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The Expansion of Mindfulness Meditation

A review of the video

Mindfulness-Based Cognitive Therapy for Depression

with Zindel V. Segal

Washington, DC: American Psychological Association, 2005. American Psychological Association Psychotherapy Videotape Series VI, Item No. 4310632. $99.95

Reviewed by
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Mindfulness meditation has arrived. Psychologists are beginning to accept what the general public has known for decades and what the Buddha preached 2,500 years ago—mindfulness has a powerful effect on the mind.

Over the past two and half decades, mindfulness meditation has rapidly spread to clinics, hospitals, training programs, and major conferences (e.g., Association for the Advancement of Behavior Therapy, American Psychological Association; APA), and there is even an annual conference for mindfulness educators, clinicians, and researchers (www.umassmed.edu/cfm). Mindfulness has a language that reaches both the general public and the scientific community, and scores of resources (books, CDs/tapes, and Internet education) are available to both communities. In addition, clinicians are becoming accustomed to seeing mindfulness discussed in prestigious journals, and recently two APA videos on the clinical application of mindfulness have emerged. *Mindfulness-Based Cognitive Therapy for Depression With Zindel V. Segal* is one (the other is *Mindfulness for Addiction Problems With G. Alan Marlatt*; APA, 2005).

Mindfulness is a true companion to the mind–body Zeitgeist, thanks in part to the seminal work of Jon Kabat-Zinn (1990) and his creation and promotion of mindfulness-

based stress reduction (MBSR), a comprehensive mindfulness program originally created for patients suffering from chronic pain and debilitating medical disorders. MBSR programs have been applied with success with patients with binge eating disorder, cancer, psoriasis, chronic stress, generalized anxiety, panic disorder, HIV, and multiple sclerosis, as well as to other medical and psychological conditions.

Because of the lack of specificity in defining mindfulness by several important practitioners and researchers in the field (Jon Kabat-Zinn, G. Alan Marlatt, Thich Nhat Hanh, Tara Brach, Jack Kornfield, Marsha Linehan, and Ellen Langer), a consensual operational definition was necessary. Bishop et al. (2004) collaborated to develop a two-part definition for mindfulness that emphasizes (a) the self-regulation of attention so that it is maintained on the experience of the present moment and (b) the adoption of a particular attitude of curiosity, openness, and acceptance to that experience.

Although other formalized programs include mindfulness training, such as MBSR, acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), and dialectical behavior therapy (Linehan, 1993), the focus of this review is mindfulness-based cognitive therapy (MBCT).

The APA Psychotherapy Videotape Series VI, a series "intended solely for the educational purposes for mental health professionals," focuses on MBCT as described by one of its originators, Zindel Segal. (Segal collaborated with Mark Williams and John Teasdale.) The video presents an interview of Segal (hosted by Jon Carlson), a taped MBCT group psychotherapy session with four depression patients led by Segal, and follow-up discussion with Segal responding to clips of the session.

Segal explains that he and his colleagues developed MBCT by disseminating the elements of MBSR most applicable in preventing depression relapse and adding in traditional cognitive therapy components. The eight-week program entails training in mindfulness skills during the first four weeks of treatment (skills acquisition) followed by four weeks of skills application integrating cognitive psychology, acceptance, thought observation, relapse prevention, and self-care with the mindfulness-building blocks (Segal, Williams, & Teasdale, 2002). Ultimately, the intent, Segal relays, is "helping people to train themselves" and providing participants a "relapse prevention kit" for future struggles.

Segal discusses common questions asked about mindfulness: What is the link between mindfulness and both spirituality and Buddhism? Is mindfulness a technique/skill or a way of life? Can mindfulness be applied to the entire spectrum of depression? Segal stresses the importance of practitioners establishing and maintaining their own mindfulness practice before teaching it. This theme is reiterated by almost all mindfulness practitioners and researchers, and it is a new way of thinking about clinical psychology (e.g., clinicians do not usually think they need to be involved in ongoing cognitive therapy to perform cognitive therapy with patients).

The video depicts an actual group psychotherapy session and provides an opportunity for the viewer to observe Segal's stance as a mindfulness practitioner. In session, Segal

practices the art of listening respectfully. He also models the particular approach he hopes group members will take in addressing their maladaptive coping patterns—that is, he exhibits a continuing attitude of interest, curiosity, openness, acceptance, gentleness, and welcoming.

This group therapy session differs from traditional group psychotherapy approaches in that the emphasis is on experiencing and practicing mindfulness rather than talking about it and analyzing it. Segal leads two mindfulness exercises in this first session—an eating meditation (with one raisin) and a body scan exercise. He queries the group following the practice: "How do you think eating a raisin in this way has anything to do with depression or with managing your feelings?" This elicits discussion, with themes of "tuning in" to the automatic pilot orientation and mindless routines of thought, and the clients begin to build a connection between awareness training and depression prevention. These subtleties of the mind will be illustrated in future sessions on acceptance, allowing/letting be, and self-care.

In response to one patient's query about whether mindfulness meditation can change the "chemical imbalance" of depression, Segal discusses how this practice changes patterns in the brain just as surely as medication, psychotherapy, and other interventions. Perhaps Segal was reflecting on the extensive laboratory work of scientists such as Richard Davidson at the University of Wisconsin, who uses some of the most sophisticated functional magnetic resonance imaging and electroencephalography equipment in the world to study neophyte and veteran meditators, tracking specific neurological, immunological, and quality of life changes (Davidson et al., 2003). Or perhaps Segal was reflecting on the Mind & Life Institute (www.mindandlife.org), a collaboration and research partnership between modern science and Buddhism in which the Dalai Lama and top Western scientists meet yearly to discuss the neuroscience of meditation, the mind–brain interface, and the neurological changes of emotions through meditation.

Segal's discussion is consistent with research on depression patients randomly assigned to either an MBCT group or a "treatment as usual" group. MBCT significantly decreased depression relapse (by 50%) for patients with three or more depression episodes in their life (Teasdale et al., 2000). This study has been replicated in another rigorous investigation.

The viewer might become curious as to why this approach is so effective for preventing depression relapse. Baer (2003) hypothesized five mechanisms by which mindfulness meditation promotes change: exposure, cognitive change, self-management, relaxation, and acceptance. More specifically, MBCT training enhances individuals' access to metacognitive sets (Teasdale et al., 2002). It changes the way an individual relates to his or her thoughts and feelings, and ultimately to self, rather than changing thinking (the emphasis of cognitive therapy). In addition, mindfulness seems to modify autobiographical memory promoting more specific and less general memories; this stands in striking contrast to the pattern observed in most individuals with depression (Williams, Teasdale, Segal, & Soulsby, 2000).

The structure of this video (interview, group psychotherapy session, and clips with discussion) is reasonable, although it is impossible to fully illustrate the approach in a 2-hr video. Showing only one session of MBCT limits the presentation of this very dynamic, fascinating approach; it would have been helpful if the video could have illustrated other mindfulness practices. This would give both the neophyte clinician and the seasoned clinician new to mindfulness a better sampling of the application and array of mindfulness practice.

This video would have been more powerful if it followed the approach of the 1993 Bill Moyers documentary *Healing From Within,* in which Moyers actually participated and filmed outpatient treatment in Jon Kabat-Zinn's MBSR program. Several weeks of treatment are depicted, several patients are followed, progress is shown, patient opinions about the program are noted, powerful emotions are processed, and additional mindfulness approaches are represented (e.g., mindful movement and yoga, in addition to clips of the raisin exercise and body scan). The film also includes interviews with Kabat-Zinn and referring physicians in addition to several group discussions. Despite these additional features, the video is only 45 min long. I show the video to patients and students in mindfulness groups, and it often becomes one of the most critical educational elements in the program. The APA video on MBCT only depicts one session, yet it is two and a half times longer.

The APA video is geared toward psychologists interested in learning about mindfulness, particularly its integration with cognitive therapy to prevent depression relapse. Viewers with little exposure to mindfulness will be fascinated by the exercises, and they can close their eyes and actually participate as Segal leads a 45-min body scan and the raisin exercise. From this vantage point, the video presents as a rare experiential learning opportunity for the viewer. At the same time, valuable teaching time in this "educational" video is lost—time that could have been spent discussing and showing the mindfulness–cognitive therapy interface, future group sessions, clips of acceptance or "observing thoughts" meditations, depiction of MBCT's relapse prevention approach, or any number of the various exercises and meditations used in later weeks of the program.

Those practitioners already implementing mindfulness in their clinical work would be better served by purchasing the MBCT book (Segal et al., 2002) than by using this video for further training. Nevertheless, I am pleased the video was made. The technical quality is adequate, Segal is as effective on video as he is in person, and one learns enough about MBCT to make the video worthwhile.

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