



# Current Tensions and Challenges in Mindfulness Research and Practice

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## Abstract

The field of mindfulness practice and research has expanded over recent years and become more established in the public consciousness. In this paper we explore four key tensions for the mindfulness community to hold in awareness. These include: *Mindfulness for me vs. mindfulness for others* (an awareness of the loss of the spiritual and collective elements historically essential to mindfulness), *Mindfulness for some vs. mindfulness for all* (understanding why mindfulness may be more appealing for some more than others), *The whole vs. the sum of its parts* (the need to understand the mechanisms of mindfulness and still preserve its integrity), and *Improving access vs. preserving fidelity* (balancing modifications to address issues such as accessibility with retaining core components). Recognising such challenges is a vital aspect of ensuring that mindfulness researchers and practitioners continue to work in a way that retains authenticity and trust within this burgeoning field and helps to support engagement from a diverse range of people across the modern world.

**Keywords** Mindfulness · Meditation · Wellbeing · Compassion · Community

The purported benefits of mindfulness, in terms of reducing suffering, increasing connection, and cultivating compassion have never been more important. We are living through difficult times: climate and biodiversity crises, violent conflict, rising costs of living, and a global pandemic. Whilst not all nations have been exposed to all these challenges to the same degree, as awareness about these global threats grows, so does universal concern and distress. Key to making ongoing progress in terms of mindfulness being able to meet some of these challenges will be the ability to bring curiosity and compassion to current areas of tension in the field. With this in mind, we present several areas of tension in this paper, to inform thinking and development in these areas for those in the mindfulness community and beyond.

## Tensions

### Mindfulness for Me vs. Mindfulness for Others

In pursuing a “secular” contemporary mindfulness practice in the West, much of its broader context (spiritual, philosophical, cultural) has been lost. It tends to be offered as a clinical treatment for symptom reduction or enhancement of individual well-being. This is in distinct contrast to the historical origins of mindfulness, in which it was one component of a set of contemplative practices based within a clear ethical framework and practised collectively (Van Gordon & Shonin, 2020). A tension arises when contemporary mindfulness is applied in a way that focuses solely upon benefits to the individual practitioner, rather than the communal benefits of practitioners in a group or community.

Mindfulness was traditionally practised in community (sangha), with dedication to developing awareness, harmony, loving-kindness, and acceptance, to transform and heal both the self and society (Hanh, 2002). When learning Mindfulness Based Interventions (MBIs) within a group setting, connections and a sense of safety can be facilitated (Cormack et al., 2018). A meta-synthesis of qualitative studies of Mindfulness-based Cognitive Therapy (MBCT) has

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shown that a supportive group is experienced as helpful and therapeutic (Cairns & Murray, 2015), since participant experiences of distress were validated and normalised by recognition of a shared experience. The group setting also helped increase participants' determination and motivation and contributed to the cultivation of their relationships, both within the group and in their personal lives. It is possible, therefore, that such benefits are lost when mindfulness is largely practiced at an individual, rather than community, level.

In today's world, we urgently need significant social transformation to adapt to global challenges like the climate and related crises. This includes developing community engagement, becoming more attuned to relevant local and global issues, building emotional resilience, and enhancing our motivation to care for, and protect, other beings. Research shows that mindfulness may be positively associated with prosocial behaviours, across both correlational and intervention studies (Donald et al., 2019). For example, the results of a systematic review support the notion that MBIs increase empathy, compassion and pro-social behaviour (Luberto et al., 2018). In particular, MBIs led to a significant improvement in at least one pro-social outcome in 22 out of the 26 randomised controlled trials (RCTs). Examples of such pro-social outcomes include making a charitable donation or giving up one's seat for an injured person. In addition, MBIs that are practiced within an ethical framework (such as highlighting notions of no-harm and interdependence of all beings) have led to greater pro-social behaviour when compared to practicing secular mindfulness (Chen & Jordan, 2020). Pro-social behaviours may also be positively associated with mindfulness practice that involves aspects of loving-kindness or compassion (Perkins et al., 2022).

Such findings could be extended into other mindfulness-based approaches including building communities of practice and cultivating 'noble' states of being (loving-kindness, compassion, appreciative joy, and equanimity). Emerging evidence supports these ideas; the cultivation of appreciative joy demonstrates benefit to self and others (Casioppo, 2020), which underpins environmentally-focused therapeutic approaches such as Active Hope (Macy & Johnstone, 2022). Furthermore, second generation MBIs which incorporate teachings on impermanence, interconnection and 'non self' offer great potential (Van Gordon & Shonin, 2020). Emphasising interconnection between self and the world could increase our empathy and compassion (Hick & Furlotte, 2009). Extending this to the more-than-human (e.g., biospheric beliefs), could support adaptation to climate change (Helm et al., 2018).

Practising mindfulness 'for others' may also bring challenges. This may include feeling distressed, overwhelmed, or excessively responsible for alleviating the suffering of

others. This can be balanced through supportive community, cultivating self-care, recognising care from others, and being realistic about what differences can be made by an individual.

### **Mindfulness for Some vs. Mindfulness for All**

The idea of trying out a mindfulness course is more appealing to some people than others. Even for those who actively seek out mindfulness, or accept the invitation when it is offered, people vary in the degree to which they engage with regular practice and derive benefit from it (Crane et al., 2014; Montero-Marin et al., 2022).

In a randomised controlled trial of MBCT for depression, Crane and colleagues (2014) collected data on participant's frequency of home practice. They found a significant association between amount of home practice and treatment outcome, in that people who practised mindfulness at home three or more days a week were significantly less likely to experience a relapse in depression, compared with those who practised less than three days a week. Our work has shown benefits of mindfulness at follow-up rather than directly following intervention (e.g., Atkinson & Wade 2015), likely a consequence of continued practice and opportunity for application. These clearly show the benefit of regular engagement with mindfulness, but despite recommendations to practise daily, people do not always choose to do so.

This leads to many questions regarding who is attracted to mindfulness, what prevents or supports engagement, what makes regular practice challenging, and what factors are associated with greater benefits. Understanding such differences could lead to optimization of mindfulness for certain groups and cautions us from assuming that 'one size' of mindfulness fits all.

Individual differences may play an important role in how people engage with and benefit from mindfulness. Preference for type of mindfulness practise has been found to be predicted by trait mindfulness, empathy, and gender ((Tang & Braver, 2020a), which can predict therapeutic outcomes ((Tang & Braver, 2020b) and attrition (Anderson & Farb, 2018) in mindfulness interventions. Furthermore, individual differences in cognitive functioning, personality and emotion regulation have all been associated with mindfulness training outcomes ((Tang & Braver, 2020b). Early experimental work within our group indicated negative affect, emotion regulation difficulty, and avoidant coping predicted sub-optimal engagement in brief mindfulness intervention, but also moderated intervention effects on negative affect (Atkinson & Wade, 2012).

In a secondary analysis of data from pupils in the MYRIAD School-Based Mindfulness trial Montero-Marin et al.

(2022) found adverse effects for those deemed as being at greater risk for mental health difficulties. A sub-group of participants who were deemed ‘high risk’ of struggling with mental health problems in the intervention group scored more highly on depression scores than the same sub-group in the teaching as usual control group. Furthermore, they found adolescents responded less well than hypothesised to the mindfulness intervention, perhaps due to lesser metacognitive awareness at this key developmental phase. Research therefore highlights that whilst mindfulness training can be safe and effective, there are differences between heterogenous groups of people, and training must reflect these specific needs.

Conversely to views on the appropriateness of mindfulness for non-clinical population, it has long been posited that mindfulness should be contraindicated in people experiencing psychotic symptoms, due to concerns it could exacerbate their difficulties. However, it has since been shown that with appropriate adaptations, mindfulness for psychosis can be delivered safely and effectively (Bøge et al., 2021; López-Navarro et al., 2022). Practises are modified with briefer 5–10 min meditations; frequent guidance avoiding prolonged periods of silence; and addressing psychotic symptoms, along with other sensations in a normalising manner (Chadwick, 2014; Jacobsen et al., 2020). Careful consideration of the needs of different populations can thus promote mental wellbeing and broaden the reach of mindfulness from some to all.

Cultural considerations are also important, as engagement with mindfulness has been found to be associated with certain demographic characteristics, with people from some groups being underrepresented. In the United States, for example, women, white adults, and employed adults have been found to be most likely to engage in mindfulness practise (Simonsson et al., 2020). Factors such as language differences, religious beliefs and mistrust in service-providers could act as significant barriers to engaging with mindfulness. These barriers can be addressed in part by using participatory research and community involvement in developing mindfulness-based interventions that are more culturally appropriate (Remskar et al., 2022; Watson-Singleton et al., 2019).

### **The Whole vs. The Sum of its Parts**

Since the development and implementation of mindfulness-based interventions, there have been attempts to understand the active components of mindfulness, through experimental work and dismantling trials (Stein & Witkiewitz, 2020). Researchers have used experimental methodologies to examine specific cognitive mechanisms, such as our work in comparing decentred versus non-judgemental stances

towards internal experiences in the context of reducing risk factors for disordered eating (Osborne & Atkinson, 2022).

Evaluating the degree to which individual components contribute to change is essential to justify their inclusion in effective, multicomponent interventions. Yet, the extent to which individual components interact with each other within a complex intervention and a real-world system is currently unclear. This is particularly important given the importance of non-specific therapy effects and the wide-ranging nature of current mindfulness intervention delivery modalities from in-person, group delivery (McKenna et al., 2017) to digital, individual access (Ainsworth et al., 2022). Such considerations should lead us to robustly define the targeted aspect of each research study. These efforts are made particularly difficult by the multitude of (sometimes competing) definitions of mindfulness itself (Van Dam et al., 2018).

Defining what is being studied is a starting point that informs other aspects of research design, including operationalisation of the targeted aspect and the selection of a suitable control group. Researchers can choose passive control groups (e.g., wait-list controls, treatment as usual) or active control groups (i.e., alternative intervention designed *not* to impact the targeted aspect such as sham mindfulness or an attention-matched control; Au et al., 2020). No choice of control group is ever perfect and in pragmatic trials of complex mindfulness-based interventions, it may be difficult to disentangle effects of the intervention from other non-specific effects.

There are challenges in translating findings from controlled experiments, focused on specific aspects of mindfulness, into understanding and applying mindfulness in complex interventions in real-world settings. Mindfulness is a complex construct involving a range of elements, such as attention training, embodiment of key principles by a well-trained teacher (e.g. non-reactivity), and attitudinal qualities of friendliness and curiosity. MBIs also require significant commitment from the individual and repeated practice often in the face of adversity. Such complexity, and the interaction effects between these elements will necessarily be lost within controlled lab-based experiments and component studies, and with this we may risk losing a sense of the ‘whole’ of mindfulness by reducing it to the ‘sum of its parts’.

### **Improving Access vs. Preserving Fidelity**

There is always an implementation gap in healthcare between interventions with an established evidence base in the research literature, and reliable access to them in routine services. For example, MBCT for depression is now recommended in the National Institute for health and Care

Excellence (NICE; UK) guidelines. However, access to mindfulness in mental health settings remains limited, and greater roll-out of mindfulness therapies requires extra investment in staff training and buy-in from commissioners and service leads (Rycroft-Malone et al., 2019). In their mixed methods framework analysis, Rycroft-Malone and colleagues discuss a range of factors which contribute towards this gap in MBCT for depression. Financial constraints may limit access to training, support, and facilities, leaving service managers understandably hesitant to compromise the quality of the MBCT offering, yet unwilling to give the go-ahead to a reduced package that is not empirically supported. The atmosphere of services may be juxtaposed with the equanimity of mindfulness practises, meaning that sessions can sometimes feel at odds with their environment. Furthermore, mindfulness training can often rely on the enthusiasm of a teacher or ‘champion’ within the service, who may be making a significant personal or financial investment in facilitating the set up of groups. In services where this champion is not present, mindfulness may not be effectively rolled out. Whilst closing this implementation gap is a key priority, a tension often arises between increasing access whilst ensuring fidelity in delivery, so that the basis on which an intervention is evidence based is still valid.

For example, the proliferation of mindfulness apps (both free and for a subscription fee) means that people can easily access mindfulness apps via their smartphones outside of a formal therapy or group (Schultchen et al., 2021). This can bring many benefits, particularly for people who may not have the time or resources to attend individual or group therapy, or where it is not on offer locally. It increases the geographic reach of mindfulness for those living in remote or under-served areas and increases flexibility for people in terms of when and how often they practise mindfulness. This is particularly important for people with complex health needs, disabilities, or caring responsibilities.

However, accessing mindfulness meditations using a purely self-guided approach can also be challenging. For example, practitioners miss out on the communal aspects and shared experience of being in a group. Furthermore, apps do not offer the opportunity for learning through teacher-led enquiry after each experiential practice. The role of the teacher is complex and multi-faceted, for example the concept of ‘embodiment’ of the attitudinal qualities of mindfulness (e.g., non-reactivity). Likewise, the lack of a group and teacher means reduced accountability mechanisms, making it more likely that audio tracks could be used as a ‘background’ activity (e.g., something to be ‘listened’ to passively whilst doing the washing up or walking the dog), rather than as active skills practice. Such reduced or passive engagement would likely lead to lesser effects

than fully committed, intensive in-person practice. An analogy might be trying to learn to swim by simply looking at a swimming pool rather than getting in the water. Nevertheless, it is important to appreciate the unique upsides digital self-guided mindfulness approaches offer (most notably the improved accessibility and reduced perceived barriers to engagement; Lyzwinski et al., 2018), and integrate them into the selection of evidence-based resources on offer, if we are to meet the needs of the broadest possible pool of practitioners. A tension therefore arises between reducing barriers to access to mindfulness, whilst retaining safeguards which ensure ‘proper use’ of mindfulness practices so that people can still benefit from them.

## Conclusions

The so-called ‘hype cycle’ is a well-known way of understanding how new ‘technologies’ are regarded over time, with initial success and enthusiasm leading to a ‘peak of inflated expectation’, often quickly followed by a ‘trough of disillusionment’. It is up for debate where we currently are in this hype cycle in relation to mindfulness; however, there are indications that the initial peak of enthusiasm is over. There is a growing backlash from some quarters in terms of criticisms of the overselling and overapplication of mindfulness. Furthermore, there are many challenges whenever anything quickly grows in popularity, including misunderstandings of the aims, applications, and theoretical underpinnings of the approach. Likewise, people setting themselves up as mindfulness teachers with limited training may lack the required skills, competencies, and supervision to safely and effectively guide others to learn mindfulness. This may lead to people having unhelpful or simply fruitless experiences of trying mindfulness, which adds to the chorus of criticism that it has been oversold.

Maintaining the integrity of mindfulness requires clarity and a systematic approach to research and practice across the mindfulness community (Crane et al., 2017). Part of this requires us to recognise various tensions and outstanding questions in the field, encouraging us to move in a productive direction. In this way, our knowledge about for whom and in what contexts mindfulness ‘works’ may be advanced. In time, this will allow us to climb out of the trough of disillusionment into the slope of enlightenment, reaching an eventual plateau, where the view is clearer.

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**Compliance with ethical standards** The manuscript does not contain

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