COMBINING COGNITIVE, EMOTIONAL, BEHAVIOURAL AND, DARE WE SAY IT, THE SPIRITUAL: A REVIEW OF *MINDFULNESS-BASED COGNITIVE THERAPY FOR DEPRESSION: A NEW APPROACH TO PREVENTING RELAPSE*

By: Zindel V. Segal, J. Mark G. Williams and John D. Teasdale

Guilford Press, New York, 2002. Pp 351. Price: $42.00. ISBN: 157230 7064

Reviewed by Tannis M. Laidlaw and Prabudha Dwivedi

Imperial College London, UK

As a therapist, did you ever see the usefulness of 'being in the here and now'? Earlier in life, did your mother ever tell you to 'get with it'? Did you have a teacher who would snap a ruler on some appropriate surface and tell you to 'pay attention'? Kabat-Zinn, a noted researcher and clinician who uses mindfulness as a therapeutic procedure, defines mindfulness as 'the awareness that emerges through paying attention on purpose, in the present moment and non-judgementally...'(Kabat-Zinn, 2003). Maybe that's why one reaction to reading *Mindfulness-based Cognitive Therapy for Depression* is 'same as, same as'; this is not a new message.

This is not to criticize the essence of the book, as the principles (the 'here and now' principle is but one example) are useful, relevant to therapists and, importantly, there is lots of evidence that these principles work no matter how you label them. In addition, the book is beautifully written.

The mindfulness approach is about maintaining treatment gains and preventing relapse. It is a practical 'how to' book (with good descriptions of their eight-session programme and client handouts) that will prove useful to many therapists who want something well thought out and functional. Therapists using hypnosis will be able to incorporate many of these techniques into a hypnotic context with ease.

To start with, the point is made that most of us function in 'doing mode'. When things get sticky, most of us react to a need for change to make things more ideal. We strive, maybe exhausting ourselves in the process, and as our mood becomes more negative, those of us prone to depression can descend into patterns of thought and behaviour that are repetitive, ruminative and self-perpetuating. The book argues that it is more useful to be in a 'being mode' without goals in these circumstances, and with no need to monitor how one is doing on the quest. Personally, we think that a term such as 'driven mode' would be more descriptive than 'doing mode'.

'Being mode', on the other hand, is the here and now. 'Being' engenders a state of freedom away from the repetitive automatic functioning that maintains negative mood states. So breaking the ruminative and behavioural cycles that perpetuate negative mood is done by learning to live in a 'being mode'.

The model has some body/ behavioural aspects to it such as instruction in therapeutic breathing (the concept of having 'breathing space' is a nice one) and the deliberate relaxation of parts of the body storing tension. Mastering this along with letting go of the need to immediately do something about the problem, then finishing the process by going onto an activity that has some 'feel-good' aspect to it completes the process. Simple. But effective.

If negative moods get established, the authors assert, then old patterns of automatic thought and behaviour will run along well-worn ruts leading to perpetuation of

the negativity and distress. For instance, the authors suggest that people suffering depression think they have a *need* to get rid of the mood they are in and they believe that they *have* to be happy. They rely on problem solving to do so instead of letting go at the beginning of the cycle. They are tempted to continually compare how they are actually doing in terms of happiness (badly) with how happy they should be. The idea is for clients to know what to do to prevent negative mood states becoming established and these techniques are taught as life skills, promoting the seeking of freedom rather than happiness.

The first difference from most interventions is that participants attend classes rather than therapy sessions. Thus the setting is a learning environment rather than a strictly therapeutic one. The core aims of the teaching are: to prevent depression returning; to be more aware of thoughts, feelings and where the body is from moment to moment; to accept and acknowledge negative thoughts and feelings rather than unwanted routines that foster depression; and to help participants choose 'skilful' ways of responding.

The first four sessions are devoted to teaching people to pay attention, the here-and-now principle discussed above. Session one devotes itself to the concept of living 'on automatic pilot' and being able to distinguish when we are in such a state. People are taught to really experience sensation with a clever exercise involving eating a raisin mindfully. They are taught to go into their bodies to experience how parts are feeling and controlled breathing is introduced. Homework is using a tape that is a guided 'scan' of the body, designed to stop the 'doing mode' and to enter into the 'being mode'. A body scan is done supine with eyes closed. The participant must bring to mind any sensations in the body as the person focuses attention on each body part in turn. The technique involves focusing on the body part, for instance, the left leg, and imagining that the in-breath can reach down beyond the lungs all the way down to the left leg and out through the toes. The out-breath starts outside of the toes and travels up to the lungs and then out of the body through the nose. Homework also consists of picking an ordinary activity like brushing one's teeth to fully experience every sensation and perception as the person carries it out.

The second session, entitled 'Dealing with barriers', consists of becoming aware of the chatter of the mind, which then controls reactions to life. Depressive thoughts and feelings can produce a downward spiral and ruminating on depressive problems furthers the problem. Emphasis is given to giving up 'doing it right', often exemplified in participant reactions to the long and eventless body scan tape the people are doing in class and for homework. A small meditation exercise is introduced in this session. Homework involves further use of the body scan tape and a breathing exercise. People are also asked to keep a detailed diary of pleasant events they experience, an interesting exercise for people inclined to seeing the negative side of life.

The third session is 'Mindfulness of the breath', apparently a difficult session with lots of resistance experienced by participants. They are learning that mindfulness is not another technique for problem solving, and they become distressed by that realization. The breathing-based meditation introduced the week before is expanded to 30–40 minutes. All the problems that can arise (mind wandering, physical discomfort, controlling thoughts) are dealt with in a group situation. The 'mini-meditation' is introduced, a useful technique where people give themselves a '3-minute breathing space', concentrating on their breathing and gradually expanding their consciousness to include the whole body. This session also includes a yoga-like set of stretching exercises. Homework is to record unpleasant events this week, using the same detailed exploration

of all sensations, perceptions and thoughts as they did for pleasant events, plus breathing meditation, yoga stretches and practising the mini-meditation.

The fourth session is called 'Staying present' and is the last of the here-and-now sessions. The theme is to acknowledge that the mind becomes scattered when avoiding thinking about certain things and at the same time trying to concentrate on others. This week, people are to learn how to 'stay present' even when things become uncomfortable. Meditation time is up to 40 minutes now and a variant of mini-meditation is taught that is to be used when distressed. The purpose is not to make the person feel better, but to allow the problematic situation to exist without interference, which may result in having a different perspective on the problem, although that is happenstance rather than a goal in this paradigm. Homework is to practise meditation using a tape, and to use the mini-meditation both regularly and when in difficulties.

The fifth session begins the second half of the course which concentrates on handling mood shifts. This session is entitled 'Allowing/letting be' with the theme of letting an experience exist without judgement or, importantly, rushing in to fix it. The practical consists of a 40-minute meditation, and watching a videotape that illustrates dealing with chronic problems such as pain, hypertension and anxiety. An exercise participants are requested to do in this session involves bringing an active problem to mind so they can practise non-interference. They are to 'soften and open' themselves to the negative feelings associated with the problem, breathing with the sensations, thus teaching them to explore what happens when the mind moves towards rather than away from what is painful. Homework again consists of meditation and mini-meditations.

The sixth session, called 'Thoughts are not facts' illustrates a good point. Thoughts are only thoughts and some people need reminding of that fact. This session is the most cognitive of the course with the difference that the person's relationship to the negative thoughts that arise in depressive thinking is now altered to one of more passive acceptance. Thoughts can be objects of awareness – mere mental events – and no one has to believe everything that comes to mind. Participants do a mood and thoughts exercise to show how mood can determine how we interpret a situation. When someone finds himself or herself being overwhelmed by negative thought, they can take a 'breathing space', which may open up a further possibility that had been obscured by their reaction to the negativity. Participants in the course are taught various cognitive devices such as writing the thoughts down on paper, or asking whether the thoughts fit with the situation. Participants are given new tapes for home practice.

The seventh session is devoted to how to best take care of oneself, a practical session devoted to each participant's personal needs. When depression looms, participants are advised to take a 'breathing space' for a few minutes before deciding which action to take. The use of early warning signs (first devised in schizophrenia research by Falloon and colleagues) are recommended, as is having pre-planned behavioural and cognitive action plans ready for use to prevent relapse (Falloon, Held, Roncone, Coverdale and Laidlaw, 1998). Homework is to identify the early warning signs of a relapse and to set up individualized plans.

The ultimate session, called 'Using what has been learned to deal with future moods', emphasizes maintaining a balance in life. This is a wind-down from the course involving whole group and small group discussions for the purpose of consolidating the learning, feedback from participants and leaving on a high note.

Full marks to the authors for being so detailed. It appears possible to take their programme and immediately apply it, if one ignores the tapes and other non-paper handouts given to participants. In an age when too many innovative clinicians or

academics are using their efforts to make money by restricting use of new techniques to those that have gone through extensive and expensive training courses, rather than publishing their techniques for the good of the wider community, this book is to commended.

Ultimately, the pudding (as in 'the proof is in...') is whether the programme works. The authors have included a chapter describing clinical research that purports to show just that. The good results (37% relapse compared to 66% for controls) are restricted to those with three or more depressive episodes in their past. Those with fewer episodes do not do as well. The authors' explanation is that the first couple of episodes of depression are more likely to be reactive to environmental circumstances, while those who have 'learned' the depressive behaviour can sink into depression due to triggering off well-worn sets of behaviour. These are the people who have responded well to this programme (Teasdale, Segal, Williams, Ridgeway, Soulsby and Lau, 2000). More research is needed, but the programme is obviously a promising one.

The programme has been criticized for leaping into print prior to the underlying principles being understood (Strauman and Merrill, 2004) although the principles of living in the here-and-now are well understood and have been accepted for 30 years or more. Recently this particular wheel is being rediscovered, if not reinvented (Borkovec, 2002) with the additional benefits, it appears, of training in meditation so that participants can easily and at will concentrate the mind on specific stimuli. Mindfulness meditation is part of other therapies as well, such as Dialectical Behavior Therapy (DLT) for borderlines (Linehan, 1993) and more comprehensively, in anxiety treatment (Miller, Fletcher and Kabat-Zinn, 1995). Of course, it is originally a Buddhist practice and Buddhist tradition equates mindfulness meditation with alleviation of human suffering. However, an important aside, there is no intention of making Buddhists of participants (Kabat-Zinn, 2003). The demands of the time involved to master this technique are more on the lines of spiritual practice than therapy (meditation times routinely of 40–60 minutes, and up to 3 hours) and may or may not be necessary therapeutically (Smith, 2004). Looking at actual recorded time of practice in one study (Davidson, Kabat-Zinn, Schumacher, Rosenkranz, Muller, Santorelli, Urbanowski, Harrington, Bonus and Sheridan, 2003), averages are around 15 minutes, which compares well with homework time spent practising self-hypnosis in current studies in our laboratory.

Using eastern meditative-like practices for therapeutic ends is becoming a tradition, even though the spiritual aspects of these practices is de-emphasized for a western audience. The 1960s and 1970s saw papers extolling the therapeutic virtues of transcendental meditation and other Hindu-like meditative practices. The mindfulness meditation used in this book is based on Buddhist-type practice. Its therapeutic use started in a small way in the 1980s, primarily by Kabat-Zinn and colleagues, and has slowly gathered interest especially in pain and anxiety management, then in DBT by Linehan, leading to the methods presented in this book emphasizing prevention of depression relapse. Our lab is currently researching a Japanese healing method called Johrei. This practice, purportedly not a meditation per se, involves a non-touch sending of subtle energy towards another person, which includes not only paying close attention to the recipient but also being openhearted and feeling goodwill towards the recipient. The word 'mindfulness', in most Asian languages, includes similar affectionate, kind-hearted characteristics when the person is attending to the here and now. Some interesting results with Johrei, and incidentally with hypnosis, have been identified both in mood (Laidlaw, Naito, Dwivedi, Enzor, Brincat and Gruzelier, 2003) and in immunological comparisons in

students about to sit examinations (Naito, Laidlaw, Henderson, Farahani, Dwivedi and Gruzelier, 2003). Similarly, Davidson and colleagues found an enhanced immune response in mindfulness meditators as well as shifts towards more positive mood and EEG patterns corroborating a more positive outlook (Davidson, Kabat-Zinn, Schumacher et al., 2003). This points towards an internal process that is inherently good for the practitioner through various modes. Currently we are examining EEG patterns in both practitioner and recipient during Johrei sessions . Much more work needs to be done to isolate the therapeutic aspects of these practices, but comparative studies may teach us much.

In conclusion, there is much to recommend in this book. If you are interested in a meditation-based therapeutic programme that is well thought out and has some research backing, you will probably find it practical and well written.

References

Borkovec TD (2002) Life in the future versus life in the present. Clinical Psychology: Science and Practice 9(1): 76–80.

Davidson RJ, Kabat-Zinn J, Schumacher J, Rosenkranz M, Muller D, Santorelli SF, Urbanowski F, Harrington A, Bonus K, Sheridan JF (2003) Alterations in brain and immune function produced by mindfulness meditation. Psychosomatic Medicine 65(4): 564–70.

Falloon IR, Held T, Roncone R, Coverdale JH, Laidlaw TM (1998) Optimal treatment strategies to enhance recovery from schizophrenia. Australian and New Zealand Journal of Psychiatry 32(1): 43–7.

Kabat-Zinn J (2003) Mindfulness-based interventions in context: past, present, and future. Clinical Psychology: Science and Practice 10(2): 144–56.

Laidlaw TM, Naito A, Dwivedi P, Enzor NA, Brincat CE, Gruzelier JH (2003) Mood changes after self-hypnosis and Johrei prior to exams. Contemporary Hypnosis 20(1): 25–40.

Linehan MM (1993) Dialectical behavior therapy for treatment of borderline personality disorder: implications for the treatment of substance abuse. NIDA Research Monograph 137: 201–16.

Miller JJ, Fletcher K, Kabat-Zinn J (1995) Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. General Hospital Psychiatry 17(3): 192–200.

Naito A, Laidlaw TM, Henderson DC, Farahani L, Dwivedi P, Gruzelier JH (2003) The impact of self-hypnosis and Johrei on lymphocyte subpopulations at exam time: a controlled study. Brain Research Bulletin 62(3): 241–53.

Smith JC (2004) Alterations in brain any immune function produced by mindfulness meditation: 'Three caveats: comment response'. Psychosomatic Medicine 66(1): 149–52.

Strauman TJ, Merrill KA (2004) The basic science/clinical science interface and treatment development. Clinical Psychology: Science and Practice 11(3): 263–6.

Teasdale JD, Segal ZV, Williams JM, Ridgeway VA, Soulsby JM, Lau MA (2000) Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. Journal of Consulting and Clinical Psychology 68(4): 615–23.

Address for correspondence:
Dr TM Laidlaw
Division of Neuroscience and Psychological Medicine
Imperial College London
St Dunstan's Road
London W6 8RF
England
Phone: +44 20 8846 7042
Fax: +44 20 8846 1670
Email: t.laidlaw@imperial.ac.uk