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Towards a second generation of mindfulness-based interventions

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In addition to featuring in the practice guidelines of the *American Psychiatric Association* and the United Kingdom's *National Institute for Health and Care Excellence* for the treatment of recurrent depression in adults, emerging evidence suggests that mindfulness-based interventions (MBIs) have applications for treating diverse psychopathologies and disorders including addictive behaviours (e.g. pathological gambling, workaholism), post-traumatic stress disorder (PTSD), anger dysregulation, attention deficit hyperactivity disorder, pain disorders (e.g. fibromyalgia), sexual dysfunction and psychotic disorders (Shonin et al., 2014). Mindfulness is also recommended by the *Royal Australian and New Zealand College of Psychiatrists* as a non-first-line treatment for binge eating disorder in adults.

However, commensurate with growing interest into the clinical (and non-clinical) applications of MBIs, there are growing concerns over the rapidity at which mindfulness has been extracted from its traditional Buddhist setting and introduced into psychiatric treatment domains (Van Gordon et al., 2015). Specifically, these concerns centre on the alleged absence within the first-generation MBIs (FG-MBIs) of the factors that, according to the 2500-year-old system of Buddhist meditative practice, are deemed to maximise the efficacy of mindfulness. Simply put, some researchers, clinicians and Buddhist scholars have suggested that mindfulness in MBIs has been altered from its traditional Buddhist construction to such an extent that it is inaccurate and/or misleading to refer the resultant technique as 'mindfulness'.

To address these concerns, a number of second-generation MBIs (SG-MBIs) have recently been formulated and empirically investigated. Thus, we explicate the key differences between FG-MBIs and SG-MBIs, appraise key empirical findings and issues relating to SG-MBIs and discuss the implications of the trend towards a second generation of MBIs for psychiatrists and service users.

Differences between FG-MBIs and SG-MBIs

FG-MBIs refer to interventions such as Mindfulness-Based Stress Reduction (MBSR; developed in the 1970s) and Mindfulness-Based Cognitive Therapy (MBCT; developed in 2002), as well as the various derivatives of these that came later (e.g. Mindfulness-Based Relapse Prevention, Mindfulness-Based Eating Awareness Training) (Shonin and Van Gordon, 2014). FG-MBIs have been influential in helping mindfulness gain acceptance within psychiatric settings, and in many respects, they represent a novel approach to regulating maladaptive cognitive and affective processes (Singh et al., 2014). For example, in addition to utilising present moment awareness, FG-MBIs advocate 'letting-go' of thoughts and feelings (whether adaptive or dysfunctional) rather than attempting to modify them as in specific cognitive-behavioural approaches.

Arguably, the most popular definition of mindfulness as conceptualised by FG-MBIs is that it '*[pays] attention in a particular way: on purpose, in the present moment, and non-judgmentally*' (Kabat-Zinn, 1994: 4). In essence, this definition implies that mindfulness is (1) principally an attentional faculty and (2) an aptitude that is not necessarily mediated by other meditative processes. A further observation of note concerning the above definition is the inclusion of the term 'non-judgementally', which appears to suggest that mindfulness requires passivity and/or impartiality towards sensory and psychological stimuli.

Although FG-MBIs and SG-MBIs both invariably follow an 8-week group-therapy format and are tailored for utilisation in Western clinical settings (e.g. they are generally secular in nature), the above-outlined FG-MBI delineation of mindfulness is fundamentally distinct from how SG-MBIs interpret and teach mindfulness. Rather than a passive or 'non-judgemental' awareness, the SG-MBI model advocates an active and discriminative form of awareness (Shonin and Van Gordon, 2014). Indeed, in addition to moment-by-moment observance, SG-MBIs teach that mindfulness requires active participation in the

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here and now. The 'participating observer' notion is intended to help mindfulness practitioners understand that it is possible (and indeed essential) to observe and 'let-go' of present moment experiences, while concurrently discerning how to respond in an adaptive manner. This helps to avoid the scenario where the patient's or another individual's wellbeing is at risk, yet due to being 'non-judgemental', they avoid taking preventative action.

One recently proposed SG-MBI conceptualisation of mindfulness defines it as the '*process of engaging a full, direct, and active awareness of experienced phenomena that is: (i) spiritual in aspect, and (ii) maintained from one moment to the next*' (Shonin and Van Gordon, 2014). In addition to advocating either an 'active' or 'non-judgemental' form of awareness, a further difference between FG-MBIs and SG-MBIs is the explicit use in the SG-MBI definition of the term 'spiritual'. This term is included to help prevent participants becoming confused (or being inadvertently misled) as to the nature of the intervention they are receiving (in fact, FG-MBIs have been criticised for being ambiguous in this respect; Van Gordon et al., 2015). A further difference between the two approaches is that SG-MBIs invariably teach mindfulness in conjunction with other meditative practices and principles (e.g. ethical awareness, impermanence, emptiness/non-self, loving-kindness and compassion meditation, etc.) that are traditionally deemed to promote effective mindfulness practice (Shonin et al., 2014).

Issues and key empirical findings

Empirical evaluation of SG-MBIs – including via the use of randomised controlled trials – has demonstrated that SG-MBIs can be effective treatments for depression, anxiety and stress, schizophrenia, pathological gambling, work addiction, work-related stress, nicotine dependence, anger dysregulation and antisocial behaviour (Shonin and Van Gordon, 2014; Singh et al., 2014). As with FG-MBIs, an increase in perceptual distance from cognitive and affective processes is generally accepted as being a primary mechanism of SG-MBIs. However, exploratory quantitative and qualitative studies of SG-MBIs – such as those investigating the 8-week Meditation Awareness Training intervention – have yielded findings suggesting that SG-MBIs also utilise the following mechanistic pathways: (1) improved regulation of ego-centric thinking patterns leading to reductions in self-preoccupation, self-disparaging schemas and asocial behaviour and (2) increased spirituality that exerts a protective influence over life-adversity and low self-purpose (Shonin and Van Gordon, 2014).

Despite these promising findings, to date, there have been no head-to-head comparison studies to ascertain whether the FG-MBI or SG-MBI approach is most effective for a given population. Consequently, SG-MBIs could be criticised for relying too heavily on expert opinion and best-practice guidelines (i.e. according to 2500-year-old Buddhist meditational theory) in order to justify their necessity.

Implications for psychiatrists and service users

The formulation and empirical assessment of SG-MBIs appear to reflect a current trend in mental health research and practice. However, there is clearly a need for further research in order to establish the full clinical applications and efficacy of SG-MBIs compared to FG-MBIs. While there is lack of studies directly comparing the two approaches, this does not necessarily undermine the value of SG-MBIs because, at the very least, they provide service users – including those interested in (or belonging to) Eastern contemplative traditions – with a non-pharmacological treatment that more closely follows a traditional (but secular) approach to mindfulness practice.

Although the development of SG-MBIs has largely been prompted by criticisms of FG-MBIs (e.g. taking a reductionist approach to teaching mindfulness), it is entirely feasible that the two approaches can co-exist or even complement each other. However, irrespective of whether future research and clinical utilisation of mindfulness focuses on one or both approaches, the growing popularity of MBIs in clinical settings combined with the interventional use of a greater range of meditative techniques (e.g. compassion meditation, loving-kindness meditation, etc.) is likely to have professional training implications for psychiatrists. Accordingly, it is recommended that psychiatrists acquire a working familiarity of meditational theory and the factors that it attributes to the onset of mental illness.

Declaration of interest

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