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Case Conceptualization in Mindfulness-Based Cognitive Therapy

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HISTORICAL BACKGROUND OF THE APPROACH

If psychology is to tackle some of the pressing problems in the contemporary world (chronic physical disease, common mental health problems, addiction, unrealized human potential), we need to broaden our focus beyond therapies that treat acute mental health disorders. We need to develop ways to prevent mental health disorders, ideally early in life before they occur (Patel et al., 2018). Prevention aims to reduce the incidence, prevalence, and recurrence of mental health disorders and their associated disability. In a broader conceptualization, prevention also seeks to improve quality of life, health, functional status, well-being, and flourishing for the population as a whole (Rose, 2008). Moreover, there is a need to expand our focus to unlocking human potential, promoting human well-being and flourishing.

One of the defining characteristics of mindfulness-based interventions (MBIs) is their focus on prevention. MBIs have potential to meet these preventative aims by teaching foundational skills, attitudes, and behaviors that promote resilience in the face of psychological and physical pain and distress. More than this, we suggest that learning these skills can help people develop the capacity to flourish in the face of opportunities and challenges in life. We outline how mindfulness-based cognitive therapy

(MBCT) was first developed as a preventative approach to depression. We further outline how MBCT has since evolved to more broadly help a range of mental health problems and chronic physical health problems and, latterly, to promote well-being in the general population. We discuss the general conceptualization of mental health and well-being that MBIs draw on, as well as MBCT's specific conceptualization of the mechanisms that drive recurrent depression. We then reveal how this conceptualization is developed through a series of milestones that make up the MBCT program. We provide a headline summary of the evidence base for MBCT's theoretical premise, effectiveness, cost effectiveness, and implementation, pointing to more detailed reviews so interested readers can pursue the original sources. But first we set out what we mean by "mindfulness," an MBI, and MBCT.

What Is Mindfulness, What Defines an MBI, and What Distinguishes MBCT?

Mindfulness is the natural, trainable human capacity to bring awareness to all experience, with attitudes of interest, friendliness, and care, in the service of alleviating distress, promoting well-being, and supporting people to make discerning choices that are the basis for a meaningful, rewarding life (Feldman & Kuyken, 2019). MBCT is designed to teach these skills through a systematic, phased group-based program (Segal, Williams, & Teasdale, 2013). It draws on both contemporary psychology and ancient contemplative traditions, both in terms of its underpinning conceptualization and the therapeutic strategies that are used to facilitate change. It was developed as part of the pioneering work of Jon Kabat-Zinn, who developed a program, mindfulness-based stress reduction (MBSR), originally for people in mainstream health care settings who were learning to manage and in many cases live with chronic ill health (Kabat-Zinn, 1990, 2011). As such, MBCT is one of a family of MBIs, each with somewhat different aims and intentions, each adapted to serve a particular set of intentions, population of people, and context (Crane et al., 2017). Although MBIs are normally taught in groups, they are sometimes taught individually; mindfulness practices have been widely integrated into other mainstream individual therapies.

The exponentially growing interest and research in mindfulness and MBIs led some of the first- and second-generation MBI developers—including one of us (W. K.)—to write a position paper defining what an MBI is and what it is not (Crane et al., 2017). We used a metaphor from the craft of weaving to articulate the defining characteristics of all MBIs ("the warp") and then what defines specific MBIs ("the weft"). The *warp* refers to the shared conceptualization of human experience that explains what causes and maintains human distress and the common pathway to alleviating distress. The *weft* refers to the way that particular MBIs, for particular groups of people or contexts, have another layer that tailors the conceptualization to that population and/or context. The universal MBI weft

remains, but for particular populations and contexts, either the emphasis shifts or elements are added to the MBI that are tailored to the particularities of that conceptualization—the weft.

A 2015 report titled *Mindful Nation UK* outlined the myriad ways MBIs are being offered in health care, education, criminal justice, and workplace settings (Mindfulness All-Party Parliamentary Group, 2015).

CONCEPTUAL FRAMEWORK

We begin by focusing on the "warp" of conceptualization common to all MBIs, that is, the psychological mechanisms common to all of us—attentional control, for example. We then consider two types of "weft": first, conceptualization at the level of a particular population, for example, the cognitive and emotional processes that drive vulnerability in people at risk for depression; and, second, the way these mechanisms play out in predictable ways for an individual (e.g., being sensitive to criticism, perhaps even in a particular domain, such relationships). The warp and weft are tightly woven together, with the universal underpinning the specific and the specific bringing out the universal in idiosyncratic ways.

In terms of the whole conceptual tapestry, the warp and weft, MBIs make several assumptions about healthy human functioning, what creates and maintains distress,[1] and what supports human flourishing.[2]

1. MBIs are based on theories and conceptualizations drawn from contemplative traditions, science, and the major disciplines of medicine, psychology, and education.
2. MBIs assume a higher order universal model of human experience that describes and explains how distress is created, maintained, and alleviated. This model extends to wider experiences of emotional and behavioral regulation that underpin everyday functioning, as well as human flourishing. The conceptualization understands the mind and body as an integrated set of neural, visceral, somatic, endocrine, and broader structures and systems. Moreover, change operates through these integrated biobehavioral systems.
3. MBIs assume that experiential, inquiry-based learning is helpful, and for this reason they use a range of formal and informal mindfulness practices as vehicles for understanding and change.
4. MBIs are rooted in empiricism, both the empiricism of the scientific method and that of first-person mindfulness practice.

MBCT is a member of a wider family of MBIs. It places particular emphasis on a psychological science conceptualization of the thinking and behavior patterns that cause and maintain distress. Although MBCT was

first developed for recurrent depression, it is being extended to other populations and contexts. There are two key reasons for this. First, MBCT can swap out the specific conceptualization of recurrent depression for a conceptualization of other disorders and adjust the therapeutic strategies accordingly. This has led to MBCT increasingly being used with new clinical populations, for example, people who are suicidal, with health anxiety, with cancer. Second, MBCT targets mechanisms that are universal. For example, attentional control and emotional and behavioral regulation are mechanisms that support resilience and well-being for everyone. This has led to adaptations of MBCT increasingly being used in general population settings to support resilience and promote well-being.

Universal Conceptualization: The Warp

It would be hubris to claim that we have a universal model of the mind, even more so to claim that this can be said to represent both the understandings from ancient wisdom traditions and modern psychology. Nonetheless, there are some areas of convergence from ancient and modern psychology that provide a useful map for MBI teachers and students (Feldman & Kuyken, 2019). We identify four areas of such convergence.

1. At its simplest, experience is made up of stimuli and reactions. Stimuli can be internally generated (e.g., a sensation or thought) or externally triggered (e.g., sounds). Our experience is made up of a continuous, dynamic unfolding process, often happening quite automatically and largely beyond awareness. For example, as you read this, the patterns of light and dark on the screen or page are turned into words, sentences, and meanings, largely automatically.

2. Although our conscious experience in any moment in day-to-day life tends to be an aggregated gestalt of multiple inputs, it can nevertheless be helpfully disaggregated into constituent parts: bodily sensations; emotions; thoughts, images, and cognitive processes (planning, remembering, mind wandering); and impulses (commonly referred to as the "five-part model"; Padesky & Mooney, 1990). Each moment arises in a particular context, either externally in the world or internally in our current state of mind and body. For example, a moment of sadness may well be associated with a memory ("This was where my father and I used to fish together before he died"), with bodily sensations of tears welling up, and with an impulse to withdraw. This five-part model is used extensively in cognitive therapy to help clients first disaggregate their experience and then see how the elements relate to one another (Kuyken, Padesky, & Dudley, 2009).

3. The unfolding of experience is in significant part driven by a mind that continually labels experience as either pleasant, unpleasant, or

neutral and then judges our experience against how it would like things to be or ought to be. This elaborative, judging mind is key to conceptualizing moments that are experienced as somehow problematic. For example, someone with a recurrent history of depression may notice symptoms of tiredness at the end of the day and, rather than simply interpret the experience as a sign of natural fatigue, have the thought "This means my depression is coming back," triggering a cycle of rumination, worry, and self-recrimination. These unintended consequences of the judging and evaluative mind can exacerbate unpleasant moments in life; but they can also blunt or contaminate the positives in life. For example, someone may travel to a beautiful location and, rather than appreciate the moment, have the thought, "If only I could live somewhere like this year round." This creates a poignant dissonance between this moment and everyday life.

4. The contextual framework of any moment powerfully shapes our experience. Context here can be considered in its broadest social and cultural sense, including our lifetime and evolutionary learning history, our disposition, our current mental state, and what happened in the previous few moments (Sapolsky, 2017). For example, we evolved to scan our environment for features that will maintain safety, satiety, and sexual reproduction. Dispositionally, people are usually able to negotiate novelty and change. In terms of immediate mental states, fatigue, caused by jet lag or a poor night's sleep, will affect our capacity for positive states and clear thinking.

MBCT further emphasizes our capacity for different modes of mind, conceptual, experiential, and observing (Feldman & Kuyken, 2019; Teasdale, 1999; Williams, 2008). Each is supported by a somewhat different mental architecture, that is to say, brain–body structures and functions (Teasdale, 1993). Each mode is a way of knowing and being that serves us in different ways, helping us to navigate our way through the world.

Perhaps the most familiar mode of being and knowing in the contemporary world is a conceptual, language-based mode of mind, in which we represent our experience with concepts, words, and ideas. For example, we are writing a chapter for a book; we are both fathers, psychologists, and scientists. This mode relies on abstractions of our experience, using conceptual representations (e.g., "father"), language, and narrative. Rather than our experience having a simple present-moment focus, just as it is, we represent our experience with concepts. The past, future, and present can all be represented through our extraordinary capacity for mental travel through time and space. This extraordinary conceptual mode enables us to have abstract thoughts, to recreate the world in imagination, be creative, plan, and have a database of rich autobiographical memories. It has enabled us to send humans into space, create the complex digital technologies that are part of everyday life, write novels, create historical narratives, and produce

political manifestos. This mode of mind enables us to respond to current and future challenges such as living longer into old age and climate change. It is extraordinary to think that spoken language may have evolved as little as 100,000 years ago (Dunbar, 2003) and is a faculty that became integrated with other ways of knowing and being that predated language and that we share with many other species whose language is not as evolved as ours. Although a great asset, this conceptual mode of mind can also be a liability. For example, emotional and relationship problems are sometimes exacerbated through conceptual attempts to *solve* them. This tends to create ruminative loops, self-recrimination about failing to meet goals, nonproductive worry about an upcoming event, and so on. Moreover, there are dimensions of human life that are not necessarily enriched by conceptual thought—making love and simple appreciation of nature, to give just two examples.

In an experiential mode of knowing and being, we experience our world directly, in the present moment, with all its particularity, bandwidth, and dynamics, be they sensations, moods, impulses, or thoughts. Experiences unfold moment to moment without being elaborated conceptually. Stimuli are first registered in one of our senses (hearing, seeing, touch, other body sensations). With this mode, this information is integrated into a whole that provides an invaluable way of understanding and responding. We share this mode with other species; it is a fundamental mode that provides us with information about changes in our internal and external world, cues about safety, satiety, energy/fatigue, and so on. Associative learning through our lifetime provides templates and heuristics enabling us to use this mode to know what to do and when. Can we stay as we are, or do we need to move to safety? Should we eat or drink, or are we sated? Should we rest, or can we be active? The experiential mode allows us to savor the positives in life (e.g., the sun on our faces and the wind in our hair when walking along the coast). It can also powerfully connect us to negative emotions, sensations, and experiences. For this reason, individuals with histories of mental health problems and/or trauma may avoid this mode of mind because it brings to mind strong negative experiences (Hayes, 2004; Hayes et al., 2004). When such individuals reengage the experiential mode, it can be overwhelming and confusing. But by losing this connection to experience, an important source of information to guide wise action is lost (Feldman & Kuyken, 2019; Robinson & Clore, 2002).

The third mode of mind is the observing mind, the ability to take a decentered view of our experience, be that conceptual or experiential. It is an intentional stance of standing back and observing what is happening. It is as though we are on a hill above the town where we lead our lives, able to look down and see our lives with greater perspective. Crucially, thoughts are seen as psychological phenomena rather than reality (Beck, 1976). From this perspective, it is possible to choose where to place attention and

potentially how to respond in any given moment, a theme we return to later. It is also the perspective from which we switch between modes of mind, asking, "Where is it skillful to place my attention, and how?" For example, being able to see when we have switched into repetitively turning over an emotional problem in our minds in a conceptual way (e.g., worry and rumination), we have the option to stop and ask, "Is this helpful?" The distance that is created by the observing mind makes it possible for people to decenter—to sit with difficult thoughts or experiences that may previously have felt overwhelming (Segal et al., 2019).

MBCT emphasizes first being able to step back into the observing mode and see both conceptual and experiential modes of mind. It then involves training in the experiential mode of mind, seeing it as a mode that can be both intrinsically enjoyable and rewarding. It can anchor our attention and serve as an important source of understanding. Crucially, MBIs conceptualize how we can first become familiar with these three modes of mind, learn to switch modes, and, over time, know when it is useful to switch modes. Sometimes being fully immersed in our experience, without judgment, is appropriate—for example, making love or listening to music. Sometimes, planning and cognitive rehearsal are appropriate—for example, preparing for a job interview. The key point is that we have this capacity to be in and know the world in these different ways and can choose to engage experiential and conceptual modes of mind to serve our intentions.

This universal conceptualization draws on psychology to map how mental processes of attention, perception, and understanding together coalesce to create our experience. This applies to the full range of human experience, not just mapping how distress is created and maintained but also explaining moments of joy, sustained well-being, and human flourishing. Several more overarching theoretical frameworks in psychology have started to consider how human flourishing might be supported by MBIs (Fredrickson & Losada, 2005; Garland et al., 2010), perhaps most notably the idea that bringing awareness at times of happiness, ease, and contentment "broadens and builds" our capacity to meet the full spectrum of experience, including the challenges of life. Over time, this has the effect of building confidence and resilience.

Conceptualizations Specific to a Population: Population-Level Weft

As noted, MBCT was originally developed for people with recurrent depression. More recently, researchers are examining adaptations of MBCT to address mechanisms that maintain other conditions. After describing the MBCT conceptualization of depression, we briefly outline three extensions of MBCT into other clinical areas to illustrate these developments, specifically, suicidality, health anxiety, and cancer.

Depression

MBCT for depression is based on a cognitive conceptualization of depressive relapse and seeks to give people the skills to prevent relapses and break up the pattern of recurrence (Segal et al., 2013). This conceptualization suggests that negative beliefs, attitudes, and assumptions characterize depression. Critically, in people at risk for depression, this cognitive configuration can be reactivated by small triggers, be they low mood, a memory, or a salient life event. When reactivated, like kindling quickly starting a fire, this cognitive configuration can take hold and rapidly escalate into a full-blown major depressive episode. The tendency to react to this process with questions such as "Why is this happening to me?"; "What have I done wrong?"; and "How can I get out of this pattern?" is like pumping oxygen into the fire (Segal et al., 2013, p. 3135). For people at risk for recurrent depression, sad mood, negative thoughts, upsetting memories, and a propensity for rumination have become problematic because they readily activate a depressive configuration that spirals into depression, often quite rapidly and with a sense of helpless horror (Segal, Williams, Teasdale, & Gemar, 1996).

Depression is also characterized by blunted and context-inappropriate emotional responses to environmental stimuli—a global "affective numbing" against a background of a habitual negative mood (Dunn, Dalgleish, Lawrence, Cusack, & Ogilvie, 2004; Rottenberg, Joormann, Brozovich, & Gotlib, 2005). Note that affective numbing is characterized by the experience of *any* emotionality in individuals with depression as aversive, even positive emotions; consequently, individuals with depression go to great lengths to avoid behavioral, cognitive, and experiential triggers of any emotion, potentially leading to anhedonia. Reluctance to engage in rewarding situations (including during mental time travel to the past and future) in part drives the loss of interest and pleasure that is a core component of depression. Further exacerbating affective numbing is a tendency among individuals with depression to "dampen" potentially adaptive appraisals of positive situations as a depressed mood begins to lift, for example, by thinking, "I don't deserve this" or "this is too good to last." These appraisals blunt the emergence of positive emotions and can precipitate even worse appraisals, such as "My not enjoying this is letting every else down," "I am so ungrateful," or "what is wrong with me?", thus reinforcing the depressed state (Burr, Javiad, Jell, Werner-Seidler, & Dunn, 2017; Yilmaz, Psychogiou, Javaid, Ford, & Dunn, 2019).

MBCT was designed to help people recognize the early manifestations of this reactivity, disengage from these ruminative and self-perpetuating modes of mind, and learn to respond in more adaptive ways. It also builds the ability to engage the positive valence system, helping people to approach and (re-)engage with pleasurable and rewarding aspects of their experience and lives.

Suicidality

Suicidality is an extreme manifestation of reactivity, in which thoughts, images, and impulses related to self-harm and death of the self are part of the mode that can become activated, and in which escalation can lead to self-injury, suicide attempts, and death by suicide (Williams, Duggan, Crane, & Fennell, 2006). Faced with an emotional state that seems overwhelming, thoughts such as, "I can't cope, this is awful, I want this to end, I want to die" can arise. At these times, thoughts such as "death would be a way out of this" can seem like genuinely viable solutions (Beck, Brown, & Steer, 1989; Steer, Beck, Brown, & Beck, 1993). These modes are, of course, distressing, so many people prone to suicidality engage in avoidance, a strategy that may be helpful in the short term but is rarely effective in the longer term (Williams et al., 2007).

MBCT was adapted to help people prone to suicidality develop strategies to stay grounded in present-moment awareness when suicidal thoughts and impulses arise and to see them as passing mental events rather than facts (Williams, Fennell, Barnhofer, Crane, & Silverton, 2015). They learn problem-solving skills for the problems that trigger such thinking and, for the thinking itself, they learn to decenter and develop meta-awareness (Barnhofer et al., 2015; Forkmann et al., 2014; Williams et al., 2006). Even the most upsetting thoughts, such as "death would be a way out of this," can be seen as thoughts and not facts. Finally, and more broadly, MBCT for suicidality teaches skills to enhance self-care, approach, and engage—all strategies that can build resilience in this group.

Health Anxiety

A cognitive conceptualization of health anxiety, or hypochondriasis, suggests that interpretations of bodily symptoms become exaggerated and catastrophized as serious medical conditions, despite all medical assurances; over time, these misinterpretations become a chronic and disabling preoccupation. For example, heart racing can be misinterpreted as sign of an imminent heart attack, or any kind of discomfort in the body as a sign of a cancerous growth. These misinterpretations quickly lead to catastrophic thinking such as, "I need to get this checked out and treated as soon as possible" or "if this is serious my family will be left bereft." MBCT helps people to experience bodily sensations directly, with curiosity and nonjudgmental moment-by-moment awareness. Participants learn to observe the interpretations and catastrophic thinking, again, as thoughts and not facts. Rather than changing thoughts and images, MBCT aims to reduce their impact by helping people step back and not be caught up in problematic thinking styles and behaviors; that is, to respond rather than react. There is preliminary evidence from a small randomized clinical trial (RCT)

that MBCT is effective for health anxiety and that it works through this hypothesized mechanism (McManus, Surawy, Muse, Vazquez-Montes, & Williams, 2012).

Cancer

People with cancer face major psychological challenges. They can experience pain, fatigue, distress, worry, anxiety, and depression and fundamental questions about living and dying. These issues ebb and flow at different stages of illness and treatment. As treatments improve, more people are living longer with cancer diagnoses, meaning they need to find ways to meet and live with these challenges.

MBIs offer practices for different stages of illness (Bartley, 2011; Carlson & Garland, 2005; Carlson, Ursuliak, Goodey, Angen, & Speca, 2001). The strategies people have used in other areas of their lives, such as problem solving or talking to friends, may not be as appropriate and effective in coping with cancer. In fact, they can backfire and lead to circular thinking and preoccupations with symptoms and treatment that is nonproductive and fuels anxiety. MBCT helps people turn toward and meet their experiences, including the difficult ones, with kindness and compassion. It directly addresses psychological processes that can feed distress, reactivity, and catastrophizing by helping people recognize and decenter from their bodily sensations, feelings, and thoughts. It encourages self-care and, because it is typically offered in a group format, creates a sense of common humanity. When taught skillfully, it can help people consider fundamental questions in a safe and contained group setting.

Conceptualizations Specific to a Particular Person: Individual-Level Weft

Although MBCT is a group-based program and much of the teaching embedded in it is focused on mechanisms common to the group, there is also the potential for MBCT teachers to work at the level of the idiosyncratic mechanisms that drive distress and suffering for each member of the group. This method supports change for those individuals, anticipates and works with their particular obstacles, and helps them move toward their individual goals. For example, with recurrent depression, although the conceptualization above may be common to many, the form this takes will be different for each individual. Each individual's history and triggers will be unique. For example, common themes in depression modes may involve interpersonal rejection or failure at work. One person may react with withdrawal and another with hostility (Kuyken et al., 2009).

To summarize, a skillful MBCT teacher uses both universal mechanisms, the warp, as well as mechanisms specific to a population or

individual, and the weft, in conceptualization. Moreover, s/he takes care to conceptualize both the group and the individuals within the group, working to enable change at both levels.

MULTICULTURAL CONSIDERATIONS

By targeting mental processes thought to be universal, MBCT should in principle be applicable to people from many diverse backgrounds. As already noted, MBCT is derived in part from ancient contemplative traditions, perhaps most notably Buddhist psychology. When the Buddha was first articulating his conceptualization of how distress and suffering are created and perpetuated, he spent years studying with a variety of teachers, using an empirical first-person approach and asking, "How does this teaching resonate with my experience and the experience of others? How does it explain how distress arises? Does it provide tools for working with difficulties? Does it offer methods to cultivate attention, joy, and well-being?" He rejected each teaching in turn, refining his own conceptualization and developing what is sometimes regarded as early psychological models of the mind that have descriptive and explanatory power. What is striking is that the Buddha did this at a time in Northern India when gender and caste prevented some groups from accessing these teachings. He concluded, radically, that the basic processes of attention, perception, and cognition more broadly were likely the same, regardless of gender or caste. With its focus on mental processes, this conclusion is potentially as true today as it was 2,500 years ago. However, the way MBCT is packaged and taught is more accessible and acceptable to some groups than others. There have been some efforts to adapt MBCT for different cultural settings, to ensure that training is inclusive, and to consider issues of culture (R. S. Crane, 2017). This this an area requiring considerably more work.

EVIDENCE BASE SUPPORTING THE METHOD

MBCT is developing within a translational model of research, in which theory, intervention development, effectiveness, and implementation are seen as each informing and building on one another (Dimidjian & Segal, 2015). We review briefly here only the research most relevant to case conceptualization, its mechanism of action, and its effectiveness.

Theory and Mechanism

There are three distinct bodies of work asking how mindfulness is implicated in attention, emotional and behavioral regulation, mental health, and

well-being. First, there is a growing body of research suggesting mindfulness is consistently associated with mental health and well-being and that these associations are in part explained at a psychological level through greater attentional control and self-regulation (Masicampo & Baumeister, 2007; Teasdale & Chaskalson, 2011). There is a corresponding, promising body of work investigating the neurocognitive (Lutz, Jha, Dunne, & Saron, 2015; Lutz et al., 2009; Tang, Holzel, & Posner, 2015) and biobehavioral correlates of mindfulness (e.g., Davidson et al., 2003; Kirschner et al., 2019). However, the more elaborate research testing these theoretical mechanisms, triangulating first-person subjective accounts and more biobehavioral measures to ask how mindfulness affects mental health and well-being, is still in its infancy. Second, several systematic reviews point to three interrelated constructs as likely mechanisms of change in MBCT: mindfulness, self-compassion, and decentering. There is some evidence that these changes are specific to MBCT and that more intensive mindfulness training leads to greater changes in these hypothesized mechanisms (Alsubaie et al., 2017; Gu, Strauss, Bond, & Cavanagh, 2015; van der Velden et al., 2015). Third, and intriguingly, there is emerging evidence that mindfulness training generally and MBCT specifically helps people strengthen the positive valence systems (PVS) in ways that broaden and build their capacity for appreciation, happiness, gratitude, and self-regulation (Garland, Geschwind, Peeters, & Wichers, 2015; Strege, Swain, Bochicchio, Valdespino, & Richey, 2018). This is an important and very promising line of work. Of course, the promise of this work is that, as we better understand how MBCT effects change, we can refine MBCT to effect greater change for more people.

Effectiveness

In terms of the populations reviewed above, the evidence base is at different stages. There are now several large and substantive reviews and meta-analyses of MBIs for a range of populations that consistently suggest they are effective in enhancing mental health and well-being and reducing stress, depression, and anxiety; across more than 300 studies and samples as a large as 12,000, MBIs appear to be more effective than no treatment and as effective as other evidence-based approaches such as cognitive-behavioral therapy (CBT; Goldberg et al., 2018; Goyal et al., 2014; Khoury, Sharma, Rush, & Fournier, 2015). There is emerging evidence of MBI's cost-effectiveness (Feliu-Soler et al., 2018). The evidence base for MBCT for recurrent depression is now compelling. Using data from nine randomized trials (N = 1,258), an individual-patient data meta-analysis demonstrated clear superiority of MBCT for preventing depression over usual care and promise as an alternative to maintenance antidepressants (Kuyken et al., 2016). The effects of combining MBCT with other treatments and how best to stage

treatments needs further work, with some confusing and contradictory findings (e.g., Huijbers et al., 2015) that need exploration in further work. Finally, an uncontrolled effectiveness study suggests that MBCT effects are replicated in a large (N = 1,554), real-world study across five mental health care settings, with comparable positive effects to those seen in RCTs and rates of deterioration similar or below those for other evidence-based therapies (Tickell et al., 2019).

The evidence base for MBCT for suicidality is much earlier in its development, but several studies, including pilot RCTs, points to its promising effectiveness and, importantly, that its effects are mediated through the theorized mechanisms of meta-awareness and specificity (Crane et al., 2008; Hargus, Crane, Barnhofer, & Williams, 2010; Williams et al., 2006). There is a substantial evidence base for the effectiveness of MBIs, particularly MBSR, for cancer patients. Systematic reviews in heterogeneous cancer patients consistently demonstrate significant small to moderate effects on various psychosocial outcomes (e.g., sleep, pain, mood, stress) in cancer patients (Baer, 2003; Cramer, Lauche, Paul, & Dobos, 2012; Greene, Philip, Poppito, & Schnur, 2012; Ngamkham, Holden, & Smith, 2019; Piet, Wurtzen, & Zachariae, 2012; Shennan, Payne, & Fenlon, 2011; Smith, Richardson, Hoffman, & Pilkington, 2005; Zhang, Zhao, & Zheng, 2019). For health anxiety, the effectiveness literature is at the early, promising phase, with evidence of acceptability and effectiveness through hypothesized mechanisms that needs testing in adequately powered trials (McManus et al., 2012).

STEPS IN CASE FORMULATION CONSTRUCTION, TREATMENT PLANNING, AND PRACTICE

MBCT is a group-based program whose primary aim is to facilitate learning for the group as a whole. As we have already argued, the primary conceptualization is of the issues the group as a whole bring (the warp). As such, the primary model of change, the route map, also applies to the group as a whole. Of course, within the group, each individual will have their particular, individual route map for change, which a good MBCT teacher is often able also to work with as well (the weft).

The MBCT program has overarching aims and intentions and a sequence of sessions that slowly builds participants' learning toward these aims. It can be usefully thought of as a route map that takes people along key milestones of change. The teacher's role is to guide participants using this route map, from each milestone to the next. MBCT's detailed aims and intentions and milestones are set out in the MBCT manuals, but broadly speaking they are to stabilize attention; to open to new ways of being and knowing; to learn to respond (rather than react); reappraisal, decentering,

and insight; and coming to embody what is learned (Feldman & Kuyken, 2019).

Milestone 1: Attention!

The first milestone in MBCT is enabling people to train and stabilize their attention, to gather their scattered minds. The program provides a series of psychoeducational elements and mindfulness practices that help people see how attention and perception play out to create their moment-to-moment experience. Skillful teachers support participants with any struggles and difficulties they encounter as they master this skill. This enables participants to recognize and start to choose to step out of automaticity and habit, especially when this is, at worst, feeding their problems (e.g., rumination and depression) or perhaps inhibiting a fuller appreciation of life. Attention is the gateway to experience (James, 1890). Participants start to take the empowering step of choosing where they place their attention, what they dwell on, and what they inhibit. Attention can also enrich experience by, for example, slowing down and deepening sensory awareness across all sense modalities (e.g., eating mindfully). As this skill is revisited, again and again, experience can be enriched through ever greater granularity in perception across the senses.

When faced with difficulties, attention can be used to anchor awareness in the here and now and on an object that provides a reliable refuge. In the midst of a stressful or difficult situation, when the mind and body can become very agitated, participants learn that they can come to this anchor. This can be the breath, a part of the body (e.g., the belly, the buttocks in contact with the seat, the hands or feet, or even an external anchor, such as fixing the gaze on an object like a clock).

When we encounter everyday pleasant experiences, it is a small step to bring attention intentionally to seeing, touching, and listening wholeheartedly—to really feel the breeze on the skin, taste the food on the tongue, hear the laughter of friends, the touch of a lover. By bringing attention to these bodily sensations, emotions, impulses, thoughts, and images, they can be savored and enjoyed. For example, when greeting and embracing a loved one after being apart for a while, the pleasure of being reunited, the sense of being together, the connection of the touch can be fully experienced rather than passed over cursorily.

Although mechanistic understanding of how MBCT helps build the positive valence system is embryonic, a key element may be that attending to the full range of experiences reconnects people to their sensory and emotional experience. Over time, people learn to have confidence that they can anchor their awareness, that attention is something which they can intentionally take control of. This is an empowering realization.

Milestone 2: A New Way of Knowing and Being

As attention is stabilized, MBCT introduces the different modes of mind outlined above: experiential, conceptual, and observing. Learning mindfulness first helps participants to see and recognize the climate of their minds. Are they on automatic pilot, running off habitual patterns of thinking and behaving? Are they in a more receptive, present-moment awareness that can be with what is? Participants learn to see their minds switching in and out of automaticity; the way different internal and external stimuli run off familiar reactions; the way experiences can be elaborated with conceptual thinking; repetitive thought, such as worry, obsession, and rumination; how hard staying present can be; and how common experiences such as agitation and sleepiness can arise. Through a sequenced series of mindfulness and psychoeducational practices, participants develop the capacity to recognize, develop a deep familiarity with, and begin to understand these modes of mind—when they can serve, and when they are problematic. They start to master intentionally orienting attention and switching between these modes of mind. Conceptual thinking is essential for planning, language is obviously fundamental to communication, and an experiential being mode can support positive states of mind, appreciation, and joy and allow negative states of mind to naturally come and go. This can be very empowering, seeing, for example, that thoughts and images can be experienced as mental events; they are "thoughts and not facts."

Milestone 3: Learning to Respond (Not React)

Stabilizing attention and opening to different ways of knowing and being support moving to the third milestone—the ability to start to respond with greater freedom, choice, and flexibility to the ongoing stream of stimuli, both internal and external. Stable attention shines light on the unfolding processes of the mind; it slows down and broadens our perception. Bodily sensations, thoughts, feelings, and impulses are seen as they are, for what they are. It becomes possible to see the moment in which an automatic, habitual reaction begins. Turning toward and allowing experiences to be as they are, with an observing, kindly attention, is the beginning of a different kind of response. When these are experienced in the present moment, it can deactivate the continual labeling, judging mind that drives a sense of experience being other than how it should be, requiring fixing. Instead, drawing on both conceptual and experiential modes of mind, it is possible to be with experiences as they are, with kindness, care, and patience; it is the beginning of a different kind of response. The more we learn that we can step back and respond differently, the more a sense of capacity and confidence grows. It is not rocket science. This in turn creates new learning; what the

mind attends to, and is inclined toward, is what shapes the mind (Feldman & Kuyken, 2019). Mindfulness training creates a space in which we can choose to respond more skillfully.

The work of learning to tolerate and then later approach difficult experiences with an attitude of curiosity, kindness, and openness can reconnect people to their capacity to experience positive emotions. This is especially so for people with a history of trauma and/or depression who have understandably learned to avoid negative experiences. Moreover, developing a nonjudgmental and nonreactive stance to positive emotions can help undo the harmful effects of dampening appraisals. Of course, a similar mechanism may also help regulate the negative valence system. An equipoise or balance develops. This equanimity is fully engaged with the unfolding of inner and outer experience.

Milestone 4: Reappraisal, Decentering, and Insight

Stable attention, a broadened and deepened way of being and knowing, and greater capacity for responsiveness changes the narratives and stories we have about ourselves, our autobiographical history, and the world. What previously seemed like a fixed reality is a process that is ever changing, open to different possibilities and perspectives. Instead of overidentifying with experience ("This is who I am" or "This always happens to me"), it is possible to say, "ah, this too shall pass" or "these are stories I am telling myself, they're not facts." Identities and self-views can have a long history and be deeply rooted. To be able to recognize, stand back, and experience this in a new way is the ground for new insights. What seems like a solid, fixed, and intractable experience can be seen as transitory and fluctuating. It is a shift, for example, from "I am a chronic pain sufferer" to "My pain changes; I am not my pain." This is an important shift in perspective about ourselves, others, and the world.

Milestone 5: Coming to Embody What Is Learned

Over time, and through beginning to apply what is learned in everyday life, there is a growing alignment between participants' intentions, thoughts, and bodily sensations and what they say and do (Feldman & Kuyken, 2019).

Skillful MBCT Teaching

The MBCT program is carefully structured to sequentially offer a series of practices and exercises that support participants' learning. MBIs typically start with an everyday activity (e.g., eating) to illustrate how much we rely on automaticity and habit. Early practices and exercises begin to

stabilize attention and teach skills to recognize and understand how the mind and body create distress and suffering. Skillful MBCT teaching supports participants on this learning journey, visiting and revisiting each milestone over and over to consolidate learning. Both the program and the teacher's embodiment help participants develop the ability to turn toward their experience with friendliness and care. Later sessions map out how distress and particular problems are created and maintained, using primarily experiential learning and some cognitive-behavioral exercises. Confidence grows alongside the reappraisal and decentering described above. Later sessions consider what sustains and nourishes participants so they can continue their learning journey and crucially apply what they learn in their lives beyond the end of the relatively brief program.

In one sense, the MBCT teachers' task is to get out of the way, to allow and enable learning through the structure of the program and the experiential learning that comes out of the mindfulness practices. But skilled teachers have the theory (map) and milestones of change (route map) to guide their teaching; they guide the mindfulness practices and exercises through the lens of the MBCT program's learning intentions. For example, the first session is titled "Waking Up from Automatic Pilot," and the aims are for participants to understand automaticity and habit, to learn when automaticity is helpful and unhelpful, and to start the process of learning to stabilize attention. Teachers keep the session closely focused and aligned to these aims with the theory guiding their teaching. In MBCT, there is a review period after each exercise in which participants are invited to share their experience and learning. Here again, skillful teachers try to align what emerges with the learning intentions, theory, and sequential milestones guiding participants' learning.

Teachers also need to balance the learning needs of the group and the learning needs of the individual participants. They need not only to promote deeper learning for particular individuals as their experiences of learning about their own patterns or mind come up (individual weft) but also to speak to the rest of the group about universal patterns of mind (the warp). In most instances, it is possible to align the needs of the group and the individual. But, in some instances, these may diverge, and the teacher needs to decide how to prioritize and respond. This may, for example, involve drawing out the universal learning and then suggesting the individual explore their learning in their home practice and bring it back to the group in future sessions. There is also the need to tailor and adapt the program based on both the group's and individuals' learning needs. For example, for people with chronic physical pain, support on how best to engage with the mindfulness practices may be needed. Likewise, for people with a history of trauma, there may be a need to adapt practices in the early stages to support grounding awareness and avoid triggering hyperarousal and intrusive memories.

Finally, MBCT teachers are trained to teach from their own experience and embodiment, to "walk the talk." In this sense they have embodied the map from their own experiential learning. This both informs their teaching and is a powerful model for participants.

CASE EXAMPLE: "LEARNING TO LIVE IN THE LIGHT"

MBCT is a group-based program, so it is possible to describe the case of a whole group or of an individual. Each group is somewhat different, learning in different ways at different paces, with perhaps a different emphasis, or different key pivotal learning (a case example of a whole group is described in Kuyken & Evans, 2014). For the purposes of this chapter, we describe an individual case of someone going through a group MBCT for depression (adapted from Feldman & Kuyken, 2019).

Ling was in her early 40s, worked as a court reporter, and was the single parent to two teenage children. She had suffered many episodes of depression in her life, which started in her early teens. After being sexually and emotionally abused in her family home, she was raised by a series of foster parents and spent time in care homes for children. At school she struggled to fit into what was expected of her academically and socially and would sometimes be excluded from school for periods of time. While Ling's first episode of depression was likely caused by these challenges at home and at school, more recently episodes of depression would coalesce without a clear trigger. Ling described her most recent episode of depression this way: "I had a plummeting feeling, I just went straight down, took to my bed, just slept, I couldn't do anything. I couldn't function." Like so many other people, Ling had to find a way to manage her recurring depression alongside working and being a single parent. At these times, she would have to take time off work and find support to help with parenting her teenage children. Antidepressants were helpful to her but did not protect her fully from such relapses. She desperately wanted to find a way to learn to avoid these dark and frightening experiences of depression.

After her most recent bout of depression, her family doctor suggested MBCT as a way to learn skills to stop getting depressed again. She approached MBCT skeptically, wondering how meditation and yoga could possibly help something her family doctor and psychiatrist had long told her was an "imbalance in her brain." In the one-to-one orientation, the MBCT teacher spent time hearing Ling's story, addressing her questions and concerns, and explaining a more psychological conceptualization of recurrent depression: that the way we think and react is part of depression and that we can learn skills to prevent depression. At the end of the session, the teacher explained that MBCT involves hard work, facing states of mind and body that can be uncomfortable; and, aware of Ling's history of

trauma, the teacher discussed how Ling might best engage with MBCT to ensure that she worked within the boundaries of what was manageable and safe. The MBCT teacher asked directly, "Are you up for this, Ling? Is this a good time in your life?" When Ling answered "Yes," the MBCT teacher asked her to engage with the course with "an open mind and heart," trusting herself, knowing what she could manage, engaging with the program as best she could and seeing what happened.

The early practices were not easy. Ling became aware how agitated her mind was, how much her body was a repository of strong and often unpleasant sensations, that she was prone to "numbing out"—a strategy that had served her well growing up in a variety of abusive settings. Nonetheless, Ling started to learn ways to stabilize her attention at these times, using either the breath in her abdomen or the sensations in her hand as an anchor. If she started to numb out, she would place her hand on her belly to make the sensations more direct and real as she sensed the movement of her belly with each breath. She learned that she could anchor her attention. She learned that there was a different way of relating to unpleasant experiences, with interest, friendliness, and discernment, learning when and how it was possible to allow these difficult mind and body states into awareness and when it was wise not to. One morning she woke at 3:00 A.M., and the first thought that came to mind was, "oh no, here I go again." Automatically and habitually, a ruminative thinking loop took hold, contributing to a vicious cycle of feeling agitated and feeling that falling back asleep would be impossible. This triggered further rumination along the lines of "Oh no, I won't be able to function tomorrow."

Ling applied what she had learned in MBCT, steadying her attention. She realized she had an active choice. She could try to go back to sleep, or she get on with her day, knowing she would probably sleep well the following night. She got up and really savored a cup of coffee (before her children woke). She did something she had been putting off for some time: writing a reference for one of her former colleagues. When she printed out the letter, it brought a smile to her face to know that her reference would help her friend get a good job. These small shifts were transformative and empowering and changed the trajectory of Ling's day.

Later in the MBCT course, Ling started to understand how her habits of thinking and reacting were completely understandable given her life history but were no longer serving her well. Her early experiences of parents, foster parents, and caregivers had made her mistrustful and doubting of her self-worth and lovability. She worked in the court system, a stressful job, which often triggered for her very upsetting memories of the physical and sexual abuse she had experienced as a child. At lunchtime, she would often go for a walk. There was a bench on a hill just out of town where she would eat her lunch. Looking down on the town and the courts where she worked, she realized it was possible to have a different vantage point. What seemed

so immediate, real, and upsetting when she was in the courts could be seen from a different, more decentered perspective. She realized that the stream of thoughts that often seemed to overwhelm her were just that, streams of thoughts, not facts. This ability to stand back was always available to her, even at 3.00 A.M. when she woke up full of worry! In the midst of a flurry of negative thinking, Ling could anchor her attention in her body, a place that was now available to her as a refuge. When she was able to access attitudes of interest, friendliness, and compassion, she was better able to turn toward and work with these difficult mind and body states. As her sense of capacity grew, her need to numb out diminished.

Over time, beyond the 8-week course, Ling extended her learning to how she parented her teenage children. Here she could recognize such thoughts as "I am a terrible parent and I am going to mess up my kids" as "wrecking ball thoughts." When she described these experiences in a reunion class, there was palpable relief, as the other group members were able to relate to her powerful metaphor with a common thought, "We, too, have wrecking ball thoughts." This ability to step back from such thoughts opens up the possibility as a parent to respond to the inevitable challenges of parenting, with greater discernment and equanimity. The metaphor is also so powerful because, if we stand back, the wrecking ball passes by without causing damage and eventually loses its power.

A few years later, Ling decided to change jobs to one that was more enjoyable and rewarding and that did not have the potential to trigger her own traumatic history of abuse on a daily basis. She described to her MBCT teacher a few years after the course that at first she engaged with MBCT as a way of working with and avoiding the darkness of depression. But in time, she had used what she learned to turn toward and "live more fully in the light." She started to enjoy the simple pleasures of life, parenting, and a kayaking club she joined, in which in time she became an instructor. She had long kept a journal, and she realized that the whole tone of her entries was changing. There was more of a sense of appreciation of her life, a sense of really engaging with her work, children, and friends in a more open, trusting way and a faith that she had the resources to negotiate challenges and difficulties. She still used antidepressants for periods of time but did so intentionally and instrumentally at times she felt she needed them as part of her approach to self-care. She had further periods of low mood and depression, but she met these experiences with greater understanding, self-compassion, and a sense of "this will pass." During periods of contentment, joy, and fulfillment, she was able to recognize and savor them. As she brought this into her relationship with her children, coworkers, and friends, they too became more stable and richer.

MBCT's conceptualization of reactivity driving depressive relapse and the milestones of change outlined above were the map Ling developed to understand her depression and then chart a way, first, to prevent depression

recurring and then, over time, to learn to live her life, professionally and personally, more fully "in the light."

LEARNING THE METHOD

The established model of MBCT teacher training evolved from more than 40 years of teaching both CBT and MBI teachers. It is outlined in a consensus statement that sets the stages of teacher training (Segal et al., 2018; Woods, Rockman, & Collins, 2019). MBCT teachers first establish a mindfulness practice by undertaking an MBCT class themselves as participants. They then learn the theory and practice of MBCT and first practice teaching in small groups of peers, with feedback from trainers. The third phase is beginning to teach MBCT either as an apprentice with a more experienced teacher or with close mentoring and supervision. After several such classes, some teachers will seek to have their teaching competency formally assessed. Ongoing training involves mentoring and supervision and continuing education alongside support to sustain and deepen personal mindfulness practice.

For MBCT teachers to teach effectively, they need to have a thorough understanding of the universal and population-specific maps and route maps—the warp and weft that make the tapestry of MBCT teaching. These maps are used to guide and shape teaching, both the group teaching of mindfulness practices and CBT exercises, but also how each interaction is handled, how the teacher responds to opportunities and challenges. When Ling said, at the end of the first long practice, "I was so agitated I wanted to be anywhere else but here," the teacher modeled curiosity, compassion, and patience, encouraging Ling to only do what felt manageable and worked with her to find ways for her to anchor her attention when she became agitated—placing her hand on her belly, tracking the movements of her breath. This first milestone, the teacher recognized, was not only an important skill in its own right but also essential for Ling to access the further teaching. The map and route map support the teacher; they are learned both conceptually and experientially. Teachers will also have had moments of agitation when they would like to be "anywhere else but here."

SUMMARY AND CONCLUSION

MBCT was originally developed based on a psychological conceptualization of depressive relapse. The program structure enabled people at risk for depressive relapse to recognize how reactivity can easily escalate into depression, to decenter from these patterns, and to respond adaptively. However, like all MBIs, MBCT also draws on a universal conceptualization of

what drives distress, suffering, and human flourishing. As MBCT evolves to be used with new populations and contexts, it requires consideration of the theoretical conceptualization that informs these adaptations, alongside programmatic translational research to establish its effectiveness. We have argued that MBCT supports people to live well with chronic and recurrent physical and mental health conditions. More than this, it can potentially promote human well-being and flourishing at the general population level.

NOTES

1. We use the term *distress* to refer to a state of "unsatisfactoriness." It can range from a low-key sense of unease to excruciating pain. It can be physical, emotional, mental, or some combination of these.
2. We use the term *flourishing* to refer to the human capacity to grow and develop in healthy, sustainable ways, mentally, emotionally, physically, spiritually, and across the domains of life (home, work, recreational). It has a sense of living with a sense of human potential (as opposed to languishing).

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