

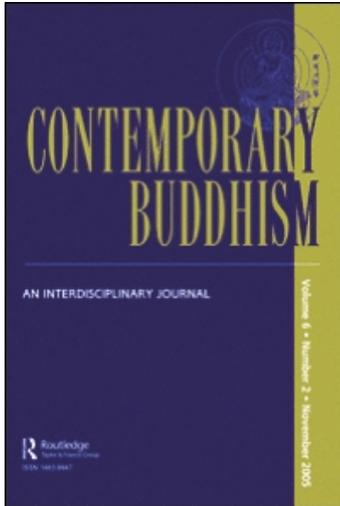
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Melanie Fennell; Zindel Segal

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MINDFULNESS-BASED COGNITIVE THERAPY: CULTURE CLASH OR CREATIVE FUSION?

Melanie Fennell and Zindel Segal

Mindfulness-based cognitive therapy creates an unlikely partnership, between the ancient tradition of mindfulness meditation rooted in Buddhist thought, and the much more recent and essentially western tradition of cognitive and clinical science. This article investigates points of congruence and difference between the two traditions and concludes that, despite first appearances, this is a fruitful partnership which may well endure.

'So where's the cognitive bit?'

In Oxford, we offer experiential eight-week mindfulness-based cognitive therapy (MBCT) courses to professionals working in healthcare and education. Participants' previous experience of mindfulness meditation varies widely, as does their familiarity with cognitive therapy. This inquiry captures the curiosity of a participant with a long established Zen meditation practice, at the end of such a course.

Mindfulness-based cognitive therapy (Segal, Williams and Teasdale 2002) represents a marriage between two very different cultures or traditions: the 2500 year old Buddhist tradition of mindfulness meditation, and the much more recent Western tradition of cognitive and clinical science. Just as in any meeting between different cultures, there is a need to foster mutual appreciation and respect—appreciation of shared perspectives and common humanity, and respect for genuine difference. Yet at times suspicion prevents a sense of shared interests, and differences may seem irreconcilable. Do these unlikely partners have enough in common to ensure continued and growing harmony? Or will the relationship end in divorce?

At first glance, mindfulness meditation and western psychological science might appear to have little in common. How can two cultures, widely separated in time and place, have anything useful to say to each other? Those who have come to MBCT from Buddhism or *vipassanā* meditation express doubts as to the wisdom of the marriage, as do those who have discovered mindfulness from cognitive therapy (CT). These doubts reflect legitimate concerns: that in integrating the two,

either might be denatured and something essential lost. In the CT camp, the concern is that the elaborated theoretical foundations of CT, together with its rigorous emphasis on empirical evaluation, will be lost. The scientific community, requiring that clinical interventions be evidence-based, suspects that Buddhism is being introduced into this secular setting by the back door, and may even associate meditation with dubious New Age practices (the fact that respected clinical scientists have developed MBCT has somewhat mitigated this concern). Amongst mindfulness practitioners, the concern is rather than subjecting meditation to radical changes in the service of clinical need, bringing it into a scientific and clinical context and putting it under the cold gaze of the research microscope, will lead to a different kind of loss: loss of the heart and spirit of the approach, its profound spiritual and ethical foundations, and the centrality of acceptance, kindness and compassion. Additionally, both cultures are understandably (sometimes justifiably) concerned that practitioners without deep understanding of the root traditions will mechanically parrot meditation practices and CT exercises or introduce meaningless innovations, because they fail to appreciate the underlying aims, intentions and conceptual framework of either.

How then was it possible for a Zen practitioner to ask the question in our opening quote? The originators of MBCT, building on the seminal work of Jon Kabat-Zinn (Kabat-Zinn 1990), recognized commonalities between mindfulness and CT, and partnered relatively intensive training in mindfulness meditation with a cognitive-behavioural conceptual framework in order to address the problem of depressive relapse. In this article, we shall explore the relationship between the two partners, identifying points of congruence and differences between them. We write as research clinicians who have approached MBCT from a home base in cognitive and clinical science and invite readers to judge for themselves whether this new marriage is based upon solid foundations, or whether the disparities are such that it must at some point dissolve.

What is mindfulness-based cognitive therapy? A brief reminder

The evolution of MBCT for recurrent depression is economically summarized in the opening chapters of Segal, Williams and Teasdale (2002). It was prompted by a growing recognition that depression is recurrent; the likelihood of future depressions increases with each episode. The authors hypothesized that, with recurrence, links between depressed mood and other symptoms (changes in cognition, behaviour and physical state) become stronger. Eventually even a small 'dose' of normal low mood can activate well-rehearsed thinking patterns which (unless interrupted) spiral into depression of clinical intensity. Depressed mood leads to gloomy, pessimistic ruminations which, in turn, reinforce and deepen it, encouraging withdrawal from others and from everyday activities that might otherwise offer a sense of pleasure or accomplishment. Thus the depressed person becomes trapped in a vicious circle: mood, thinking and behaviour feed into one another.

The central intention of MBCT is to reduce the likelihood of recurrence. Sufferers learn to identify the earliest warning signals of a change in mood and to respond differently, neither taking refuge in avoidance nor becoming entangled in analysis and rumination. The programme, closely based on Jon Kabat-Zinn's mindfulness-based stress reduction (MBSR; Kabat-Zinn 1990), is usually delivered to groups of 10–12 people in eight weekly two hour classes. Independent home practice (mostly meditation practice) is emphasized (up to one hour, six days each week). A day of mostly silent practice may be included, and up to four follow-up sessions may be offered. The course integrates mindfulness meditation with elements drawn from CT for depression (the nature of depression, the role of negative thinking, the impact on mood of nourishing and depleting activities, and relapse prevention). The effectiveness of MBCT for patients (now in recovery) who have experienced three or more episodes of depression, is now supported by controlled outcome trials (Godfrin and van Heeringen 2010; Kuyken et al. 2008; Ma and Teasdale 2004; Teasdale et al. 2000; Segal et al. 2010). These show that it reduces relapse probability in the year following treatment (the period of greatest vulnerability) by about 50% compared to treatment as usual. Contrary to initial expectations, promising preliminary data (as yet to be confirmed by large scale trials) suggest that MBCT may also be helpful to patients who are actively depressed (Barnhofer et al. 2009; Eisendrath et al. 2008; Kenny and Williams 2008).

What is cognitive therapy?

Cognitive elements of MBCT can seem simplistic, even trivial, to practitioners unfamiliar with their theoretical context. However, just as the meditations included in MBCT reflect only a small part of Buddhist practice, so too these exercises are the tip of a larger iceberg, which we shall now explore.

We focus on the CT developed in the mid-twentieth century by Aaron T. Beck (Beck et al. 1979). Beck, a psychoanalyst by training, became intrigued by distressing patterns of thought which were readily evident in therapy sessions within or just below the surface of patients' conscious awareness, and hence accessible to introspection (Beck 1976, 4). These early observations grew into a new, systematic therapeutic approach, initially (like MBCT) developed specifically for depression. Beck saw no discontinuity between the mental processes of people in distress and human beings in general; we all make the best sense we can of our experiences, usually on the basis of incomplete information, and influenced by our immediate context and learning history. Thus CT's underlying theory is not purely a theory of depression, or indeed of pathology, but rather a framework for understanding how human beings function in the broadest sense. Accordingly, it has been possible to adapt CT for depression for a much wider array of conditions, from common mental health problems (anxiety, eating disorders) to longstanding difficulties, severe mental illness, and physical problems including chronic pain and illness.

CT and depression

Beck's cognitive model

The first outcome trial of CT for depression was published in 1977 (Rush et al. 1977). A treatment manual soon followed (Beck et al. 1979). An extensive evidence base now supports CT's effectiveness with moderate-to-severe depression, both post-treatment and in the longer term (Derubeis et al. 2005; Hollon, Stewart and Strunk 2005; Hollon et al. 2005). Thus MBCT, rather than supplanting CT, built on its success in reducing the probability of relapse and recurrence. MBCT was an attempt to capture important elements of CT that might be taught to people when they were well, in order to prevent new episodes of depression.

Beck's model (shown along with an illustrative case example in Figure 1) suggests that, on the basis of early experience, people reach conclusions about themselves, others and the world ('schemas' or 'core beliefs'). Assuming the truth of these, they evolve personal guidelines which encapsulate what they *must do and be* in order to consider themselves worthy human beings, make and keep relationships and succeed in life ('dysfunctional assumptions'). So long as they can fulfil the terms of these, all is well. But if circumstances conspire against them, problems arise. Failing to perform to standard, or please others, or be fully in control—whatever the assumptions require—is seen to reflect inherent shortcomings which will also affect the future. Thus the *meaning* of an event (rather than the event itself) prompts progressive lowering of mood, further negative thinking and increasing changes in thought, emotion, behaviour and body state. The idea of 'cognitive reactivity' (Lau, Segal and Williams 2004; Segal, Gemar and Williams 1999) further suggests that, following repeated depressions, mild normal low mood and other possible symptoms (fatigue, irritability) can trigger this sequence. Instead of being understood as part of the human condition, they become loaded with negative significance.

Beck called the problematic moment-by-moment thinking present in depression 'negative automatic thoughts' (Westbrook, Kennerley and Kirk 2007, 7–8). 'Negative' reflects association with unpleasant emotions, and 'automatic' indicates that these thoughts simply pop into people's heads, rather than being a product of conscious reflection. Beck suggested that depressive thinking was characterized by negative automatic thoughts about the self, the world and the future. These result from processing biases (for example jumping to conclusions, automatic self-blaming) which incline perception, interpretation and memory towards the gloomy and pessimistic. Contrary information is filtered out, ignored, or dismissed. The result is a bleak view which reinforces low mood, saps motivation and energy, and undermines self-esteem—the vicious circle we referred to earlier.

CT for depression

CT is characterized by three essential features: a coherent theoretical framework; a collaborative therapeutic alliance; and an emphasis on empirical investigation. We shall briefly consider each in turn.

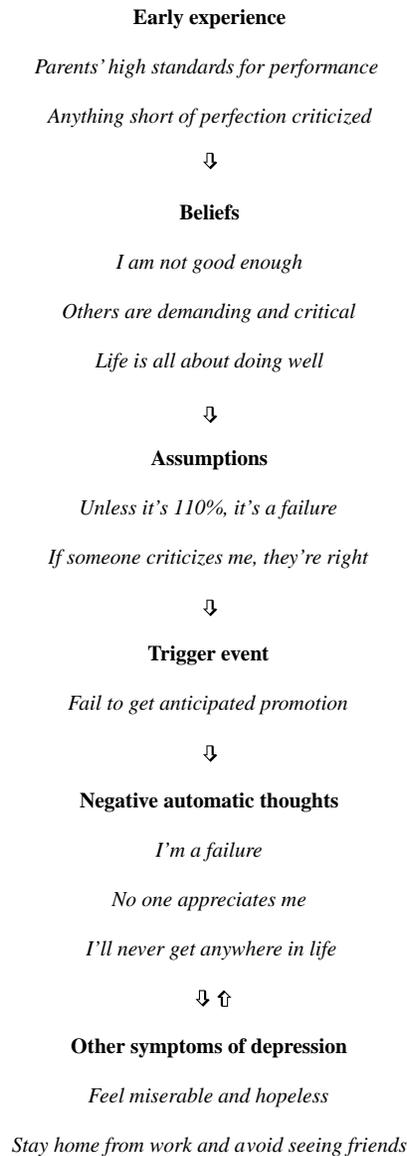


FIGURE 1
 Beck's cognitive model of depression

Coherent theoretical framework. The cognitive model forms the core of therapy, and is the framework for individualized case formulations (see Figure 1) which help patients to map the development and persistence of their difficulties, and guide the selection and sequence of interventions. Thorough assessment

helps patient and therapist understand what created vulnerability to suffering depression *at some point*, how depression developed *at this point*, and what psychological and environmental factors are *now* preventing recovery. The model indicates how to facilitate recovery and reduce the chances of relapse. Breaking vicious circles that maintain depression is the first priority, not understanding the deep past. In early sessions, moment-by-moment negative thoughts which prevent people from re-engaging with pleasurable and rewarding activities are addressed. Patients keep structured diaries, recording how they spend their time and their satisfaction with what they do, and then using this information to initiate changes—increasing activities that bring enjoyment and a sense of mastery. Through this process, they learn to notice self-defeating thoughts ('There's no point', 'I won't enjoy it'). With the therapist's guidance, they begin to investigate how accurate and helpful these are. As mood lifts, the focus broadens to a wider range of unhelpful thoughts. Through systematic self-observation, again using written records, patients learn to use changes in mood as cues to investigate associated thinking. They learn how to question their thoughts, rather than assuming them to be true, and to find out through direct experience whether they are valid ('behavioural experiments'; Bennett-Levy et al. 2004). As these skills are established, and mood continues to lift, treatment targets the broader attitudes (over-stringent standards, negative beliefs about self, world and future) which create continuing vulnerability to depression. Finally, patients summarize new learning in a 'blueprint for the future', planning how to respond skilfully to warning signs of depression.

The therapeutic alliance. Beck, from the outset, characterized CT as a humanistic therapy and emphasized the centrality of the therapeutic relationship. A therapist who embodies the classic qualities of accurate empathy, unconditional acceptance, warmth and genuineness creates a secure context in which trust develops and change becomes possible. As mindfulness instructors embody acceptance and compassion, so CT therapists model (a cooler word) the stance they encourage patients to adopt towards themselves: non-judgemental interest, curiosity, and open-mindedness. In CT, the alliance is viewed as *necessary but not sufficient* for successful outcome: it facilitates delivery of effective cognitive-behavioural interventions, but is not itself the prime vehicle for transformation.

Central to the relationship is the idea of 'collaboration'. Therapist and patient work as an investigative team, exploring the nature of experience, and searching for new perspectives that are more realistic (free from biases derived from old beliefs and assumptions) and thus more helpful. Therapy is both active and interactive, with a sense of sharing knowledge and expertise, and transparency about theory and about what interventions might be helpful and why. This explicit emphasis on knowledge and skills-transfer reflects therapists' intention to help patients use new learning independently—to make themselves redundant, in other words. This is why treatment includes extensive between-session 'homework' assignments.

Emphasis on empirical investigation. Just as CT has progressed through research, so patients learn not simply through discussion, but through empirical investigations of their own thinking patterns. In the very first session, patients are introduced to the core of the cognitive model (cognition influences emotion, body state and behaviour), and to the treatment rationale (becoming aware of unhelpful thought patterns, as they happen, makes it possible to modify them, and thus change how you feel and what you do). Patients are invited to view their ideas as hypotheses, which can be questioned and tested through experience, rather than as reflections of an objective truth. Therapy then becomes an extended joint investigation of this idea.

CT: The bigger picture

In the last 35 years, CT has expanded radically and is now a psychological treatment of choice for a wide range of mental and physical health problems. Correspondingly, specific cognitive-behavioural models and treatment protocols have been developed, refining understanding of the exact patterns of thought and behaviour that create vulnerability to different conditions and cause them to persist, and demonstrating the clinical power of targeting these with precision. This theoretical and practical specificity is reflected in the focussed intentionality of MBCT for depressive relapse, and implies that CT elements of the treatment protocol described by Segal, Williams and Teasdale (2002) will likely need modification if the approach is to be successfully applied to other psychological difficulties where predominant vulnerabilities and maintaining factors are different from those present in depression.

CT and mindfulness: points of difference

Let us move on to explore differences and congruencies between CT and mindfulness-based interventions (MBIs) in more detail.

Contributions to MBCT

CT and mindfulness meditation make different contributions to MBCT. From MBSR, MBCT draws mindfulness of the breath, of the body in stillness and in movement, of mental activity, of everyday experiences (eating, routine activities, hearing, pleasant and unpleasant experiences), and a spirit of compassion and acceptance. It also includes (sessions 5–7) meditations inviting participants to remain in contact with unpleasant or difficult experiences that arise and, if none are present, to invite one into awareness. Rather than backing off or becoming entangled in ‘thinking about’ the difficulty, participants practise exploring it in the body, with an attitude of curiosity and compassion. From CT, MBCT draws the conceptual framework described above, experiential elements which (albeit in

rather different form) are also part of CT itself (for example, exploring the relationship between thoughts and feelings), and an emphasis on empirical evaluation.

The CT elements in MBCT are often called ‘didactic’, implying a shift of gear in instructors from mindful embodiment to lecture mode (the same is perhaps true for educational elements of MBSR—the nine dots, stress reaction/response and so forth). Certainly these exercises have an educational function (such as learning how depression works), and whiteboard and pens can be useful in summarizing information gathered from participants, drawing flowcharts, etc. However, in order to encourage ownership by participants, these elements are better taught interactively. That is, key learning points most helpfully emerge from participants’ reflections on the exercises, rather than from the mouth of the teacher whose main task is not to tell, but to validate experience, facilitate self-awareness, guide discovery, highlight and summarize. This is also precisely the role of the skilled cognitive therapist.

Individual case formulation

CT is a formulation-based therapy (Butler, Fennell and Hackmann 2008, chapter 3), in which understanding and treatment of an individual patient is shaped by a specific theoretical model of emotional disorder, investigated and tested through experimental and clinical research. Case formulation transforms the deep structure of the cognitive model of depression, applicable to thousands of people, into a unique map of this particular person’s experience. Thus, in the hands of skilled therapists, CT reflects standardized models and treatment protocols, but does so without being merely formulaic or mechanical. No two case formulations, and no two treatments, are exactly alike.

Training in CT thus requires understanding of its theoretical and clinical principles, and of existing and emerging evidence bases. This fosters ethical practice, gives therapy coherence, and ensures that treatment is precisely targeted, efficient and directly relevant to patients’ problems and valued goals. Without it, therapists may ‘drift’, seduced by the latest exciting treatment development regardless of its proven utility (Waller 2009). This does not mean that CT is closed to innovation; on the contrary, it would not have survived and evolved without exploring new territories and testing innovative treatment methods—including of course MBCT. However, CT’s scientific roots and the imperatives of clinical responsibility demand that creativity be tempered with rigor and careful evaluation of the impact of innovation.

In MBCT, the balance between the idiosyncratic and the generic is different. Pre-class interviews offer opportunities to develop shared understanding of patients’ experience, but are rarely as spacious and detailed as the assessment preceding one-to-one CBT. Thereafter, the focus is rightly not so much on what is unique to each person (though this emerges and is explored, session by session, through inquiry), but rather on what participants have in common (for example, the processes of misinterpretation, avoidance and mental elaboration) (Williams 2008). These transdiagnostic (indeed, universal) processes allow us to work effectively with groups of people who have the same diagnosis but different life experiences,

or different diagnoses, or no diagnosis at all. The balance between the shared and the unique, however, is more a product of the class format than necessarily inherent in mindfulness-based interventions. A similar balance would likely be evident in group CT, and MBCT offered in individual psychotherapy could (like individual CT) use assessment and formulation as foundations for focused personal work.

Goal-orientation

CT accepts that people seek therapy because they want things to be different, and offers effective ways of achieving this. CT is intentionally designed to 'fix' things, and does it very well. This is perhaps the most difficult transition for cognitive therapists learning MBCT to make: intentionally not 'fixing' can at first feel like doing nothing, rather than doing something equally valid, but different.

CT has an active change agenda. During assessment, problem identification leads into goal definition, through questions such as: 'How do you want that problem to change by the end of treatment?', 'What would mean to you for therapy to "work"? How would we know?' The emphasis on defined objectives means a commensurate emphasis on outcome evaluation—have the goals been reached or not? Has therapy succeeded or failed? This is highlighted, for mindfulness-based interventions as for CT, in research and healthcare contexts where treatment effectiveness and cost-effectiveness are major issues, and service evaluation is routine. The same intention also influences session structure; unlike many other forms of psychotherapy, each CT session opens with therapist and patient agreeing an 'agenda', encapsulating what they wish to address that day. Sessions are structured (barring the unexpected) so that the agenda is covered. A number of standard items are normally included: a mood check; feedback on the last session; a homework review; new homework arising from the work of the session; a learning summary; and feedback on the session just completed. This means that CT usually has a focussed, 'let's roll up our sleeves and get down to business' feel. In the hands of the unskilled this can tip into rush and rigidity. Skilled therapists, however, balance the wish to work productively in an agreed direction with sensitivity, warmth and a willingness to be flexible and responsive. For patients, this offers a sense of being both empowered and contained.

In contrast, mindfulness-based interventions explicitly discourage attachment to particular desired outcomes, and encourage willingness to allow things to unfold in their own time and to tolerate uncertainty and 'don't know mind'. There is however a something of a paradox here. In the field of healthcare at least, people undoubtedly come to classes because they are suffering and hope for relief—and presumably therapists/instructors would not provide classes unless they believed this was possible. Thus it is not entirely accurate to say that mindfulness-based interventions have no goals. Rather instructors engage in what may seem like a paradoxical balancing act: on the one hand, accepting and validating the understandable longing for freedom from suffering—and even setting goals that the client would like to work towards—and on the other hand,

encouraging themselves and their participants to let desired outcomes fade into the background and remain open to emerging experience, whatever it is.

'Are we nearly there yet?' thinking is helpful neither to CT nor to MBIs, because it results in constant emotional temperature-taking that makes it difficult, if not impossible, to retain an attitude of open-mindedness, curiosity, and possible friendliness/acceptance towards every experience no matter how unpleasant, and the willingness to experiment necessary for new learning.

Different methodologies

CT utilizes an extensive repertoire of treatment methods designed to help patients to discover that it is in their power to change how they think and act and that, if they do so, emotional transformation and problem resolution will follow. Careful self-observation allows problematic sequences of thoughts, feelings and behaviours to be identified with some precision. Such insights create a foundation for a systematic process of inquiry and exploration, through which patients learn to question their thoughts (rather than taking it for granted that they must be true), and to seek for more realistic and helpful alternatives, and to test them out in everyday life. Thus change in CT arises from close attention to the detail of specific day-to-day experiences, often guided by worksheets which help patients to follow the sequence systematically, rather than becoming mired in distress and confusion. The process is a collaborative enterprise, with therapist and patient working as a team to find a way forward. New skills are established in session, and practised independently between sessions. Over time, repeated practice leads to new general understandings, for example: 'Change is possible', and 'Just because I believe something, it doesn't follow that it's true'. Thus hope is cultivated and a new relationship to old patterns of thought emerges.

In mindfulness-based interventions, intensive mindfulness meditation practice is viewed as the prime vehicle for nurturing insight and a steadier, more spacious perspective. Through a sequence of practices, patients learn to heighten their awareness of thoughts, emotions and body sensations and acquire the capacity to see these clearly without over-engaging with them or attempting to avoid them, and with an attitude of friendly curiosity and acceptance. So although the outcome (a decentred perspective) is at least somewhat similar in both approaches, the route by which it is reached is different.

Different languages

Therapists from other traditions sometimes find the language of CT military in tone. Depression programmes, for example, have titles like 'Beat the blues' and 'Defeat depression'. The implication might be that this psychological state is undesirable and should be eliminated—a 'pest control' approach to psychopathology, if you will. And indeed the success of CT is usually measured in terms of improvement in and recovery from problematic states. However this somewhat

combative language, while reflecting something of CT's active problem-solving stance, too easily gives rise to a 'cartoon image' of the therapy and misses its warmth and humanity, the sound therapeutic relationship on which it rests, and the atmosphere of exploration and discovery that characterizes it at its best. As we noted above, the cognitive model assumes continuity between healthy and problematic functioning:

Psychological problems are not necessarily the product of mysterious, impenetrable forces but may result from commonplace processes such as faulty learning, making incorrect inferences on the basis of inadequate or incorrect information, and not distinguishing adequately between imagination and reality. (Beck et al. 1979, 19–20)

CT thus connects easily with everyday life experience. It encourages therapists to recognize the common humanity they share with patients, and allows them to address issues that arise in therapy (including activation of their own unhelpful beliefs and assumptions) using exactly the same conceptual framework and treatment methods.

Nonetheless, the emphasis on change reflected in the language of CT indeed implies a process rather different from mindfully acknowledging and accepting that unpleasant experiences and suffering are a part of the human condition, and that what is necessary is the capacity to witness their presence without grasping or aversion, and with a spirit of compassion.

Different training trajectories

Mindfulness-based interventions usually teach a programme over a time-limited period (8–12 weeks, with up to four follow-up classes over 6–12 months). This means 16–32 taught hours, plus (say) 36 hours of home practice—a drop in the ocean compared to training in meditation in other contexts, which may continue over years. Instructors' experience varies. Some have a long personal practice (including extensive retreat experience) before they begin to teach. Others may have much less, and learn to teach by establishing their own meditation practice, then following a carefully structured supervised pathway with a more experienced instructor or an indepth training programme at a recognized centre, followed in both cases by regular supervision, further training, collegial contact with other teachers, and continued personal practice and retreat attendance.

CT therapists also require formal specialist training, often following achievement of a university-based professional qualification (in psychiatry or clinical psychology). For accreditation to practice by professional bodies, ongoing supervision and continued professional development are also required. However, there is no direct equivalent to lifelong mindfulness meditation practice. Some European countries expect psychotherapists to undergo their own personal therapy as part of their training; for CT, the UK, Canada and USA (for example) do not. Even those therapists whose training includes experiencing CT, or who have

needed it for personal reasons, would not be expected to continue sessions forever. This reflects CT's assumption that lasting transformative experiences are possible within a limited time-frame and that, once defined objectives are reached, there is no need for further work.

A question as yet largely unexplored follows: how much knowledge of CT and its underlying theory do MBCT instructors require, who have approached it from other mindfulness-based interventions or psychotherapeutic traditions? There would be a sharp intake of breath in the mindfulness community if a cognitive therapist began teaching MBCT classes on the basis of reading the manual and perhaps attending a one or two day workshop—and rightly so. This is not ethical practice, nor is it consistent with the spirit of the approach. Do the CT elements of MBCT perhaps deserve a similar respect?

Clearly, given that they are not aiming to conduct CT, MBCT instructors do not need to become cognitive therapists. However, what Beck said about becoming a cognitive therapist may also hold true here: 'we do not believe that the therapy can be applied effectively without knowledge of the theory' (Beck et al. 1979, 4). That is, just as MBCT instructors are required to have in-depth understanding of the principles and practice of mindfulness meditation, so too they might be most helpful to participants if they had a sound grasp of the psychological processes that CT suggests lead to the development and persistence of distress. Further, just as becoming a mindfulness instructor rests on personal experience of mindfulness meditation, so too learning about CT, rather than being purely verbal/conceptual, might include an experiential element: systematic self-observation, self-reflection, and opportunities to use the approach to explore personal issues and experiment with change. This may be especially important for instructors planning to alter elements of the programme derived from CT theory and research, to adapt the approach for new client populations where psychological vulnerability and maintaining factors may be different, and to train other MBCT teachers. Exactly what knowledge and skills are necessary, how much time this should take, and precisely how it should be done remain issues for investigation and debate.

CT and mindfulness: points of congruence

As we have outlined differences between CT and MBIs, readers might be forgiven for wondering if this marriage is viable. In fact, these unlikely partners have much in common.

A common intention

The fundamental intention of both approaches, despite their different conceptual frameworks and methodologies, is to understand and to relieve suffering. Thus non-judgment, compassion and a movement towards clear seeing are central to both. However, within the Buddhist tradition behind mindfulness

meditation this is a part of a much broader intention: liberation, including the experience of joy. In CT, alleviating suffering in a more focussed therapeutic sense is the prime *raison d'être*.

A map of the mind and an investigative tool

From their different perspectives, both approaches offer maps of the human mind-body system, together with sophisticated investigative tools—the practice of mindfulness meditation on the one hand, and systematic self-observation and self-reflection on the other.

How persistent distress is understood

Both approaches, in their different ways, see the roots of persistent human distress in somewhat similar (though by no means identical) terms. Both assign an important role to old habitual patterns, many learned through experience and activated by current circumstances (causes and conditions). Both see automatic, unconscious processing ('thoughtless thinking'; Beck et al. 1979, 5) and identification with thoughts (being lost in subjectivity) as feeding distress. Equally, both highlight the role of mental filters and biases in perception and interpretation, and how these add suffering to inevitable pain and adversity. Both see the difficulties inherent in attachment (in CT, in relation to substance misuse, for example, and more subtly in the way assumptions insist that the person, others or life must be a certain way), and in aversion (from a CT perspective, for instance, adding to pain by demanding it be eliminated, and the avoidance and withdrawal associated with anxiety and depression). Both too give an important role to mental elaboration (*papañca* in the Buddhist tradition; rumination and worry in CT). Both distinguish between pain (physical or emotional distress) and suffering (a negative evaluation of pain and what caused it, followed by unhelpful reactions such as elaboration or avoidance). Perhaps these commonalities reflect the fact that both are based on close observation of the same human minds.

The essential present moment

Both traditions advocate focusing on what is happening now, rather than on the deep past. Classical CT and newer evidence-based protocols concentrate predominantly on thinking and behaviour that is maintaining old beliefs and assumptions in the present day, asserting that problems are most effectively and efficiently resolved by breaking these vicious circles rather than investigating their origins. In mindfulness-based interventions, the present moment is recognized as the only point where awareness can be cultivated and transformation is possible—the only possibility of being truly alive to experience, rather than lost in mental constructions of past or future.

The learning process

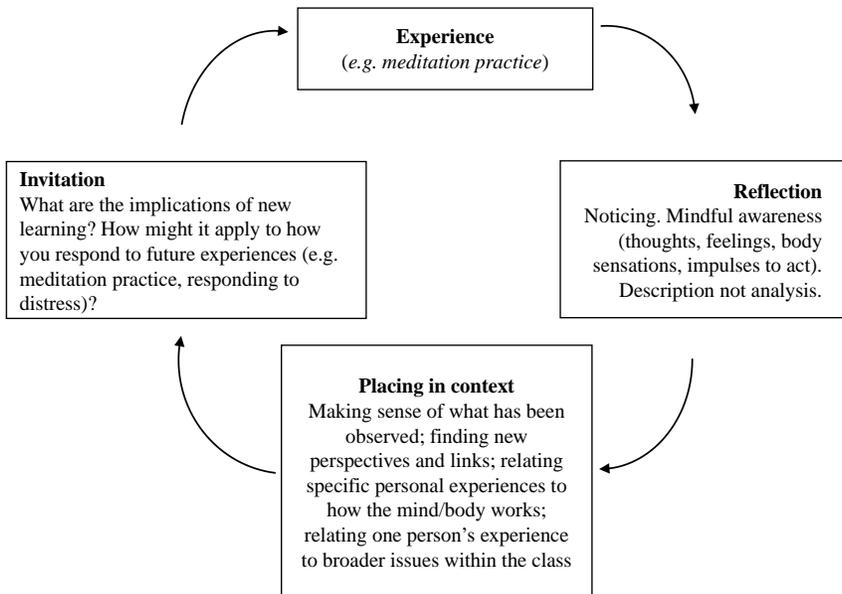
Both approaches view human beings as learning organisms rather than fixed entities. Both cultivate awareness based on close investigation of immediate experience, albeit by different means. Both thus assume that it is both possible and valuable to explore the workings of the mind, and that such awareness enhances the capacity to respond flexibly to experience, even in distress.

Both CT and mindfulness-based interventions offer step-by-step learning, supported by systematic and extensive practice, which is intended to establish new insight, knowledge and skills so firmly that they can be independently maintained. Both approaches may be seen as forms of training—training in focused concentration, in close observation, in responding in accordance with insight into mental phenomena, in acquiring a particular stance in relation to experience (interested, curious and kind), and (in the case of CT) in questioning habitual thinking patterns and testing them out through experience. The evidence on CT's long-term impact on depression suggests that it engenders shifts in perspective which endure (e.g. Paykel et al. 2005), and mindfulness meditation (if people so choose) is for life.

As to the process of learning itself, both approaches are highly experiential. In CT, verbal interventions are important in questioning cognitions but, for emotional transformation to occur, discussion is not enough. It may provide conceptual understanding, but not the 'gut level' learning necessary for profound change. So new perspectives must be translated into changes in actual behaviour in the real world. With the same intention of uniting head and heart, metaphor, imagery, stories, pictures and poems are also an integral part of both approaches (Blenkiron 2010; Hackmann, Bennett-Levy and Holmes 2011; Segal, Williams and Teasdale 2002; Stott et al. 2010).

In MBIs, new learning arises from extensive personal practice of meditation. In CT, it arises from repeatedly approaching painful thoughts and feelings in a different way. The framework of adult learning theory, and in particular the learning process encapsulated in Kolb's (1984) learning circle, has been used to suggest how this may most effectively be done (Bennett-Levy et al. 2004). This same sequence can be applied to the process of learning in MBIs (see Figure 2).

Kolb suggested that effective learning and remembering arises from sequence of steps, each building on the one that precedes it, and laying a foundation for the one that follows. For successful learning, direct experience is necessary (in MBIs, meditation practice itself; in CT, testing cognitions through behavioural experiments). However, experience is of little value unless what has been experienced is clearly seen. Equally, lessons derived from specific experiences and observations are unlikely to become part of a new way of being unless reflection follows—placing new observations in context, relating them to pre-existing knowledge, creating meaning. Within mindfulness-based interventions, observation and reflection are facilitated by the inquiry process that follows meditation practices. What may be learned from what emerged within the moment? What did

**FIGURE 2**

The learning process.

Note: Based on Kolb's (1984) learning circle

participants notice? How do these noticings relate to their experience in a more general sense, to the workings of the human mind, to the experience of other participants and—in some contexts—to Buddhist teachings? Within CT, a similar process of guided discovery is facilitated by 'socratic questioning' (Westbrook, Kennerley and Kirk 2007, chapter 3), an exploratory process by which patients are gently guided through observation and meaning-making by open questions interspersed with empathic reflections and capsule summaries. What happened? What thoughts, feelings, body sensations and behaviours did you notice? What do these observations mean? How do they relate to broader assumptions and beliefs? To previous experiences? To the overall case conceptualization? The next step is an invitation to think ahead. How may what has been learned be carried forward? Within mindfulness-based interventions, this might mean preparing for the next practice (for example, preparing to pay particular attention to the feeling tone of some aspect of experience). Within CT, it might mean preparing a new behavioural experiment. And so the cycle begins again.

A common change mechanism?

Teasdale (Teasdale et al. 2002) questioned received wisdom that CT achieved its effects by changing cognitions (for which at that point there was little evidence), and suggested an alternative mechanism: 'metacognitive awareness'.

This means a fundamental change in how people relate to their cognitions, rather than in the cognitions *per se*. By observing the activity of the mind, in the moment, in a spirit of inquiry rather than judgement, and by repeatedly decentring from old mental routines, questioning and testing them, patients learn to *experience* thoughts as events in the mind, rather than 'the truth' or 'me'. The findings of Teasdale and his colleagues suggested that indeed this might be a key mechanism in both CT and MBCT.

This process will be immediately recognizable to mindfulness practitioners. However, whilst mindfulness meditation is attentive to the workings of the mind in the broadest possible sense, within the framework of Buddhist thought, CT has a tighter focus on specific aspects of experience relevant to the particular patient group, and draws on relevant theory and research into the origins and persistence of distress. In working with depression, for example, this means addressing the nature of depressed thinking (Segal, Williams and Teasdale 2002, session 4). In contrast, in chronic fatigue syndrome the emphasis is more on responses to activity and to physical symptoms such as pain and fatigue (Surawy, Roberts and Silver 2005), in eating disorders on eating behaviour and attitudes to weight and shape (see Baer, Fishcher and Huss 2005), and in psychosis on the experience of voices (Chadwick, Newman-Taylor and Abba 2005; Chadwick et al. 2009). In working with mixed groups whose members are experiencing a range of different psychological problems, the narrow spotlight pans out to illuminate more general, transdiagnostic processes such as avoidance and rumination.

Conclusion

We have outlined the theory and practice of CBT, and have highlighted ways in which it is different from mindfulness-based approaches, rooted in Buddhism, and ways in which it is congruent. What then are the prospects for this marriage? Does MBCT represent a real meeting of minds, a creative integration, or does it reflect clashing cultures that will never ultimately be reconciled? Despite authentic differences that deserve to be respected, it would seem that these unlikely partners have enough in common for a productive and peaceful union to evolve and endure.

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Melanie Fennell, Oxford Mindfulness Centre, University of Oxford Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX, UK. E-mail: melanie.fennell@psych.ox.ac.uk.

Zindel Segal, Centre for Addiction and Mental Health, University of Toronto, Ontario, Canada.