging client groups or in difficult/hostile therapeutic environments. See also Section on Mindfulness for Healthcare Workers in Part 2.

Several studies indicate that therapist mindfulness *alone* has positive impacts on the wellbeing of the therapist (Martin-Cuellar et al., 2019), and the therapeutic encounter (Dunn et al., 2012; 2013; Grepmair et al., 2007; Grepmair et al., 2008). Clients seen by a therapist with their own mindfulness practice have better 'symptom' outcomes with their clients (Grepmair et al., 2006), and even a short duration 'centering' exercise led to clients perceiving the therapist as more present and the sessions as more effective (Dunn et al., 2012).

Therapists using mindfulness for personal wellbeing may be easier to supervise (Christopher et al., 2010), as they are more attuned to physical and mental reactions (their own and their clients). They are less judgemental about mistakes, and therefore more open and honest in supervision. Christopher et al. (2010) report 'My experience supervising those students who had mindfulness training is that they had a different kind of experiential foundation, one in which they were able to experience less reactivity, less automaticity.' (p.123)

Personal mindfulness can help when working with clients with chronic emotion dysregulation difficulties (the cluster formerly referred to as borderline personality disorder, c.f. the DBT requirement for the therapist's own therapy). In these challenging therapeutic relationships, mindfulness skills can help therapists to notice more quickly when they are being pulled into unhelpful relating dynamics, and maintain a compassionate stance. See also Section on Mindfulness for people with personality disorder.

Another client group where this may be helpful is working with individuals with chronic eating and body image difficulties. Here the impact of the work on the therapist can be significant (Graham et al., 2020), and the engagement of the client group may be insufficient for standardised mindfulness training (Boudette, 2010). See also Section on Mindfulness for people with problems related to eating and body image.

A mindful therapist may also be more equipped to face the challenges of working with individuals with chronic (or terminal) health presentations that require management rather than provide options for 'successful treatment' (Orellana-Rios et al., 2017). See also Section on Mindfulness based interventions for people with physical health problems.

Singh's work provides a wonderful example of how education on the principles of mindfulness (and particularly the concept of 'beginner's mind') was helpful for staff working in the learning disabilities setting (Singh et al., 2006). Whilst not neglecting risk, being present with these clients in a mindful way, provided opportunities for change and growth that were less inhibited by prevailing narratives 'enshrined' in hefty case notes. See also Section on Mindfulness for people with intellectual disabilities.

SHARING MINDFULNESS MATERIALS

Clients are increasingly arriving into the therapeutic setting with an awareness of mindfulness. The popularity of mindfulness books, apps, online and in person courses, suggests that they are offering something that is needed in both the general and clinical populations. Within UK health services, the IAPT pathway offers a model of how bibliotherapy and digital approaches

can be used in the context of a stepped CBT model (Thew, 2020), but is this appropriate for mindfulness-based work?

An exhaustive review of what is available is beyond the scope of this document. The reader is encouraged to be familiar with the recommended texts from reliable sources (see Appendix 2 for suggested reading materials), explore for themselves the digital resources circulating in the general population, and listen to what their clients say about the materials *they* are finding helpful. Some, but not all, may be suitable preparation or adjuncts for psychological therapy (mindfulness or other). Key things to consider when sharing self-help tools are shared in the box below, (see also Russell et al., 2018).

THINGS TO CONSIDER WHEN SHARING MINDFULNESS MATERIALS

- Clients with trauma or body focusing issues (e.g. eating disorders, dissociation, depersonalisation, etc.). may need a scaffolded learning approach to enter into the preliminary mindfulness exercises such as the Body Scan.
- Clients with avoidant tendencies (e.g. addictions or other coping strategies based on avoiding emotions) may need more support when using tools that invite them to turn towards difficulties and stay with discomfort.
- The level of distress, support available to the individual should anything arise, and (in the case of physical health), timing of the recommendation should be considered. For example, mindfulness of the body and breath may be particularly challenging for a person who has just received a terminal diagnosis.
- The type of 'meditation' in the app may have implications for some clients. Meditation apps cover a range of exercises from a variety of psychological and contemplative traditions under the heading of 'mindfulness'. This might include open monitoring, open awareness, imagery, trance induction and/or visualisation techniques. Some of these may promote dissociation or depersonalisation, and be at odds with the intent of secular mindfulness as a way to be present with what is happening here and now in a non-judgemental way.
- Check with the client what they are using, how often, their experience and inquire 'Does this help?' and 'How does this help?' or 'What are you finding easy or difficult?' Be alert to unusual or unexpected effects. See also the commentary on monitoring unusual or unexpected effects within the Clinical Governance section.

BOOKS

Service users may have worked independently through books such as *Finding Peace in a Frantic World* (Williams & Penman, 2011) or *The Mindful Way Through Depression* (Williams et al., 2007). Alternatively, they might be supported to work through these texts within individual work. This could be an option for clients who are unable (or unwilling) to attend groups, or who may also need further support to contain what might come up for them as they increase their self-awareness. Psychologists need to be personally well acquainted with the book's contents and methods. Please see Appendix 2 for a selection of book recommendations.

This model of working is more in line with ACT and DBT skills based approaches, and less often utilised for MBSR/MBCT. A comparison of self-taught versus instructor led use of Finding Peace in a Frantic World to train mindfulness in a *(non-clinical)* sample of educators found that although gains in wellbeing and self-compassion were seen in both trial arms, the instructor led arm also

improved anxiety, perceived stress, burnout, depression, mindfulness and was seen as more credible (Montero-Marinn et al., 2021).

A meta-analysis of 15 self-help studies in *non-clinical samples* self-referring for a variety of mental and physical health conditions, demonstrated improvements in mindfulness and acceptance, and reductions in depression and anxiety (Cavanagh et al., 2014). These studies contrasted therapist-supported (less than 90 minutes total support) and self-directed interventions (books, apps, online courses), lasting between two weeks and six months, with wait list, no intervention, and monitored online discussion board conditions. Variable levels of therapist input was observed across studies, some of whom used these resources to augment other approaches, but in all cases was less than in a traditional psychological intervention. The results from this meta-analysis suggest small to medium effect sizes for self-help interventions under these conditions.

Hazlett-Stevens et al. (2017) contrasted bibliotherapy with an MBSR workbook with a no treatment control group (*in a student sample*). They report decreases in depression, anxiety, stress, perceived stress and anxiety sensitivity. There were no statistical group effects for social relationships, quality of life, work or experiential avoidance measures. Generalisation of these findings to clinical samples requires further research. These approaches tend to be more often offered in the health psychology setting (e.g. Hearn et al., 2018; Tavallaei et al., 2018), rather than the mental health setting.

ONLINE

A variety of online mindfulness courses are available. Some stick more closely to the standardised protocol template, while others have been more creatively adapted. These interventions could be asynchronous (meaning self-directed), synchronous (meaning there is some contact with a professional in the online environment), or fully therapist guided. These easier to access options may be suitable for individuals who might struggle to attend sessions due to time constraints (e.g. carers; see Hearn et al., 2019), or their psychological profile (e.g. autism or PTSD, see Gaig et al., 2020; Wahbeh et al., 2014). They may have more appeal for young people (Ritvo et al., 2021), and might be a good preventative option for high risk populations (e.g. university students, but see Burrows, 2015, for caveats). In an open survey of more than 500 individuals, Wahbeh's research found that individual and internet interventions were preferred by their sample, with 11 per cent of individuals indicating they would refuse to attend a group (Wahbeh et al., 2014).

A review of the literature (Spijkerman et al., 2016) examined effect sizes from 15 online mindfulness studies.These included ACT, MBSR, MBCT and some bespoke interventions delivered online to adults over 18 years of age with a range of presenting problems and some community samples. Moderate effects were found for improvements in stress, with small effects for depression and anxiety. Subgroup analysis showed that guided online interventions had larger effect sizes than self-guided. Effect sizes for stress reduction were moderated by the number of sessions completed.

A mindfulness and CBT online offering was contrasted to wait list control by Gaigg et al. (2020) in a sample of adults with autism. Relatively durable reductions in anxiety were observed for both the mindfulness and CBT groups, although on broader measures of mental health and wellbeing (e.g. CORE-OM) there was little impact. Note-worthy with this study was the high engagement of participants with the online programmes. For certain populations who might struggle with group mindfulness or individual therapy, these self-help digital offerings may prove a viable alternative. More research is needed in this area.

Shao et al. (2021) also demonstrated that a six-week guided self-help intervention based on mindfulness reduced the distress of rumination in women with breast cancer (compared to a wait list control group). See Vignette below for the importance of the *timing* for this sort of intervention.

THINGS TO CONSIDER

Balancing what is gained (accessibility, time requirements, reduced cost) and what might be lost (group/therapist support, a model of mindfulness in the teacher, deeper structural changes in psychological processes) will be important. Two key considerations are the level of distress experienced by the individual, and the amount of support available should any unusual or unexpected effects arise. While there are many resources available to the general public, the use of these by those engaged in services (with expected higher levels of distress, or more likely to have self/other relational difficulties) has been less well evaluated. For the majority, mindfulness is likely to offer something helpful, but for some, it may be insufficient and even detrimental. The reader is also referred to the Section on Unusual and Unexpected Side Effects.

NICE recently reviewed (2019) a very popular digital mindfulness intervention for use within IAPT Step 1 and 2. The panel concluded it did not meet eligibility criteria for a therapist guided model of care.

Those interested in this area may benefit from the updated guidance on best practice for the delivery of mindfulness groups online, aligned to the Mindfulness-based Instructor Teacher Assessment Competencies (Sansom et al., 2020).

VIGNETTE:

One of the authors worked in a gynaecological oncology service spanning both in and outpatient treatments. Often, GPs would recommend mindfulness resources for women recently diagnosed with gynaecological abnormalities. The evidence that mindfulness helps with stress reduction could be part of the driver for this well-intentioned recommendation. Certainly the experience of receiving a diagnosis (or needing further investigation) might be less traumatic if stress levels are managed. However, asking women who recently have discovered that their body is 'letting them down' to complete (unsupervised) mindfulness of the body scans on a regular basis may serve to increase stress and anxiety rather than decrease it. Mindfulness of the breath might also trigger awareness of mortality, and the very real insight that the number of breaths available is limited.

TEACHING A STANDARD (GROUP) PROTOCOL TO AN INDIVIDUAL

There is some evidence that group and individual mindfulness confer similar benefits (Schroevers et al., 2016). The standard training pathway for MBSR/MBCT would still be a requirement for the therapist, with some additional training and supervision to support learning around individual delivery and some of the challenges this raises. Tovote et al. (2014) reported positive outcomes for mood (compared to waitlist and equivalent to CBT) in individuals with diabetes who completed individual MBCT. Three things to consider are outlined below: the role of the group; skillful sharing and disclosure from the therapist; and individual formulation.

THE ROLE OF THE GROUP

The benefits of the group environment for mindfulness training are likely important contributors to its efficacy. Qualitative studies indicate these can include offering a sense of community

and support (Allen, Bromley, Kuyken & Sonnenberg, 2009; Bogosian et al., 2016; Finucane & Mercer, 2006; Fitzpatrick, Simpson & Smith, 2010), providing opportunities to learn from others (Chambers, Foley, Galt, Ferguson & Clutton, 2012; Griffiths, Camic & Hutton, 2009; Mackenzie, Carlson, Munoz & Speca, 2007), and offering 'positive peer pressure'/motivation to maintain mindfulness practice (Allen et al., 2009; Griffiths et al., 2009; Langdon, Jones, Hutton & Holttum, 2011). As such, group based mindfulness approaches have much to offer, on top of the individual benefits of mindfulness.

SKILLFUL SHARING AND DISCLOSURE

However, there may be instances where group mindfulness is not an option and is therefore offered in the individual setting. Without the group to support the processes described above, the psychologist must skilfully and appropriately find ways to share their own experiences and motivate engagement. Self-disclosure from the therapist may increase (and is informed by the therapist's own experience of mindfulness) which can shift power hierarchies in the room. Mace (2007) provides a general introduction to mindfulness in the therapy room across psychotherapeutic modalities.

INDIVIDUAL FORMULATION

If using an individual mindfulness-based approach psychologists are advised to make an individual formulation of the client's psychological difficulties such as ruminations, voices, overwhelming emotional states and then tightly couple the use of mindfulness practice to this particular issue. Mini formulations for the mental phenomena that are causing distress may be helpful, alongside an exploration of what it would be like for the individual to maintain their current behaviour, or try something different. For example, the benefits or costs of trying to avoid the voices, versus experimenting with turning towards them and being curious. This might be done initially within a motivational interviewing framework.

KEY POINTS

- Therapist personal mindfulness can support their own emotion regulation and relating capacity in ways that increase personal wellbeing, and enhance therapeutic alliance. Highly recommended for these reasons.
- A therapist may suggest biblio/digital self-help mindfulness materials during a waiting list period or to augment therapy work. More aligned to DBT/ACT ways of working, and may not be suitable for some client groups.
- A therapist may teach mindfulness skills directly to the client in session. This might include teaching a formal protocol such as MBCT/MBSR to an individual. Requires personal fluidity with the concepts and process. Small evidence base for this.

Clinical governance: competences, unusual and unexpected effects, inclusion

COMPETENCIES

Clinical governance is important to protect clients, clinicians and the organisations in which they work. In addition, it is important to protect the integrity and standards of mindfulness as an approach. There is ample evidence in this document to demonstrate that mindfulness is an effective and safe intervention for a range of clinical problems and client groups, and that it should be widely available both in the NHS and from private providers. In considering clinical governance for mindfulness-based approaches the following factors are important:

- What degree of training and experience does the clinician need to be able to deliver this particular mindfulness-based approach competently and safely?
- Is the clinician planning to use the mindfulness-based approach personally to develop their abilities and hopefully improve performance, or is it an intervention with others, teaching a staff member about group mindfulness practice or teaching service users mindfulness practice?
- If with service users, what is the evidence for the use of any mindfulness-based approach with the client group they intend to work with, and in addition the evidence for the specific mindfulness-based approach that they plan to use with this client group?
- If with service users, what degree of psychological stability does the service user have at that time? This can be more important than any diagnostic category that might be given to them.
- Is the clinician keeping their personal practice, maintaining CPD and do they have appropriate supervision to cover the mindfulness-based approach?

What distinguishes the MBSR and MBCT from the ACT and DBT approaches is that the former two require the facilitator to be a mindfulness practitioner themselves, whereas ACT and DBT are less rigid on this point. This impacts on the training pathway for therapists using the different types of approaches. However, there is certainly evidence that all these approaches have been helpful to those suffering from psychological distress (see meta-analysis listed in Appendix 1).

While there are not currently any statutory regulations relating to the teaching of mindfulness-based approaches, MBSR and MBCT have a formal training pathway that includes a minimum amount of personal practice and retreat experience. Crane and colleagues in the Mindfulness Teachers Network have published guidance on the recommended requirements for those teaching mindfulness (Crane & Hecht, 2018; Crane et al., 2010, 2012). The newly developed Mindfulness-based Interventions Teacher Assessment Competencies Framework also provides guidance on what is needed to competently and safely deliver mindfulness in the clinical setting (Crane & Kuyken, 2019), and online (Sansom et al., 2020). There is also now an adherence scale to standardise protocol delivery (Segal et al., 2002), and clear supervision guidelines (Evans et al., 2015; 2021). The reader is also referred to The Mindful Nation report (2015) by the UK's All-Party Parliamentary Group which makes suggestions for maintaining the integrity of MBIs as their popularity grows (p.64).

The training for DBT is licensed and standardised in the UK. It requires training in the four components offered in the standardised comprehensive DBT framework:

- Individual therapy for the client (approximately 60 minutes/week);
- Group educational skills training (approximately 120 minutes/week);
- Team meeting/therapist support (approximately 90 minutes/week);
- Unscheduled telephone calls (variable duration).

There is no formal requirement for mindfulness training in DBT therapists, yet as these core mindfulness skills support emotion regulation and interpersonal skills (the main targets of the work), familiarity with mindfulness personally will likely support the process.

Training in ACT is often through short courses or workshops. There are no specific requirements for the therapist to practice their own mindfulness. CFT, CMT and MSC have similar training pathways (introductory workshops, practical experience with supervision and advanced training). There are recommendations for personal familiarity with the exercises and processes (Kolts, 2018).

UNUSUAL AND UNEXPECTED EFFECTS

Mindfulness should not be considered to be something that is beneficial to all people at all times in all circumstances. Part of the aim of this document is to draw out some of the circumstances that are more likely to be beneficial, such as conducting standardised group mindfulness protocols with people with recurrent depression, and those that may be less so, such as a clinician without a robust personal practice who 'bolts-on' mindfulness to their general clinical work with clients.

Perhaps a difficulty engaging with these kinds of effects is that mindfulness has been presented in parts of the media as a universal good that can do no harm. Criticisms have been raised, in mainstream media as well as academic and practitioner journals, about the lack of reporting of unusual or unexpected effects (Britton, 2016, 2019; Farias & Wilkholm, 2016; van Gordon et al., 2017). One systematic review of the more broadly defined 'meditation therapies' indicated 'adverse effects' at a prevalence rate of 8.3 per cent, noting this figure is similar to what is reported in psychotherapy practice in general (Farias et al., 2020).

This figure is broadly similar to that reported by Baer et al.'s (2021) evaluation of harmful effects in schoolteachers and university students participating in an adapted MBCT programme. In this self-report study, the proportion of students reporting harm from the course ranged from 3–7 per cent. This was in the context of a large majority (roughly two-thirds) of participants reporting unpleasant experiences (although these were determined to be not at all, or somewhat upsetting).

However, mindfulness can still be understood as something which is in itself a healthy thing to do, but for certain people in certain circumstances it will not be, just as going for a run is a healthy thing to do, but not for someone with pneumonia.

TERMINOLOGY

The terms 'unexpected' or 'unusual' effects are chosen as preferable to the more medical language of 'contraindications' or 'adverse effects'. In other parts of our clinical work, such effects might be seen as something going wrong or that the person's experience of a mindfulness practice has, at least in the short term, led them to being in a more negative psychological state. From a mindfulness perspective, this is the moment to amplify compassion and curiosity, as *here* is the possibility of changing the relationship to difficult experiences. This stance is easier if the mindfulness work is held in a psychologically safe container by an embodied practitioner, and is more challenging for an individual working alone.

Wong et al. (2018) report relatively few adverse effects in MBSR/MBCT relative to control groups, with the caveat that the collation of adverse events is not common in the reported literature, and ideally needs to be routine/standardised.

Farias et al.'s more recent review (2020) found that 'adverse' events were not uncommon, and affected people who had no previous history of mental health mental health problems. The most common adverse events included anxiety, depression and cognitive abnormalities, with gastrointestinal and suicidal behaviours less frequent. Similarly, van Gordon et al. (2017) acknowledge that participation in MBIs has both empirically and anecdotally been related to a variety of unexpected effects (e.g. executive memory impairments, depersonalisation, asociality, panic attacks, psychotic episodes, addiction (i.e. to mindfulness) and/or impaired reality testing).

Burrows (2015) raises concerns in relation to offering mindfulness interventions to vulnerable college students. College students in his pilot study offered the following insights around their experience of being taught mindfulness:

'heightened anxiety; a sense of panic; my heart beating madly; like my body is on autopilot and its acting on its own accord; as though I need to find a way to maintain my sense of self; as if I am not actually present; as if I am watching myself; hyper aware; as though I am checking out; like zoning out; as if I am losing spontaneity and second guessing myself; increased self-talk; numbness; as if I am on mute; as if I have left my body; that my body is freaking out; and seeing light spots that float around.' (Burrows, 2015, p.285)

To contextualise these findings, Lindahl et al., (2017) report on a range of unusual experiences seen in Westerners engaged in traditional Buddhist meditation. In this setting, these obstacles or 'traps' are well-delineated, often welcomed as indicating advancements on the 'path', and usually have particular remedies advised by the teacher or guide. These are experiences to be worked with and through with a trusted advisor who has significantly more experience and training.

MAKING THINGS WORSE?

In the clinical setting, unexpected events may take the form of secondary distress arising as the ability to mindfully observe behaviours and make contact with difficulties that were previously 'unseen'. Mitchell et al. (2018) raise this issue in the case of ADHD, hypothesising that enhanced perceptions of impairments may feed into notions of being 'broken'. Thus for some, an unintended side effect of mindfulness is feeling more helpless or flawed.

A related issue was observed in the early work with psychosis. Mindfulness training increased the confidence to engage with, and report on, hearing voices. On standard psychiatric scales, service users reported more voices (seemingly an increase in symptoms following mindfulness). However, the critical question in mindfulness is 'and what happened next?'; an inquiry into how the individual related to that symptom and the resultant level of distress. These findings point to the challenges of using standard symptom rating scales as a metric in mindfulness work. Reducing avoidance and increasing self-compassion may very well lead to increased reporting of symptoms, yet distress may be reduced as the individual learns to kindly and gently accept the experience.

Britton and Sydnor (2015) have suggested that there may be certain capacities that need to be established before engaging in certain forms of mindfulness or meditation training (p.413). This might include supportive and grounding activities to establish resilience and ego strength, and the provision of self-soothing options (including relaxation). As Britton (2016) states: 'A lot of psychological material is going to come up and be processed. Old resentments, wounds, that kind of thing. But also some traumatic material if people have a trauma history, it can come up and need additional support or even therapy'.

'Trauma-informed mindfulness' is gaining traction as a type of mindfulness intervention that prioritises self-soothing and self-regulation activities, prior to attentional and awareness training (Kiyimba, 2020; Treleaven & Britton, 2018). Elements of DBT/CFT and MSC are more aligned to this approach – starting the process with the emphasis on compassion and self-soothing, before enhancing awareness of patterns of behaviour or cognition that may be driving or amplifying distress.

There may also be unusual or unexpected effects when standardised practises are not suitable for the specific needs of the clinical group. See Hearn et al. (2020) for commentary on 'Trying to bring attention to your body when you're not sure where it is' or adaptations to the MBCT protocol for those with respiratory disease (Farver-Vestergaard et al., 2018). The reader is also referred to the work of Ellet and Chadwick (2021) for the monitoring of possibly harmful effects in the application of mindfulness for those experiencing psychosis. Part 2 details more on problem-specific adaptations extant in the literature.

THERAPIST RESPONSE IS VITAL

Unexpected events may be more problematic in groups taught by inexperienced clinicians (van Gordon et al., 2017). When unusual or unexpected effects occur, the practitioner has an important role in helping the person through them by drawing upon their training, their personal practice, their supervision and their familiarity with the client group. Part of the art is to recognise an unusual or unexpected effect as such, but at the same time to be non-reactive to it, in order to model a mindful response to the person or group.

The need for this level of expertise is stressed by Dobkin et al. (2012) in relation to MBSR and is equally applicable to all forms of mindfulness-based approaches: 'As MBSR becomes more 'mainstream', one must ensure that the instructors are adequately prepared to assist individuals who encounter serious difficulties (e.g. panic attacks and increases in pain) during or after the programme.' (p.47). Personal practice, CPD and supervision will help the clinician to ascertain whether it is necessary and kind to not persist with the mindfulness practice, or to 'stay with it' and move them through it in a mindful way.

When working with a group, if one person is experiencing an unusual or unexpected effect, the process will involve holding the group as a whole, as well as supporting the person experiencing the unusual or unexpected effect. Dobkin et al. (2012) gives such an example where one facilitator worked with a group member who was in distress and desired to flee, while the other worked with the group and their desire to help and to fix. Co-facilitation of groups can help to manage such instances (in a way that would be challenging with a single facilitator). Those delivering mindfulness online may need to manage 'leaving the room' in a different way.

Psychologists who practise mindfulness-based approaches need to embrace the concept of unusual and unexpected effects with courage and explore their own reactivity and impulse to 'fix' when things go 'wrong'. There is a need for colleagues to be compassionate and non-judgemental in discussing these situations so that maximum learning can occur. This is also an area which is clearly in need of further research.

BOX: SOME OF THE SKILLS OF A MINDFULNESS PRACTITIONER AND TEACHER

Being a mindfulness teacher and practitioner requires certain skills that include the following:

- The ability to help participants integrate both the positive and negative experiences that occur during their practice.
- The ability to help people who find groups difficult to participate in and benefit from group delivered mindfulness.
- Where mindfulness is delivered in a group setting to be aware of the group dynamics that develop.
- To be able to help participants respond positively to the state of being in beginner's mind.
- To be able to hold uncertainty themselves and help participants with their relationship to uncertainty.
- To be able to understand the complexity some people find in showing kindness to the self.
- To be aware of the challenges some people find in expressing compassion for themselves, compassion to others or in receiving compassion.
- To have an awareness of mental health and how mindfulness might impact individuals with different presenting problems. To know how to signpost to appropriate resources and support as indicated.
- To have an awareness of spirituality and where the experience of a mindfulness group may for some participants may demonstrate unmet spiritual needs with appropriate signposting.
- Teachers and practitioners outside of clinical services need awareness that they may attract people from a clinical population who may be using the mindfulness intervention as an additional support or as the only support mechanism for current difficulties. A screening process will allow this to be clarified before participants enrol on the intervention. Clear referral pathways to services such as GP or other mental health providers should be available if the facilitator is worried about anyone.
- Facilitators must know at what point the stance of acceptance and non-judging needs to switch to clinical judgement/discernment for those who may be experiencing unusual or unexpected effects that need more support.

ETHICAL MANAGEMENT OF UNUSUAL OR UNEXPECTED EFFECTS

Researchers and clinicians need to be vigilant for these effects; adopting standardised assessment and reporting tools so that these experiences can be collated systematically. Clinicians need to make their clients aware of the possibility of adverse effects, and create psychologically safe environments where it is ok to say 'this is not working'. Managing expectations can help. See the Box below for recommendations offered by Oxford Mindfulness Centre for those individuals engaging with their Mindfulness-based Cognitive Therapy for Life Course (aimed at the general public).

BOX: OXFORD MINDFULNESS CENTRE INFORMATION FOR PARTICIPANTS

What are the challenges?

- At first, practising meditation may feel strange or unfamiliar. As best you can, keep an open mind.
- It is not obvious at the outset which practices will be most helpful and you may not see benefits immediately. Practise gentle persistence, and remember that people respond differently.
- The amount of practice can feel daunting. However, consistent practice may increase the likelihood of benefitting from the course.
- Some people feel apprehensive about being in a group. However, learning from others and seeing that you are not alone can be very beneficial.
- You may face emotional issues that you would prefer to avoid. Difficulties that arise can be informative and the course will teach you skilful ways of responding to them.
- You may find yourself wanting to give up at times. This is common. Please speak to a teacher about any issues that are making things difficult for you. Teachers are available after sessions, or you can email to ask a teacher to contact you.

Source: https://www.oxfordmindfulness.org/mindfulness-based-cognitive-therapy-for-life-mbct-l/

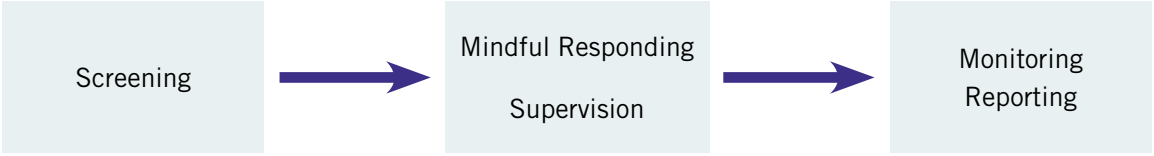
Formal screening is recommended for MBSR/MBCT group participation in order to ensure this is the right intervention and mitigate possible harm. Those with addictions, suicidal ideation, depersonalisation and recent bereavement may need special consideration. The timing of the intervention is relevant, noting that the strongest evidence base for MBCT/MBSR is for *preventing* relapse in depression, and the management of *chronic* pain. Hedman-Lagerlöf et al.'s (2018) meta-analysis concluded that the evidence of the effectiveness of mindfulness on 'Common Mental Disorders' in the *acute* phase was weak. If this is the case then it does not suggest that MBIs are of no use, but that the correct place for training (such as MBSR/MBCT) would be in the recovery and relapse prevention phase, with more applied mindfulness (e.g. DBT) suitable as an aid to manage more intense emotional dysregulation.

It may be useful to be aware of a person's trauma history before engaging in mindfulness-based approaches with them, for example using the Adverse Childhood Experiences International Questionnaire (WHO, 2011). This may not always be possible, and in some cases (e.g. working with staff groups) not appropriate. Presence of these issues does not necessarily mean the person cannot use mindfulness to good effect, but the timing and level of support around the intervention needs consideration. More applied MBI's (such as ACT/DBT) might also be considered as a first port of call.

In group dynamics, social expectancy effects may silence those who are having a different (e.g. negative) experience from the rest of the group, so must be actively elicited. For example, if one or several members of the group enthusiastically share how relaxing or helpful an exercise has been, enquiring 'Did anyone experience anything different, or even the opposite of this?'. Here the embodiment of the therapist is essential to model the ability to be equally curious and compassionate about things that are 'working' as well as things that are 'not working'. See above Section on Therapist Response. Anonymous feedback forms post intervention can also provide permission and a safe space for individuals to share unusual or unexpected effects, without feeling ashamed or inadequate. Remain actively curious and record information about attrition or disengagement.

Finally, Purser (2019) suggests that mindfulness situates the problem in people's heads and therefore takes attention away from the social injustices that are the root cause of people's problems. This criticism can be made of any individual based and focused therapy, including CBT. Providing an individual with skills to deal with their situation does not negate the need for paying attention to the social factors, and for people to advocate and take action for social change. In fact, being able to use mindfulness may make a person more effective in doing so.

Figure 4: Mitigating Unusual or Unexpected Effects in Mindfulness-based Interventions.



INCLUSION

Mindfulness-based approaches in our therapy work are not immune to the long-standing challenges faced by our profession to be inclusive. The strongest evidence base from the more robust large-scale meta-analyses report largely on participants that are female and Caucasion – those who are more likely to approach and engage with psychological therapies more generally (Chin et al., 2019).

Researchers are now actively exploring barriers to mindfulness in people of colour, trying to understand more about the effectiveness of MBIs in more diverse groups (Sun et al., 2012), and be mindful of any relevant cultural adaptations (Castellanos et al., 2020; Kirmayer, 2015). There is also emerging consideration (but little research) of the experience of mindfulness within the context of indigenous communities (Kirmayer et al., 2011). Clinicians with an interest in cross-cultural psychology may wish to explore this aspect of mindfulness further.

Increasingly, services are engaged in co-design and co-production of mindfulness interventions. This is particularly relevant in clinical populations where significant modification or adaptations of the standard mindfulness protocols is warranted (e.g. learning difficulties; Singh et al., 2011), in health populations where user experience can offer vital insights into what will really be manageable in terms of specific practices, or settings where non-specialist carers may have more contact with service users (e.g. older adults and some chronic health conditions).

The reader is alert to the distinction between programmes designed by experts by experience who also have significant personal or professional training in mindfulness, and those where the person with experience works alongside a clinician. Two such examples of the former include Breathworks (see the section below on Illustrative Extensions of MB models for more on this programme), and the Heartfulness Project. The Heartfulness project is an early stage protocol designed by a psychologist trained as a mindfulness and self-compassion teacher who uses compassion and mindfulness herself to help manage the challenges of a life with stage 3 heart failure (Campbell et al., 2019). This approach is distinct from co-designed adaptations, which might include therapists with mindfulness training and experience working alongside service users to make adaptations (for example, co-designed audios for those with Tourette's, see Anderson, 2019).

This is an emerging area of mindfulness innovation that very clearly prioritises the voice of service users who can provide their own unique experience of the 'embodiment' of mindfulness. Their journeys and experience may offer additional encouragement and motivation for others facing similar difficulties. Yet there may be issues arising from the lack of formal training in how to teach/share mindfulness-based approaches. These pieces of work can be harder to evaluate

empirically and may lend themselves more to service audits and programme evaluations rather than academic research. This would ideally include anonymous feedback opportunities from participants, including asking about unusual effects, and sensitive supervision for all parties involved in delivery and design.

ILLUSTRATIVE EXTENSIONS OF CURRENT MBI MODELS: THE EVOLVING LANDSCAPE OF MINDFULNESS

In this section we offer examples of where mindfulness has been used in a way that extends beyond standardised protocols and recognised models. Three illustrative examples are offered to promote wider thinking around mindfulness interventions that are aligned to the principles of psychological work in our current context.

1. Given the increased importance placed on working with experts by experience, we share an example of a mindfulness training protocol (Breathworks) developed by an individual with expertise in their physical health condition, as well as significant training in Buddhist mindfulness. This is one of the more thoroughly developed 'peer led' programmes, but there are many (unpublished) examples across UK services where experts by experience have been encouraged to lend their voice to bespoke interventions.

2. Our profession is often engaged in deep reflection about the benefits and costs of working with diagnostic categories. Transdiagnostic approaches to mindfulness are aligned to its ultimate ethos (the core human response to suffering), yet are hindered by research, publishing and service structure constraints. We offer the four-stage neurocognitive model (Russell, 2017) as a transdiagnostic and pan-therapeutic heuristic to thoughtfully formulate and innovate using the principles of applied translational neuroscience in the delivery of mindfulness in increasingly complex service environments.

3. Critiques of the type of mindfulness offered in healthcare have pointed to the lack of contextualisation, citing that mindfulness as a 'standalone' intervention fails to recognise the dynamic nature of the individual in context. In our psychology work, we strive to be acutely aware of the individual in context, and the impact of the complexities of the systems in which they operate. We share insights from a mindfulness-based multi dynamic approach.

BREATHWORKS APPROACH

The Breathworks approach has been developed by Vidyamala Burch following an enlightened and personal journey of self-discovery using mindfulness to manage severe pain. The conceptualisation of the Breathworks model thus necessarily derives from the Buddhist writing of 'the two arrows' describing the differences between 'primary' (pain/illness) and the automatic resistance-based responses leading to 'secondary' suffering, in other words the suffering caused by the typical human response to such initial pain/illnesses (see Table 3 below), hypothesising that such typically human response to pain/illness (reacting) maintains a cycle of suffering.

Table 3: Responses to pain and secondary suffering.

SECONDARY SUFFERING (TWO OPPOSITE WAYS OF CAUSING THIS)	
Blocking	**Drowning**
Hardening against unpleasant sensations	Being overwhelmed and swallowed by unpleasant sensations
Restlessness inability to stop	Exhaustion
Extreme drive	Inactivity (physical leading to loss of important function)
Various addictions (food, drink, cigarettes, excessive talking/working)	Giving up
Anxiety	Lack of interest
Denial/avoidance	Depression
Control strategies	Catastrophising
Spending lots of time in the head and little in the body	Loss/lack of interest / demotivation
	Being dominated by unpleasant physical experience

Adapted from 'Living Well with Pain and Illness, p.46 (Burch, 2008)

Burch further postures that appropriate responding (as opposed to reacting) to the primary suffering will lead (with practice) to liberation from secondary suffering. Burch (2008) suggests that, in the context of pain, mindfulness skills allow the individual to develop a '...steady, calm and kind awareness' (p.68) and even empathy towards secondary suffering that will ultimately help breaking the unhelpful reactive cycle and that mindfulness in this context may be understood as five developmental steps, named 'Awareness' (Step 1), 'Moving towards the unpleasant' (Step 2), 'Seeking the Pleasant' (Step 3), 'Broadening awareness to become a bigger container' (Step 4) and 'Choice: Learning to respond rather than react' (Step 5).

The Pain Programme is the main package, consisting of an eight-week course. The main ingredients (apart from learning about the model) are Body Scan, Breathing and Kindly Awareness meditation exercises, as well as Mindful Movement and Pacing (the latter is unique compared to other approaches to mindfulness in that evolved from ideas within multidisciplinary Pain Management Programmes and adapted to suit a Mindfulness context). This has more recently been developed further and referred to as Mindfulness-based Pain Management (MBPM) by Burch and Penman (2012) as a package aimed at supporting all those experiencing health-related difficulties. An additional Stress Management package is also available. Early stage evaluation of this programme has been conducted (Cusens et al., 2010).

Anyone wishing to access Breathworks teacher training would need to have a minimum of six months personal meditation practice prior to embarking on a Teachers Training course, involving three separate developmental retreats.

Breathworks focuses on personal development, community and openness to all, professionals, complementary and alternative therapists and sufferers alike. Key and essential for a clinical psychologist's ability to fully appreciate the Breathworks approach, is an ability to let go of the habitual automatic tendency to analyse and formulate within different therapeutic approaches. This automatic pilot, idiosyncratic to clinical psychologists is seen as a barrier to fully appreciating the Breathworks approach and a hard one to overcome. This would be a key part of the development of a clinical psychologist who may choose to specialise in the Breathworks approach.

A FORMULATION HEURISTIC USING THE FOUR STAGE MINDFULNESS MODEL

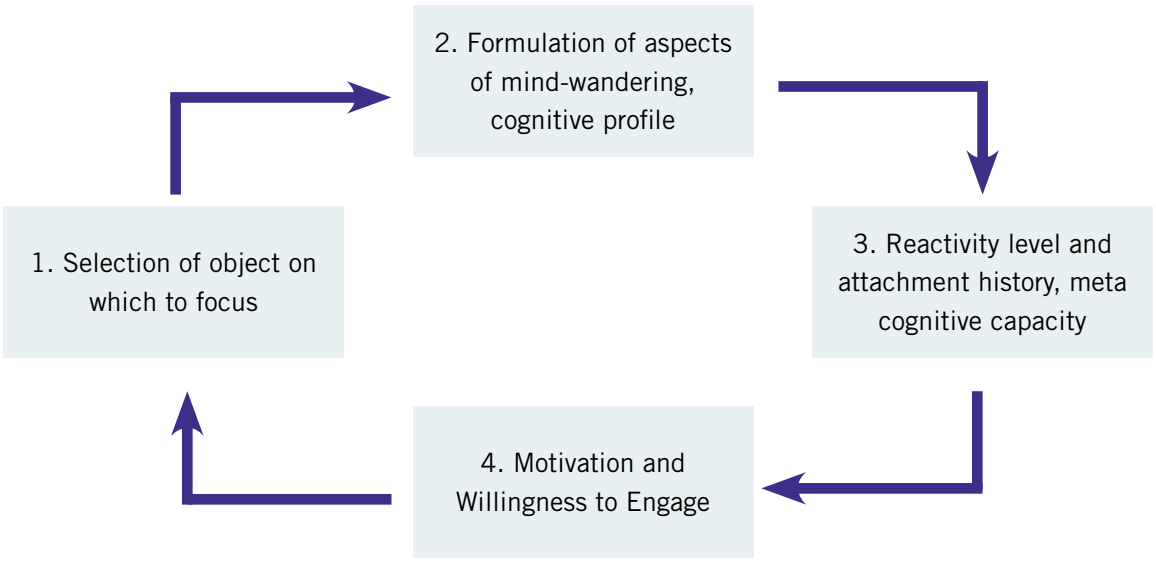
There is a move to integrate current psychological knowledge of mental ill-health, the mechanisms of mindfulness, and research from clinical neuroscience (Lutz et al., 2015; Tang & Leve, 2016; Wielgosz et al., 2019). The descriptions of mindfulness given above (and shown schematically in Figure 2, p.12) broadly indicate that four key processes are involved in a 'mindful moment' – focusing, mind wandering, kind awareness of mind wandering and re-orienting attention back to the present moment anchor. Hasenkamp's neuroimaging study examining a mindfulness of the breath exercise has indicated that these four stages are supported by three key brain networks (the attention network, the default mode network and the salience network; Hasenkamp et al., 2012). These three networks are sometimes referred to as the 'triple network'.

The triple network model is gaining traction as a way to help understand a variety of presenting psychological and developmental issues (Menon, 2011). The combination of understanding changes in triple network functioning (transient or developmental), mapped against the requirements of training in mindfulness, can provide a useful heuristic that can help clarify where a particular client group may struggle with mindfulness, as well as how to make thoughtful adaptations to delivery as required. This applied translational neuroscience framework is transdiagnostic and can be used pan-therapeutically.

This is necessarily a simplistic description yet it is offered to help reflect on, and share, the core tasks required in mindfulness training. Its strong face validity has made it useful when sharing mindfulness concepts with healthcare workers, clinical clients, mindfulness practitioners (especially experts by experience, innovators, and those who have less access to professional mindfulness training). It illustrates the core cognitive tasks required which may make it helpful when considering how and what to adapt as mindfulness is offered to groups with different attentional capacities (e.g. ADHD), default mode functioning (theory of mind/reflexive capacity; e.g. those on the autistic spectrum), and/or those with adverse childhood experiences or trauma who may have alterations in salience network 'tuning' (e.g. psychosis, depersonalisation).

The model can additionally help to demonstrate *why* repetition and practice is critical for the benefits, the importance of intentions, and why responding kindly rather than reacting is the key to 'success' in mindfulness practice. It normalises the early experience of many clients who often end up in self-judgmental loops as they find it hard to maintain focus on a single object. It may be particularly useful for those who need a more concrete explanation of mindfulness, for example, those with learning difficulties. It has been used in a creative mindfulness project 'Sew Mindful' – a mindfulness training for women experiencing postnatal depression – where it was used to help illuminate (and de-shame) the judging and comparison mental habits that so often contribute to the low mood of these women (Alfrey, 2017). The core features of this approach are outlined in Russell (2017), and the model is shown schematically in Figure 5.

Figure 5: A schematic of the four-stage neurocognitive model of mindfulness as used to formulate mindfulness interventions. 1. Selection of the appropriate object may be influenced by what is known about the individual's capacity to pay attention and the environments in which they are attempting to be mindful (including internal/emotional as well as external/context). 2. Understanding of the types of mental activity the individual is working with (cognitive patterns of avoidance or attachment, dissociation/fantasy), speed and velocity of thinking processes. 3. Consideration of the attachment history and capacity to generate self-compassion, alongside abilities to 'de-couple' through metacognitive skills. 4. The motivation and intention of the individual as they engage with mindfulness (and what supports are necessary to keep them 'on track' with practice).



MINDFULNESS-BASED MULTIDYNAMIC APPROACH (MMT)

Psychology may be applied in ways that are purest to models such as psychodynamic psychotherapy or cognitive behaviour therapy, or an integrated approach that aims for a broader perspective and understanding a person within their context. Mindfulness-Based Multidynamic Therapeutic approach (MMT) is another example of how mindfulness is integrated into other existing models.

Individuals and cultures constantly adjust to the transient nature of their environments. In the process, certain factors become fixed, leading to the development of patterns of beliefs, interactions and processes. These are both internal to the individual (and include genetic and individual psychological structures) as well as external (familial attitudes and socio-cultural structures).

In Mindfulness the present is the single moment of primary relevance of attention. Psychodynamic theories focus on how the development of the individual and their experiences influence that present moment. Ideas within the biopsychosocial model bring an understanding of the genetic, psychological and social /cultural environment of the individual. In MMT people are understood as an interplay of all the dynamic areas that influence their present moment. Individuals can view themselves as both static and dynamic, knowing that what is static may change in some way and that what is dynamic may become more fixed for a period of time.

Mindfulness encourages people to stay with both the ease and discomfort of their experiences, whether previous or current, and to refocus their perspective on what is taking place right here,

right now. This permits movement beyond thoughts and includes sensations, instincts, drives, barriers, reactions and responses (Rezek, 2010). People are understood as a combination of their existence in all forms (genetic, social, familial, psychological), if they can become more aware of what drives them and how they react to forces that influence their everyday existence they can make use of meta-cognition and adapt.

Mindfulness assists in allowing people to recognise and stay with their responses through its emphasis on focusing and refocusing attention, this can increase awareness of reactions to others and to the world by intentional awareness. This can lead to changes in psychological and physical health, workplace attitudes and the choices they make as managers of themselves and those around them in private and organisational settings (Rezek, 2010, 2012a, 2012b, 2013).

MMT aims to build resilience and develop resourcefulness and stability to deal with both pleasant and difficult emotions or experience. Through working with the mind and body, sensations and thoughts, flexibility and rigidity it allows for fluid and wider perspective where the person can exert personal choice over how they wish to be within this moment of time. MMT aims to create a curiosity in people about themselves, and a greater sense of integration between all the dynamics. In clinical settings, by holding in mind that greater sense of awareness, it opens opportunities to engage and understand the human being sitting in the room. In this, mindfulness has a vital role.

Rezek has applied MMT across a range of contexts and detailed predominantly qualitative and descriptive data in the following areas: general settings (Rezek, 2010, 2012a, 2015b), health settings (Rezek, 2015a, 2015b, 2016a, 2016b, 2016c, 2019a, 2019c), mental health settings (2015a, 2016b, 2016d, 2019c), for leadership (Rezek, 2012b, 2013) and children (2016d, 2019b).

CHAPTER 2

Mindfulness and different populations

Part 2: Mindfulness and different populations

INTRODUCTION TO PART 2: MINDFULNESS AND DIFFERENT POPULATIONS

In Part 2 we look at mindfulness-based approaches with different populations. In reading these sections please hold the following in mind:

1. Each section was created by a psychologist/clinician with specialist knowledge of that population. Details are in the list of contributors at the start of the document. The editors have developed some of the sections further. Please attribute any errors to the editors and not the specialist contributors.
2. Whilst the literature reported is reasonably thorough, please note these are not systematic literature reviews.
3. We acknowledge that the literature selected is necessarily biased towards publications in the English language, and from academic centres with the resources to publish in high impact journals. We are aware we are contributing to this bias.
4. There is a difference between the USA and UK literature. The USA literature leans more towards MBSR with adaptations based on presenting problems of different client groups. The UK work offers more tightly formulated understandings of the clinical complaint, with a bespoke mindfulness intervention designed to fit.
5. The USA has produced significantly more implementation trials. In Part 2 we draw upon both UK and USA studies.
6. We have endeavoured to include the important meta-analysis which can provide the reader with useful additional reading from their reference lists.
7. Many of the reports cited are pilot, acceptability and feasibility studies. Mindfulness research is young, but is growing fast.
8. We have included important theoretical conceptual papers as well as research in this section.
9. We have included qualitative studies and are of the opinion that a well written qualitative or narrative study can, in this field, often provide rich insights into what actually happens when mindfulness is brought into therapeutic work.
10. We have aimed to familiarise the reader with the important people working in each area of specialisation.
11. We encourage practitioners to do regular literature searches as this is a rapidly developing area of research.

MINDFULNESS FOR PEOPLE WHO EXPERIENCE DEPRESSION

Central elements of the expression of depression include low mood most of the day nearly every day and loss of interest or pleasure in most activities. Some additional difficulties can include shifts in weight, sleep, energy, or concentration and these can be accompanied by thoughts of death or suicide. The number and extent of difficulties alongside their impact on functioning influences the severity of depression (National Institute for Health and Clinical Excellence; NICE, 2009). Depression is reported to affect 2.6 per cent of adults (Singleton et al., 2001) and is associated with a higher mortality rate (Sartorius, 2001) with each new episode of depression associated with an increased risk of relapse (Kupfer, 1991).

It was in this context that MBCT was developed to reduce the risk of future relapses for adults who had previously experienced depression. A cognitive model of vulnerability to depressive relapse underlies MBCT (Segal, Williams & Teasdale, 2002). Consequently MBCT is designed to support disengagement from the rumination that plays a central role in the maintenance of depression (Nolen-Hoeksema, 1991). There is a large and growing evidence base for the use of MBCT for depression (Williams & Kuyken, 2012). However, other third wave therapies (e.g. ACT) that incorporate mindfulness have also been evaluated. The points below summarise the evidence for how mindfulness might be helpful for an adult who is experiencing depression.

RISK OF RELAPSE

NICE (2009) recommends that those who are not currently experiencing depression but who have experienced three or more previous episodes of depression and are therefore at risk of relapse should be offered MBCT. MBCT should be offered in a group format comprising eight to 15 participants who meet for two hours per week, on a weekly basis for eight weeks. This should be followed by four follow-up sessions in the 12 months following the completion of the MBCT group. There is a specific pathway of qualification for those who wish to lead these MBCT groups.

The evidence suggests that MBCT is more effective for those individuals with a higher number of relapses (Chiesa & Serretti, 2011; Piet & Hougaard, 2011). A meta-analysis of six Randomised Control Trials (RCTs) including 593 participants found that, relative to those who received Treatment as Usual or a placebo, individuals who had experienced depression on three or more occasions and completed a MBCT course were 43 per cent less likely to experience recurrence. Conversely, a relative risk reduction was not found for those who had experienced depression on two or fewer occasions (Piet & Hougaard, 2011). There was a (non-significant) trend for those with two or fewer episodes of depression to have an increased risk of relapse (Ma & Teasdale, 2004; Teasdale et al., 2000). An RCT with an active control group (Williams et al., 2014) suggests that relapse prevention is attainable following mindfulness training for those with three or more episodes of depression who also have a history of childhood trauma.

Geschwind, Peeters, Huibers, van Os & Wichers (2012) found that MBCT can reduce residual depressive difficulties in those with fewer than three previous episodes of depression, yet the evidence base suggests that even if symptoms are improved, there is the potential for increasing risk of relapse. Geschwind et al. (2012) suggest offering MBCT to people who have relapsed fewer than three times needs careful consideration in light of current evidence.

For those individuals who ask about the possibility of reducing medication, there are two studies which explore risk of recurrence in this context (Piet & Hougaard, 2011). These suggest that MBCT is at least as effective as maintenance antidepressants at reducing relapse (Kuyken et al., 2008, 2015; Segal et al., 2010); participating in MBCT whilst reducing antidepressant medication over a six-month period (where 75 per cent of participants had ceased taking

antidepressants six months after completion of MBCT) was not significantly different to continuing with maintenance antidepressants with respect to risk of relapse (Kuyken et al., 2008, 2015).

Despite the evidence base for mindfulness as an effective intervention for preventing relapse in depression, making it available as a standard intervention across services has been a challenge. This has been termed by Rycroft-Malone (2019) as the 'implementation cliff'. Implementation across the country has been patchy, and often depends on the actions of people who of their own volition become mindfulness champions in their place of work. Services or individuals are also asked to make a hefty investment in staff training and the service provision time to organise, administer and run groups.

CLIENTS EXPERIENCING CURRENT ACTIVE DEPRESSION

MBCT was specifically developed to reduce risk of relapse and it was suggested that the nature of MBCT (e.g. the requirement of attentional control) meant that it was not recommended for people currently experiencing depression (Teasdale et al., 2000). However, reviews show that for people who have experienced three or more episodes of depression, MBCT can improve current – including residual – depressive difficulties (Chiesa & Serretti, 2011; Sipe & Eisendrath, 2012). Studies have shown that, for those who have experienced three or more episodes of depression, MBCT is as effective for those who are not currently depressed as those who are (van Aalderen et al., 2012) and booster sessions can help to maintain gains (Mathew et al., 2010). That being said, some people have experienced a worsening of symptoms and although they attributed this to usual mood fluctuations, this issue needs further research (Kenny & Williams, 2007). In addition, Crane and Williams (2010) were able to establish through research that the people who were most likely to drop out of MBCT were those most likely to benefit from it, those with cognitive reactivity, brooding and depressive rumination.

Keng et al. (2011) identified six controlled studies that measured mood before and after an Acceptance and Commitment Therapy (ACT)-based intervention that included elements of mindfulness. Participants included people with mixed mood and anxiety diagnoses. ACT reduced depression better than control or at least as well as alternative evidence-based interventions. Meta-analysis of studies continue to demonstrate that ACT is effective for depression. For example, Zhenggang et al. (2020) found its effectiveness compared to a control group for three-month follow-up particularly for mild depression, with more work needed on longer follow ups and for moderate to severe depression. It is considered to be a viable alternative to standard CBT for depression, Samaan et al. (2021).

Keng et al. (2011) identified six RCTs comparing self-reported mood before and after participation in a Mindfulness-Based Stress Reduction (MBSR) course. Participants in these studies did not have formal diagnoses of depression but comprised community samples or those with physical health difficulties. These studies found that those completing MBSR experienced greater reductions in depression or enhanced wellbeing than those in control groups.

SUMMARY

There is good evidence that MBCT can reduce risk of relapse and improve current difficulties with depression for people who have experienced depression on **three or more occasions**. For those who experience depression but do not fit these criteria, the evidence is more tentative and may even be contraindicated.

Although reviews suggest that both MBSR and ACT may be helpful, there is no evidence directly comparing these different approaches.

Future research needs to address this by utilising dismantling designs that enable comparison of clinical interventions and identification of mechanisms of action of mindfulness-based interventions (Keng et al., 2011; Piet & Hougaard, 2011; Shapiro, Carlson, Astin & Freeman (2006).

MINDFULNESS FOR PEOPLE WHO EXPERIENCE ANXIETY

Anxiety is characterised by worried thinking as well as physiological changes associated with fear that is in response either to worries (including worries about the meaning of physiological reactions) or to situations perceived to be threatening (Wells, 1997). This may be accompanied by avoidance strategies that serve to perpetuate anxiety and worry (Wells, 1997). Anxiety can range from non-clinical or mild anxiety to severe and clinical levels of anxiety, with a number of specific anxiety-based diagnoses, including panic disorder, social phobia and generalised anxiety disorder. Collectively, anxiety disorders have a UK prevalence rate of 18.2 per cent (Fineberg et al., 2013) whilst co-occurrence of anxiety and depression has a UK prevalence rate of nine per cent (Psychiatric Morbidity Survey, 2000, as cited by Layard, 2006). Thus, anxiety has significant social and financial implications for many people living in the UK (Fineberg et al., 2013).

HOW MIGHT MINDFULNESS REDUCE ANXIETY?

Self-regulation models of emotion and mood argue that discrepant current and desired emotional states are accompanied by negative affect that trigger cognitive and behavioural sequences aimed at reducing the discrepancy and retaining subjective wellbeing (Carver & Scheier, 1990). If the discrepancy is not addressed, one might continue to engage in repetitive thought (rumination or worry; Harvey, Watkins, Mansell & Shafran, 2004) until the goal is achieved or discarded (Martin & Tesser, 1996). Thus, as an effective means of achieving this goal, rumination and worry perpetuate negative affect and play central roles in the maintenance of depression and anxiety respectively (De Lissnyder et al., 2012; Nolen-Hoeksema, 1991; Nolen-Hoeksema, Wisco & Lyubomirsky, 2008).

Mindfulness, however, encourages paying attention to the present moment with an attitude of acceptance (Kabat-Zinn, 1994): taking the 'decentred' perspective of noticing thoughts and emotions rather than being caught up in them (Teasdale et al., 2002). This stance is argued to improve emotional regulation and consequently improve mood (Lykins & Baer, 2009; Teasdale, Segal & Williams, 1995). Certainly there is some evidence that supports these assertions: mindfulness is associated with increased decentring alongside reduced negative affect (Tanay Lotan & Bernstein, 2012); and decentring with improved emotion self-regulation (Carmody, Baer, Lykins & Olendzki, 2009) and low cognitive reactivity (Fresco, Segal, Buis & Kennedy, 2007). MBSR can reduce rumination and worry (Chiesa & Serretti, 2009; Vollestad, Sivertson & Nielsen, 2011); and the association between mindfulness and reduced distress has been shown to be partially mediated by reduced rumination (Coffey & Hartman, 2008; Jain et al., 2007)

and reduced recurrent negative thought (comprising rumination and worry; Clack, Unwin & Smith, 2012).

MINDFULNESS AND ANXIETY

MBSR (Kabat-Zinn, 1990) was initially developed in the context of physical health and MBCT (Segal et al., 2002) aimed to target relapse in depression. Specifically, neither of these approaches was developed explicitly to target and reduce anxiety. Consequently, the evidence base for the use of mindfulness to reduce anxiety is less conclusive than the evidence base for mindfulness and depression, for example.

In their meta-analytic review of 209 studies, Khoury et al. (2013) demonstrated that the effects of a meditation-based mindfulness treatment significantly reduced anxiety for those with clinical levels of anxiety as well as those who presented with anxiety at non-clinical levels. The effect size was moderate and in those studies including follow-up, positive outcomes were maintained. Similarly, Hofmann et al. (2010) found that mindfulness-based treatments reduced anxiety in clinical populations.

Toneatto and Nguyen (2007) reviewed 15 studies that examined the impact of MBSR on depression and anxiety and concluded that MBSR does not have a reliable effect on anxiety or depression. However, this may be because studies that did not describe an improvement did not focus on anxiety. However, a randomised controlled trial (RCT) showed that compared to a wait-list control, MBSR significantly reduced anxiety for those with heterogeneous anxiety diagnoses (Vøllestad et al., 2011). A systematic review of RCTs showed that MBSR reduced anxiety in clinical populations with anxiety-based diagnoses (Fjorback et al., 2011) and a systematic review including 12 anxiety outcomes in 10 studies showed that MBSR reduced anxiety (de Vibe et al., 2012). The effect size was moderate and improvements were maintained at follow up.

Evidence regarding the use of mindfulness to reduce anxiety for those with specific anxiety-based diagnoses is sparse and inconclusive. MBSR has been shown to reduce acute symptoms of anxiety or panic (Baer, 2003; Vollestad et al., 2011). For people with a diagnosis of generalised anxiety disorder, a few reviews have indicated that mindfulness-based interventions can reduce anxiety and other clinical symptoms (Baer, 2003; Chiesa & Serretti, 2010; Hoffman et al., 2010; Piet & Hougaard, 2011). Hoge et al. (2018) found mindfulness meditation did have an effect on biological acute stress responses in generalised anxiety disorder and provided the first combined hormonal and immunological evidence that MBSR may enhance resilience to stress. However, with respect to social phobia, one systematic review showed that MBCT was associated with improvement (Piet & Hougaard, 2011) and another suggested that MBCT did not impact on social anxiety (Chiesa & Serretti, 2010).

In terms of other approaches that include mindfulness, a meta-analysis by Bluett et al. (2014) demonstrates that ACT is comparable in its effectiveness for anxiety and OCD to standard CBT.

SUMMARY

There is evidence that mindfulness-based interventions that include meditation can reduce symptoms for people who present with anxiety – whether at clinical or non-clinical levels.

With respect to those who present with clinical levels of anxiety, there is some evidence that compared to waitlist controls or treatment as usual MBSR is effective and yields a moderate effect size that is maintained at follow-up.

However, the studies contributing to this evidence base have been identified as being of moderate quality (de Vibe et al., 2012), which suggests caution when choosing mindfulness for anxiety-based difficulties. The key issue is that RCTs have not utilised active controls and when active controls have been used, evidence for the efficacy of MBSR is mixed (de Vibe et al., 2012; Toneatto & Nguyen, 2007).

Notwithstanding these limitations, MBSR can reduce worry and acute symptoms of anxiety. Therefore, if the formulation suggests a mindfulness-based approach might be useful (e.g. presentation includes worry and rumination; or depression and anxiety are present; or perhaps CBT is not tolerated or indicated) then the evidence base suggests a meditation-based approach, especially MBSR could be used.

The limitations of mindfulness for this group of individuals may be related to the challenges of focusing on body and breath at a time when these sensations are heightened within an anxiety response. In these cases, relaxation training may be a more appropriate first step to activate the soothing system, prior to engaging in direct observation of feared sensations. Shorter practises (including movement), scaffolded practises, opportunities to experiment or exit may help.

MINDFULNESS FOR PEOPLE WHO EXPERIENCE PSYCHOSIS

The experiences of psychosis, where a person's sense of reality may change, where they may believe things others find strange, and where they may have unusual experiences such as hearing voices are increasingly being understood from a psychological perspective. The efficacy of psychological interventions for psychosis is well established in reducing symptoms and distress and improving functioning. This is reflected in the recommendation of cognitive-behaviour therapy for psychosis (CBT-p) in the latest clinical guidelines published by the National Institute for Clinical Excellence (NICE, 2014). Recently there has been an interest in the use of mindfulness-based approaches for this group of individuals, particularly in relation to working with those who struggle with distressing voices (auditory hallucinations), see Chadwick (2005, 2014, 2019).

CBT for psychosis is based on the premise that it is not the psychotic symptom that is the problem *per se*, but rather the person's interpretation of their experiences, which determine the unwanted emotional and behavioural responses. This is compatible with a mindfulness approach which is aimed at changing people's relationship with their experience, not trying to get rid of the experience itself.

People with distressing psychosis often get caught up trying to run away from their experiences (experiential avoidance) or getting lost in them (e.g. rumination, arguing with voices). Mindfulness offers an alternative way of being with psychotic experiences; bringing non-judgemental awareness, acceptance of the present moment and letting go of struggling or fighting against

experiences as put forward in Chadwick's 2005 model. This approach may be particularly appropriate for people who may not want to talk about the content of their experiences in detail, as mindfulness can be practised and cultivated without explicit discussion about what voices are saying. Mindfulness-based approaches are also normalising and non-stigmatising, as they are framed as applicable to all of human suffering and something which can promote wellbeing for everyone. This makes mindfulness potentially more acceptable to people with psychosis who do not relate to or find helpful the idea of having a mental illness or who do not agree with the disease model of psychosis.

EVIDENCE BASE

The potential benefit of applying mindfulness to psychosis has been recognised by experienced academic clinicians in the field who have developed clear theoretical models, robust clinical guidelines and methods for recording unusual or unexpected effects (Ellet & Chadwick, 2021). There has been a small but growing evidence base that supports suitably adapted mindfulness interventions as safe and effective for people suffering distressing psychosis (Cramer et al., 2016; Jansen et al., 2020).

The first papers published on evaluating mindfulness for psychosis focussed on group interventions. Chadwick et al. (2005) reported outcomes for the first 10 people to complete a series of mindfulness groups, comprising six group sessions. Participants showed significant improvement on a measure of general clinical functioning, and an improvement in mindfulness skills. This pilot study was followed by a larger randomised feasibility trial which replicated the earlier finding of a general improvement in clinical functioning and increased mindfulness of thoughts and images for participants following a five-week mindfulness group (Chadwick et al., 2009).

These initial positive results have since been extended to community settings in Spain (Langer et al., 2012), France (Bardy-Linder et al., 2013) and the Netherlands (van der Valk et al., 2013) as well as to inpatient and community settings in the UK (Jacobsen et al., 2011, 2019).

Cramer et al. (2016) from a meta-analysis of RCTs looking at mindfulness and acceptance based therapies for a total of 434 people were able to conclude that 'Mindfulness- and acceptance-based interventions can be recommended as an additional treatment for patients with psychosis'. Two of the RCTs reported in this meta-analysis included safety data and indicate no serious adverse effects were reported. In a systematic meta-analysis of 16 studies and 1268 participants, by Jansen et al. (2020) found that acceptance and mindfulness-based interventions were effective and safe for people who experience psychosis. Moderate to large effect sizes were found for overall symptomatology and hospitalisation at endpoint, and there was stronger evidence for the impact of mindfulness on negative, as contrasted to positive symptomatology.

In addition to quantitative outcomes, several studies have reported qualitative data on participants' experiences of mindfulness groups. Findings have been consistent across different studies, and common themes include the acceptance of psychotic experience and of self, letting go of struggle and avoidance and developing new ways of relating to experiences (Abba et al., 2008; Ashcroft et al., 2012; Dennick et al., 2013). One pilot study shows a reduction in self-reported stress after group mindful movement class (Russell, 2011). The formulation here is that reductions in stress and increased agency through movement practices may help to create more favourable conditions that support a change in relationship to symptoms.

Mindfulness for psychosis delivered as individual therapy has been less well evaluated. Case study evidence indicates positive effects of mindfulness training within individual therapy for reducing distress associated with voices (Taylor et al., 2009) and persecutory beliefs (Ellett, 2013).

There is a growing evidence base for the use of ACT and mindfulness in psychosis (see Morris et al., 2013). Louise et al. (2018) conducted a meta analysis of 10 studies with third wave CBT approaches for people with psychosis finding that third wave approaches were beneficial for the symptoms of psychosis. A more recent review suggests caution (Brown et al., 2021) if this approach is solely aimed at reducing symptoms.

In areas of current innovation, a feasibility study by Jacobsen et al. (2020) examined the benefit of mindfulness interventions for people with psychosis on acute wards and found that it was possible and acceptable to offer these interventions and that they may reduce readmission in the short term. This is an area that requires more research.

ADAPTATIONS TO MINDFULNESS IN PSYCHOSIS

Bringing mindfulness-based approaches into clinical practice for this client group has been a challenge and held back for a number of reasons, according to Böge et al. (2021). One reason is the dominance of the medical model and a continued reluctance to offer psychological therapies to people who experience psychosis. Another is the fear of encouraging people with psychosis to pay attention to their inner experiences. Finally, there are a number of case reports of people having psychotic breakdowns on meditation retreats (see Kuipers et al., 2007). These reports, while providing valuable insights, were often case studies of vulnerable people responding badly to intensive retreat conditions. This may have limited generalisability to the way mindfulness is offered to those experiencing psychosis in everyday clinical practice.

These factors seem to have impacted on clinician decision making, while the empirical evidence base has had less impact. As a consequence people with psychosis experience othering and marginalisation in relation to being offered mindfulness in the same way as they have done in other areas of service provision (Böge et al., 2020).

Mindfulness as delivered within the health setting, by a suitably experienced professional and with the adaptations suggested in the Things to Consider box below, is likely to be beneficial rather than harmful. ‘Existing data show that mindfulness for psychosis can be implemented safely, if delivered by experienced clinicians with appropriate mindfulness training and supervision, in both in-patient and community routine care settings.’ (Böge et al., 2021, p.72).

Chadwick (2019) has also put forward ideas about how mindfulness might be particularly beneficial when delivered in a group for people who experience psychosis. He proposes that constructive engagement in group processes whilst engaging in mindfulness practice have a humanising effect where there person experiences themselves as more than just the psychosis and that the self can be balanced and changes. This could be a direction for future research.

The reader is additionally referred to Ellet and Chadwick (2021) for a thorough review of the best ways to monitor and report possible adverse effects when offering mindfulness to those experiencing psychosis.

THINGS TO CONSIDER/ISSUES

Adaptations for those experiencing psychosis might include the following:

- Shorter exercises – usually limited to 10 minutes or less to accommodate difficulties with concentration and attention and keep exercises achievable.
- More frequent guidance and avoiding long silences. This reduces the tendency for people to get lost in reaction to unpleasant voices, thoughts and images and keeps them grounded via the facilitator's voice.
- In contrast to MBSR/MBCT the skills are taught either individually or as a smaller group.
- Consider starting with movement prior to (or replacing) stationary exercises. See Russell and Arcuri (2015) for a consideration of the neuropsychological and neurophysiological aspects of mindfulness movement for this group.
- Grounding in the body can be highlighted through guidance and may be especially helpful to come back to when lost in reactions to voices and for people who have a tendency to dissociate.
- Inquiry is focussed on the cultivation of metacognitive insights which has been defined by Chadwick (2006) as 'observations about a general quality of sensations, cognitions, emotions or the relationships among them'. Examples of these insights might include 'thoughts are not facts' and 'voices are not always present but they come and go'.
- Less emphasis on home practice. The challenge of asking people to turn to distressing thoughts and images and to voices that have been perceived as omnipotent whilst practising at home is recognised and acknowledged.
- The voice of service users may provide further encouragement for clients who wish to explore this approach. This short video was created by those using a recovery service in South London and Maudsley Hospital (What is Mindfulness from SHARP @ SLAM – https://youtu.be/Ui26s768ITM)

SUMMARY

It is important to remain cautious in the application of mindfulness in psychosis. A high degree of skill and experience is required both as a mindfulness practitioner and as a clinician with expertise in psychosis in order to do this work competently. However, if these conditions are met then this client group should not be excluded from mindfulness-based approaches.

ACT may offer a more accessible entry point to mindfulness for psychosis, requiring less specialist training.

MINDFULNESS FOR PEOPLE WITH ADDICTIONS

The nature of addiction has been widely debated and theories abound, ranging from attachment to an idealised 'other', to addiction as the product of a set of reinforcement contingencies. Understanding patterns of behaviour and what drives us has yielded interventions which have become widespread as the foundation of addictions services and includes individual or group counselling and/or CBT approaches.

Cognitive-behavioural interventions are based on helping the person to identify common high-risk situations and triggers for craving, in addition to identifying strategies to deal with cravings including distraction, thought challenging, and seeking support (Wanigaratne et al., 1990). NICE Guidelines for Alcohol Misuse (NICE, 2011) recommends the use of CBT in group formats for people who have been alcohol dependent. However, the generalisability of CBT strategies worked on in group or individual treatment provides a serious challenge as clients attempt to implement these in their day-to-day lives. Mindfulness training and the cultivation of moment-by-moment awareness may be a route to support this transition. Awareness of sensations, feelings, thoughts and experience, provides a route to effective application of strategies to ride out craving and reduce unwanted behaviours. Training in how to see the 'big picture' and the development in expertise in detecting the chains of conditioned, habitual behaviour may augment current intervention strategies and increase their efficacy.

When we use substances or engage in behaviours to distract ourselves from reality, we can spend time in an internal past or future which bears little relation to our current reality. Many people with a history of substance problems have spent their time seeking a state of oblivion which provides escape from physical and mental pain. Cultivating mindfulness provides a way of changing our relationship to what we may perceive as our emotional pain.

EVIDENCE BASE

A fascinating and practical answer to this question comes from the development of a fusion of mindfulness-based approaches and Relapse Prevention, developed by Bowen, Chawla and Marlatt over a period of 15 years, culminating in writing their treatment manual in 2011. Marlatt and his colleagues led a 10 day vipassana meditation retreat at a minimum-security jail in Seattle with inmates who volunteered to participate. This form of retreat is an Indian meditation practice that involves complete silence and aims for the person to see things clearly and truly as they are. Results obtained three months after participants' release from prison showed statistically significant reductions in alcohol, cocaine and marijuana use and improved psychiatric symptoms and enhanced optimism, compared to the control group (Bowen et al., 2006).

Mindfulness-Based Relapse Prevention (MBRP) is based on Mindfulness-based Stress Reduction (Kabat-Zinn, 1990) and Mindfulness-based Cognitive Therapy (Segal et al., 2002) and is an eight-session group programme delivered weekly. The sessions comprise mindfulness exercises, inquiry and conventional relapse prevention elements. Mindfulness practice fosters exploration, acceptance of craving and urges experiences, both at the mental and physical level of experience. MBRP was designed as an aftercare programme and for those people wishing to maintain abstinence from substances or those with a goal of controlled or reduced substance use.

A number of studies have examined the efficacy of MBRP in this population. For example, Bowen et al. (2014) found that MBRP was more effective than just relapse prevention at a 12 month follow-up for people with alcohol and drug problems. MBPR has been found to be effective with people who have addiction and mood problems. Glasner et al. (2017) found that MBRP reduced stimulant use in stimulant dependent adults who experienced anxiety and depression use.

Similarly, Zemestani et al. (2016) conducted an eight-week MBRP for people with substance problems and depression which led to lower ratings of craving, depression and anxiety after the intervention that remained at a two-month follow-up. MBRP has also been used in forensic settings. Witiewitz (2014) in a study of women offenders using MBRP, found that 15 weeks after intervention they experienced less drug use days, medical and legal problems than those who received standard relapse prevention.

There have been enough studies now for systematic reviews to have been conducted. A systematic review by Grant et al. (2017) of nine previous randomised control trial studies found limited confidence in small effect size for mindfulness-based relapse prevention in comparison to other interventions. They question the methodology of the studies they examined which had led to more positive views of previous research. However, a meta-analysis of Li et al. (2017, p.62) of 42 studies revealed 'significant small-to-large effects of mindfulness treatments in reducing the frequency and severity of substance misuse, intensity of craving for psychoactive substances, and severity of stress.' (p.62). Penberthy et al. (2015) conclude that 'future research will need to entail large, longitudinal, well-controlled studies that examine the intentions, psychological, behavioural, and physiological characteristics of individuals participating in treatment in order to define mechanisms of action and help further the ability to tailor this treatment for most effective implementation.' (p.157)

In relation to other approaches with a mindfulness component, a meta-analysis of Lee et al. (2015) which included 10 previous studies compared ACT to other active interventions for addictions to drugs and alcohol and found favourable results for ACT.

The application of mindfulness-based approaches to addictions problems is relatively new and has developed alongside a period of rapid understanding of the neuroscience of addictive behaviour. Garland and Howard (2018) consider that it offers great promise for this client group: 'Insofar as the original purpose of many mindfulness meditation practices was to extinguish craving by revealing the middle way between attachment to pleasure and aversion to pain, MBIs may ultimately provide a skilful means of liberating the individual from the push and pull of hedonic dysregulation underlying addiction.' (p.12).

THINGS TO CONSIDER/ISSUES

The following are points may aid the psychologists working with this client group:

- The most effective way of encouraging new service users to try mindfulness practices is by providing opportunities to discuss with existing mindfulness group members at pre-course meetings.
- Home practice does not have to be formal to be effective – group members describe mindful participation in everyday activities and its effect on noticing craving 'creeping in'.
- Qualitative feedback indicates improved ability to deal with stress and worry.
- Quantitative feedback in terms of Situational Confidence pre-post group comparison scores will be useful in determining substance-related changes.

As in other settings, mindfulness practice can co-exist with interventions of a different philosophical orientation. Clients describe attending 12-step or CBT-based mutual aid programmes and MBRP groups concurrently. Perhaps the practice of mindfulness may broaden our understanding and acceptance of the useful elements of different therapy types and encourage us to be open to the possibility of change by different routes.

SUMMARY

MBRP is a promising approach for people with addictions, though more research is necessary to establish its utility. In theory, mindfulness should help enable people to be aware of potential internal prompts for relapse. The client's experience of present moment awareness needs considering as they may use substances to deal with the distress of their present moment or unpleasant memories.

MINDFULNESS FOR PEOPLE WITH BIPOLAR DISORDER

People with a diagnosis of bipolar (in its variety of expressions) typically experience periods of clinical depression, with associated lowered mood and motivation, and periods of mania where they experience an increase in energy and activity. Mindfulness-based interventions may potentially offer people with this condition the chance to prevent relapses into depression in a similar way to MBCT and depression, as well as develop emotional stability and increased self-compassion.

The experience of bipolar varies greatly so using a 'one size fits all' psychological interventions approach may not be suitable. The largest scale study of cognitive behavioural therapy for relapse prevention for people with a diagnosis of bipolar disorder indicates that this intervention is not particularly effective (Scott et al., 2006) and it is also resource intensive (16 sessions of one-to-one work). Therefore, there is room for improvement and innovation in the psychological interventions for people with a diagnosis of bipolar disorder (Salceedo et al., 2016).

The current evidence base for the use of MBCT relates to individuals with recurrent depression but there is interest and on-going research activity related to its use for people with a diagnosis of bipolar disorder. People with this diagnosis can make very good progress with the right help; however, what is offered to this client group is often not optimal and may be restricted to a medication intervention only. The application of a training that allows individuals to cope more skilfully with the ongoing chronic nature of their condition therefore seems a positive development.

EVIDENCE BASE

There is a small but growing research literature on the effectiveness of mindfulness practice for people with a diagnosis of bipolar disorder using MBCT. A meta-analysis by Bojic and Becerra (2017) of 13 previous studies (*N*=429) was able to conclude that MBCT was a promising intervention in conjunction with medication and was 'associated with improvements in cognitive functioning and emotional regulation, reduction in symptoms of anxiety depression and mania symptoms (when participants had residual manic symptoms prior to MBCT'; Bojic & Becerra, 2017, p.573)'. They point, however, to small sample sizes, lack of active control groups, idiosyncratic adaptations and the need to monitor possible adverse effects in this client group.

An RCT by Perich et al. (2013a) showed that the eight-week MBCT protocol did not lead to changes in symptoms or relapse rates but did have an effect on reducing anxiety. Subsequently, the authors found a correlation between the number of days of meditation completed during the MBCT programme and lower depression scores at 12-months follow-up (Perich et al., 2013b). Mindfulness meditation practice during the programme was associated with improvements in depression and anxiety symptoms if a certain minimum amount of mindfulness practice was completed (three times per week or more; Perich et al., 2013b). A smaller RCT (*N*=8 in the

experimental and wait list control groups) showed a reduction in anxiety and depression for people with a diagnosis of Bipolar Disorder following MBCT (Williams et al., 2008).

A controlled study of MBCT compared to wait list showed a reduction of depression and anxiety and an improvement in emotional regulation (Ives-Deliperi et al., 2013).

Two non-controlled studies with people who were 'not in full clinical remission', reported a significant decrease in the depressive symptomatology after MBCT (Miklowitz et al., 2009; Deckersbach et al., 2011); changes were maintained at a three-month follow-up (Deckersbach et al., 2011). In contrast, Weber et al. (2010) did not find a significant reduction in 'symptom severity' in an open study, although a negative correlation occurred between changes in mindfulness skills and depression severity.

Hanssen et al. (2020) conducted a feasibility study into MBCT for people with a diagnosis of bipolar disorder; the findings were that with adaptations it was possible to conduct mindfulness-based approaches with this client group. Adaptations included more flexibility and additional support dependent on participants' current level of mania or depression. Two teachers were suggested for the group with one able to work with any participant who needed one to one away from the group because of their mood state.

Similar results for depression and affective regulation have been reported in a trial using DBT which has a large mindfulness component (van Dijk et al., 2013). In this latter study, participants receiving DBT had fewer emergency room visits and admissions in the six months following treatment compared to a wait-list TAU comparison group. More recently, an open trial feasibility study (Eisner et al., 2017) examined the impact of brief (12 weeks) DBT group skills training in a sample of individuals with bipolar (with residual symptoms). In this predominantly female sample, the DBT skills acquisition model supported mindfulness, emotion regulation and distress tolerance. It also increased psychological wellbeing and decreased emotional reactivity. This is an area very much in its infancy in terms of research.

The potential impact of the training on brain activity and cognitive functioning, particularly executive function (Stange et al., 2011; Ives-Deliperi et al., 2013) and attention (Howells et al., 2012; Deckersbach et al., 2011) is now being evaluated. The attention-training aspect of the practice is particularly appealing for this client group who often report problems with attention and concentration. This does, however, mean that modifications in the mindfulness training protocols taking this into account may be necessary. Stange et al. (2011) showed improvements in self-reported executive functioning, memory, and ability to initiate and complete tasks, correlated with increased mindfulness, non-judgement of thoughts and awareness of thoughts, feelings and sensations.

Individuals with a diagnosis of bipolar disorder report mindfulness training is helpful in the self-management of their problem (Weber et al., 2010). Subjective benefits of MBCT have been detailed in a qualitative study (Chadwick et al., 2011), which revealed the following themes: focusing on what is present; clearer awareness of mood state/change; acceptance; mindfulness in different mood states; reducing/stabilising negative affect; relating differently to negative thoughts; and reducing impact of mood state.

HOW MINDFULNESS CAN HELP PEOPLE WITH BIPOLAR DISORDER

Mindfulness practice can help this client group in the following ways:

- Greater sensitivity to changes in mood (e.g. noticing mood increasing or decreasing).
- Greater sensitivity to changes in mental state (e.g. noticing racing thoughts and engaging in a less reactive way to mental imagery).
- Acceptance of their psychological problems and the uncertainty this brings.
- Better ability to recognise stress and act effectively to combat its deleterious effects.
- Better ability to cope with the chronic anxiety (which often remains inter-episode).
- Improved communication with family and loved ones.
- Training attention networks for improved focus and concentration

SUMMARY

Research is in its infancy and larger studies with more participants and adequate control groups are required. Typically the studies have included participants who are not experiencing suicidal thoughts or mania. Those who are rapid cycling may not be appropriate for this training in a group format. Modifications to the standard training may be necessary and include the exploration of not only aversion to negative feelings but also attachment to hypomanic experiences, and working with images as well as thoughts as part of the mental phenomena experienced. Modification to take into account extant attentional deficits may be required. Bojic and Becerra (2017) state a need for larger participant size, active controls, more standardisation in interventions and research that examines adherence and possible adverse effects of MBCT.

MINDFULNESS FOR PEOPLE WITH PROBLEMS RELATED TO EATING AND BODY IMAGE

Problematic relationships to food and eating can take various forms including over-eating, restrictive eating (anorexia), binge eating, bulimia, and avoidant/restrictive eating (Hay, 2020). Although the more severe and enduring eating disorders are relatively rare in the general population, their impact can be devastating (Smink et al., 2012). Mortality rates in anorexia nervosa have been identified as one of the highest among all mental health disorders (Arcelus et al., 2011). Problems with food and eating are also present in a variety of other presenting conditions (e.g. intellectual difficulties, autism spectrum, psychosis; Atti et al., 2022). The latter are not considered here, but those working in this area may hold in mind that mindfulness offerings for these groups might also include mindful eating components that could be helpful.

Challenges with eating and body image have variable prevalence rates across gender and cross-culturally, with diagnostic categories continuing to evolve as more is understood about these issues related to food and body image (Smink et al., 2012). This work is also contextualised more broadly in society's beliefs and expectations of weight, health and appearance; particularly for women (Hesse-Biber et al., 2006), and increasingly now for men. This remains a heterogeneous clinical group that often presents with co-morbidities and remains a challenge for those offering psychological therapy. These clients are seen across a variety of settings (inpatient psychiatric

and medical, community mental health services or general health settings) and by a variety of multi-disciplinary professionals. Individual and group work are both offered. There is high heterogeneity in presentation and treatment efficacy, and particular challenges with a group referred to as 'severe and enduring anorexia nervosa' (SEAN; Zu et al., 2020).

The treatments recommended by NICE in the management of eating problems include individual eating-disorder focused cognitive therapy (CBT-ED), the Anorexia Nervosa Treatment for Adults (MANTRA), and specialist supportive clinical management (SSCM). Eating-disorder-focused focal psychodynamic therapy (FPT) can also be considered (NICE, 2017).

Alterations in a healthy mind-body relationship are inherent in those with eating and body image problems and as such, mind-body approaches such as MBSR and other mindfulness-based approaches may have appeal (Dimidjian & Linehan, 2006; Pisetsky et al., 2019). Intuitively, mindfulness and eating 'pathology' (broadly defined) seem at odds. This is supported by Sala et al.'s (2020) meta analysis of 74 independent samples showing that mindfulness was negatively associated with ED psychopathology.

On the basis of the research into MBSR/MBCT, many adaptations are being developed for use with those with problems related to eating and body image. The stress reduction, cognitive flexibility and self-compassion elements may be distinct mechanisms that individuals can be supported to change their relationship to their body, bodily sensations and mental representations of the body. As mindfulness training supports change more generally towards healthy physical and mental habits, this aspect may also contribute to positive impacts.

Mindfulness may have a role in recovery from problems with restrictive or binge eating by helping to cultivate intuitive eating (Warren et al., 2017). In intuitive eating the person learns to eat in accordance with what their body tells them rather than the rules about eating and food that they have developed (Koller et al., 2020). Mindfulness creates a space for individuals to understand a thought as just a thought rather than the statement of a rule that normally they would automatically follow. For example, rather than thinking that a particular type of food is bad, the person through mindfulness learns to be aware that they are *thinking* or *judging* that a certain food is bad.

Grider et al.'s (2021) recent systematic review of 13 studies of mindful and intuitive eating interventions (including studies with participants who were of healthy weight or were overweight or obese, but not presenting with anorexia, bulimia nervosa or binge eating) suggests caution in this work. In this review, mindfulness and intuitive eating interventions did not impact on energy intake or diet quality. Better quality studies are required.

The use of mindfulness-based interventions for people who have problems with eating and body image is still in its infancy but showing promising results (de Campora & Zavattini, 2021; Wanden-Berghe, 2011). As with much of the mindfulness literature, early research centred on case studies (for anorexia, Albers et al., 2010; Heffner, 2002), and small scale pilot feasibility studies across a range of presenting problems including binge eating (Smith et la., 2006; Leahey, 2008), bulimia (Proulx, 2008), and over-eating (Dalen et al., 2010). This early work sought to draw on existing mindfulness protocols and explore theoretically driven adaptations.

RESEARCH ON BINGE EATING

Baer reported on one of the first studies to apply a modified version of MBCT to binge eating (Baer et al., 2005). This study included 10 women who met criteria for BED. The recommended MBCT protocol was followed with adaptations. Ten sessions rather than the standard eight were conducted and material related to depression was replaced by psychoeducation around binge eating. Overall favourable results were obtained with positive changes in binge behaviour. As can often occur in mindfulness work, there was an increase in the rating of subjective binges after the treatment. Examination of food records and client interviews showed that this effect was due to the increased ability to discriminate between hunger and other cues. The authors conclude that 'the increase in reported subjective binges appeared to reflect increased sensitivity to internal states, rather than increased binge eating *per se*'.

Wanden-Berge's (2011) systematic review yielded eight studies (including ACT, DBT, MBCT and some MBSR 'derivatives' adapted for eating and body image problems). The majority of these studies focused on Binge Eating, Bulimia Nervosa and Over-Eating. They concluded that mindfulness is a promising approach, but more research is needed as sample sizes are small and more robust methodologies are required. They advocate the need for the formulation of how mindfulness is defined and which aspects or elements of mindfulness-based interventions may be beneficial for the different types of distress seen across the different presenting problems. There is also a need to be more specific about the language. Mantzios (2021) points to the distinction between mindfulness (as trained through exercises such as mindfulness of breathing and the body) and mindful eating (an event based applied practice focusing on texture, shape, smell, etc., of a food object).

Kattermnan et al. (2014) conducted a systematic review of previous studies and report on 14 studies in total that looked at the benefits of mindfulness-based interventions for binge eating, emotional eating and weight change. They found that mindfulness-based meditation reduced binge and emotional eating, with mixed effects for weight loss. While targets for weight loss may be at odds with the ethos of acceptance and non-striving inherent in a mindfulness-based approach, this is often an important outcome for individuals and services. Katterman et al. (2014) report that MBSR alone (without additional behaviour weight management intervention) was not sufficient to impact on weight loss (p.202). They also point to the distinctions between studies that rely predominantly on mindfulness training (MBSR/MBCT) as compared to those that include mindfulness as part of a multicomponent intervention (e.g. ACT/DBT). In working with individuals who may struggle to engage with therapies (mindful or other; DeJong et al., 2011), the requirements for personal practice may inform the choice of mindfulness-based intervention.

Warren et al. (2017) conducted a structured literature review and reported broadly similar findings. Mindfulness-based approaches appear most effective in addressing binge eating, emotional eating and eating in response to external cues. There is a lack of compelling evidence for the effectiveness of mindfulness and mindful eating in weight management, although some evidence that mindfulness training may be a useful precursor to weight loss interventions (Lattimore, 2020; Warren et al., 2017).

One of the more well-developed derivatives of MBSR for those with eating and body image difficulties is Mindfulness-Based Eating (MB-EAT). Kristeller and Hallet (1999) evaluated a six-week mindfulness-based eating training protocol that draws broadly on standard mindfulness exercises from the MBSR protocol, alongside specific adaptations for those with over-eating. In a single group extended baseline design, 18 women meeting criteria for obesity showed decreases in binge frequency and severity, as well as reductions on the Binge Eating Scale (BES)

and standard anxiety and depression scales. Decreases on the BES were related to the time participants engaged with eating related mindfulness exercises (consistent with findings from mindfulness interventions in the more developed fields, for example, mindfulness for depression).

From this work Kristeller and Wolever (2011) developed the conceptual foundations for the Mindfulness-Based Eating Awareness Training; now a 12 session protocol designed to help those with binge eating (MB-EAT; Kristeller & Hallet, 1999; Kristeller & Wolever, 2011). MB-EAT involves training in mindfulness meditation and guided mindfulness practices designed to address the core issues of BED: controlling responses to varying emotional states; making conscious food choices; developing an awareness of hunger and satiety cues; and cultivating self-acceptance. Evaluated in an active control RCT, this protocol has been shown to decrease binge eating and related symptoms to a clinically meaningful level, with the amount of mindfulness practice related to outcomes (Kristeller et al., 2014).

RESTRICTIVE PATTERNS OF EATING

Broadly speaking, mindfulness may target stress reduction, emotion regulation/ distress tolerance, and body awareness. These may be more appropriate for binge or overeating client groups. A much smaller evidence base exists for work with anorexia. Dunne (2018) indicated that results were mixed for the eight studies that met inclusion for their review. Multimodal interventions demonstrated some efficacy. Compared to distraction techniques, shorter interventions may be either equivalent, or in some cases result in greater anxiety. Qualitative data indicated that participants felt mindfulness was challenging but beneficial.

Caution is warranted in the application of mindfulness for people with severe problems with eating and body image where there is a diagnosis of Anorexia, particularly during in-patient stays. The additional stressor of the admission may exacerbate problematic emotional states. Engaging patients with these conditions is often challenging (Dejong et al., 2012), therefore programmes (such as mindfulness) that require motivation and engagement for their success must be carefully thought through. Using standard mindfulness exercises (for example, mindfulness of the breath working with sensations of the belly) seems unhelpful for these patients.

The following observations come from an open controlled trial conducted on an adult inpatient eating disorder inpatient unit in Brazil over the period 2012 to 2020 (Stubing et al., 2021). Working with individuals with BMI as low as 11, this research was aimed at identifying specific ways to deliver mindfulness exercises for severe and enduring anorexia nervosa (including those with comorbidities).

Skilful use of micro-mindfulness exercises was helpful. For example, a brief mindfulness of the hands, or mindfulness of the hands as they interact with the environment, or hands as they use playdough/clay or explore textures may be entry points to becoming present with the body. Focusing on tactile sensations of the hands and feet supported the management of panic reactions (for example, during the high intensity moment of food consumption).

A mindfulness formulation and psychoeducation was offered to help explore the links between mental cognitive patterns and sensations in the body. For example, support to notice how thinking impacts on the body, and how working mindfully with the sensations (and movements) in the body to support changes in cognitive patterns.

Mindfulness exercises that supported awareness of cognitive patterns were targeted towards the specific mental phenomena that keep these clients trapped in self-destructive and self-harming loops. In those with restrictive eating, it was shown to be helpful to share a 'Buddhist-informed' model of the mind (e.g. Grabovac et al., 2011); exploring the beliefs and understanding of where

tightly held rigid expectations originated. Support to explore the possibility to observe thoughts as thoughts, but additionally thoughts as a product of a mind, and the notion that 'I am person who has a mind, and that mind has thoughts'. This is a 'triple' decoupling process account (see also Park et al., 2011, 2012) goes a step further than 'thoughts are not facts'. It opens up the possibility of choice in a more nuanced way.

The preliminary results from this project demonstrates these patients are able to engage with these cognitive exercises, showing that cognitive impairment due to low body weight is not a limiting factor. Furthermore, significant reductions in anxiety and depression levels may be part of the mechanism that reduces distress and supports engagement with disorder specific treatments (Stubing et al, 2021; Rawal et al., 2009; Cowdrey et al., 2013).

Working at this level requires a high degree of personal mindfulness training and understanding of philosophy of mind in the practitioner. The delivery and development of these exercises needs to be carefully considered and theoretically driven based on models of emotion (dys) regulation and body schema. In practical terms, it could be counter productive to introduce exercises that involve food (e.g. the Raisin exercise used in Session 1 of MBSR/MBCT) or the full body (e.g. the Body Scan) for this client group. These exercises would *not* be the first entry to mindfulness for those with body sensitivities or disruptions in interoception (Jacquemot & Park, 2020). Those with restrictive patterns may benefit initially from a greater awareness of the cognitive patterns that support the maintenance of eating problems (e.g. rigidity, rumination, experiential avoidance; see Cowdrey & Park, 2012). Rawal et al. (2009, 2010, 2011) have been developing theoretical models based on rumination, beliefs about rumination, experiential avoidance and aspects of schematic thinking that may guide the practitioner's thinking.

ACT and DBT: Several cognitive therapies for people with problems related to eating and body image have successfully incorporated the concept of mindfulness, with a reduced emphasis on the formal exercises. Among them are Acceptance and Commitment Therapy (ACT-ED; Sandoz et al., 2010) and Dialectical Behaviour Therapy (DBT; Linehan, 1993; Safer et al., 2009, 2010).

ACT's ability to improve cognitive flexibility may in part underpin its effectiveness for those with eating problems (Tchanturia et al., 2004). Similarly, the ability to increase distress tolerance and develop interpersonal skills as taught in DBT, may be helpful in the management of personality comorbidities. Mindfulness may have generic effects on underlying personality traits that impact on eating behaviours. Pigeon and Graingers (2013) non-clinical cross-sectional study with university students, demonstrated that the variance in problematic eating was accounted for by neurotic personality traits and insecure attachment style. The introduction of mindfulness (assessed via questionnaire) significantly reduced this variance.

DBT STUDIES

A recent review of the literature for adapted DBT for adults with binge eating and bulimia (DBT-BED and DBT-BN) indicates that the 'Stanford Model' is the most robustly researched adaptation (Ben-Porath et al., 2020). Lynch et al. (2013) found that 35 per cent of patients with Anorexia (AN) were in full remission and 55 per cent in partial remission in an inpatient setting after completing a comprehensive DBT programme, Radically Open DBT (RO-DBT) and mindfulness focused therapy. Chen et al. (2008) found a significant reduction in suicidal behaviour, self-injury, binge-eating and secondary ED concerns, with improvements in social functioning with patients that had a dual diagnosis of BPD and ED after completing a standard DBT approach.

The Stanford Model DBT adaptation for bulimia (BN) and binge eating (BED) yielded positive results with 89 per cent of women abstinent from binge eating compared to 12.5 per cent on

waitlist. 67 per cent were abstinent at three-month follow-up (Telch et. al 2001). Hill, Craighead and Safer (2011) found that after DBT-Appetite Focused treatment there was a significant decrease in binge, purge and cognitive symptoms of their ED. Sixty-one per cent no longer met criteria for BN.

Adolescents with BED that participated in an outpatient DBT skills group with individual therapy and phone coaching showed significant decrease in behaviours, with 42 per cent no longer meeting criteria for BED (Fischer & Peterson, 2015). Two studies have explored the use of DBT for working with eating problems in adolescents (Peterson et al., 2020; Reilly et al., 2020).

Studies using mindful eating interventions have been conducted with people in community outpatient settings (Albers, 2010; Baer, 2005; Smith et al., 2006). Hepworth (2010) applied a mindful eating group as an adjunct therapy to outpatients. In this pilot study, after 11 sessions, results showed a significant reduction in scores on the EAT-26 (Eating Attitudes Test-26) scale with large effect sizes.

OVER-EATING

For people whose problem in relation to food is overeating and weight gain, mindfulness may potentially be effective in helping some people with weight loss (Fulwiler et al., 2015; O'Reilly et al., 2014). O'Reilly et al. (2014) literature review reported that 18 out of 21 studies (using a variety of mindfulness interventions) demonstrated improvements in the targeted eating behaviours.

For many people, weight gain is the result of emotional eating to manage stress. Teaching moment by moment awareness of internal states may be beneficial for people with this issue to help them have better control over eating. It is suggested that through mindfulness, people become less judgemental and less reactive to external events, and they may manage stress better without using food. Brewer (2018) proposes that mindfulness can be used to alter eating habits. It may enable people to focus on the intrinsic benefits of healthy eating and self-compassion, instead of extrinsic rewards from weighing or measuring oneself.

The current stage of research in this area is one where there is a need for controlled RCTs. There are promising studies and systematic meta-analysis. Levoy et al. (2017) conducted two studies into the effectiveness of MBSR to reduce emotional eating. The outcomes were positive but there were no control groups. Rogers et al. (2017) examined 14 previous studies through meta-analysis and found that they lacked the rigour and longitudinal criteria to make firm recommendations. Carrière et al. (2018) in a systematic meta-analysis of studies so far found moderate support for mindfulness-based interventions being effective in weight loss and eating behaviours. Fuentes Artiles et al. (2019) in a systematic meta-analysis of ten previous studies showed mindful eating was better than non-intervention controls but not superior to conventional weight loss programmes. Although the theoretical rationale for working mindfully with over-eating has good face validity, more empirical data is required to make firm conclusions.

THINGS TO CONSIDER

The literature suggests that there may be different underlying theoretical models used to formulate the mindfulness intervention for the different forms of problems with eating and body image. While emotion regulation and tolerance skills are appropriate for those with binge eating problems and a diagnosis of bulimia, a different approach may be warranted with a diagnosis of anorexia, where understanding of more cognitive elements of mindfulness meditation is indicated. Clarity around what is meant by 'mindfulness intervention' in this clinical population is also encouraged.

Mindfulness may have a place in the wider system (staff and family members) to help manage the experience of supporting an individual with eating problems (Graham et al., 2020). Mindfulness aims to work on and develop acceptance, non-judgement, gentleness and openness to experiences and it is likely to be helpful if the therapist (and families and carers) embody these skills. Boudette (2010) details the benefits of mindfulness for both therapist and client in the context of working with those with eating and body image problems.

The current state of research indicates larger studies, use of control groups and more specific designs for different types of problems with eating and body image and their stage of recovery journey. Tighter formulation seems warranted given the broad range of cognitive, emotional and body-related habits expressed across different presenting problems.

SUMMARY

- For people with problems with eating and body image with binge eating or a diagnosis of Bulimia Nervosa there is an emerging evidence base for adapted Mindfulness-based Interventions.
- It seems critical to be really clear which aspect of eating and body image is being targeted, as well as being clear on the psychological or motivational model that underpins the selection of the intervention (e.g. general stress reduction, working with addictive impulses, changes in body weight/BMI, cognitive or belief based changes, improving cognitive flexibility or self-compassion, etc.).
- For people with problems with eating and body image diagnosed with Anorexia Nervosa, it is still in the theoretical development stage and requires a high level of practice and skill by the person teaching mindfulness. The work with over-eating is promising and theoretically sound, but in its infancy.
- As recommended throughout these guidelines, it is important that the therapist has their own mindfulness practice.

MINDFULNESS FOR PEOPLE WITH ADHD

Attention Deficit Hyperactivity Disorder (ADHD) is a form of neurodiversity that starts in childhood and can continue into adulthood. This section concerns (ADHD) in adults. ADHD in children is covered in the children and young people section. ADHD affects people's ability to concentrate and to focus attention; and presents with restlessness and impulsivity. The three core symptoms are inattention, impulsivity, and hyperactivity. The prevalence rate in adults is believed to be 2.8 per cent worldwide (Fayeed et al., 2017), with prevalence rates higher in high income countries (3.6 per cent), and upper middle income countries (3 per cent) as compared to low/low-middle income countries (1.4 per cent).

According to Ginsberg et al. (2014) 80 per cent of people who meet the diagnosis for ADHD go undiagnosed, and they often make contact with health care services for another condition. Comorbidities are common, with 90 per cent meeting criteria for another psychiatric condition (Ginsberg et al., 2014).

The NICE guidelines for ADHD (2018) suggests practitioners consider non-pharmacological treatments for adults with ADHD if they have chosen not to pursue a medication option, have trouble adhering to medication regime or if medication is ineffective or with adverse effects.

Psychological or behaviour interventions may also be offered to those who do take a medication route, yet whose symptoms are still causing significant impact in at least one domain of functioning (e.g. work, relationships).

The specific effects of mindfulness on various subsystems of attention (Jha et al., 2017) suggests that mindfulness training could be potentially beneficial for people who have problems with attention. Repeatedly returning attention to a present moment anchor can strengthen the brain's capacity to manage differently with some of the symptoms of ADHD. Other mechanisms that may underpin improvements include improving working memory (Backmann et al., 2018) and inhibitory control (Zhang et al., 2018).

There is a proposed neurological basis to the expectation that mindfulness will improve ADHD symptoms supported by neuroimaging (Mitchell et al., 2015). Areas of the brain proposed to be affected by mindfulness training overlap with where problems are expected to be seen in people with a diagnosis of ADHD.

Mindfulness may enable a person to better regulate their attention and emotions to remediate the impact of the challenges associated with ADHD in a way that evokes experience dependent neuroplasticity. Currently, research into the neurological understanding of mindfulness and ADHD is in its infancy (Backman et al., 2018).

A study by Zylowska et al. (2008) of 24 adults and eight adolescents on an eight-week mindfulness training programme, the Mindfulness Awareness Programme (MAP) found that the majority completed, reported satisfaction with it, reported improvements in ADHD symptoms and improvements in mood, anxiety and depression. Gu et al. (2016) in a study of college students (ages 19 to 24) compared the outcomes for students who attended an MBCT group to those on a wait list; the active group showed improvements for ADHD symptoms, mindfulness, and sustained attention.

Poissant et al. (2019) in a systematic review of studies for mindfulness-based approaches and adult ADHD found improvement in ADHD symptoms in all of them, in addition executive function and emotion dysregulation also showed improvements. However the majority of studies reviewed had problems, including biases, lack of control conditions, and attrition. Improved studies are needed before clear recommendations can be made, nevertheless, this is an area of promise (Oliva et al., 2021); in addition adaptations to take account of the problems that this client group experience are needed (Mitchell et al., 2018).

Zhang et al. (2018) in a meta-analysis of six RCTs of adults with ADHD undertaking broadly defined 'meditation based therapies' demonstrated them to be significantly more effective than control in decreasing core symptom severity (inattention, hyperactivity/impulsivity). Three studies found significant effects on measures of working memory and inhibitory control. However, 33 per cent of the studies were considered 'unclear' and 67 per cent had a high risk of bias.

Janssen et al. (2019) found in a multicentre, single-blind, RCT that MBCT+TAU was more effective than TAU, with benefits maintained at six month follow up, both for clinician rated and self-reported symptoms improved in the MBCT+TAU condition. Self-reported symptom reduction and subjective improvements in executive functioning were present at six-month follow-up. These results are similar to Hepark et al., (2019) who used a 12-week intervention (as opposed to the eight-week MBCT protocol used by Janssen et al., 2019).

A comparison of MAP to psychoeducation for adult ADHD by Hoxhaj et al. (2018) found a difference between these two interventions for core symptom reduction (with both interventions

benefiting participants); there were notable gender effects with women improving more irrespective of treatment arm, and men benefiting most from the MAP intervention.

ACT for ADHD has been explored, Munawar's scoping review summarises the literature (Munawar et al., 2021). Acceptance of the ADHD experience, as well as practice aligning to core values may support those with ADHD to work compassionately and kindly with their ADHD symptoms. The more practical and applied mindfulness skills of ACT may be particularly useful.

THINGS TO CONSIDER

When teaching mindfulness to people with ADHD the following adaptations may be beneficial. These are taken from the MAPs approach:

- Psychoeducation is important, giving participants an understanding of ADHD and the rationale for why mindfulness practice might help with the symptoms of ADHD. Participants are encouraged to consider their own profile of ADHD symptoms for how mindfulness might impact on them.
- The length of sessions needs to be short at the start and increased gradually. The starting point may be as short as five minutes and the longest sessions may be just 15 minutes. This is substantially shorter than in many other approaches such as MBCT and MBSR and is a response to the clinical features of ADHD (e.g. restlessness). Mindful movement is also encouraged.
- An increased emphasis on mindfulness in everyday moments to develop informal moment-to-moment, non-judgemental awareness. Regular daily formal practice may be difficult for someone with the clinical features of ADHD, therefore mindfulness exercises need to be built into the activities of everyday life and supporting approaching tasks in a mindful way.
- Use visual imagery as much as possible, for example, blue skies and clouds to represent awareness (the blue skies) and clouds (the content of thoughts), or the use of 'Pause' stickers.
- Incorporate loving kindness and compassion practices to deal with the negative self-talk that is often associated with ADHD.
- Use CBT derived approaches to help with setting up a way of maintaining engagement with mindfulness after the course with the teacher has concluded. Include the use of apps and (ideally visual) reminders to support the intention to continue to practice.
- Utilise acceptance and change strategies similar to those in ACT to allow the person to redirect their attention when they are engaging in maladaptive behaviours.
- Make use of the STOP technique from MBSR which is S = Stop, T = Take a breath, O= Observe in the present moment, P = Proceed. This can be used by people with ADHD to check if their current focus of attention matches their intention for their activity at this moment.
- Use Mindfulness buddies, these may be members of a mindfulness group of friends or relatives who help keep the person maintaining their practice.

SUMMARY

The empirical evidence suggests that mindfulness-based approaches are worth considering as interventions for people with a diagnosis of ADHD. Mindfulness for this client group needs more studies that are rigorous with controls and good outcome measures.

Conducting mindfulness-based approaches with people with a diagnosis is best undertaken by a teacher who has a good working knowledge of both ADHD and mindfulness, or joint sessions with two teachers one experienced in each.

People with a diagnosis of ADHD attending general mindfulness groups may experience adverse effects which should not be too problematic but could be if the teacher is not familiar with the effects of this condition.

The MAPs approach has been one specific development for this client group which contains specific adaptations and would be a good starting point for clinicians wanting to involve mindfulness in the work with this client group.

MINDFULNESS FOR PEOPLE WITH PERSONALITY DISORDER

Personality disorders are a group of diagnoses given to people who struggle to regulate their emotions, interact with others, and have a clear sense of identity. This is an area of controversy and debate according to the mental health charity Mind (2020). People receiving this diagnosis have often experienced trauma, and it has been suggested that complex trauma might be a better name for the experiences of this client group. However, other researchers, theorists, and experts by experience suggest that these are distinct if co-existing conditions (Ford, 2021; Hebert, 2021).

There is some research highlighting the connection between mindfulness meditation and personality. The mental training in mindfulness has been linked to the development of a more coherent and healthy sense of self and identity (Crescentini & Capurso, 2015). Mindfulness has also been shown to support improved interpersonal problem solving, impulsivity and neuroticism in those individuals with Borderline 'features' to their presentation (Wupperman et al., 2009). However, despite this connection there are limited psychological interventions focusing on mindfulness for personality disorder.

Mindfulness in this client group is most often associated with the treatment of Borderline personality disorder (BPD – also known as emotionally unstable personality disorder), using Dialectical Behavioural Therapy (DBT). DBT sits within the wider family of Cognitive Behavioural Therapies, yet has mindfulness as a core element of the approach (for both the client and those providing treatment). Most of the clinical application research for personality disorders and mindfulness concerns DBT and BPD. DBT was included in the NICE guidelines for Borderline personality disorder with the statement that: 'For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive dialectical behaviour therapy programme.' (NICE, 2009).

Linehan and colleagues developed DBT as psychotherapy for women with repeated suicide attempts and self-harm (Linehan 1993a, 1993b). It was then extended out as an intervention for people who meet the criteria for BPD. In the development of this approach mindfulness was an integral part of the therapy. Mindfulness supports the other components of DBT; helping clients

to tolerate and accept distressing and painful emotional experiences, learning how to choose responses, and practising boundary setting and communication to enhance relationship skills.

The mindfulness utilised in DBT has its origins in Zen Buddhism (according to the creator Marsha Linehan). Linehan herself suffered from emotional instability and so brought both an expertise from experience as well as psychology training in her creation of this program. At the heart of this programme is a radical acceptance of self, alongside skills to support the management of emotions and experiences that frequently overwhelm. The mindfulness skills are activated as a means to create space for wise intentional action aligned with values. As such, these might be considered as mindfulness tools, rather than mindfulness training (as offered through MBCT and MBSR approaches for example).

It is notable that mindfulness is practised in each therapy session and before each skill group module; by both the client and therapist. The practice is different to that in MBCT and MBCT being shorter and more integrated into everyday life. This adaptation is necessary due to the challenges with emotional regulation and heightened emotion that this client group experiences, making longer sessions and more traditional (self-directed) practice more challenging. The practice of mindfulness by the therapist each session may contribute to the effectiveness of the approach by enabling the therapist to maintain self and other compassion in these often challenging therapeutic relationships.

Systematic reviews of the evidence for DBT and BPD show improvements in reducing self-harm, mood and hopelessness as well as functioning (Storebo et al., 2020: Hawton et al., 2016; Flynn et al., 2017). However, the quality of studies is variable including sample size and use of controls (Kounidas & Kastora, 2021).

Researchers have made preliminary studies into the specific characteristics seen in personality disorders that may be positively influenced by mindfulness. For example, Soler et al. (2016) found that mindfulness helped people with a diagnosis of BPD deal with some features of impulsivity, the delaying of gratification and the perception of time. This is supported by the work of Farres et al. (2019) who examined how mindfulness impacts on impulsivity and emotional dysregulation in this group. Although impulsivity appeared to decrease, there were additional effects on emotional clarity and emotional acceptance. Other researchers, such as Schiebner et al. (2017) have suggested that self-compassion is the mediating factor between the effects of mindfulness and improvements for people with borderline personality disorders.

There is very little research into the use of mindfulness with personality disorders other than the diagnosis of BPD. Sng and Janca (2016) suggested mindfulness is a promising tool for the treatment of personality disorder and is adaptable to different types of personality disorders but further research is required to support this and reveal the underlying mechanism. According to Sng and Janca (2015), case studies show promise in using mindfulness to help people diagnosed with avoidant, obsessive-compulsive and paranoid personality disorders. From a preliminary study with a sample of 83 offenders Velotti et al. (2016) suggest that mindfulness may moderate the effects between aggression and antisocial personality disorder.

SUMMARY

The research into mindfulness for people with a diagnosis of personality disorder has centred on DBT for BPD. DBT does have mindfulness as a core component and mindfulness runs through the therapy in one to one and group work. The evidence for effectiveness is positive but the studies that have demonstrated this are problematic in their quality. The effectiveness of mindfulness with this client group may involve its effects on impulsiveness and the development of self-compassion. Research into mindfulness and other personality disorders is in its infancy and further research is required.

Note that DBT has a distinct training pathway for therapists who wish to offer this approach. They are advised to amplify their own mindfulness training as part of this work.

MINDFULNESS FOR PEOPLE WITH INTELLECTUAL DISABILITIES

There is emerging interest in adapting mindfulness approaches for people with intellectual disabilities and an increased use of these approaches in clinical practice. There is promising evidence that people with intellectual disabilities can engage with key mindfulness meditations and experience a range of emotional and behavioural benefits as a result (Singh, 2020; Singh & Hwang, 2020). The majority of this work has been conducted by Singh's group in the USA, using a specific practice called 'Soles of the Feet'. An initial feasibility study in the UK has been conducted by Roberts et al. (2020).

'SOLES OF THE FEET' MINDFULNESS-BASED CBT

Nirbhay Singh and colleagues have developed a simple and accessible mindfulness procedure and published a series of studies demonstrating its use with people who have intellectual disabilities. The Soles of the Feet mindfulness-based cognitive behavioural technique teaches people how to divert their attention away from a thought, event or situation that they find emotionally arousing by focusing on the soles of their feet, an emotionally neutral part of the body. With practice it should become possible to calm the mind by focusing on this part of the body rather than the thought or the situation. This enables the person to stop and choose how to react to the event, situation or thought. The steps involved in teaching the Soles of the Feet technique and examples of role-play originally outlined in Singh et al. (2003) are expanded upon in a recently published manual (Singh, 2012). Cost-benefit (USA setting) has also been evaluated (Singh et al., 2008a).

Several studies have shown positive outcomes when the Soles of the Feet technique has been taught to people with intellectual disabilities (either as a standalone intervention or in conjunction with other strategies) to help control physical and verbal aggression (Singh et al., 2003, 2007a, 2011a), reduce smoking and weight (Singh et al., 2008b, 2011b, 2011c, 2014) and to modify inappropriate sexual arousal amongst adult offenders (Singh et al., 2011d).

People with intellectual disabilities who have received mindfulness training have reported that they valued learning to control their own feelings rather than having to follow directions from other people (Singh et al., 2011d). Whilst they might initially find mindfulness procedures difficult to understand, repeated practice and the use of role-plays help them to overcome such difficulties (Singh et al., 2007, 2011d). Although an experienced psychologist usually provided training, there is some evidence that people with intellectual disabilities trained in Soles of the Feet can teach the technique to their peers (Singh et al., 2011a). Singh and colleagues have also developed the Mindful Observation of Thoughts procedure, which involves visualising thoughts

as clouds drifting by in the sky, and is intended to help people with intellectual disabilities to disengage with their thoughts as a further way of increasing self-control (Singh et al., 2011d). Singh et al. (2013) describe in detail the use of the Soles of the Feet technique to reduce aggression; however, the technique has been less successful when targeted at sex offending (Singh, 2011d).

Research studies by Singh and colleagues also suggest that teaching paid carers and parents in mindfulness techniques can benefit people with intellectual disabilities in terms of increased observed happiness (Singh et al., 2004), reduced use of physical restraints and PRN (as required) medication (Singh et al., 2009) and improved family interactions (Singh et al., 2007b). Staff working with people with intellectual disabilities report increased work satisfaction (Singh et al., 2006) whilst parents report improvements in parental satisfaction and parental stress (Singh et al., 2007) after mindfulness training. Singh et al. (2016) are confident enough to state that for Mindfulness-based Positive Behavioural Support it is the case that 'the accumulating proof-of-concept studies strongly indicate that the programme may be effective in enhancing the overall quality of life of the staff as well as their clients, and result in financial benefits to the provider service agency'.

ADAPTATIONS OF OTHER MINDFULNESS APPROACHES

A smaller number of studies have adapted other mindfulness approaches for use by people with intellectual disabilities. Miodrag et al. (2013) reported outcomes for 24 adults with Williams syndrome attending a five-day residential music camp who completed small group-based mindfulness activities for two hours each day based on an MBSR protocol. The authors reported group members' anxiety and cortisol levels to be consistently lower following each mindfulness session.

There are some studies on the use of Dialectical Behaviour Therapy (DBT) which has a mindfulness component, with a forensic population of people with intellectual disabilities. For example, Sakdalan et al. (2010) reported positive improvements for men with intellectual disabilities and convictions for violence. Morrisey and Ingamells (2011) also reported improvements for male offenders in a high secure service and Verhoeven (2010) reported encouraging results for DBT with sex offenders with ID. However, it is not possible to distinguish the effects of mindfulness separately from the full DBT package. Chilvers et al. (2011) implemented twice-weekly 30-minute mindfulness groups for women with intellectual disabilities in a medium secure unit over a six-month period and found aggressive incidents to reduce significantly, see also Thomas et al. (2012a, 2012b). The reader is referred to Howells et al. (2010) for a broader review of mindfulness in the forensic mental health setting.

There have been two case reports detailing use of ACT with adults who have intellectual disabilities. Pankey and Hayes (2003) reported on a four-session ACT protocol to treat psychosis in a 22-year-old woman with mild intellectual disabilities. They noted improvements in eating, sleeping, taking medication, and obsessive behaviours together with reduced distress in response to hallucinations. A case of a young woman with moderate to severe intellectual disabilities who had obsessive and anxious thoughts was described by Brown and Hooper (2009). Following 10 sessions of ACT the young woman was reported to be less avoidant of her thoughts and emotions, to feel calmer and to have re-engaged in her college course. ACT-based interventions have also been used with support staff (Noone & Hastings, 2009; Smith & Gore, 2012), but as yet the outcomes have only been evaluated in terms of reductions in staff stress rather than direct changes for people with intellectual disabilities supported by the staff.

For all approaches described above there are methodological limitations within much of the evidence (for example, small sample size, lack of comparison groups, lack of clear definitions of mindfulness and assessment of intervention fidelity), which means that the findings should be treated with caution and that further research is required (Chapman et al., 2013; Hwang & Kearney, 2013).

RECOMMENDATIONS FOR CLINICAL PRACTICE

Prior to the start of any mindfulness programme, initial work should be carried out to support future attendance of sessions (for instance, by using visual time tables). It may also be helpful to support clients to develop key skills in identifying and labelling bodily sensations, feelings and thoughts and ways of recording these (Robertson, 2011) together with examples of emotional and behavioural difficulties for later reference. Simple rating scales or a mindfulness journal/scrapbook might also be effective here. The 'stress bubbleometer' used in work with psychosis (Russell, 2011; Jacobsen et al., 2020) may offer an example. In addition, it may be necessary to consider individualised strategies for supporting those with a history of displaying challenging behaviours during sessions.

It is essential to create a safe and supportive context from the start of a programme. The approaches to be used will likely be rather different to other more didactic therapeutic or support groups that clients may have encountered. There is great value in taking steps to minimise power imbalances between facilitator and group members so that all can work together to develop mindfulness and increased emotional wellbeing. The non-threatening, less goal-driven and experiential nature of mindfulness programmes provides a firm foundation for client engagement and motivation. As with all mindfulness-approaches it is essential that the course facilitator be well grounded in their own mindfulness practice, and adopt an open approach to developing and discussing this with those they support.

It is advisable to make modifications to session times and structure to allow processing of ideas and increased support to practice and refine exercises. Extending the length of the course (e.g. to 12 sessions), teaching a smaller variety of exercises, making these shorter (20 minutes rather than 40) and repeating these until clients are able to engage fully has been found to be beneficial in practice. Workshop models have also been explored (Chapman & Mitchell, 2013) and indicate that exercises such as the Body Scan can be completed and are subjectively valued as helpful for managing stress by individuals with learning difficulties.

The need for breaks during sessions should also be anticipated and planned for (Brown & Hooper, 2009). It is also important to recognise that facilitated reflective discussions following a mindfulness exercise remains a key element by which people with learning disabilities can learn from their direct experience.

Abstract language should be minimised during discussions with simple, brief and clear language used to explain all exercises. In practice it has been found that greater emphasis on more concrete aspects of meditations, like breathing and awareness of bodily sensations is often most useful. These may also be further adapted to increase accessibility. The four-stage model as described in Part 1 (Figure 2) may provide a useful diagram to support understanding of what is being invited. A body scan exercise for instance may be focused on a smaller number of primary body regions (feet, legs, arms, etc.) rather than more specific areas that are harder to identify (eyelids, ankles). The mini body scan Hands and Face from Body in the Mind Training (developed for those with psychosis, Russell, 2011; Russell & Tatton-Ramos, 2014) draws on the neuroscience of sensory processing in the human brain. Much larger regions of the brain are dedicated to processing information from the hands and face which may make these targets easier to attend

to. These regions additionally hold emotions, so mindfulness of the hands and face can also augment emotional awareness (see Russell, 2015, p.78). When delivered in this way, people with intellectual disabilities have been found to report experiences that are consistent with a state of mindfulness. For instance, following a meditation on body and breath a group member supported by the third author reported: 'I noticed my breath in my chest, and butterflies in my stomach' – 'They [butterflies] got less when I noticed them'.

Some degree of direct support may be required when facilitating movement-based meditations as used by Miodrag et al. (2013), to teach Qigong. Creative exercises can be useful for teaching mindful breathing, Robertson (2011) suggests blowing bubbles may be a useful strategy. Visual methods have been found to support understanding more broadly. For instance, Brown and Hooper (2009) worked to draw a 'river of thoughts' and Miodrag et al. (2013) described using a 'glitter ball' as a concrete reference point during discussions of feelings.

Significant attention should be given to promoting and supporting mindfulness practice outside of sessions. This should include providing group members with tailored written materials and adapted CDs and should draw upon existing support from family carers and paid staff (Chapman et al., 2013). In practice, active support from someone at home, either reminding people to do the daily home practice, or better still doing it with them, makes it much more likely that group members will keep going and benefit from the course. By attending mindfulness sessions carers may help to facilitate group members' engagement and understanding and may develop their own understanding and personal practice of mindfulness. Carers will then be well placed to model mindful awareness and promote generalisation and rehearsal of exercises for clients. This is an example of how supporting the development of mindfulness of those who work with (or care for) individuals with chronic and enduring difficulties can not only help the carers manage their own feelings but also impact on the experience of the client.

The reader is also referred to the Good Practice Guidelines: Mindfulness-based programmes for people with Learning Disabilities compiled by Griffith and Hastings available from Bangor University.

SUMMARY

- The area of mindfulness with people with intellectual disabilities has been dominated by the work of Singh and colleagues and their Soles of the feet technique where attention is diverted emotionally arousing thoughts, events or situations to focusing on the soles of the feet as an emotionally neutral part of the body.
- Studies have shown that this approach has been effective for a number of presenting problems for people with intellectual disabilities.
- It has also been shown to be valued by people with intellectual disabilities.
- Carers and parents can also train in mindfulness to deliver it.
- A smaller number of studies have looked at adaptations of MBSR, DBT and ACT for people with intellectual disabilities.
- For this client group, support to attend groups is required, a safe and supportive context is needed, session times need modifying, and abstract language minimised.
- Direct support may be needed for movement meditations.
- Practice needs support outside of sessions by paid carers or family members.

MINDFULNESS FOR OLDER ADULTS

OVERVIEW

As any Buddhist practitioner will tell you, it was the recognition of the inevitability of old age that led Siddhartha on his path (Hesse, 1922). Facing the reality of ageing can create a sense of urgency to focus upon the inward journey toward an understanding of the truth of our existence. An older person may learn that a chronic condition may not be cured but managed and that life can be lived fully despite complex physical and cognitive disabilities. Mindfulness-based approaches can provide a way in which an older client and a group facilitator can develop the interdependence that can lead to therapeutic intimacy and healing.

Since the beginning of the development of mindfulness-based stress reduction (MBSR), older people have always made up a large proportion of the clinical populations Kabat-Zinn (1990) and Santorelli (1999) studied. Yet, in tandem with the ageist bias in healthcare organisation and delivery (Hill, 2011; Royal College of Psychiatry 2009a, 2009b), older people have also generally been omitted from the applied research that has focused on mindfulness-based approaches in recent years. During the last decade there have, however, been a small number of papers exploring mindfulness and older people, within the context of promoting 'healthy ageing'. A review by Fountain-Zaragoza and Prakash (2017) found that the evidence is mixed; with improvements in attention and wellbeing shown in some studies but no benefits reported in others. They stress the need for better quality studies with placebo controls.

Li and Bressington (2019) included six eligible RCT studies in their meta-analysis of the effects of MBSR on depression, anxiety and stress in older adults. They report the evidence is limited and of relatively low quality. Their review shows some evidence that MBSR is more effective than wait-list-control groups to reduce depression in older adults with clinically significant symptoms immediately following the intervention. However, there is no clear evidence that the intervention reduced the perception of stress and anxiety, or that positive effects are maintained over the longer term. See Hazlett-Stevens et al. (2019) for similar results looking exclusively at MBSR and MBCT interventions.

A note of caution for the effectiveness of mindfulness-based approaches and older adults comes from the systematic review of Thomas et al. (2020) who considered 10 studies that studied the effectiveness of mindfulness for anxiety and depression in older adults. Their findings were that evidence was insufficient and that studies to that date were methodologically flawed.

Some more promising results have been found by Reangsing et al. (2021) who limited their meta-analyses to studies exploring the effects of mindfulness meditation interventions (MMI) on older adults with depression. Nineteen studies (1076 participants over the age of 64 and presenting with symptoms of depression) were included and the results demonstrated that MMIs significantly improved depressive symptoms when contrasted with active controls. Some intriguing moderator effects were also reported in this study. Looking across cultures, Asian participants tended to show greater improvements compared to Europeans and North Americans. Shorter duration programmes showed greater impact, as did those programmes that used guided (as opposed to self-directed) meditation practice.

Qualitative studies such as those of Parra et al. (2019) help to augment our understanding of the experience of group participants. This qualitative study shared insights from 41 adults (age 65–85) who had exposure to MBSR as part of a clinical trial (note there were also mindfulness plus exercise, and exercise alone conditions as part of this study). These participants reported that mindfulness training was beneficial for their mental and emotional state, with benefits for managing relationships and improved sleep. They stated the practices helped them to be more

relaxed, calm and understanding of others. They reported the time commitment (45 minutes of practice, as per the standard MBSR protocol) was a struggle to fit into their daily routine. Some sample quotes from this study are presented below to give flavour of the participant response. Note that those who engaged with the focus groups may be biased towards those who found benefits and wished to share, reinforcing the need to ensure that there are avenues for unusual and unexpected effects to have voice in any research protocol.

QUTOES FROM PARA ET AL. (2019) QUALITATIVE STUDY ON OLDER ADULTS PERCEPTIONS OF MINDFULNESS TRAINING

'More relaxed and being aware of what is around me. Looking at sights and sounds and what is around me…my receptors are working.'

'… lessens the tension and stress that I experience. I also like yoga exercise because I feel the benefits."I have calmed down a lot; little things do not get to me anymore.'

'Very reassuring, I have been feeling terrified about what is going on with me. I thought I had Alzheimer's, I didn't know what to do. This has made me calm down and realize that there are many more things to focus on in life.'

'I am falling asleep so much better, my mind is not wandering anymore.'

'…significant change in my marriage relationship mainly from being aware of tension points and having alternatives ways to deal with such.'

Han et al. (2021) recently completed a systematic review and meta-analysis of 10 RCTs that explored the benefits of MBIs on psychological symptoms, cognitive functions and quality of life in older adults with dementia or mild cognitive impairment. From this review they found no overall significant effect of MBIs on any of these variables. They concluded that higher quality studies are required but that the current evidence base is insufficient to recommend MBIs as a routine part of care for this population.

RECOMMENDATIONS

Provided below is a set of guidelines based upon this material for practitioners working with older people and their clients who are considering whether mindfulness-based approaches might be of value.

- A community-living older person may find that MBSR courses can aid in stress management and provide social support (Szanton et al., 2011).
- Those who also have chronic lower back pain find MBSR can lead to an improvement in the 'acceptance of pain and physical functioning' (Morone, et al., 2008, 2009).
- People who have mild to moderate depression or Parkinson's disease are likely to find that an MBCT course is 'acceptable' and are likely to 'benefit' in the same way and to the same level as a working age adult (Smith, 2004; Smith et al., 2007; Splevins et al., 2009; Fitzpatrick et al., 2010).
- An older adult experiencing depression following a course of DBT skills training and telephone coaching will experience a significant reduction of their depressive symptoms and it may act to augment antidepressant medication (Lynch et al., 2003).

- ACT is an 'acceptable' intervention to use with older people with generalised anxiety and reduces mild depressive symptoms and worry (Wetherell et al., 2011).
- Work with dyads of someone who has dementia and their carer using mindfulness-based approaches is a promising intervention to help them develop resilience and deal with challenges (Berk et al., 2018).

The small number of studies above and their weak research design all indicate that 'larger more rigorous trials must be undertaken to convincingly demonstrate effectiveness' (Morone, 2008).

- Older people with cognitive impairment and frail older people living in nursing home settings can learn the techniques of mindfulness meditation and gentle yoga and integrate these into their everyday lives. There are copious examples of single cases, descriptions of practices, and teacher requirements so that anyone can deliver this work (McBee; 2008). These types of programmes have shown some short-term reduction in agitation and behavioural problems (Lantz et al., 1997), and improved mood (Shalek & Doyle, 1997; McBee et al., 2004).
- A mixture of MBSR and MBCT groups for relatives and carers of older people with cognitive impairment have found a 'moderate beneficial effect': self-reported depression, perceived stress and sense of burden all decreased during the interventions. However, these benefits dissipate quickly over time, and are similar to the benefits from other comprehensive longitudinal dementia caregiver intervention programmes (Lopez et al., 2007; Oken et al., 2010; Epstein-Lubow et al., 2011).

SUMMARY

Community-living older people without cognitive impairment do not need specific adaptations to the content or process of the mindfulness-based interventions. They should have access to, and benefit from, the same set of interventions as younger people and no longer be excluded from these on the basis of age alone.

A research framework which includes a range of research strategies needs to be agreed and put into practice for older people with cognitive impairment and their formal and informal carers. This would identify the necessary, sufficient and adjunctive components of mindfulness, the characteristics of older people and their facilitators that are critical, and what processes occur in session that bring beneficial outcomes.

The issues of therapist training, supervision and cost effectiveness need consideration.

These strategies must be embedded within a positive ageing framework.

MINDFULNESS FOR CHILDREN AND YOUNG PEOPLE

IS MINDFULNESS ACCEPTABLE TO CHILDREN AND YOUNG PEOPLE?

In a growing research field, the literature suggests that mindfulness-based approaches are feasible and acceptable to children and young people (Burke, 2010; Miller et al., 2017; Murrell et al., 2005, 2011; Weare, 2013). In fact, young children often appear to be in a natural state of mindful awareness, playful, in the moment, and curious about their surroundings, their bodies, and their sensory experiences. It has, therefore, been argued that some children may find it easier than some adults to engage with mindfulness practice (Goodman, 2005). It has also been suggested that the typical use of metaphor and story within mindfulness and acceptance-based approaches appeals to all ages, developmental stages and abilities, and supports therapeutic work with children (Greco et al., 2005; Greco & Hayes, 2008). The experiential and practical nature of mindfulness may also be particularly suited to working with young people (Hayes et al., 1996). Interactive exercises using play, movement, and sensory stimulation (e.g. mindful listening, mindful eating) can be creatively tailored to the child's age and ability. Books and resources published, for both clinicians and parents, which detail novel and age-appropriate mindfulness practices specifically for children and young people, suitable for both one-to-one and group settings (Hanh, 2011; Kaiser-Greenland, 2010; Willard, 2010).

In the following section, the evidence base for a variety of mindfulness-based approaches (MBSR, MBCT, ACT and DBT) in the clinical setting is shared. In this work, mindfulness is used to treat a presenting problem. Given the preventative nature of mindfulness-based approaches, it is perhaps not surprising that there is great interest in the use of mindfulness to support young people in the school setting, within the context of social and emotional learning skills. The research from mindfulness in the education setting is considered, followed by some practical reflections from educational psychologists who have offered mindfulness in the school setting. The table below offers some general things to consider in offering mindfulness to young people.

THINGS TO CONSIDER/ISSUES

Compared to adult mindfulness approaches the key developmental adaptations highlighted in the literature for children and young people include:

- Shorter session length: Due to shorter attention spans and developmental stage many younger children will need shorter sessions (Woodberry & Popenoe, 2008). Goldstein et al. (2007) recommend shorter skills training sessions with young people with emotion regulation difficulties.
- Shorter formal mindfulness practices, such as body scan or sitting practice (typically between 1-20 minutes; Thompson & Gauntlett-Gilbert, 2008).
- Shorter amount of time spent on home practice.
- Use of technology, for example, PowerPoint presentations, mobile phone text reminders, email reminders, or web-based support packages may be useful with older children and young people.
- As in all areas of child-focused therapeutic work, the consideration of the role of the parent/carer and the whole family is paramount. O'Brien et al. (2008) suggest that clinicians must consider the systemic aspects of the difficulty and that the involvement of the parent is likely to be needed. Some MBCT/MBSR adapted courses also run parallel

mindfulness training to parents alongside child-focused groups (Bogels et al., 2008). Specific mindfulness-based approaches have also been developed for parents and carers of children and young people with psychological or physical health difficulties (Blackledge & Hayes, 2006; Dumas, 2005).

- The explanation of concepts needs to be developmentally appropriate for the child or young person and metaphors, stories, and visual aids can be used to explain more complex concepts (Heffner et al., 2003; Thompson & Gauntlett-Gilbert, 2008).
- Thompson and Gauntlett-Gilbert (2008) highlight the importance of balancing variety with repetition of key concepts.
- Helping young people to generalise mindfulness to their everyday lives may increase motivation to practice and support therapeutic effectiveness.

MBSR FOR CHILDREN AND YOUNG PEOPLE IN CLINICAL SETTINGS

Interventions based on the eight-week MBSR course are beginning to show some promise for adolescents with a variety of physical and mental health issues including: chronic pain and functional symptoms (Ali et al., 2017; Greco et al., 2005); Type 1 diabetes (Ellis et al., 2018); cardiac issues (Friedenberg, Hinds & Freedman, 2017; Gregoski et al., 2011); HIV (Sibinga et al., 2008, Sibinga et al., 2011, Webb et al., 2018); addictions and sleep issues (Bootzin & Stevens, 2005; Britton et al., 2010); and mixed mental health presentations (including anxiety and depression) (Biegel et al., 2009; Diaz et al., 2018; Vohra et al., 2019; Zhang et al., 2019).

Some of these studies examine the impact of a shorter six-week adapted MBSR course (Britton et al., 2010; Bootzin & Stevens, 2005), or a longer 12-week intervention (Gregoski et al., 2011), while others utilise an eight-week model more similar to the adult version (Biegel et al., 2009; Sibinga et al., 2011; Vohra et al., 2019). The research shows that MBSR is generally accepted and tolerated by young people. Diaz et al. (2018) comment on how young people may not engage in more formal mindfulness practice outside of sessions and highlight the importance of supporting young people to integrate mindfulness into their daily lives.

Biegel et al. (2009) conducted a randomised clinical trial on the effectiveness of a modified MBSR with young people (14–18 years) attending a psychiatric outpatient clinic with a range of clinically significant difficulties. Significant improvements were found in self-reported symptoms of anxiety, depression, and somatic distress, global assessment of functioning, self-esteem and sleep quality. These effect sizes were maintained at three-month follow-up.

Gregoski et al. (2011) conducted an RCT on a 12-week mindfulness intervention with 166 young adults at risk of cardio-vascular disease. Improvements were found on measures of systolic and diastolic blood pressure and heart rate, compared to the control group. Sibinga et al. (2008) and Sibinga et al. (2011) developed an eight-week MBSR course for young people (13–21 years) living with HIV. Improvements were seen in self-reported health-related quality of life and on one domain (of nine) of psychological distress.

Chi et al. (2018) carried out a meta-analysis of 18 RCTs (*N*=2092) for MBSR for young people (12 to 25 years) who were experiencing depression. They found that there were moderate effects on depression post intervention. They highlighted the need for long-term follow-up of effects. In addition, they consider that their findings suggest the need for longer interventions, for eight weeks or more.

MBCT WITH CHILDREN AND YOUNG PEOPLE IN CLINICAL SETTINGS

A number of studies have evaluated the effects of an eight-week MBCT adapted programme for young people diagnosed with ADHD and a parallel mindfulness course for their parents (Bogels et al., 2008; Van der Weijer-Bergsma et al., 2012; Van der Oord, et al., 2011). Van der Oord et al. (2011) completed a randomised control trial with an eight-week follow-up period. They found significant improvements in both child and parent self-reports for the problem and parental mindfulness, but not on measures of parental stress. Zylowska et al. (2007) researched the benefits of an eight-week mindfulness intervention for adults and young people with a diagnosis of ADHD. They found improvements in both in child and parent self-report measures for the problem and test performance on tasks measuring attention and cognitive inhibition. For a recent review of MBI's for ADHD in adults and children see Oliva et al. (2021).

MBCT-C is a 12-week manualized group therapy aimed at 8–12-year-olds (Semple & Lee, 2011). MBCT-C has been shown to improve anxiety, inattention and emotional dysregulation in non-clinical samples (Lee et al., 2008; Lee et al., 2020; Semple, 2005; Semple, 2010). A recent randomised control trial examined the efficacy of MBCT-C for children who met criteria for anxiety disorder (Shetty, Kongasseri & Rai, 2020). Fifty-two children were randomly assigned to MBCT-C or group therapy. MBCT-C was found to be more effective than group therapy in improving anxiety among children. Cotton et al. (2020; 2015) have researched the effects of MBCT-C on young people (9–16 years) with anxiety disorders who are at risk of bipolar disorder. Their most recent waiting list control study included 24 young people, mean age 13 years. Their findings suggest that MBCT-C has high levels of acceptability and feasibility and may be effective at improving overall clinical severity in youth with anxiety disorders who are at risk of bipolar disorder. They conclude that further RCT studies are warranted.

ACCEPTANCE AND COMMITMENT THERAPY (ACT) FOR YOUNG PEOPLE

A number of studies (including case studies and randomised control trials) have been conducted on the use of ACT for chronic pain in children (Wicksell et al., 2005, 2007, 2009, 2011, 2015). Gauntlet-Gilbert et al. (2013) examined the effectiveness of a three-week residential ACT approach with 98 young people (mean age 15.6 years) with chronic pain. Improvements were reported in levels of anxiety, school attendance and physical functioning associated with increased acceptance. They concluded that 'an intensive ACT-based pain rehabilitation course was an effective treatment for young people with disabilities and chronic pain' (2015, p.72). A more recent study examined the feasibility and preliminary effects of an online eight-week ACT-based intervention for young people 13–17 years with chronic pain, and their parents (Zetterqvist et al., 2020). The outcomes were promising with young people and parents reporting reductions in pain, low mood and insomnia symptoms. However, the authors note some issues with feasibility including slow recruitment, low compliance, and a delay in completion of follow-up assessments.

As well as physical health issues, ACT may well be effective with children and young people for a range of mental health problems including anxiety (Hancock et al., 2018), depression, obsessive compulsive disorder (Armstrong, Morrison & Twohig, 2013), trichotillomania (Lee et al. 2020), eating difficulties/ disorders (including anorexia nervosa) and body image issues (Harris & Samuel, 2020; Heffner et al., 2002, 2003; Heffner & Eifert, 2004). Swain et al. (2015) in a systematic review of 21 studies into the use of ACT with children and adolescents found preliminary evidence of its effectiveness in improving symptoms and quality of life and increasing psychological flexibility. In line with this review, a recent randomised controlled trial comparing the effects of ACT and CBT on children's anxiety reported that both interventions were superior to the waitlist control across outcomes such as anxiety, QOL, and acceptance/ diffusion. These benefits were maintained at three-month follow-up (Hancock et al., 2018).

DBT WITH CHILDREN AND YOUNG PEOPLE

A small body of studies have examined DBT for young people (8–19 years) with suicidal ideation, deliberate self-harm and 'Borderline Personality traits' in both inpatient and outpatient settings (Berk et al., 2020; Fleischhaker et al., 2011; James et al., 2008; Katz et al., 2004; Miller et al., 1997, 2000; Perepletchikova et al., 2011; Rathus & Miller, 2002; Saito, Tebbett-Mock & McGee, 2020; Sunseri, 2004; Tebbett-Mock et al., 2020; Woodberry & Popenoe, 2008). Goldstein et al. (2007) used DBT with young people (14–18 years) with a diagnosis of bipolar disorder based on the treatment manual of Miller et al. (the version from 2006, now updated to Miller et al., 2017) and included individual and family skills training. There was high patient satisfaction with the programme and participants exhibited significant improvement in suicidality, non-suicidal self-injurious behaviour, emotional dysregulation, and experiences of depression. More recently, McCauley et al. (2018) conducted a multisite randomised clinical trial with adolescents at high risk of suicide. The young people who received six months of intensive DBT reported significantly fewer suicide attempts, episodes of self-harm and/or self-injury compared to those young people who received individual and group supportive psychotherapy. While both groups continued to demonstrate improvements at 12-month follow-up, there were no significant differences between DBT and IGST. Clarke, Allerhand and Berk (2019) report that 'at this time, DBT is the first and only 'well-established' treatment for suicidal and SH adolescents' (p.5).

DBT programmes have also been successfully modified for adolescents with eating disorders (binge eating disorder, bulimia nervosa, and anorexia nervosa) and body image issues (Accurso, et al., 2018; Kamody, et al., 2019; Peterson, et al., 2020; Safer et al., 2007; Salbach-Andrae et al., 2008). A helpful systematic review paper by Vogel, Singh and Accurso, (2021) reported on 10 studies utilising DBT with this population. They conclude that DBT may be an acceptable and feasible intervention for young people with eating disorders and state that there is preliminary evidence of DBT's effectiveness. However, the authors highlight the need for more rigorous randomised control trials and comparison studies of DBT versus other treatment modalities.

The DBT distress tolerance skills taught through mindfulness may also be helpful in the management of trichotillomania in adolescents (see Welch & Kim, 2012, for a case study).

DBT has been adapted further for younger preadolescent children by Perepletchikova (2020). This model follows very similar concepts, skills, and strategies as the adult model, but makes adaptations for the developmental and cognitive level of younger children and includes parent training. Perepletchikova et al. (2017) conducted an RCT study on DBT-C with preadolescents (7–12 years) with Disruptive Mood Dysregulation Disorder (DMDD). Results suggested that DBT-C was acceptable to children and their parents and was significantly more effective in decreasing DMDD symptoms than Treatment-as-Usual (TAU). Further research is needed.

LIMITATIONS AND METHODOLOGICAL ISSUES

There is a growing body of research into mindfulness-based approaches with children and young people: there are some RCTs, but most are non-controlled pilot studies, with small sample sizes and a lack of standardised measures. There is also variety across the studies, in terms of the interventions offered and the demographics. Therefore, caution is warranted when generalising the research findings to different groups and more research is needed. However, Tan (2016) is hopeful for improvement in the quality of studies 'with the availability of recent and age-appropriate mindfulness measures for adolescents, more rigorous and robust research looks promising.' In addition, The Mindful Nation report (Mindfulness All-Party Parliamentary Group, 2014) recommended that MBCT for young people be evaluated as a relapse prevention intervention to determine if there is similar efficacy as seen in adults.

SUMMARY

Mindfulness-based approaches have been shown to be effective with children and young people. Some children may find it easier than adults. Research though is limited. Adaptations need to be made: shorter session length, shorter formal practice, and shorter time practice at home, the use of technology as prompts and concepts explained in age appropriate ways.

There have been pilot studies examining mindfulness-based approaches with children and young people in school settings; in clinical settings, Mindfulness-Based Interventions (MBI's) are beginning to show promise as treatments for various physical health issues in young people including chronic pain. Studies on MBI's have also yielded encouraging results as acceptable and feasible interventions in improving a variety of mental health issues including: ADHD; anxiety disorders; depression and suicidality; behavioural disorders; eating disorders and body image issues.

MINDFULNESS IN EDUCATION SETTINGS

GROUP-BASED MINDFULNESS PROGRAMMES WITH CHILDREN AND YOUNG PEOPLE IN SCHOOLS

There have been a number of programmes designed and adapted to introduce mindfulness into schools (Herrnleben-Kurz & Walach, 2014). As there has been an increase in psychological problems in young people, and mindfulness has been used to help with a range of psychological problems as well as organisational challenges, its introduction into schools seems a logical and almost inevitable thing to have happened. See Dunning et al. (2019) for a comprehensive robust review of this literature.

A small number of studies have examined the impact of mindfulness-based programmes with children and young people in schools and colleges (Harnett & Dawe, 2012). Most of these programmes have been designed to fit alongside the national curriculum for the general population to enhance wellbeing, and improve behaviour and school performance (Weare – web resource; Harnett & Dawe, 2012). These range from emotional wellbeing interventions which include some mindfulness practice, to more formal standardised mindfulness programmes such as the Mindfulness in Schools Project (MiSP) programme (Flook et al., 2010; Huppert & Johnson, 2010). Unfortunately, due to the pilot nature of many of these non-clinical programmes the evidence base is limited by a lack of robust research methodology and design. However, some of the reported benefits of mindfulness for children and young people within educational/non-clinical settings include: increased wellbeing and self-esteem, reduction in worries, decreased anxiety and distress, improved sleep, relaxation and calm, increased self-awareness and self-regulation, decrease in behavioural problems and reactivity, improved concentration, executive functioning and improved memory.

Weare (2013) has summarised the evidence for the impact of mindfulness with children and young people and concluded that if schools were to integrate mindfulness, 'when well taught and when practised regularly, it has been shown to be capable of improving mental health and wellbeing, mood, self-esteem, self-regulation, positive behaviour and academic learning' (Weare, 2013, p.141).

The Mindful Nation report (Mindfulness All-Party Parliamentary Group, 2014) has called for an increase in provision of mindfulness-based training in the school setting with a particular focus on initially training teachers to a high standard to enable them to facilitate this work with integrity.

The recently published Mindfulness and Education Strategy (The Mindfulness Initiative, 2020) is available online and summarises the evidence base and best practice for mindfulness-based school initiatives.

It is important that the quality of the mindfulness training offered is robust and consistent. Schools face immense problems in implementing initiatives due to funding constraints and there is a risk that cheaper initiatives could impact upon the quality of what is provided. Those teaching mindfulness to children need to have awareness for any adverse effects that a child may present with in response to a mindfulness practice. The teacher's own experience of mindfulness and continued personal practice is a hugely relevant factor (see Montero-Marin et al., 2021, for some of the issues related to offering mindfulness training to educators).

Some children may need additional adaptations to the practice, for example, those with a diagnosis of ADHD or ASD and this may need taking into account when teaching whole classes or setting up groups. In addition, issues of consent for participation need to be carefully considered with children able to opt out if they find it unpleasant in a way they could not opt out if they were in a French or Mathematics class. Delicate management of cultural and/or religious needs may also be required in multi-cultural settings (see Section on Mindfulness in religion, faith and spirituality for guidance on this aspect).

The evidence so far is mixed and has not been shown to change two of the key areas that educators may be aiming for, academic performance and behaviour. According to Maynard et al. (2017) 'Mindfulness-based interventions in schools have positive effects on cognitive and socio-emotional processes but do not improve behaviour and academic achievement' (p.1). They emphasise the point that money should not be taken from established interventions to fund bringing mindfulness into schools. However, see also the Flook et al. (2010) RCT study which demonstrated improvements in executive functioning after an eight-week MAPS intervention (contrasted to the control group). The impact on executive functioning appeared to be more pronounced for youngsters in their sample who entered into the trial with lower scores on these domains.

Whilst introducing mindfulness into schools is to be welcomed it should not be seen as a magic fix and the ethical and political dimensions should be considered. McCaw (2020) argues that there is a danger that mindfulness may be stripped of its deeper spiritual and ethical foundations and context, and that this could do unintentional harm. He warns of mindfulness being presented and taught as a set of techniques to improve behaviour and education outcomes in individuals. This may risk placing the emphasis on 'fixing' pupils and staff and providing tools to cope in a potentially unhealthy and stressed system. Instead McCaw (2020) advocates for taking a broader ethical approach when implementing mindfulness, promoting value-rich, and compassionate cultural change within the whole school system itself. Implementation is likely to take time and be a nonlinear process with setbacks that could discourage progress; patience and resilience is required (Wilde et al., 2019). The effectiveness of these programmes is still out for debate as research is conducted.

MINDFULNESS IN SCHOOLS: THE EDUCATIONAL PSYCHOLOGIST PERSPECTIVE

Within schools educators have observed increased stress, decreased wellbeing and challenges with maintaining mental health. This has been exacerbated by the Covid-19 pandemic, school closures and additional pressures on both staff and students. Teacher burnout and shortages are a concern for many schools amid budget cuts and difficulties recruiting. Young people are also struggling and the waiting lists for mental health services are long. Interventions and activities that can support and improve wellbeing within school are vital to education professionals and mindfulness can be considered as one of these.

OUR APPROACH TO THIS SECTION

There is a range of emerging research evidence that suggests that learning and practising mindfulness within a school context can lead to positive outcomes for children, young people and school staff. Our wish is not to repeat discussion of the large body of research evidence that has already been addressed (see above section) but to draw attention to additional specific research projects that have explored the application of mindfulness-based programmes within a school context.

In discussion, we think that we can also offer the most 'value' by integrating and reflecting on our professional practice experiences, as educational psychologists who have our own practice and teach children mindfulness. We do this to offer reflections on what mindfulness looks like within an educational context, and share the most frequent issues and considerations that arise for us, with the hope to contextualise the research findings previously discussed in other sections.

OUR POSITION AND VALUES

We wanted to be clear about our own position in relation to this issue and area of interest.

DAN

I first encountered mindfulness aged 19 when I experienced anxiety and panic during my undergraduate final year. After accessing the student counselling service I participated in an eight-week Mindfulness-based Stress Reduction course. Here I was introduced to the work of John Kabat-Zinn and a key learning from this experience was my automatic reactions to physiological experiences. Following positive experiences, my interest was piqued and I continued to deepen my understanding and practice over the next 10 years through reading, group practice and reflection. In 2017, after integrating learning from cognitive-behavioural and acceptance-commitment approaches into my educational psychology practice, I trained to teach mindfulness to children and young people.

TERESA

I first heard the word 'mindfulness' at a conference that I attended as a Trainee Educational Psychologist (TEP). Having always had an interest in meditation and yoga, mindfulness intrigued me and I signed up for an eight week MBSR (Mindfulness-based Stress Reduction) Course. This led me towards developing my own practice and conducting my doctoral research project on mindfulness. I explored the feasibility of delivering a published mindfulness course in a school for students who had ASD and language needs and found that mindfulness was very accessible to this group of young people. I continued to use mindfulness throughout my doctoral studies and noticed the positive benefits (as well as noticing that these occurred less when I did not maintain my practice). I have trained to deliver courses to students from the early years to school age and found this both rewarding and enjoyable. Following several short staff training sessions and after becoming aware of the lack of courses that adults can attend in my area I recently trained to deliver the MBSR course to adults as well.

We have both experienced positive outcomes as a result of our mindfulness practice and have chosen to cultivate our practice over a number of years. We have also pursued opportunities to train to teach mindfulness to children and young people, actions stemming from a belief that mindfulness has the potential to benefit children and young people if delivered effectively. We are practitioner educational psychologists and, of course, mindful of the necessity to exercise criticality with regards to the application of potentially costly interventions within often resource-scarce school contexts. We are both of the view that 'mindfulness' can often be a misunderstood concept with claims made that go far beyond the research and practice evidence. We are both critical of the 'mindfulness as a panacea' narrative that has emerged in recent years, particularly as we believe that this viewpoint is set against a backdrop of life experiences that are the anti-thesis to the foundations of mindfulness, such as systemic violence, rising poverty and inequality, and experiences of oppression, discrimination and exclusion.

RESEARCH EVIDENCE RELEVANT TO OUR REFLECTIONS FROM PRACTICE

Studies have variously explored a range of cognitive and mental health outcomes related to school-based mindfulness programmes. In a systematic review and meta-analysis, Zenner et al. (2014) found that participation in mindfulness-based programmes could promote student resilience, wellbeing and cognitive performance. The idea of 'improved cognitive performance' has been extended by Kuyken et al. (2017) who explicated the links between mindfulness practice in children and young people, improved executive functions and reduced mental health issues. Executive functions, or skills, are those '...skills required for humans to effectively execute, or perform, tasks and solve problems' (Guare & Dawson, 2013, p.11). A further meta-analysis of randomised controlled trials (Dunning et al., 2018) also demonstrated that mindfulness had a positive impact on executive functioning, depression, anxiety and stress. Other researchers have concluded that mindfulness-based interventions can improve *experiences* of anxiety, perhaps more explicitly raising the notion that positive outcomes are associated with *orientation towards experience*, rather than conceptualising the intervention as 'treating' stress or anxiety (Kuyken et al., 2013; Kallapiran et al., 2015).The effects of mindfulness-based interventions in schools have been explored beyond pupil populations. Emerson et al. (2017) conducted a systematic review and narrative synthesis on research that had explored the effects of mindfulness interventions for teachers, in schools. The authors suggest that

> Through participation in mindfulness training, an individual may see gains in mindfulness (e.g. decentering, regulation of attention) and self compassion that lead to more effective emotion regulation strategies and increased professional self-efficacy and ultimately reduced stress. (Emerson et al., p.1145).

A later meta-analysis (Zarate, Maggin & Passmore, 2019) offered similar findings, suggesting that mindfulness was related to a perceived decrease in teacher stress, anxiety, depression and burnout. Lawlor (2014) recommendations for implementation include: a focus on the teacher, high quality implementation, ongoing evaluation.

REFLECTIONS FROM PRACTICE

As educational psychologists who teach and deliver mindfulness curriculums to children and young people within school settings, we thought it would be useful to offer our reflections from practice. We hope these reflections further contextualise the use of mindfulness within educational contexts and prompt further reflection and discussion.

SCHOOL ORGANISATION

School structures and organisation are a key consideration for the implementation of mindfulness-based interventions in schools. Given how school terms are organised, with splits after six or seven week – the half term holidays – it can be difficult to ensure that there are consistent and consecutive weeks to deliver an in-depth curriculum that in part relies on the principle of 'little and often'. As professionals we often look to avoid over-burdening schools in the first and last weeks of term, filled as they often are with activities that might differ from a 'normal' weekly timetable.

In organising any mindfulness intervention we've required degrees of flexibility and pragmatism. A mindfulness curriculum might be designed to be delivered twice a week for eight weeks, but this is unlikely to work within the structure of a school half term. Therefore, flexibility within delivery (for example, repetition of a session following a break) is key when working with children.

Our experience of delivering mindfulness interventions in schools also speaks to points about school priorities. Many schools structure their daily timetables to ensure that literacy, numeracy, English and mathematics teaching happens in the morning. This means that it is highly unlikely that formalised curriculums will be able to be delivered before lunch time as schools, understandably so, will prioritise these learning activities. This does have implications for when it might be best to work with small groups or whole classes. The afternoon in schools is not particularly long, two to two-and-a-half hours at most. Too close to the end of lunch break and classes can be restless and still managing any potential issues that happened in the playground. Too close to the end of the day and interest can wane as home time approaches.

BELIEFS ABOUT MINDFULNESS WITHIN THE EDUCATION SETTING

In our experience there can be a number of misconceptions about mindfulness within education settings. We can summarise these as, mindfulness is about:

- Being calm and relaxing
- Reducing your stress
- Feeling good
- Changing or getting rid of difficult thoughts and feelings
- A reward (or punishment)
- A silver bullet
- Something religious

These varying beliefs can have a significant impact on how mindfulness interventions are delivered, received and then acted on at an individual, whole class and whole school level. In our experience there is some 'unlearning' that educational staff and young people need to go through, before an intervention can begin. We have found that many educational staff have heard of 'mindfulness' and thoughts about it can range from 'it's essential to the wellbeing of students' through to 'it's a whole load of mumbo-jumbo' (direct quotes from teachers we have worked with).

These reflections speak to how important it is to have at least one person within the educational setting who has grounding in mindfulness and has their own personal practice. We understand that it will not be feasible for every staff member within an educational setting to undergo their own training and practice and indeed some might not want to. At the very least we have found it beneficial to organise a whole staff in-service training session, where the principles of mindfulness can be articulated and where staff can ask questions. Such an introduction also allows for assumptions and beliefs to be identified and gently challenged and reframed.

As an example, we have worked with educational staff who have understood mindfulness solely to be about 'being happy' or 'getting rid of negative thoughts/emotions'. During preparatory work and initial meetings with classes, it has become clear that these beliefs and supposed outcomes have also been communicated to children and young people. Uncovering these pre-existing beliefs and assumptions has increased the importance of focusing on intention to practice, and has necessitated some degree of psycho-education for children and young people.

We have also been keenly aware of many activities, within school, being labelled or described as mindfulness when in fact more accurate descriptions might be 'relaxation', 'using your imagination', or activities that might be better understood as 'flow' – '...an absorbing mental state that arises spontaneously when one is engrossed within an optimally challenging activity' (Sheldon, Prentice, & Halusic, 2014, p.1). Children, young people and educational staff may believe that 'mindfulness' is related to specific activities (such as colouring) and so we have reflected that part of our approach has been to reframe this understanding to one that sees mindfulness as a quality of attention that you can bring to any type or activity (Harris et al., 2016).

MINDFULNESS ALONGSIDE SCHOOL SYSTEMS AND APPROACHES

Each education setting will vary with regards to the numbers of students, proportions of students with special educational needs, available funding and the willingness, readiness and ability to complete mindfulness interventions. Two reflections we have here are about teacher participation and the function of mindfulness interventions in school.

TEACHER PARTICIPATION

We have experienced varying degrees of teacher involvement while delivering mindfulness curriculums to small groups and classes. The continuum of involvement might range from:

- Key staff, such as classroom teachers, being entirely absent while 'expert outsider' delivers mindfulness.
- Key staff being actively involved in learning and experiencing a child centred mindfulness curriculum.
- Key staff with established mindfulness practice who deliver the mindfulness intervention to groups of children and young people within their own educational settings.

In our experience mindfulness interventions delivered within educational settings are more successful when key staff, such as classroom teachers, are involved and actively participating in the learning experience. In our view this communicates the importance of the work to children and young people and teachers can act as powerful role models for the children in their class. Such participation from key adults also means that learning within more structured teaching sessions can be generalised and applied 'beyond the lesson'. When key staff are present and actively involved, this also has an effect on the dynamic of a class and it is often more explicit that the same behaviour standards are expected.

The ability of key staff to participate however depends on their position, role and workload within the educational setting. Class teachers are entitled to weekly planning, preparation and assessment (PPA) time, equalling half a day per week. We have experienced various push and pull factors that have led to decisions for mindfulness interventions to be delivered during a teacher's PPA time. This can place teachers in a difficult position. On the one hand they may recognise the value of the intervention and their involvement, on the other PPA time is a scarce, valuable resource. We have also found it important to explore key adults' capacity and willingness to commit to participation and involvement. Key adults may express a desire to participate in whole class or small group mindfulness teaching, but in reality this may offer these professionals

several hours per week that they can use to mark work, email parents, complete funding paperwork or any of the other pulls on teacher's time.

PARENTAL RESPONSE

For mindfulness to have the greatest impact, practice outside of the delivered sessions is important. Children who practice daily and complete the 'homework' learning tasks find it easier to engage with mindfulness and use it in their daily life. Parental support, therefore, will impact on how much the child practices, how able they feel to share what they are doing outside of school and how supported they are. Parents can also hold similar misconceptions about what mindfulness is and why their child has been invited to participate.

Transparent communication, sharing of accessible information and the opportunity for parents to ask questions in our experience has led to increased support for the young people at home who have then felt more comfortable completing their practice outside of school.

THE FUNCTION OF MINDFULNESS INTERVENTIONS

In recent years there has been increasing focus on the social, emotional and mental health of children and young people and schools have been positioned as central to enhancing the psychological wellbeing and health of their students. In response the range of support teams, training and interventions available to schools to support pupil mental health has increased exponentially. This has, to some extent, coincided with the increasing awareness and popularity of mindfulness within the UK context.

In our experience there has been a risk that mindfulness is perceived as a 'fix all' to a variety of 'problems' within educational settings. Mindfulness has been perceived as a solution to the following, to name a few:

- Specific learning needs
- Attentional difficulties
- Hyperactivity
- Emotional literacy needs
- Friendship problems
- Home-based family conflict
- Anxiety
- Attachment needs
- Low mood
- Low self-esteem.

This has required us as practitioners and mindfulness teachers to be clear about the *motivation* for seeking mindfulness input within an educational setting. Developing an understanding about *why* educational staff think such an approach would be useful has allowed us to get a sense of the expectations already in place. While mindfulness can support some of the difficulties highlighted above, often the needs of young people are much more complex and multifactorial and mindfulness is best delivered alongside quality first teaching and pastoral support as well as other recommended interventions.

We have found that within education settings there are many interventions and strategies that have fallen under the umbrella 'mindfulness' but have very little supporting evidence from research or practice, and do not relate back to the original principles of mindfulness or have a basis in helping children to be present. When this is the case, perceptions of mindfulness' effectiveness can be

low as the work being delivered is not true mindfulness and will not have the same impact as a properly delivered course.

Each education setting will vary with regards to the numbers of students, the level of SEN, the capacity of teachers and staff to engage with mindfulness and budgets. All of these factors impact upon how and when a school can deliver mindfulness and indeed if it is the right intervention for them at a given point in time.

Working as Educational Psychologists we do recognise that there are pressures on schools' budgets, time, staffing and resources and it will not always be feasible to train staff extensively or commission larger scale projects. There are a variety of good quality mindfulness resources that staff can access and use with the understanding that the impact of resources on their own whilst positive may be less than if they fully embed mindfulness.

CASE STUDY

Below are two examples of schools that have chosen to utilise mindfulness resources in different ways.

Example 1

School A commissioned an EP to deliver a Key Stage 2 course to two of their classes. The SENCo and year 4 lead were to support delivery and observe the sessions. During delivery, the class staff sat with the students and participated fully, whilst managing behaviour and non mindfulness-related issues. Following this delivery, the SENCo and the year 4 lead attended their own eight week adult mindfulness course and developed a personal practice before completing training so that they could deliver the children's mindfulness programme. They currently deliver mindfulness for all students in the school once per academic year and run smaller groups for students who benefit from additional practice. The ethos of mindfulness is referred to throughout the school day and outside of the classroom. Mindfulness has been successfully embedded in the school for the students and is felt to be important by the SLT as well as class teachers.

Example 2

School B received a day of training from a mindfulness teacher who provided information about the theory, underlying principles and the impact that mindfulness can have in schools. Staff were also invited to experience a range of different practices and to explore resources including books, cards and downloadable meditations.

School B did not have adequate staffing or budget to fund further training for mindfulness and so opted to use some simple strategies and resources within their classes to help students start to develop their awareness and ability to be present. Short one-to-two minute meditations were introduced at the end of each morning and simple teacher-led tasks (such as counting the breath) were taught to children to help them feel calm and ready for learning.

RECOMMENDATIONS

- Before introducing mindfulness into a school, senior leaders and wellbeing staff need to receive training (or have their own personal training and experience). To embed mindfulness into a schools' ethos, a long-term plan needs to be created and mindfulness needs to be properly funded, resourced and supported. Mindfulness must not be viewed as a 'quick fix', rather a long-term approach to providing children with life skills to manage challenges.
- Advice can be sought from a trained professional (such as Educational Psychologists) prior to creating systemic change so that the evidence from research and practice can be considered and the mindfulness programmes, courses and materials can be tailored to fit in with the individual school and their needs. Educational Psychologists who are trained in teaching mindfulness and who have their own practice will be well placed to deliver courses and formal mindfulness sessions in schools given their extensive knowledge of child development, school systems and learning.
- If professionals within an education setting intend to teach mindfulness well and safely, they should be appropriately trained and experienced in delivering the courses or materials selected. Training needs to have been completed by a properly trained and certified mindfulness teacher and mindfulness has a bigger impact if taught by an adult who has their own personal experience and practice.
- For adults, eight week mindfulness courses have the best evidence base. The Mindfulness-based Stress Reduction (MBSR) course is considered to be an evidence based, 'gold standard' course. Other courses that would provide staff with a good grounding in their own mindfulness practice are the MBCT (Mindfulness-based Cognitive Therapy) and the MBLC (Mindfulness-based Living Course). An eight week course should include twi hours per week of delivery as well as daily personal practice and a half day or full day retreat.
- There are a number of mindfulness courses available for delivery to children. Courses with a growing evidence base include the programmes created by the Mindfulness in Schools Project (MISP) for students from preschool up to secondary school age (Wimmer & Dorjee, 2020); (Thomas & Atkinson, 2017); (Kornhoven & Dorjee, 2017). Further courses that can be delivered in schools include the Mindful Attention Programme (MAP) and the Youth Mindfulness Curriculum.
- For schools that are aiming to embed mindfulness into their ethos, delivering courses with strong research support, for staff and students, will yield the best results. The benefits of delivering a course are that students are guided through by an experienced teacher and taught the skills that they need to know in order to participate in mindfulness practice. Alongside these skills they are also provided with a grounding in the mindfulness attitudes that can also impact on daily wellbeing including kindness and non judgement. A combination of theory, practice and experience will lead to the best outcomes for students.
- Some schools may choose not to deliver courses due to time or financial constraints. Alternatives to delivering courses include selecting good quality materials and guiding students through them. When selecting books staff should look for an author who has experience/ training in delivering mindfulness and materials that provide them with guidance on how to teach the activities. Information that explains the purpose of the mindfulness practice to the school staff will also be important as this helps them to understand what the aims are.
- Schools need to be aware that while there may be benefits to students from engaging in short practices throughout the week, these will likely not be as big as if they had been formally taught.

- Advice on useful resources (such as books, courses or materials) can be sought from education professionals or outside agencies who have had their own training in mindfulness and who can recommend good quality materials.
- Each school using mindfulness courses, approaches or practices should have a named 'mindfulness lead'. This should be a member of staff who has their own personal practice and training/experience in delivering and planning mindfulness interventions
- Due to the nature of mindfulness, engagement in the meditation practices should be on an 'opt in' basis for both staff and pupils. For pupils who choose not to engage with meditations, they can be guided to remain quiet and not to distract others during their mindfulness practice.

SUMMARY

Within educational settings mindfulness can have numerous benefits including improved cognitive performance, enhanced executive skills, improved wellbeing and decreases in stress and anxiety, for staff and students. This is important given that both student and staff wellbeing is frequently cited as a significant concern.

The biggest impacts will be seen when a course is delivered by an adult who is trained in using mindfulness approaches and who has their own practice. It is also important that students are given as much choice and autonomy over their engagement with mindfulness practices and lessons.

Alongside delivery of courses, a staff commitment to the ethos and underlying principles of mindfulness will support this approach being fully embedded within the school day. Students who are taught the principles of mindfulness alongside the practices will learn how to develop their sense of curiosity, non judgement and kindness.

Where it is not possible to deliver a full course (for example, if staff are not trained in delivering the course or where a school hopes to 'test the waters' before investing) schools may opt to start by introducing some short practices throughout the week. When selecting the activities staff should ensure that they opt for materials that are designed by trained mindfulness teachers and that have accompanying guidance notes that will help with introducing, summarising and recapping on the selected practices.

MINDFULNESS FOR STUDENTS IN THE SECONDARY EDUCATION

While there has been a large focus on mindfulness in primary education, a body of research is also emerging looking at the benefits of mindfulness in secondary education (Laner et al., 2015). Many of the caveats and considerations for delivering in the school setting detailed above, remain relevant. The basis of this work draws on the high rates of mental health complaints that have their origins in the adolescent phase of life (Ford et al., 2021). Adolescence is a time of great re-organisation in the brain, and as such may be a particularly fruitful time to cultivate healthy mental habits that may act preventatively (or protectively; see Sanger & Dorjee, 2015). This same feature of neuroplasticity (low impulsivity, high self-consciousness) may conversely, make it a more tricky time to engage adolescents in these types of activities). As with all adolescent work, finding creative ways to engage young people (and ideally co-create with them), is often the key to success.

Those working in this area should be aware of the 'My Resilience in Adolescence' (MYRIAD) project currently underway in the UK (Kuyken et al., 2017, Montero-Marin et al.. 2021) . This

is a large-scale research project led by the Oxford Mindfulness Centre which aims to contrast the effectiveness and cost-effectiveness of mindfulness training and 'normal' school provision in emotional and social learning via a thorough research methodology.

HIGHER EDUCATION

The higher education setting is often a life transition that some young people find difficult. Being away from home, in new environments, and needing to manage life tasks, educational demands, debt/financial responsibilities, and the task of becoming an adult, can often precipitate mental health difficulties (Lewis et al., 2021). There is mounting concern about the mental health of higher education students (Gunnell et al., 2018). Mindfulness may be just one of many types of support that could help young people navigate these tasks. Barker et al. (2021) detail the organisational steps taken to integrate mindfulness into the higher educational setting. This may provide a useful model for those working in higher education with similar aspirations. A key question is where to place this offering – as a general wellness training for all students, or positioned within the mental health provision.

A recent review by Chiodelli et al. (2022) found 19 papers that reported on the benefits of mindfulness in the undergraduate setting. The majority of studies report adapted interventions, with variable metrics of mental health (including anxiety and depression), specific conditions (e.g. sleep problems), general wellbeing and coping. While the various MBIs demonstrated efficacy, there was lack of robustness in the reporting of effect sizes, unusual effects, dropout rates and use of active control conditions.

Galante et al. (2018) report on a randomised controlled study conducted at the University of Cambridge (UK). Mindfulness Skills for Students (MSS) training was contrasted with a 'support as usual' condition. MSS is an adapted variant of the book *Finding Peace in a Frantic World* (Williams & Penman, 2011). Offered as part of an intervention to support students during the highly stressful exam period, their results (using the CORE-OM as the primary measure) indicated that 57 per cent of the 'usual support' group had distress scores above clinical threshold, relative to 37 per cent of participants from the mindfulness skills training group. They conclude that 'our study suggests that offering openly accessible mindfulness interventions aimed at the well student population, separate from specific mental health services, is a useful addition to robust clinical interventions delivered by university counselling services. The eight week mindfulness course adapted for university students tested in this trial is an acceptable, feasible, and effective component of wider student mental health strategies.' (Glante et al., 2018, p.e80).

Mindfulness offerings in this setting often include e-based learning or the use of apps and self-paced learning. There is on-going debate about the benefits and disadvantages of synchronous versus asynchronous e-learning as compared to face to face groups. Ease of accessibility, accommodation of those who may struggle with groups (either due to practical or personality factors), and 'on the go' training via e-learning may be more suitable for this age group, in this demanding context.

Chung et al. (2021) offered a brief online (asynchronous – self-paced) mindfulness intervention or wait list control intervention to a total sample of 427 students (Australian and UK higher education settings). One-hundred-and-fifty-two students completed the whole study. Wellbeing (measured with the Warwick Edinburgh Scale), stress (measured with the Perceived Stress Scale), and mindfulness measures were obtained. Regression modelling revealed the asynchronous online mindfulness intervention accounted for up to 12 per cent of the variability in change in student wellbeing, stress and mindfulness between the start and end of semester (when controlling for

baseline). The authors point to the need to place more effort and understanding on the barriers and facilitators of engagement in this student population.

However, there are several authors (Burrows, 2015; Wikholm & Farias, 2017) who suggest caution when offering mindfulness in the higher education setting, and particularly so for those who might be more vulnerable. Burrows (2015) qualitative research asked community college students (*N*=14; average age 20) who had opted to take a 'mindful communication' course to share their experiences. Over 10 weeks they had been taught a variety of practices including mindfulness of the breath, loving kindness, body scan, awareness of distracting thoughts, judgements and sitting with discomfort. Notable, Burrows (2015) shares that *'12 of the 13 participants who chose to participate reported a range of unusual perceptions, sensations, and altered states and experiences of self as a result of mindfulness meditation. Only one participant reported unambiguously positive effects such as increased relaxation, focused attention, productivity, and reduction in stress and worry'* (p.284).

Wikholm and Farias (2017) make the following suggestions when offering mindfulness in the higher education setting.

- *'Mindfulness groups should not be considered the standard mental health intervention offered to students; instead, a mindfulness-based approach should be available as one option among many, including counselling, mentoring, and referral for assessment for NHS psychological therapies.*
- *Empowering students is a common goal of higher education and this should be upheld when it comes to accessing mental health interventions.*
- *Students should be provided with information as to the origins of mindfulness meditation and the range of effects that can be experienced, both positive and potentially challenging. Not to scaremonger, but to enable them to make informed decisions, access the most suitable support, and prevent them from being mindless recipients of a mindfulness intervention.'*
- *Source:* https://www.bacp.co.uk/bacp-journals/university-and-college-counselling/november-2016/being-mindful-of-mindfulness-in-higher-education/*)*

Finally, it may also be helpful to reflect on how certain types of higher education training (e.g. medical or healthcare related) may attract students with certain personality characteristics (e.g. perfectionism, competitive, personal wounds, etc.), that both make it more essential (and perhaps also more difficult) to engage with mindfulness training. See Epstein (2020) and Dobkin et al. (2013) for commentaries on these specific contexts and the challenges faced.

Daya and Hearn (2018) report on 12 articles exploring the benefits of mindfulness in medical education. Of these 12 studies, seven reported improvements in at least one targeted outcome. Which outcome to target for this group remains contentious. Some studies explored stress more generally, others looked at 'burnout', while others targeted mental health symptoms such as anxiety and depression. Half of the studies reviewed included predominantly female participants, so further thinking is required to understand the barriers to engagement for male students. Given the culture of medicine and the stigma surrounding 'not coping', those offering mindfulness in this setting would be wise to consider how best to position this work to make it more appealing and accessible.

MINDFULNESS INTERVENTIONS FOR PEOPLE WITH PHYSICAL HEALTH PROBLEMS

MBSR was developed for people living with chronic medical problems. There is evidence for the benefits of mindfulness-based interventions for this population considered generally, and for people who have any of a wide range of specific conditions. Cultivating mindfulness provides a way of changing our relationship to our physical symptoms, and to the mind and body as an integrated whole, including all of our struggles, resources and humanity.

AWARENESS

Receptive, gentle attention to all of our experience, just as it is right now, can change our relationship with the thoughts, emotional responses and actions which often add to the distress of living with a chronic medical problem. Habitual reactions to symptoms can become so rapid and automatic; they are difficult to distinguish from the symptoms themselves. Increased mindful awareness of these reactions can help us to change them, and to respond more skilfully to what is happening in our bodies.

Mindfulness practice increases our capacity to orient attention, and can thus reduce hypervigilance (Jha et al., 2007). Becoming more able to simply notice what is happening in our minds and bodies, without immediately thinking the worst, can be particularly valuable (Garland et al., 2013). Developing greater mindful awareness of sensations as sensations and thoughts as thoughts can weaken the vicious cycles of heightened attention to, and negative thoughts about, physical symptoms which often arise in chronic conditions (Vujanovic et al., 2007).

ACCEPTANCE AND MINDFUL ACTION

Mindfulness-based approaches cultivate acceptance of the situation as it is right now, and of those aspects of it which cannot be changed, balanced with mindful action towards valued change, where such change is possible. This can be immensely valuable in supporting skilful self-management. In many conditions, symptoms vary from day to day and moment to moment. Being aware of these changes can help us to respond flexibly to them, including doing nothing (e.g. not taking extra medication) when that is the most skilful thing to do. Learning how to be kinder towards ourselves can reduce the frustration and self-criticism which often accompanies adjustment to physical changes and limitations.

PHYSIOLOGY

There is evidence for direct physiological benefits of cultivating mindfulness, including improved immune response (Davidson et al., 2003), reduced physical manifestations of stress, such as cortisol levels (Turakitwanakan et al., 2013) and decreased baseline blood pressure (BP) and changes in BP in response to stress (Nyklicek et al., 2013). Additionally, the inclusion of mindful movement practices within MBSR and other mindfulness-based exercise interventions can be beneficial more broadly for increasing physical activity and mobility (Son & Choi, 2018).

PAIN

In an early study, Kabat-Zinn et al. (1985, 1986) demonstrated ‘moderate to great improvement’ in pain reported by 60–72 per cent of those who completed an MBSR programme. This was maintained over four years, and a majority of participants continued daily meditation. In particular, they tended to notice increased awareness of how they responded to their pain, and increased relaxation. Struggling to control pain is related to pain, disability, depression and avoidance (McCracken et al., 2007). Developing greater mindfulness can attenuate pain through cultivating acceptance, developing greater stability and flexibility of attention, reducing unhelpful

cognitive and emotional responses and supporting reappraisal of pain (and related thoughts and feelings) as changing over time. This is reflected in altered neurological processing (Zeidan et al., 2012).

MBSR has been found to have benefits equal to a multidisciplinary pain programme in reducing pain intensity and distress (Wong et al., 2011). The Breathworks programme, which was specifically developed for pain and stress, has been shown to improve depression, outlook, catastrophising, pain self-efficacy and, most powerfully, pain acceptance (Cusens et al., 2010). Hann et al. (2014) in a systematic review of RCT with chronic pain for ACT was better than inactive treatment however how measures were used in studies were problematic.

CANCER

There is a large literature on the benefits of mindfulness in cancer care (Ngamkham et al., 2019; Schell et al., 2019; Xunlin et al., 2020).

A recent meta-analysis examining the evidence for MBSR in cancer care reported significant improvements in anxiety, depression, stress, sexual difficulties, physiologic arousal, and immune function across all interventions (Shennan et al., 2011). As with many studies, methodological limitations were identified, including a great amount of diversity in study design and interventions making comparison between studies difficult. Two meta-analyses, one examining MBSR among breast cancer survivors and one Norway-based review, suggest improvements in stress symptoms, mood disturbance, and improved QOL in cancer patients (Matchim et al., 2011; Musial et al., 2011). The Mindful Nation Report (2015) has called for NICE to review the use of mindfulness-based interventions in cancer in the next revision of their guidelines.

Foley et al. (2010) conducted a large randomised controlled trial of MBCT in this client group and reported large decreases in depression and anxiety; they also describe how the programme was adapted for their needs. The programme included discussion of information about common physical and psychological challenges associated with cancer (as information about depression is included in standard MBCT). They took a particularly gentle approach, to allow for participants' physical limitations, fatigue, and vulnerability to overwhelming distress. This included encouraging participants to move as they needed to during the practices. Shorter home practices were recommended, and there was a break midway through the sessions. For many participants, bringing awareness to the body, particularly to the cancer site, was difficult. Options were offered for graded practice, including starting with awareness of clothing and using a different aspect of present moment experience (e.g. the breath or sounds) as an anchor, returning to the body when ready. Carers were invited to participate in the programme alongside the person they cared for.

Those interested in MBCT for cancer would benefit from an awareness of the work of Bartley (2012, 2016) and the on-going evaluation of MBCT-Ca (Mindfulness-based Cognitive Therapy for Cancer) in the UK National Health Service. This protocol is an adaptation of MBCT specifically tailored towards cancer patients that has been developed over the last ten years through gradual refinement of the programme during routine delivery in the oncology setting.

Hulbert-Williams et al. (2014) suggest that ACT can build on the empirical evidence of mindfulness to offer a beneficial intervention for people with cancer. Meta-analysis shows that ACT improves quality of life, emotional state and psychological flexibility in oncology patients, (González-Fernández & Fernández-Rodríguez, 2019). However the studies are heterogeneous and with limitations.

NEUROLOGICAL CONDITIONS

For people with neurological conditions such as spinal cord injury and multiple sclerosis, evidence is emerging which provides support for the benefits of mindfulness within such groups. In particular, the Breathworks programme, which was specifically developed for pain and stress, has been shown to improve symptoms of depression, anxiety, and pain unpleasantness, but not pain intensity, in people with spinal cord injury (Hearn & Finlay, 2018).

Other work has seen mindfulness associated with improved mood in people with spinal cord injury (Skinner et al., 2010). The use of mindfulness interventions has also been demonstrated to enhance the mental health and quality of life of people with multiple sclerosis (Blankespoor et al., 2017; Simpson et al., 2017, 2019a) and they have been recommended for consideration with people with Functional Neurological Disorder (LaFaver et al., 2021). Likewise, the evidence for the Breathworks programme has extended to caregivers of people with long-term neurological conditions such as spinal cord injury (Hearn et al., 2019), suggesting that mindfulness interventions could be used as dyadic interventions, working with both people with chronic health conditions and their partners/caregivers. In a meta-analysis of third wave therapies by Robinson (2019) it was found that there is promise for these therapies in dealing with transdiagnostic properties of long-term neurological conditions.

Whilst the evidence surrounding mindfulness for people with neurological conditions is positive, care needs to be taken when interpreting the research and when working with such groups as the research is still in its infancy. Indeed, people with spinal cord injury (Hearn et al., 2020; Finlay et al., 2021) and multiple sclerosis (Simpson et al., 2019b) have reported significant physical and psychological challenges which may prevent or reduce a person's engagement in a potentially meaningful intervention. For example, (i) the difficulty of undertaking body scans when sensation is not present (Finlay et al., 2021); (ii) perceived expectations of supine meditation (Simpson et al., 2019b); (iii) 'mindful walking' as a central tenet of standardised mindfulness-based interventions (Kabat-Zinn, 2013; Simpson et al., 2019b), something which is not achievable after paralysis; and (iv) the lack of standardised adapted mindfulness practices for wheelchair users. Such barriers need to be further acknowledged and addressed to maximise accessibility to mindfulness for people with neurological injury or impairment to ensure optimum therapeutic benefit. As such, it may not be entirely adequate to deliver standardised interventions to such populations (indeed this may risk exacerbating condition/injury-related distress, for example; Finlay et al., 2021). Attention is drawn particularly to Simpson et al. (2019a) who report adverse events in two of the studies included in their review of mindfulness for multiple sclerosis. These included an exacerbation of chronic neuropathic pain during the 'Raisin Exercise' spasticity during guided progressive muscle relaxation; anxiety following the MBSR retreat (Simpson et al., 2019a, p.1056).

MINDFULNESS AND OTHER CONDITIONS

There are studies demonstrating the benefits of mindfulness-based interventions in reducing symptoms and distress and improving coping in a range of medical conditions including psoriasis (Kabat-Zinn et al., 1998), rheumatoid arthritis (Zautra et al., 2008), HIV (Seyed Alinaghi et al., 2012), multiple sclerosis (Grossman et al., 2010), spinal cord injury (Hearn & Finlay, 2018; Hearn et al., 2020), irritable bowel syndrome (Garland et al., 2012) and fibromyalgia (Grossman et al., 2007). Kian et al. (2018) found in a study of 60 patients in an RCT that MBSR had a remarkable improvement on emotional wellbeing and glycaemic control of patients with type 2 diabetes.

The evidence base for mindfulness-based interventions covers a wide range of conditions. It is particularly strong for cancer and for pain. Such interventions, particularly MBSR, have often been delivered to good effect to mixed groups of people who are living with a range of medical conditions. However, there is also evidence for the benefits of programmes tailored to the needs of people with a specific condition. Such a programme might include specific information and CBT components relevant to that condition, for example, pacing for chronic pain. In particular, for people with neurological injury/impairment (e.g. spinal cord injury, multiple sclerosis, and functional neurological disorder) some adaptation is required to acknowledge and accommodate the loss of sensory function in these groups.

A key issue is timing. There is good evidence for the benefits of mindfulness-based interventions in well-established chronic conditions. However, caution is needed in the more acute phase, following a major diagnosis or other significant life event. Mindfulness is a skill and cultivating it can be demanding. MBSR and MBCT involve quite long practices, which have great value in deepening awareness, but can be very difficult at times of acute distress. Also, these programmes require a significant commitment to attending sessions and practising at home. This might not be possible at a time in someone's life when they have many other appointments and commitments. It is best to delay until there has been some time for processing and adjustment. However, individuals with an existing mindfulness practice may benefit from support to maintain it at difficult times. There is also some evidence for the benefits of brief mindfulness practices with much supportive guidance (somewhat similar to that used by Chadwick and colleagues with people experiencing psychosis), as seen in the work of Horton-Deutsch et al. (2007) with people undergoing bone marrow transplant.

Those teaching mindfulness to people with medical problems should have experience in working with their client group, and have knowledge of the common physical and psychological sequelae of their conditions, or should work with an assistant or co-facilitator who does have such experience. Practices should be led in a way which is gentle on the body. This is most obviously the case for mindful movement but is relevant to practices which invite being still for long periods. For example, longer practices may not always be appropriate to those with neurological conditions, or wheelchair users. Additionally, floor-based meditations may have limited accessibility for people with chronic health conditions, as additional clinical support and props may be required to help facilitate changes in posture.

Consideration should be given to inviting carers to participate alongside the person they care for. Developing mindfulness together can be a powerful and positive experience for both parties. Graham et al. (2016) reviewed studies for ACT and long term conditions finding that for parents of children with long term conditions ACT.

Outcome measures should be carefully chosen to be both meaningful and likely to be sensitive to change, especially when working with people whose medical condition is deteriorating. Consideration should be given to process measures (such measures of mindfulness, self-compassion and cognitive flexibility) and ratings of progress towards individual valued outcomes.

SUMMARY

MBSR was developed for people living with chronic medical conditions, so it is no surprise that there is a role for mindfulness-based interventions for people with chronic medical problems. Mindfulness provides a way to change our relationship with physical symptoms. Mindfulness helps people develop their ability to orientate attention. Mindfulness helps cultivate acceptance of the situation and mindful action. Mindfulness has effects on physiology. Mindfulness-based interventions have been shown to help with dealing with pain, cancer and neurological conditions. Though the research needs better well controlled studies.

MINDFULNESS IN SPORT

Sport psychologists work with athletes to support them with their performance, mental health and wellbeing. Although not always referred to explicitly as mindfulness, sport psychologists and coaches working with athletes will often employ interventions such as the use of self-talk to help athletes normalise negative feelings of distress, or work with athletes to accept difficult emotions such as those related to memories of previous poor performances (Baltzell et al., 2014). Approaches used include helping athletes to be in the present moment by focusing on process rather than outcome and promoting some acceptance in a non-judgemental way, over aspects of sport which are uncontrollable (Baltzell, 2016).

Athletes experience different emotions during various competitive performance phases which can be summarised as pre-performance, performance and post-performance. It is important for athletes to develop suitable ways to regulate their emotions in each of these phases. These emotions may include elevated performance anxiety, fear of failure, reduced self-esteem and burnout. Emotions relating to career disappointments and injury are also commonly experienced with many athletes facing dual career challenges involving balancing sport and education as well as transitions that may be more difficult to prepare for, such as those resulting from injuries (Schinkea, Stambulova, Sic. & Moore, 2018).

Kabat-Zinn et al. (1985) provided applied mindfulness training to collegiate and Olympic rowers, two decades before Mindfulness-based Interventions (MBI) programmes were introduced by Gardner and Moore (2004). MBI programmes, some of which include acceptance-based approaches such as The Mindfulness-Acceptance-Commitment programme (MAC; Gardner & Moore, 2004) have been used with athletes to support performance and wellbeing. Over the past 20 years, MBI have become an alternative approach to the more traditional Psychological Skills Training (PST) interventions used with athletes, where PST focuses on the athlete working towards obtaining an internal state that is optimal for their athletic performance (Gardner & Moore, 2017; Röthlin & Birrer, 2019). PST differs from MBI, where the goal of the latter is 'to teach athletes to accept their cognitions, emotions, and sensations and to commit themselves to action, rather than fighting against negative thoughts and unpleasant emotions' (Bernier et al., 2009, p.331). This helps athletes to turn their attention towards their performance by learning to accept experiences that may otherwise act as distractors, such as anxiety or fear of failure. Some of the benefits that athletes have experienced with the use of MBI include a decrease in burnout, a feeling of being more mindful, and prevention of injuries (Mahoney & Hanrahan, 2011; Noetel et al., 2019). Similar to the benefits of mindfulness shown in a non-athlete population, MBI have shown to help athletes be more focused on a task and decrease their levels of stress (Kiens & Larsen, 2020). This may include helping the athlete to focus on the present and practise accepting unpleasant experiences such as pain and discomfort, by changing their relationship to these experiences (Birrer et al., 2012).

EVIDENCE BASE

Several mindfulness programmes have been specifically developed for athletes; The Mindfulness-Acceptance-Commitment programme (MAC; Gardner & Moore, 2004), The Mindful Sport Performance Enhancement (MSPE; Kaufman, Glass & Arnkoff, 2009) and Mindfulness Meditation Training for Sport (MMTS; Baltzell & Akthar, 2014). Lutkenhouse, Gardner, and Moore (2007 cited in Moore, 2019) used The Mindfulness-Acceptance-Commitment programme (MAC; Gardner & Moore, 2004; Moore, 2009) to conduct a trial with collegiate athletes, which was both randomised and controlled, and found that a significantly greater number of athletes completing MAC programmes (32 per cent versus 10 per cent of athletes receiving traditional psychological skills training PST) demonstrated a clinically significant increase in coach ratings of performance at posttest. The MAC intervention includes seven modules of one-hour duration, over a period of eight to 12 weeks.

The Mindful Sport Performance Enhancement (MSPE) is a mindfulness meditation-training programme developed by Kaufman et al., (2009). MSPE was developed from MBSR and MBCT for athletes, and uses the mindfulness exercises from these programmes, for example, sitting meditation, body scan, and walking meditation.

MSPE was delivered weekly as a two-and-a-half-hour session for four weeks to a group of archers and golfers. The programme was designed to look at how mindfulness could affect performance, flow states and psychological characteristics such as confidence. Following MSPE, improvements in flow states, performance and confidence were found in both groups of athletes but there was no significant quantitative change in their sporting performance although athletes did report that they felt their performance had improved following the programme (Kaufman et al., 2009).

Baltzell and Akthar (2014) developed a Mindfulness Meditation Training for Sport (MMTS) programme. MMTS was provided for white female varsity soccer players by an experienced meditation teacher in 12 30-minute sessions over six weeks. The aim of the study was to assess the impact of MMTS on the positive and negative emotions of the athletes, but not their sporting performance. When compared with a group of female rowers, who did not receive the intervention, the soccer players showed an increase in mindfulness but no change in their emotions, whereas the rowers showed an increase in negative emotions. This may be explained by research which has shown that practising meditation over time, can reduce the experience of negative emotions (Frewen et al., 2008).

Bernier et al. (2009) conducted research which looked at mindfulness and acceptance approaches and the relationship to sport performance in swimmers and golfers. The first study gathered qualitative data using semi structured interviews from a group of male and female swimmers (N=10) and showed that those who experienced a state of flow also described aspects of mindfulness and acceptance. The swimmers noticed body sensations such as pounding heart rate prior to a competition and even if they found these sensations unpleasant, they were able to accept them.

They then conducted a second study with male and female elite golfers (N=7) using a mindfulness and acceptance education programme based on Cognitive Therapy (MBCT; Segal et al., 2002) and ACT (Hayes & Strosahl, 2004), this was added to a pre-existing Psychological Skills Training (PST) programme. A non-randomised controlled trial was conducted to compare the effects of this programme with a control group of golfers (N=6) receiving a separate pre-existing PST programme. The national ranking for the golfers who received the mindfulness intervention improved compared with only two golfers in the control group who followed the psychological skills intervention.

Kiens and Larsen (2020) delivered a mental skills intervention programme based on the principles of ACT and mindfulness to elite school aged dual career athletes. There were three aims of the study; to develop an understanding and application of mindfulness in and out of sport, to develop flexibility around thoughts and feelings and skills required to lead a balanced dual career and to introduce mindfulness. The programme consisted of 16 sessions, twice a week for 50-80 minutes, with student-athletes aged 15-17 (*N*=39). Qualitative feedback from the students showed that they had a better understanding of mental and attentional skills such as concentration and self-awareness and they were better at managing their emotions of distress.

Doron et al. (2020) conducted a study with 29 elite badminton players to look at mindfulness- and acceptance-based interventions (MABI) in sport settings. This study aimed to design and implement an MABI and look at the impact on sport performance-related outcomes. Participants were assigned either to the eight-week MABI programme (*N*=18), or the eight-week placebo programme (*N*=11) which included relaxation techniques. Post-intervention, the badminton players assigned to the MABI programme showed a greater awareness of positive and negative stimuli and a better understanding of developing acceptance and a non-judgemental attitude towards their sport but found the skills they had learnt were difficult to apply in a high-performance environment. Performance worries and task-irrelevant thoughts differed significantly across the groups with those receiving the MABI intervention reporting fewer task-irrelevant thoughts; however, their performance worries increased post-intervention. This may be a result of the athletes improving their awareness of their situation more quickly than improving their acceptance skills, which take longer to develop, for example, they found it easier to refocus on the present rather than accepting when they had made a mistake. There was no significant improvement in sport performance related outcomes between the group that received the MABI and the placebo group.

Gardner and Moore (2012) provide a narrative review and summary of direct sport-related mindfulness and acceptance intervention studies. They concluded that research using MABI showed that such interventions are viable and empirically informed and they provide an effective way to support athletic performance and wellbeing.

Sappington and Longshore (2015) conducted a systematic review of mindfulness-based therapies (ACT, MAC and MSPE) with athletes. This review had two main aims: 'to evaluate the efficacy of mindfulness-based therapy as a performance enhancement intervention for athletes and to evaluate the methodological quality of the research conducted on mindfulness interventions in sport' (p.236). The conclusions of the review, from the small number of randomised trials, suggests that mindfulness-based interventions may improve sport performance. A more recent review Bühlmayer et al. (2017) broadly comes to the same conclusions from their meta-analysis that included nine studies (which included either randomised or non randomised active control conditions as contrasts). Of note from their article is the conclusion that mindfulness-based interventions may be particularly helpful for sports that require precision (e.g. shooting, dart throwing).

However, there are some issues with research looking to provide a causal explanation between mindfulness and enhanced sport performance and in many of the studies randomisation is unclear and sample sizes are small (Sappington & Longshore, 2015). A variety of mindful interventions are also used, which causes a problem with heterogeneity and, as highlighted by Baltzell and Akhtar (2014), the experience of those who delivered true mindfulness programmes is often unclear and this may have impacted the efficacy of the interventions. Piet et al. (2016) have highlighted the importance of mindfulness programmes such as MBSR and MBCT being delivered by practitioners who have a background and training in mindfulness, which may support the issues highlighted by Baltzell and Akhtar (2014). Other difficulties with the research include the way

mindfulness training is delivered, that is, the number of training sessions and duration of each session which may vary widely between different sports.

Though some sport-based MBI have been reported to have some benefit to the participants by enhancing their sport performance, future research also needs to consider appropriate ways to assess how MBIs have impacted sport performance for athletes. More studies conducting quasi-experimental interventions that directly assess changes in performance are needed.

SUMMARY

While research has shown that athletes may experience enhanced mindfulness following MBI which can reduce the experience of negative thoughts and stress (Frewen et al., 2008), a direct relationship between mindfulness training and improved performance is not as clear. Some of the mechanisms underlying MBI such as acceptance, may take longer for athletes to assimilate which may affect the impact of any intervention. MBI may, therefore, need to be more embedded into the training environment (Doron et al., 2020). It is important that future research provides a greater understanding of the underlying mechanisms of MBI so that more effective interventions can be developed to help improve outcomes in sport performance among athletes (Gardner & Moore, 2017; Doron et al., 2020).

Research has shown that MBI can increase athletes' resistance to stress, improve their stress-coping responses to sport and life, and generally help with wellbeing (Birrer et al., 2012). Interventions have been shown to enhance performance, however, elite sport and its associated pressures expose athletes to a different environment compared to non-athletes. These factors may affect the efficacy and the way mindfulness interventions are used within an athlete population, who may be unable to spend the time needed to undertake a programme such as the eight-week MBSR course. Further research into mindfulness, acceptance and optimum performance needs to consider the effects of MBI in different sporting environments (Bernier et al., 2009).

MINDFULNESS IN THE WORKPLACE

The workplace is a source of psychological pressure for many employees, and this appears to be a situation that is worsening. A worldwide increase in work-induced stress has been reported by Korn Ferry (2018), alongside the trend for flatter company structures, with 33 per cent of respondents claiming that the amount of work required of them is unreasonable. 828,000 employees reported work-related stress, depression, or anxiety in 2019/20, accounting for 17.9 million lost workdays in the UK alone (Health and Safety Executive, 2020). These conditions are reported most frequently in public service industries, such as education, health and social care, public administration and defence. These sectors include nurses and therapists, teaching professionals, welfare professionals, care professionals, and protective service occupations such as police officers and customer service occupations. These occupations share high levels of public contact or interaction, and many are also mainly within the public sector, which raises concerns for both public service provision and its users.

The workplace stressors contributing to these conditions clearly need to be addressed by employers, and mindfulness has been mooted as a means by which to reduce the adverse reaction people have to excessive pressures or other types of demand placed on them at work. The contribution of mindfulness to other work performance indicators has also been examined with positive initial results. The benefits of mindfulness in the workplace have yet to be

comprehensively demonstrated, but there are recent literature reviews and original research that outline its potential application across a variety of relevant dimensions. It should be emphasised, however, that mindfulness practice is not recommended as a sticking plaster for underlying systemic workplace stressors, and that it should not replace healthy workplace environments in a bid for increased performance alone.

The workplace is becoming more and more demanding across a range of organisational settings. People are increasingly expected to achieve a higher level of quality in their work while also increasing efficiency and productivity. In the first part of the 20th century the work environment became more stimulating, as staff work in larger, busier offices, and with increasing access to advancing technology. On top of this, the workplace and requirements for work are constantly changing. Adapting to rising expectations and high rates of change poses a real challenge for staff and their employers. This was seen with the responses to the Covid-19 pandemic and many office workers switching to working from home and using technology more.

The following sections discuss the existing research into mindfulness interventions in the workplace and the evidence of their effectiveness across various stress and performance-related dimensions. It is hoped that this will be helpful to both organisational psychologists who are seeking effective interventions, and for coaches working with employees in professional contexts.

MINDFULNESS AND WORKPLACE STRESSORS

The employees experiencing the highest reported levels of stress are those working in the service sector. These individuals are facing clients, customers, or the public as an integral part of their role, and often experience emotionally charged interactions at work. This type of emotional labour can lead to distress and emotional exhaustion, a central component of burnout (Maslach, Schaufeli & Leiter, 2001). Self-trained mindfulness is related to decreased emotional exhaustion in a sample of health, education, and public-facing workers (Hülsheger, Alberts, Feinholdt and Lang, 2013), and thus may contribute to a reduction in burnout. This holds promise for the support of employees working in this type of environment, however, more research is necessary to establish if mindfulness is more effective than other cognitive-behavioural and relaxation techniques that have proven effective in employee distress management (Richardson & Rothstein, 2008).

Other workplace stress studies have found encouraging results. Smith (2014) found that stress and anxiety were reduced for nurses following an eight-week Mindfulness-based Stress Reduction (MBSR) programme. An eight-week on-site mindfulness intervention for workers in a high-stress ICU, increased staff resilience and engagement, as well as providing a reduction in stress-indicating respiration rates (Suess et al., 1980). There is further evidence that for health care staff, MBSR can reduce stress, negative affect, anxiety, and rumination, and increase positive affect, creativity, empathy and self-compassion (Beddoe & Murphy, 2004; Shapiro et al., 2005; Irving et al., 2009). This is promising for the service users also, as it may follow that increased empathy and self-compassion in healthcare workers, alongside reduced stress, will increase compassionate care for patients and other health care customers (Pollack et al., 2011; Chaskalson, 2011). This is borne out by research into mindfulness interventions with psychotherapists, who were rated more positively by clients, who also reported greater symptom reduction compared with the control group (Grepmair et al., 2007; see also Therapist Mindfulness in Part I).

Research in the teaching profession shows tentative progress also. Primary school teachers in the UK were offered an eight-week course of MBSR and saw improvements in anxiety, depression, and stress (Gold et al., 2009) and although the sample size was small (N=11), some outcomes were significant, with implications for this highly stressful profession (Chaplain, 2008). Roeser et al.

(2013) have further demonstrated more focused attention and working memory capacity, greater self-compassion, and lower work-related stress following a mindfulness intervention with teachers. Improvements in teacher-student interactions have also been found, leading to reduced negative social interactions (Singh et al., 2013).

Research into mindfulness interventions for work-related stress in office environments is in its early stages but is also showing results suggesting that some interventions may reduce employee stress. Bostock et al. (2018) employed a mindfulness intervention delivered via a smartphone application (app) at two major office-based UK companies to assess its use in reducing job stress. Participants reported less job stress and strain following the intervention, as well as a significant decrease in self-measured workday systolic blood pressure. A study into middle managers across various financial and service sectors (such as banks and insurance companies), who are considered at risk of stress due to ever-present restructuring threats, also found a significant reduction in participant stress levels following MBSR (Ẓołnierczyk-Zreda et al., 2016).

Overall, mindfulness interventions, particularly eight-week MBSR courses, appear to perform favourably as regards work stress. This is confirmed in a literature review of the effects of mindfulness on stress reduction (Janssen et al., 2018), and a recent meta-analysis of workplace mindfulness interventions (Vonderlin et al., 2020). These results provide hope that positive effects may be generalisable across all working environments.

Querstret et al. (2020) recently reviewed 49 studies (*N*=4, 733 individuals) that offered MBSR or MBCT to non-clinical samples. These mindfulness-based protocols, when contrasted with a passive control, significantly reduced symptoms of rumination/worry; stress/psychological distress, and anxiety. Significant improvements in quality of life and wellbeing were also indicated. Of note, this study revealed that MBCT generated larger effect sizes than MBSR. This may be important when considering if a general stress reduction strategy is required versus a mechanism that more precisely targets cognitive patterns that help or hinder wellbeing (decentering/rumination respectively). While the focus on 'stress management' may be in line with the language of organisational psychology, the statistics suggest that a large number of the healthy working population are in fact meeting criteria for mild to moderate depression and anxiety. As such, MBCT may be a more appropriate intervention. One programme (Workplace MT; Adams, 2016) has attempted to hold the essence of MBCT as delivered in the clinical setting in a programme designed with the workplace in mind. This may offer an appropriate compromise and a way to bring 'therapeutic' work into the workplace.

However, it is yet to be established that the reduction of stress provides work performance enhancement over and above the facet of employee wellbeing to which it applies, although it does contribute to reduced turnover (Glomb et al., 2011). It is therefore important to consider in more detail the research relating to other work performance factors to gain a better understanding of the potential benefits of mindfulness practice at work as it relates to commonly accepted organisational performance metrics. The reader is also referred to Jamieson and Tuckey (2017) for a critique of this current literature.

MINDFULNESS AND WORKPLACE PERFORMANCE

As Passmore (2019a, 2019b) notes, clear evidence of mindfulness' contribution to job performance must be established for it to find a place in workplace interventions. He cites some promising results in restaurant employee performance (Dane & Brummel, 2013) as measured by the Mindfulness Attention Awareness Scale (MAAS), which was also used to discern a positive relationship between higher manager ratings and higher levels of individual mindfulness in a sample of 231 restaurant workers (Reb et al., 2013).

Similar results have been found in healthcare workers, notably higher clinician mindfulness being associated with better patient ratings (Beach et al., 2013), and mindfulness interventions being related to improved family-friendliness of admissions teams (Singh et al., 2002). Academic performance has also been linked in female MBA students to trait mindfulness (Shao & Skarlicki, 2009).

Mindfulness has also been linked to other factors which may contribute to job performance. It has been suggested by Dane (2010) that attentional breadth is useful in dynamic task environments as it allows for attention to a wide range of stimuli. Herndon (2008) found that trait mindfulness was associated with fewer cognitive failures such as blunders and forgetting, which suggests favourable work performance is likely. The connection extends to self-reported safety behaviours in nuclear power plant employees tasked with complex work (Zhang et al., 2013; Zhang & Wu, 2014).

These initial studies are encouraging, although more experimental evidence is needed as to how and why mindfulness predicts performance in the workplace, and whether it is generalisable. Two areas of interest appear to be emerging as worthy of further attention and which are known to contribute to performance: relationships and leadership.

MINDFULNESS AND WORKPLACE RELATIONSHIPS

A high proportion of work life is inherently relational, including communication, leadership, teamwork, trust, partnerships, and coordination. Dienesch and Liden (1986) emphasise how important staff relationships are with supervisors and managers, and group or teamwork depends on cooperation between colleagues (Mathieu et al., 2000). Mindfulness, although an individual attribute, affects interpersonal behaviours and outcomes at work, for example, in being less judgemental of others (Beckman et al., 2012). In another related study, Reb et al. (2015) found higher ethical and prosocial behaviour, as well as lower deviance, was related to trait mindfulness; this is corroborated by a confirmed link between trait mindfulness and lower counterproductive behaviours (Krishnakumar & Robinson, 2015).

Such social processes are vital to effective teams, as they lead to both cohesion and collective performance (Good et al., 2015). It has been suggested that mindfulness may support such performance through better conflict management by promoting less aggressive communication (Barnes et al., 2007), and perspective-taking for better negotiation (Galinsky et al., 2008).

Mindfulness may also help team functioning by modulating the emotional tone within teams. Mindful employees may be less reactive to negative events, thus reducing the potential of emotional contagion. This has been demonstrated in the form of less hostile behaviour (Saavedra et al., 2010) and reduced emotional reactions. Teamwork may also benefit from the stable attention provided through mindfulness, serving as the basis for coordination and shared mental models (Metiu & Rothbard, 2012).

An ever-increasing body of work indicates that positive workplace relationships build critical resources that foster employee communication and citizenship behaviours, factors which are established in the literature as contributing to both individual and team performance (Glomb, 2011). Mindfulness appears to contribute to these resources by way of reducing emotional reactivity and promoting social cohesion.

MINDFULNESS AND LEADERSHIP

According to the Health and Safety Executive (2020), the predominant causes of work-related stress, depression or anxiety were workload and too much pressure or responsibility. Other factors identified included a lack of managerial support, organisational changes at work, violence, and

role uncertainty. As it is arguably the case that leadership or leadership decisions affect all these factors, a mindful and therefore self-aware and attentive leader may play a part in reducing their resulting number of lost workdays. Chaskalson (2011) suggests that this is the case, and that mindful leadership results in a more engaged and effective workforce.

In terms of the evidence to hand at present, Vonderlin et al.'s (2020) meta-analysis of randomised controlled trials of mindfulness-based programmes (MBPs) in the workplace concludes that MBPs effectively promote the health and wellbeing of employees in various occupational settings, though notes that further research is needed to investigate potential benefits on work-related outcomes and effects. There are, however, several results in the literature at this stage which show promise for leadership mindfulness outcomes in leadership performance. The work of Reitz & Chaskalson (2016a, 2016b) provides a quick read, high-level scoping of the work and issues.

Leader mindfulness was positively related to employee's positive affect and job satisfaction and negatively related to their psychosomatic complaints in a study by Pinck and Sonnentag (2017). Positive leadership behaviours have also been observed resulting from leader mindfulness, as perceived by both followers and leaders, an effect that extended to followers' work attitudes, in research investigating the links between mindfulness and authentic leadership attributes (Nübold et al., 2020). Additionally, middle managers have been shown to receive higher job performance ratings following mindfulness training, compared to both the control group and their previous ratings (Shonin et al., 2014).

A serial mediation model proposal by Schuh et al. (2019) brought very promising results. The hypothesis, that leader mindfulness enhances employee performance, and that this relationship is explained by increased leader procedural justice enactment and, subsequently, reduced employees' emotional exhaustion, found strong support in the data.

An interesting study by Cheung et al. (2020) finds that employee mindfulness is positively related to supervisor-rated creativity, which becomes non-significant when employees perceive their supervisors as low in humility, a feature of servant leadership. Servant leadership increases perceptions of benevolence and increases trust, key elements of effective leadership (Stedham & Skaar, 2019). This highlights the important moderating role of leadership in employee creativity and may be worth investigating in other areas. We see a growing awareness that leader mindfulness influences collective workplace mindfulness (Sutcliffe et al., 2016) and positively influences some individual outcomes.

Understandably, research participants have been self-selecting in this context. It is important for employees to have awareness and self-empowerment in being able to make valid decisions about not wishing to be upset in front of bosses or colleagues, and their bosses respectfully allowing autonomy on these important personal decisions. What needs to be avoided is what Hyland et al. (2015) note where mindfulness training is offered as a 'means to pacify disgruntled employees, maintain the status quo, and ultimately manage and manipulate the workforce'. Mindfulness is effective and needs to be utilised in ethical as well as evidence based ways.

APPLYING MINDFULNESS INTERVENTIONS AT WORK

The application of mindfulness interventions in the workplace needs to be adapted to the requirements and circumstances of the organisation where they are delivered. As outlined here, eight-week MBSR courses have shown good initial results for stress reduction, some aspects of performance, relationship-building, and leadership. Shorter MBSR courses, such as ones of four weeks (Jain et al., 2007) have also seen positive results, the benefits of which had been maintained after four months. Other tailored approaches have also included, for example, mindful emailing at Google to build employee emotional intelligence (Chaskalson, 2011).

Passmore (2019b) in the second part of his publication on mindfulness in organisations, has developed guidance for practitioners in this area, specifically to explore the application of mindfulness in organisational development as regards leadership development, workplace wellbeing and coaching. He outlines the case for wisdom as a mark of leadership development and provides practical guidance on developing relevant mindfulness training programmes for leaders. He also provides advice regarding mindfulness wellbeing programmes, from drop-in lunchtime sessions to longer weekly interventions, with specific practice techniques from his own work with colleagues (Passmore & Amit, 2017).

Hafenbrack (2017) has also outlined some guidelines for practitioners of mindfulness in the workplace for on-the-spot interventions, including a guide for employees to understand when cultivating a state of mindfulness is likely to be helpful to them versus when it is likely to be counterproductive. The article outlines necessary conditions for effective mindfulness training: awareness of the problem situation; awareness of mindfulness as a tool; and employee execution of intervention.

As with any workplace intervention, the practitioner needs to be aware of the organisational requirements, employee needs and abilities, and have gained a thorough grounding in mindfulness theory and practice to develop effective implementations. This is a challenge, given the lack of generalisable or comprehensive research into workplace mindfulness. However, the initial results of research in this area are promising, and the body of evidence is growing rapidly. It is therefore expected that over the coming months and years, practitioner support and guidance will expand and allow mindfulness teachers to grasp the complexities of training design for specific groups and contexts.

ADAPTING MINDFULNESS APPROACHES

There is a need for mindfulness interventions to be compatible with the requirements and boundaries of the organisation and staff where they are delivered. Adapted forms of MBSR have provided promising results for stress reduction, such as Mindfulness-Based Mind Fitness Training in the military (Stanley et al., 2011). Positive results have also been found for abbreviated MBSR courses, including as short as four weeks (Jain et al., 2007). Barzako et al. (2013) replaced six of the eight face-to-face group sessions of MBSR with group telephone sessions and found that nurse participants had improved general health, reduced stress and burnout, and increased empathy and self-compassion following the programme. Benefits were maintained at four-month follow-up.

Where stress reduction is not the main aim, MBSR is often not used, and mindfulness programmes are tailored individually to the particular organisational setting. Chaskalson (2011) describes how mindful emailing was taught at Google and helped to build employees' emotional intelligence. Such studies suggest that mindfulness is a versatile and transferable skill that can be applied to meet different organisational needs and in different settings. However, the individualised nature of such interventions means that it is hard to predict how effective a particular mindfulness intervention is likely to be at achieving the desired outcome in a specific work setting.

Recent work by Carter and Tobias Mortlock (2018) working in the military setting has pointed to the need for 'next generation' mindfulness training to develop collective capacity to manage stressors differently in high-performance teams. This approach relies less on the individual to develop their own mindfulness skills, rather, co-creating processes informed by mindfulness that the whole team signs up to. This approach may reduce the perceived stigma associated with mindfulness as 'self-help' in high-performance cultures, and also make it more likely that the whole team can activate mindfulness skills in a moment of challenge.

Mindfulness teachers need to be aware of the needs of the organisation, the needs of the attending staff, and have a sufficiently rich grasp of mindfulness to be able to implement it creatively in this context. This may be difficult as currently there is little known about the interaction between individual factors, such as between components of mindfulness teaching and outcome. One study that looked at trainee psychotherapists' experiences of learning loving-kindness meditation found that it was experienced as improving therapeutic skills and compassion but was also challenging emotionally (Boellinghaus et al., 2013).

Mindfulness trainers, therefore, need to be aware of the appropriate support needed for staff and the potential challenges for staff in learning mindfulness. Further qualitative research into staff's experiences of learning mindfulness in different settings and for different aims would be helpful. This would help to inform mindfulness teachers of complexities surrounding training, so as to help design mindfulness training programmes for specific groups and settings.

SUMMARY

- Workplaces are increasingly stressful and mild to moderate psychological distress (anxiety and depression) are now the norm.
- Mindfulness-based interventions are likely to provide some relief and improve wellbeing and mental health.
- Cognitive and performance benefits are predicted by the mechanisms of mindfulness models, but more real-world research is needed to confidently state performance and productivity benefits.
- Mindfulness may help develop healthy relationships, improving cohesion and psychological safety. Modelling and leading from the top are likely to enhance these effects.
- MBCT (or derivatives) may provide more targeted metacognitive changes that help to ameliorate mental health symptoms.
- It is important not to 'oversell' the benefits of mindfulness.
- Contextual adaptations are required.
- Awareness of culture and leadership ethos are vital components for successful implementation.
- Team mindfulness training embedded in work processes may offer more scope for culture change as compared to individual mindfulness training.

HEALTHCARE WORKFORCE

Research has looked into the effects of mindfulness approaches for healthcare staff across a range of physical and mental healthcare settings. The most widely used mindfulness programme when working with staff groups is Mindfulness-Based Stress Reduction (MBSR). There is evidence that for staff within healthcare, MBSR can reduce stress, negative affect, anxiety and rumination, and increase positive affect, creativity, empathy and self-compassion (Beddoe & Murphy, 2004; Irving et al., 2009; Shapiro et al., 2005).

Ruths et al. (2012) in a study of MBCT with mental health professionals found that increased adherence to the practice related to increased mindful awareness and attention, together with increased psychological wellbeing and reduced psychological problems. Rudaz et al. (2017) in

a review of studies into acceptance-based training for staff in relation to self-care and reduced stress, found 24 quantitative studies with most of these supporting these trainings were of benefit.

Spinelli et al. (2019) included 38 studies (*N*=2505) in a recent meta-analysis of mindfulness training for healthcare professionals. They reported that mindfulness training (including a variety of standardised and adapted training protocols) had significant moderate effects on anxiety, depression, psychological distress and stress. Small to moderate effect sizes were found for burnout and wellbeing. There were no significant effects found for burnout and performance. Adapted MBSR had better individual outcomes and long-term effects. Electronically delivered training produced some of the strongest benefits, so this more accessible delivery mode may be suited to the workplace demands of clinical staff. These findings speak to the need to adapt training to the working culture of healthcare (often time-pressed and with low permission for self-care).

Suleiman-Martos et al. (2020) reported on 17 studies where mindfulness had been offered to nursing staff (*N*=632). Their systematic review and meta-analysis demonstrated that mindfulness training reduces burnout, with lower scores on emotional exhaustion and depersonalisation questionnaire items, and an increase in personal accomplishment.

Salvado et al. (2021) conducted a systematic review and meta-analysis to analyse the effects of MBIs to reduce burnout in primary healthcare professionals. Emotional exhaustion and depersonalisation were significantly reduced and personal accomplishment increased. The studies were rated as having a high risk of bias and limited quality evidence.

Doctors may need their own bespoke mindfulness interventions. Typically, due to the demands on their time and the competitive and high-pressure culture of 'doctoring', shorter more intensive interventions are favoured (see Manoch). Epstein et al. (2021) recently reported that an intensive, four-day mindfulness-based workshop for physicians had clinically significant positive effects on clinician wellbeing, quality of interpersonal care and work satisfaction, and meaning and engagement. They suggest that future iterations of the programme should increase the focus on teamwork.

Naehrig et al. (2021) systematic review of six RCTs with general practitioners made a similar point about the importance of the mindfulness intervention being contextualised within the organisational system. This reflects the dual role of medical practitioners as healthcare workers, and organisational leaders.

TAKING CARE OF STAFF HELPS THOSE THEY CARE FOR TOO

In health care, it feels intuitive that clinicians' increased empathy, self-compassion, and reduced stress will impact positively not only on staff, but also for service user experience. The Francis Report discusses the need for more focus on compassion and caring in nursing recruitment, training, and education (Francis, 2013). Given such news of failings of care in healthcare services, finding ways of increasing compassionate care is crucial for the wellbeing of patients and users of health care.

Grepmair et al. (2007) conducted a randomised clinical trial which found that psychotherapists in training who underwent mindfulness intervention were rated more positively by clients in terms of the therapeutic relationship, problem-solving, and communication. These clients reported greater symptom reduction compared with the control group. See also section in Part 1 on Therapists Own Mindfulness.

Research has found that awareness of one's own feelings, body experience, and thoughts leads to increased empathy for others' (Singer, 2006), and when the quality of this awareness is compassionate, this self-compassion can lead to compassion for others (Chaskalson, 2011). Increased empathy is significant as clinician empathy improves service user experience (Pollack et al., 2011), and this suggests that increases in self-awareness through learning mindfulness may have a positive impact on service user experience.

THINGS TO CONSIDER

- The timing of the training of healthcare workers may be important (e.g. offering mindfulness to those in training as compared to those already embedded in the organisation).
- Staff in different parts of the organisation may need different adaptations and/or to be offered different spaces for training (e.g. nursing, doctors, allied health, management staff). Each group has different demands, different psychological profiles, needs and subcultures.
- Doctors prefer to do their mindfulness training in their own peer groups. As the individuals with the highest 'power' in the organisation, they are best considered as occupying leadership roles. If they can engage in training alongside other colleagues this brings maximum benefits (embodied leadership). Psychological safety is, however, a priority, and they may need a separate debriefing space.
- Healthcare workers are highly trained, practised and conditioned to prioritise the needs of others. This may make the task of turning the lens of care towards the self more challenging than working with the general public or patient groups.
- The culture of medicine and healthcare, although changing, has historically struggled to accommodate mental ill health in its ranks.
- Many enter the field of healthcare to soothe their own physical and psychological wounds. 'Wounded healers' may have extra layers of conditioning and defence that need to be worked through in order to develop the self-compassionate stance that augments the benefits of mindfulness.
- Cultural sensitivity is required to meet the needs of a culturally diverse workforce.
- Healthcare workers may be experiencing vicarious trauma and burnout. In this context, trauma-informed mindfulness-based approaches may be warranted.

CHAPTER 3

Appendix

Appendix 1: Meta-analysis and Key Review Papers for MBSR and MBCT

Grossman et al. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of Psychosomatic Research, 57*(1), 35–43.	MBSR
Grossman, P., Niemann, L., Schmidt, S. & Walach, H. (2010). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Focus on Alternative and Complementary Therapies, 8*(4), 500–500.	MBSR
Hofmann, S.G., Sawyer, A T., Witt, A.A. & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 169–183.	MBT
Fjorback, L.O., Arendt, M., Ornbøl, E., Fink, P. & Walach, H. (2011). Mindfulness-based stress reduction and mindfulness-based cognitive therapy: A systematic review of randomized controlled trials. *Acta Psychiatrica Scandinavica, 124*(2), 102–119.	MBSR and MBCT
Chiesa, A. & Serretti, A. (2011). Mindfulness-based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. *Psychiatry Research, 187*(3), 441–453.	MBCT
Keng, S.L., Smoski, M.J. & Robins, C.J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review, 31*(6), 1041–1056.	MBTs: MBSR, MBCT, ACT and DBT
Piet & Hougaard (2011). The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis. *Clinical Psychology Review, 31*(6), 1032–1040.	MBCT
Williams, M. & Kuyken, W. (2012). Mindfulness-based cognitive therapy: A promising new approach to prevent depressive relapse. *British Journal of Psychiatry, 200*, 359–360.	Overview of MBCT development over the last 10 years
Khoury, B., Lecomte, T., Fortin, G., Masse, M., Therien, P., Bouchard, V., Chapleau, M.A., Paquin, K. & Hofmann, S.G. (2013). Mindfulness-based therapy: A comprehensive meta-analysis. *Clinical Psychology Review, 33*(6), 763–771.	MBSR and MBCT

Abbreviations: MBT (Mindfulness-based Therapies); MBSR (Mindfulness-based Stress Reduction); MBCT (Mindfulness-based Cognitive Therapy); DBT (Dialectical Behavioural Therapy); ACT (Acceptance and Commitment Therapy)

Appendix 2: Suggested Books and Websites

Please note these are recommendations rather than an exhaustive list.

BOOKS FOR THERAPISTS

Crane, R. (2017). *Mindfulness-based cognitive therapy: Distinctive features*. Routledge, An Imprint Of The Taylor & Francis Group.

Feldman, C., Willem Kuyken & Segal, Z.V. (2019). *Mindfulness: ancient wisdom meets modern psychology*. New York, Ny ; London The Guilford Press.

Gilbert, P. (2008). *Compassion: conceptualisations, research and use in psychotherapy*. Routledge.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Routledge.

Kolts, R.L. (2018). *Experiencing compassion-focused therapy from the inside out: A self-practice/ self-reflection workbook for therapists*. The Guilford Press.

Mccown, D. (2013). *The ethical space of mindfulness in clinical practice: An exploratory essay*. Jessica Kingsley Publishers.

Segal, Z.V., G.M., Teasdale, J.D. & Kabat-Zinn, J. (2018). *Mindfulness-based cognitive therapy for depression* (2nd ed.) The Guilford Press.

Shapiro, S.L. & Carlson, L.E. (2017). *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions*. American Psychological Association.

Williams, M.G. & Kabat-Zinn, J. (2013). *Mindfulness: Diverse perspectives on its meaning, origins and applications*. Routledge.

Kimberly, A., Schonert-Reichl, K.A. & Roeser, R. (2016) (Eds). *Handbook of Mindfulness in Education: Integrating Theory and Research into Practice*. Springer Link.

BOOKS FOR CLIENTS

Teasdale, J.D., G.M. & Segal, Z.V. (2014). *The mindful way workbook: An 8-week program to free yourself from depression and emotional distress*. The Guilford Press.

Williams, M. & Penman, D. (2011). *Mindfulness: A practical guide to finding peace in a frantic world*. Piatkus.

Williams, M., Teasdale, J., Segal, Z. & Kabat-Zinn, J. (2007). *The Mindful Way through Depression*. The Guilford Press.

Vidyamala Burch, Penman, D. & Williams, M.G. (2013). *Mindfulness for health: A practical guide to relieving pain, reducing stress and restoring wellbeing*. Piatkus.

Russell, T. (2017). *#whatismindfulness* (2017) Watkins.

Russell, T. (2015). *Mindfulness in Motion*. Watkins.

Gilbert, P. (2009). *The compassionate mind: A new approach to life's challenges*. Robinson.

Gilbert, P. & Choden. (2015). *Mindful compassion: Using the power of mindfulness and compassion to transform our lives*. Robinson.

Irons, C. & Beaumont, E. (2016) *The Compassionate Mind Workbook: A step-by-step guide to developing your compassionate self*. Robinson.

Hayes, S.C., Strosahl, K.D. & Wilson, K.G. (2016). *Acceptance and commitment therapy: The process and practice of mindful change*. Guilford Press.

Mckay, M., Wood, J.C. & Brantley, J. (2007). *The dialectical behavior therapy skills workbook: Practical DBT exercises for learning mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance*. New Harbinger Publications, Inc.

Neff, K. & Germer, C.K. (2018). *The mindful self-compassion workbook: A proven way to accept yourself, build inner strength, and thrive*. Guilford Press.

Neff, K. (2013). *Self-compassion step by step – the proven power of being kind to yourself*. Sounds True Inc.

Rezek, C.A. (2016). *Anxiety and depression: The mindful way.* London: Sheldon Press.

Rezek, C.A. (2016). *Pain management: The mindful way.* London: Sheldon Press.

Rezek, C.A. (2016). Monkey mind and the mountain: Mindfulness for 8–80 year olds (and older). London: Leachcroft.

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