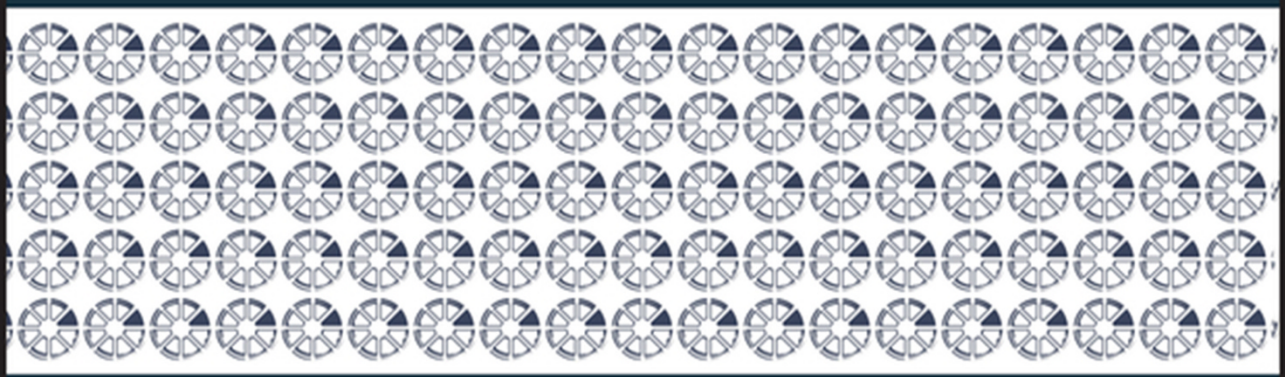
THE CLINICAL HANDBOOK OF MINDFULNESS-INTEGRATED COGNITIVE BEHAVIOR THERAPY

A STEP-BY-STEP GUIDE FOR THERAPISTS



BRUNO A. CAYOUN • SARAH E. FRANCIS • ALICE G. SHIRES

Includes online resources

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Mindfulness-integrated CBT has made a unique contribution to evidence-based approaches in health care – centrally relevant for those interested in teaching or learning mindfulness and those who practice Cognitive Therapy. The evidence shows that it helps people with some of the most serious physical and emotional difficulties, as well as working well to enhance flourishing and well-being. This manual for therapists and teachers is a very welcome step forward to make MiCBT even more available across the world.

Professor Mark Williams, PhD
Emeritus Professor of Clinical Psychology, University of Oxford
Co-author of Mindfulness-based Cognitive Therapy for Depression

It is an investment when you buy a book (both time and money). I recommend that you invest in the best authors. There is none better for MiCBT than Cayoun, Francis and Shires.

Professor Bruce A. Stevens, PhD
Clinical psychologist, Wicking Chair of Ageing and Practical Theology,
Charles Sturt University Canberra
Author of Happy ever after? A Practical guide to relationship counselling for clinical psychologists

Dr. Bruno Cayoun and his colleagues Drs. Francis and Shires have written the most comprehensive book to date integrating mindfulness and CBT in a framework successfully designed to give therapists practical guidance to foster well-being in clients with an array of difficulties. Highly recommended.

Arthur P. Ciaramicoli, Ed.D.,Ph.D.,
Clinical psychologist
Author of The Stress Solution: Using Empathy and Cognitive Behavioral Therapy to Reduce Anxiety and Develop Resilience

Bruno Cayoun developed a concise and effective mindfulness program in Mindfulness-integrated Cognitive Behaviour Therapy. Now, Dr. Cayoun and his colleagues have offered a valuable companion book for clinicians and clients that brings compassionate care into the lives of therapists and their clients as co-participants in mindfulness. It is a privilege for me to have known Dr. Cayoun as friend and colleague and to appreciate deeply the precision of his thinking and practice. This clinical handbook reflects not only his talent and insights, it highlights his dedication to colleagues who can join him in providing an important level of ethical and effective therapeutic care to others.

Lynette M. Monteiro PhD,
Psychologist, Director of Ottawa Mindfulness Clinic
Co-author of Mindfulness Starts Here and co-editor of Practitioner's Guide to Ethics and Mindfulness-based Interventions

MiCBT integrates the principal evidence-based methods of traditional CBT with mindfulness meditation with seamless grace and an ability to preserve the important elements of both. I highly recommend this comprehensive and helpful clinical handbook to mental health professionals.

Shauna Shapiro, PhD
Professor of counseling psychology, Santa Clara University
Author of The art and science of mindfulness and Mindful Discipline

This important work is a masterful integration of mindfulness meditation training and clinical science for individual and group therapy. It fills a gap in the literature by linking the essence of mindfulness practice—equanimity—with carefully articulated behavioral change strategies. The authors explain the theoretical foundation of MiCBT, followed by generous, session-by-session instructions for every aspect of treatment. Almost 2 decades in the making, MiCBT is an innovative, transdiagnostic approach to clinical care that will surely inspire and inform clinicians for years to come.

Christopher Germer, PhD
Lecturer (part-time), Harvard Medical School
Author, The Mindful Path to Self-Compassion
Co-editor, Mindfulness and Psychotherapy

The Clinical Handbook of Mindfulness-integrated Cognitive Behavior Therapy

The Clinical Handbook of Mindfulness-integrated Cognitive Behavior Therapy

A Step-by-Step Guide for Therapists

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I slept and dreamt that life was joy.
I awoke and saw that life was service.
I acted and behold, service was joy.
—Rabindranath Tagore

Contents

About the Authors

Bruno Cayoun is a clinical psychologist and the principal developer of Mindfulness-integrated Cognitive Behavior Therapy (MiCBT), which he and his colleagues have been teaching to mental health professionals since 2003. He is also the founder and Director of the MiCBT Institute, a leading provider of training and professional development services in MiCBT to mental health services and professional associations internationally. Dr. Cayoun keeps a private clinical practice in Hobart, Australia, and undertakes mindfulness research at the MiCBT Institute and in cooperation with universities in various countries. He has practiced mindfulness meditation in the Burmese *Vipassana* tradition of Ledi Sayadaw, U Bah Kin and S. N. Goenka, and undergone intensive training in France, Nepal, India and Australia since 1989. He is the author of research articles and books, including *Mindfulness-integrated CBT: Principles and Practice* (Wiley, 2011), and *Mindfulness-integrated CBT for Well-Being and Personal Growth: Four Steps to Enhance Inner Calm, Self-Confidence and Relationships* (Wiley, 2015).

Sarah Francis is a registered psychologist trained in a number of mindfulness-based therapies. She specializes in Mindfulness-integrated Cognitive Behavior Therapy (MiCBT) and has been implementing it since 2006. In addition to her work in clinical psychology, Sarah has worked in a number of professional contexts including education, human resources, and business consulting. She is the author of *Workplace Communication: A Teacher's Guide* (Pitman, 1993). She is the convenor of the Melbourne MiCBT Interest and Research Group and a senior trainer for health professionals who train through the MiCBT Institute. Sarah's research interests include the measurement of mindfulness and the differential efficacy of MiCBT and treatment-as-usual in clients with a range of mental health disorders at Monash University.

Alice G. Shires is a clinical psychologist and Director of the Psychology Clinic and senior lecturer at the Graduate School of Health, University of Technology, Sydney (UTS) and was a founding Board Member of the Australian Clinical Psychology Association. Alice is a teacher, trainer and supervisor of clinical psychologists and has worked in acute and specialist mental health services in the United Kingdom. She has developed an interest in mindfulness and its integration with cognitive and behavioral therapies and has established a mindfulness-integrated research clinic at UTS. Her research includes the efficacy of MiCBT in chronic pain, the

process of supervision and assessment of competencies in clinical psychology, and the inclusion of mindfulness training in the clinical psychology training process. Alice is a senior teacher of MiCBT for mental health professionals and supervises clinicians during the course of their MiCBT training.

Foreword

Discover real peace and harmony within yourself, and naturally this will overflow to benefit others.

—S. N. Goenka

As clinicians, we are continually looking for best practices that assist our clients to decrease their suffering. We begin by holding awareness of the certainty that a reduction in suffering *is* possible. Mindfulness-integrated Cognitive Behavior Therapy (MiCBT) supports us in the ensuing process of making meaningful change manifest for clients. It does this through the skillful integration of equanimity cultivated in meditation practice and cognitive behavior therapy-based exposure techniques. The authors of this manual accompany us step-by-step through the four stages of MiCBT, anticipating challenges and providing demonstrable advice and strategies for optimizing skill development.

I first met Bruno through our common commitment to precision and proficiency in meditation practice, and clarity of underlying theoretical frameworks, in an effort to optimize the rigor and effectiveness of mindfulness-based interventions. Alice, Bruno and Sarah bring decades of combined clinical wisdom across the full range of mental health conditions to this practical guide. They integrate their personal meditation experience within the Burmese *Theravada Vipassana* tradition of U Ba Khin with a structured therapeutic approach that can be adapted to a wide variety of clinical issues. The authors' integrity and embodiment of insights gained through meditation imbue both the explanations of the theoretical framework of MiCBT and the associated clinical examples with lucidity; this assists the clinician in merging the personal and experiential with the interpersonal and clinical.

This guide is an essential resource for therapists in that it provides an accessible, structured approach to applying MiCBT principles in both individual and group settings. It provides demonstrations of how to assist clients to identify clear treatment goals, including specific behavioral changes, and develop awareness of the benefits they will experience as motivation to establish and sustain a twice-daily meditation practice. The theoretical framework underpinning MiCBT emphasizes that it is automatic reactions to the hedonic tone of co-emerging sensations in the body, fueled by identification with experience, that in large part drive clients' symptoms and habitual behaviors. Therapists will find a refreshingly

clear rationale for each stage of the therapy process, along with suggested methods for adjusting the treatment protocol based on clinical progress and need.

One of the challenges we repeatedly face as clinicians is skillfully selecting and applying the most appropriate components of mindfulness to meet the immediate needs of the client in the room. The content of this book, as carefully crafted by Alice, Bruno and Sarah, addresses this by clearly outlining the links between the various facets of mindfulness and their clinical effects. For instance, they explain *how* practicing mindfulness of breath develops metacognitive awareness, which, in turn, generalizes into daily life, resulting in decreased rumination. Importantly, they also provide examples of effective ways to explain these mechanisms to clients, serving as a further source of motivation for their daily mindfulness practice.

Throughout the book, considerable attention is devoted to problem-solving specific clinical situations, illustrated by clinical vignettes. With forethought to the challenges our clients may face in their CBT and meditation practices, such as difficulty accepting unpleasant bodily sensations or managing intrusive thoughts, the authors recommend specific practice modifications. By providing a comprehensive, yet adaptable, in-session and at-home therapeutic framework, while also clearly explicating the rationale for progression of practice as taught in MiCBT, this manual enables the clinician to adjust the treatment for each clinical case.

Having this handbook when I was first eagerly implementing MiCBT would have saved me much time in determining how to summarize succinctly the purpose of each practice for clients and how most effectively to bring together the mindfulness and CBT components. Most importantly, this manual empowers us to carry the insights gained in our personal mindfulness practice into the therapeutic relationship, equipping our clients with the skills not only to reduce their own suffering but also to express their full and unique potential.

Andrea Grabovac, MD, FRCPC
Vancouver, Canada, 2018

Acknowledgments

We express our gratitude for the traditional teachings and teachers of Vipassana meditation, which have inspired and taught us and from which this program is developed. We thank Gabrielle Cayoun for her assistance with figures, and Karen Cayoun and Dr. Glenn Bilsborrow for their reviews of drafts. We are also grateful to our colleagues and past clients for their permission to include their experience in the book, and to the entire team at Wiley for their patience and support. We would also like to express our gratitude to all mindfulness researchers who endeavor to remain true to the original teaching of mindfulness and provide an invaluable support to the clinical field and assist in the modern understanding of this ancient approach to cultivating well-being.

Introduction

The faculty of voluntarily bringing back a wandering attention, over and over again, is the very root of judgement, character and will. An education which should improve this faculty would be an education par excellence. But it is easier to define this ideal than to give practical instructions for bringing it about.

—William James, 1890

As we become more insightful in our therapeutic work, we progressively direct our interest to methods that best suit our personality and approach to life in general because we feel more at ease with these methods. Additionally, as we grow as human beings, becoming wiser over time, we choose what we believe are genuinely wholesome therapeutic tools. A wiser mind is more attracted to tools that promote wisdom, such as mindfulness. Since mindfulness is the art of being objective about subjectivity, many therapists from various disciplines choose to use mindfulness-based interventions as their primary toolset.

Over the past 15 years, there has been a surge of interest and requests for training in mindfulness-based therapies all around the globe. Among the most cited approaches that include mindfulness meditation are Mindfulness-Based Stress Reduction (MBSR; Kabat-Zinn, 2014) and Mindfulness-Based Cognitive Behavior Therapy (MBCT; Segal, Williams & Teasdale, 2002), but there are many more. Some of these approaches are associated with a second generation of mindfulness-based interventions, partly because they preserve skills that have been traditionally integral to mindfulness training, such as ethics and compassion training, and require extended education and mentoring (see Van Gordon, Shonin, & Griffiths, 2015, for detailed description). Second generation mindfulness-based interventions include Mindfulness Based Symptoms Management (Monteiro & Musten, 2013), Meditation Awareness Training (Shonin, Van Gordon, Dunn, Singh, & Griffiths, 2014), Mindfulness-Based Positive Behavior Support (Singh et al., 2014), Mindful Self-Compassion (Neff & Germer, 2013), Compassion Focused Therapy (Gilbert, 2009), and Compassion Cultivation Training (Jazaieri et al., 2013).

Mindfulness-integrated Cognitive Behavior Therapy or MiCBT (pronounced M-I-C-B-T) has become an important contributor to this growing field. Despite

some inevitable overlap with other mindfulness programs, MiCBT differs in several key areas, which are discussed in Chapters 1 and 2. It offers a practical set of evidence-based techniques derived from mindfulness training in the Burmese *Vipassana* tradition of Ledi Sayadaw (1965/1999), U Ba Khin (1995/2011) and Goenka (2000), and the principles of Cognitive Behavior Therapy (CBT) to address a broad range of psychological disorders. Its increasing popularity may be best attributed to its novel ability to address both crisis and chronic conditions as well as help prevent relapse.

This book reflects 17 years of effort to develop, implement, research and teach MiCBT as an efficacious transdiagnostic approach to address a wide range of conditions, including those with complex comorbidity. We have written this volume to offer therapists a trusted guide that informs and assists them in their group and individual applications of this unique approach, across a wide range of disorders. Two volumes have already been written on the topic. One was written for professionals with a focus on the scientific basis and mechanisms of action of MiCBT (Cayoun, 2011). The other (Cayoun, 2015) was written as a step-by-step self-implementation to assist clients in therapy and provide an opportunity for the general public to use MiCBT for well-being and personal growth. These books have since been translated in several languages and continue to be widely used. However, there was no comprehensive guide to assist therapists in clinical settings until now. This book was written to fill this gap and provide a detailed week-by-week implementation of MiCBT.

When our publisher suggested that we write a workbook for therapists, it was important to us that the book serve therapists in the best possible way, so we conducted a survey of 233 clinicians known to use or to be interested in using MiCBT as their primary approach to therapy, to probe their format preference. About 15 % preferred a book written for clinicians only, the large majority (74 %) responded in favor of a workbook for clinicians that includes information for clients as well, and 11 % didn't mind. We went with the majority, which resulted in this book that guides both the therapist and their clients. This is because not all clients are able or willing to read, or can afford the self-implementation guide (Cayoun, 2015)—although we highly recommend it if they can, as it has proven to be an excellent resource for clients undergoing MiCBT.

Part 1 of the book contains three chapters that will provide you with important information about MiCBT, including a clear explanation of its origins and development, its structure and content, the scientific underpinnings and empirical evidence. Part 2 of the book contains ten chapters, called "sessions" to fit with the delivery of the ten-session program. It will guide you through the entire program, using an easy, conversational and engaging style which will encourage you to engage clients in the program. Your clients will learn about themselves in three complementary ways: through psychoeducation, through questioning their own views, and through their own experience. This clinical handbook contains precise guidance for each session, including suggestions on ways to overcome common difficulties, and worksheets and handouts that can be photocopied or downloaded and given to clients to assist them as they progress through the program. With this book, you and your clients are also given free access to the entire set of audio instructions for mindfulness training, which can be streamed online or downloaded

in MP3 format. Appendix 2 also contains the scripts for these instructions, which include basic and more advanced methods given by the first author, an experienced *Vipassana* meditator and mindfulness teacher.

As you will notice, occasional references are made to Buddhist psychology and sometimes to the historical Buddha. The reason for this inclusion is simply good writing practice and ethics. One would expect responsible authors to include sources of their information, especially when the phenomena and methods they discuss are well established and documented. While some authors of mindfulness-related books may not acknowledge the source of the teachings they discuss, we feel grateful for having received this rich source of knowledge and are bound by good and ethical academic practice. However, this does not make this book a "Buddhist" book, nor does it make MiCBT a "Buddhist" therapy. Irrespective of the place, culture, or period from which psychological frameworks originate, "Psychology is the science of mental life, both of its phenomena and of their conditions" (James, 1890, p. 1). In our perception, 2 + 2 = 4 for Buddhists, Christians or atheists. As long as the information is validated, we do not discriminate between cultures, and we are transparent about its source and original meaning. We hope that these occasional references to Buddhist psychology will be perceived in the light of our intention and will be a useful and enriching source of additional information.

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About the Companion Website

This book is accompanied by a companion website:

www.wiley.com/go/Cayoun/Mindfulness-integrated

The website includes:

- Handouts
- Audio

Part 1

The MiCBT Approach, Theory and Validation

1

Principles of MiCBT

The real voyage of discovery consists not in seeking new lands but seeing with new eyes.

—Marcel Proust, 1923

This chapter describes the origins and development of Mindfulness-integrated Cognitive Behavior Therapy (MiCBT), as well as the core principles and theoretical basis for this integrated transdiagnostic approach. The chapter also discusses how we can conceptualize "suffering" in a way that productively guides our attitude and approach to using MiCBT. It also provides a brief description of the four stages of MiCBT, including the therapeutic mechanisms and supporting research evidence. We begin by describing our operational definition of mindfulness to ensure that the term used with regards to MiCBT is accurately understood.

Definition and Purpose of Mindfulness

Origins and Common Confusions

Mindfulness has a double meaning in the English language. The online *Oxford English Dictionary* defines mindfulness in its common meaning outside the meditative context as "The quality or state of being conscious or aware of something." As you can imagine, this can lead to all sorts of misinterpretations of the term when trying to apply it to the Buddhist teaching of mindfulness. In modern day Western psychology, mindfulness has progressively become an umbrella term related to purposeful sustained attention in the present moment. This understanding is not only inaccurate, but it also misleads newcomers to mindfulness training. For example, a cat sitting attentively in front of a mousehole, ready to jump on its prey, sustains attention from moment to moment; however, it is not a mindful cat. Similarly, a sniper paying purposeful attention in the present moment, ready to

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Companion website: www.wiley.com/go/Cayoun/Mindfulness-integrated

kill in the context of following orders without making judgments, is attentive but not mindful. Unfortunately, this initial misunderstanding of the construct engenders low construct validity in both mindfulness measurement tools and the studies that use them, but a discussion on these issues is beyond the scope of this chapter.

In the Buddhist psychological context, the term "mindfulness" is a translation of the Pali term *sati*. Pali was the common language used in northern India during the time of the Buddha, over 25 centuries ago. *Sati* has been interpreted by various monastic and lay teachers as "awareness" (Goenka, 2000, p. 135), "mindfulness or awareness" (Narada, 1988, p. 183; Rahula, 1974, p. 48), and as "remembering or bearing in mind" (Rhys Davids, 1881, p. 107; Sharf, 2014, p. 942;). The British Buddhist scholar Rupert Gethin explains that *sati* should be understood as that which allows us to be aware of the full range and extent of phenomena—as an awareness of phenomena and their relative value—and is therefore what causes the mindfulness practitioner to "remember" that any experience exists in relation to a whole variety of experiences that may be skillful or unskillful, wholesome or unwholesome, ethical or unethical (Gethin, 1992). The traditional purpose of mindfulness practice, since its origination in Buddhist teaching, is to develop wisdom and reduce suffering.

Unlike some of the current Western teaching models, the traditional approach teaches mindfulness as a quality of mind to be cultivated at all levels of experience. In particular, it involves developing our mindfulness skills across four modalities so that mindfulness permeates through all domains of functioning. This encompasses "the constant mindfulness with regard to body (*káyánupassaná*), feelings (*vedanánupassaná*), thoughts (*cittánupassaná*), and mind objects (*dhammánupassaná*)" (Narada, 1988, p. 182). Note that "feeling" (*vedana*) is meant to signify "interoception" and the associated pleasant, unpleasant or neutral hedonic tone, and is frequently used interchangeably with "body sensations" in the literature (e.g., Rahula, 1974, p. 48). Hence, *vedana* has more to do with "feeling" (the verb) than with "feelings" (the noun). Although it is not necessary to explain these details to clients, it is helpful for therapists to know the original purpose of mindfulness training and understand clearly the definition of mindfulness, as some clients will ask about it.

In particular, it is important that clients understand the differences between attentiveness, awareness and mindfulness. In brief, we understand attention to be the mental effort that directs awareness to an object or stimulus and awareness is the action of conscious apprehension of the object. While mindfulness requires both attentional effort and awareness of what is occurring in the present moment, it must be free from any bias, such as liking or disliking what we attend to, and the propensity to desire or resent the object. The attentive cat in the aforementioned example craves the appearance of the mouse, and the sniper may resent the target or crave a successful shot. Mindfulness meditation needs to be understood as a training in *unbiased* attention to our ongoing experience, preventing any personal interpretation or interference with the object of observation. Mindfulness must, therefore, include a sense of detachment from, and non-identification with, the object that we attend to.

For this reason, mindfulness practice must be accompanied by equanimity (*upekkha* in Pali), which is *a detached, neutral and balanced mental state that is neither elated nor depressed, which enables a non-reactive attitude irrespective of the type of experience being encountered*. Researchers are starting to express the

importance of equanimity in mindfulness practice (e.g., Desbordes et al., 2015). Mindfulness practice requires mental neutrality, which allows us to investigate safely, objectively and with a healthy curiosity. Hence, to use the term mindfulness accurately, it must be understood as a tool, *not as a goal*. As we progressively acquire the ability to stabilize attention, our observation deepens and we notice that all things change, including our thoughts, emotions, physical body and the entire world around us—nothing remains the same, including what we call "the self." Thus, mindfulness is a tool for both self-investigation and "self-desensitization" through direct exposure to whatever we call "I," "my," or "mine" while preventing the reinforcement of a sense of self, as is discussed in the next chapter and revisited in Part 2 as we implement the stages of MiCBT.

Operational Definition

Most teachers agree that mindfulness practice requires paying attention to our present experience, without adding or subtracting any aspect to the experience, while preventing biased judgment, reactivity and identification with the experience. When gathering the essence of traditional and modern descriptions of mindfulness, we can summarize a mindful mental state as *a heightened sensory and metacognitive awareness of the present-moment experience, free from reactivity, biased personal values and self-referential evaluation*. Training in mindfulness meditation requires *deliberate sustained attention to sensory and cognitive processes with unconditional acceptance of the experience*. This necessitates a deliberate effort to inhibit one's learned reactions (craving and aversion) and develop greater objectivity, acceptance and detachment with each experience.

MiCBT applies mindfulness training in the Vipassana tradition of the Burmese teachers lineage of Ledi Sayadaw, Saya Tetgyi, Sayagyi U Ba Khin and, later, S. N. Goenka. Accordingly, MiCBT may be defined as *a theoretically congruent and technically complementary integration of traditional mindfulness training and CBT, which provides a transdiagnostic approach to address emotional distress across a wide range of disorders*.

Origin and Development

MiCBT, originally called Mindfulness-based CBT (MCBT) until 2005, was initially conceptualized between 1989 and 1997 and developed by the first author between 2001 and 2003 to address a range of moderate to severe psychiatric symptoms (Cayoun, 2003). It was then piloted in several clinical and community settings (e.g., Cayoun, Sauvage, & van Impe, 2004; Lindsay, 2007) and progressively modified until 2010, which led to the first publication of a comprehensive book on the principles and practice of MiCBT (Cayoun, 2011). Since then, the MiCBT approach has been studied across a range of disorders, age groups and contexts, as will be discussed in the next chapter, and only minimal adjustments have been necessary despite a wide range of applications. Clinician training in MiCBT has also been piloted through the supervision of numerous therapists undertaking courses in various countries since 2003.

In contrast with an increasing number of mindfulness-based interventions (MBIs) over the past 20 years, MiCBT was not derived from Jon Kabat-Zinn's (1990) Mindfulness Based Stress Reduction (MBSR) approach, which was not well-known outside America at the time. Rather than integrating an existing adaptation of the original teaching of mindfulness, MiCBT was independently composed of the core mechanisms underlying cognitive and behavioral therapies (Barlow, 2002; Beck, 1976; Hawton, Salkovskis, Kirk, & Clark, 1989) and traditional *Vipassana* (insight) meditation, taught in Northern India over 2500 years ago by Siddhartha Gautama, better known as the historical Buddha, who was also the prince of the Sakya province situated in current Southern Nepal. This doesn't mean that MiCBT is a "Buddhist" approach. It simply makes use of the profound phenomenological wisdom that the early teachers of mindfulness described in their approach to human psychology, henceforward referred to as "Buddhist psychology."

For most mindfulness-informed therapists, what makes the Buddha's story interesting is that he shunned a theistic approach (Hindu religion) and embraced a psychological perspective with the aim of reducing human suffering. The uniqueness of his approach was twofold: he only believed in verifiable and replicable phenomena and he only taught systematically applicable methods that showed evidence of efficacy in the reduction of human suffering. Of course, unlike today, the only means of gathering evidence then was through the direct experience of phenomena. Hence, the methods he taught were passed on through the science of phenomenology, which is the study of consciousness and the objects of one's direct experience through introspection.

The early pioneers of Western psychology were also known as "introspectionists." As with the Buddha's approach to psychology, they used introspection to examine the nature of consciousness and experiential phenomena. One of the fathers of Western psychology, the introspectionist William James, stated very similar realizations to those reported by the Buddha 2400 years earlier. Some of the most strikingly similar realizations found in James' seminal book *Principles of Psychology* (James, 1890), still commonly cited today, are that "A man's ME is the sum total of all that he can call his," and that "Thought is in constant change." These phenomenological realizations are not limited to Buddhist and modern Western psychologies, as many similar observations were made by Greek philosophers, especially Heraclitus, whose fundamental doctrine was that everything is in a state of flux, and that perpetual change is the fundamental nature of life. This understanding is not only shared by traditional teachers of mindfulness, it is also an important characteristic of human experience that mindfulness training helps us understand and accept.

Of note, Albert Ellis' Rational Emotive Behavior Therapy (REBT) has been frequently associated with elements of Buddhist philosophy, partly because of its common emphasis on unconditional self-acceptance. Ellis wrote that the approach of the Buddha and other ancient philosophers, which stated that "people are disturbed not by things but by their view of things", became the basis of REBT (Ellis & Drysden, 1997, p. 2). In the early days of MiCBT (then called MCBT), Henry Whitfield in the UK corresponded with one of us (BC) and saw much value in combining the basic elements of MiCBT with REBT, which resulted in a hybrid model of therapy combining these two approaches (Whitfield, 2006). Whitfield's mindfulness-based REBT seems to already be a common practice among REBT therapists (David, Lynn, & Lama Surya Das, 2013).

Over the past 17 years, the growth of MiCBT has been steady, and has been purposefully and carefully controlled because MiCBT was initially developed for clinical purposes, which necessarily places restrictions on who may use it and whom to use it with. Our understanding of professional ethics and our prudence with therapist training inclusion criteria made the overall research and dissemination of MiCBT slower than MBSR-based MBIs, which have historically been more compromising in this regard. One important point of the code of ethics for psychologists in Western countries is to abstain from teaching therapeutic methods to individuals who lack the professional background that enables them to use the methods safely and appropriately. We have remained continually aware of the importance of limiting access to MiCBT training courses to only those clinicians that have the appropriate professional qualifications and experience. We have also carefully monitored their levels of competency using MiCBT in clinical settings.

The first 10 years of research following MiCBT's initial piloting comprised a majority of convincing but unpublished research theses. Before the first book on MiCBT was published (Cayoun, 2011), we also discouraged MiCBT studies where the researchers were not formally trained in MiCBT because of the risk of poor implementation validity and low representativeness. MiCBT research is now blooming, including teams in India and Iran who have been industriously exploring the effects of MiCBT across a range of conditions, providing some indications of its transcultural efficacy.

Basic Principles

Approach to Learning

Learning from someone else can be engaging, but it relies on faith in another person's knowledge or experience and is limited to one's beliefs in someone else's view or knowledge. Our personal engagement in the learning process is minimal. In the therapy context, this would involve simply practicing the therapy methods that we have been taught without questioning their validity, just because we trust our teacher. People who train to be teachers of mindfulness are not immune to this exclusively devotional approach to learning. The same applies to clients, some of whom might engage in a mindfulness-based intervention because a friend, sibling or medical doctor they trust suggested it.

Critical thinking, on the other hand, requires more personal involvement in the process of learning. We question, verify the evidence beneath the assumed validity of a phenomenon, and eventually decide for ourselves on the basis of our findings. In the context of therapy, we verify whether the rationale for an approach makes sense, we may check the evidence in the literature, and ask questions with an open mind and healthy rationality. This learning process requires greater personal engagement than relying on faith and hearsay. Nonetheless, research evidence today is easily invalidated tomorrow. New findings cancel the previous, and what we thought made sense for a while has to be put into question; this is the nature of science and its evolution. The same applies to long-term clients, some of whom might have been told that a certain therapeutic approach was the "gold-star"

evidence-based treatment 15 years ago and are now told that other treatment methods that lacked research backing 15 years ago have progressively been shown to be more efficacious than the original "gold star" treatment.

In contrast to belief and critical thinking, direct experience is by far the most personally engaging approach to learning, especially when learning about ourselves. During experiential learning, what is happening in the present moment is undeniably factual to a person; it is not hypothetical or based on others' experience. Meditation practice is the most profound and reliable method to learn about personal phenomena, including the experience of our sense of self. For this principal reason, therapists learning about MiCBT are required to meditate. However useful a manualized guide may be, it will not suffice for the successful implementation of MiCBT. Without our personal experience of what we teach our clients, it is very difficult to understand our clients' experiences during meditation and to guide them accurately. Again, the same applies to clients, many of whom are depressed or anxious because they have not had the benefit of directly experiencing rapid change in their symptoms by just noticing the ephemeral nature of experience, including that of profound sorrow or panic symptoms. It is through sitting quietly, observing objectively, and accepting the experience equanimously, that the ensuing relief teaches clients about the true nature of their predicament.

Approach to Therapy

Psychological therapies have been categorized in various groups of approaches (Corey, 1991). Among these, the "common factors" approach proposes that the efficacy of different approaches to therapy and counseling is enabled by factors that are inherent in all evidence-based therapies (e.g., Dollard & Miller, 1950). These factors include the therapeutic relationship, empathy, and active listening skills, but the factor that seems unequivocally present in effective therapies is learning (Tryon & Tryon, 2011). It has been proposed that mindfulness is also a common factor across various therapy approaches. Martin (1997, p. 291) has suggested that mindfulness is a "core psychotherapy process," on the basis that the development of mindfulness promotes access to new perspectives and disengagement from habitual response sets, including automatic thoughts and behavior. The "technical eclecticism" approach to therapy (e.g., Lazarus & Beutler, 1993) selects convenient techniques from various approaches, including mindfulness skills, according to the therapist's perception of the client's needs. This approach is inevitably limited by the client and therapist's insight into the origins and maintenance of symptoms. The "theoretical integration" approach to therapy (Norcross & Goldfried, 2005) aims at putting diverse theoretical systems together under a greater metatheoretical framework.

MiCBT uses a "theoretical integration" approach which incorporates the most central common factors, including learning, acceptance, self-awareness, disengagement from habitual response sets and therapeutic relationship. It is based on a multidisciplinary metatheoretical framework that integrates essential elements of Buddhist and Western psychologies into a single step-by-step manualized intervention. Specifically, MiCBT tightly weaves learning theory through the co-emergence model of reinforcement (Cayoun, 2011), cognitive and exposure

techniques, affective and social neuroscience, the natural law of impermanence and its effects on one's sense of self, mindfulness, equanimity, and existential components through the theory of non-self directly experienced during mindfulness practice.

One advantage of working with a clinical intervention that is based on an established theory is that we operate from a clear understanding of mechanisms of action. We can then more easily understand and resolve difficulties commonly encountered in clinical practice. For instance, if the theory that we integrate in our therapy model is learning theory (operant conditioning; Skinner, 1953), we can easily case-conceptualize an unhelpful behavior and understand the maintaining or reinforcing factors at play, irrespective of the therapy techniques used. In contrast, an eclectic orientation tends to encourage using any potentially useful method from "our toolbox." The downside of this is an over-reliance on empirical findings with little understanding of how underlying mechanisms of action function to alter behavior. This can result in a lack of depth and grounding in the science underlying a therapeutic model.

The notion of theoretical integration lends itself to encouraging a scientist-practitioner approach to therapy. Being based on theory also prevents future modifications from jeopardizing the efficacy of the approach, since any model adaptation (e.g., for children) must remain in line with the underlying theoretical framework. As will be discussed in the next chapter, the central theoretical framework for MiCBT is the co-emergence model of reinforcement (Cayoun, 2011; Cayoun & Shires, submitted for publication), which is a neurophenomenological extension of operant conditioning. Although MiCBT is constructed with a tight integration of mindfulness and CBT, the level of integration varies according to the level of expertise. Our observation over years of providing professional training is that therapists initially tend to *juxtapose* CBT and mindfulness methods and perceive them as two different systems, and then *integrate* them and perceive them as various methods of the same system as their expertise increases.

Approach to Symptomatology

It is not easy for clients to understand that our mental and emotional difficulties arise not only from *within* our mind, but also because of our *attitude* toward our mind. As will be described in some detail in the next chapter, when we give thoughts personal importance, even subconsciously, body sensations co-emerge with them, quickly intensifying to produce an emotion, irrespective of the disorder. Mindfulness practice develops better understanding of these and other mental processes, so that the mechanisms, and not just the content, of cognition can be altered. The purpose for which mindfulness was taught over the past 2500 years is to develop the necessary wisdom to perceive, understand and abandon our tendency to maintain suffering, as well as to promote a sense of well-being. It is possible that this description differs from what your client may have previously read about mindfulness.

One of the fundamental needs for human beings is to grow and evolve. Unknowingly guided by suffering, people feel the need to change for the better. When we avoid discomfort, we miss the teachings inherent in suffering. Therapists

are primarily students of suffering. They examine its multiple facets and their consequences, and eventually learn enough from it to develop means of reducing its unpleasant effects. What we mean by "suffering" is *an experience that leads to, or maintains, dissatisfaction or emotional reactivity following an unfulfilled expectation*. Buddhist psychology provides a profound understanding of suffering that supports the application of a transdiagnostic intervention. It helps us understand the common factors of suffering across all emotional disorders, as well as in life dissatisfaction in general. Human suffering can be divided into three types: (1) common suffering, such as physical pain and illness; (2) the effects of change; and (3) the effects of conditioning (Bodhi, 2000). Of course, these three types continually interact and cannot really be separated, but the way people learn and condition their mind is by far the most complex type to understand and is the principal reason for which they see a therapist.

It is useful to operationalize conditioned suffering in behavioral terms within the MiCBT theoretical framework, to demonstrate that the intervention is theoretically congruent with the problem. The *precipitating factor* (the trigger) for suffering is the fact that things change all the time, impacting all aspects of our life; this includes our sense of self, because of our attachment to our views, our senses, and our body and possessions. The *reinforcing factor* for suffering is our reactivity. Because of our attachments, we react with craving for the things we don't have and want, and we react with aversion to the things we don't want and have. As explained through the model of reinforcement in Chapter 2, our reactive behavior is positively reinforced when we obtain what we crave, and negatively reinforced when what we resent subsides. Our conditioned mind is extremely restricted by this ongoing, yet subconscious mental habit. As a consequence, our unawareness of these phenomena constitutes the principal *maintaining factor* for suffering because it prevents us from understanding these underlying mechanisms and correcting our habits accordingly.

Thus, the *mechanisms* of suffering, rather than their symptoms, form the transdiagnostic target of MiCBT. We make use of these mechanisms as a tool for growth, and not just "therapy," as will be explained in Part 2 of the book. Based on the understanding that unawareness can be replaced with insight, developing insight allows us to outgrow the factors of suffering. To the best of our knowledge, mindfulness is the most productive tool a therapist can offer clients to develop this kind of insight. Over the past 25 centuries, the main purpose of cultivating mindfulness through the long chain of traditional teachers, including our own, has been to develop insight and wisdom to alleviate suffering in people from all cultures and walks of life.

Approach to Comorbidity

It is now well-established that core mindfulness principles can be used for a wide range of symptoms and conditions (Keng, Smoski, & Robins, 2011). MiCBT was developed for clinical purposes as a transdiagnostic approach, partly to address the problem of comorbidity—between 60 % and 85 % of clinical cases contain one or more comorbid conditions, which makes diagnostic-specific therapies sub-optimal. Transdiagnostic interventions have recently been developed using

exposure as the principal mechanism of action and are increasingly appealing to clinicians in general because they can address comorbidity more easily.

For instance, a standard diagnostic-specific therapy deemed efficacious to treat depression is not necessarily as useful when depressive symptoms are accompanied by panic or OCD symptoms. Transdiagnostic CBT is generally showing either equivalent or superior results to current evidence-based gold-standard diagnosis-specific CBT for most common anxiety disorders (Norton & Barrera, 2012), they tend to show a smaller dropout rate (Barlow et al., 2017), and the size of their effects is not affected by comorbidity (Pearl & Norton, 2017). Transdiagnostic interventions are also very useful in addressing barriers to the dissemination of evidence-based treatments. Thus, using one protocol instead of multiple single-disorder protocols can be a more effective way of treating most commonly occurring emotional disorders, and certainly easier to teach and learn.

Randomized controlled studies show that addressing crisis and comorbidity with MiCBT is possible when clients commit to sufficient frequency, duration and accuracy of mindfulness practice and integrate CBT skills, even in non-Western cultures (e.g., Bahrani, Zargar, Yousef-Ipour, & Akbari, 2017; Yazdanimehr, Omidi, Sadat, & Akbari, 2016). A brief review of MiCBT study outcomes is provided in Chapter 2.

Structure and Content of MiCBT: The Four Stages

MiCBT teaches mindfulness according to the original fourfold establishment of mindfulness (*Mahasatipatthana Sutta*; see Walshe, 2012, for translation), which includes mindfulness of body (posture and movement/physical activity), body sensations (including those associated with emotions), mental states (including emotional states) and mental content (thoughts, images, etc.) (Brahm, 2006; Hart, 1987; see also Thanissaro Bhikkhu, 2011, for a translation of the *Satipatthana Sutta*, and Goenka, 1990, for discourses and useful commentaries on the *Satipatthana Sutta*). Of course, MiCBT is not presented to clients as a "Buddhist approach," and this information is intended for you, the therapist, to know the components of MiCBT and their origins.

MiCBT is composed of four learning stages grouped into "internalizing" and "externalizing" phases that enable change at a systemic level. The stages are designed to develop mindfulness, cognitive and behavioral skill-sets across the main domains of functioning: intrapersonal ("personal stage"), situational ("exposure stage"), interpersonal ("interpersonal stage"), and transpersonal ("empathic stage"), typically denoted as Stages 1, 2, 3, and 4, respectively. The stages are usually delivered hierarchically, although the program can be delivered more flexibly when necessary. The purpose of this hierarchical integration is first to teach clients to internalize attention in order to regulate attention and emotion, and then externalize these skills to the contexts in which their psychological condition is triggered or maintained.

As will be discussed in Chapter 3, MiCBT is used in individual and group therapy with equivalent clinical efficacy (Roubos, Hawkins, & Cayoun, 2011) and usually requires between eight and twelve sessions for effective treatment of most emotional and behavioral disorders, but at least twice as long for moderately

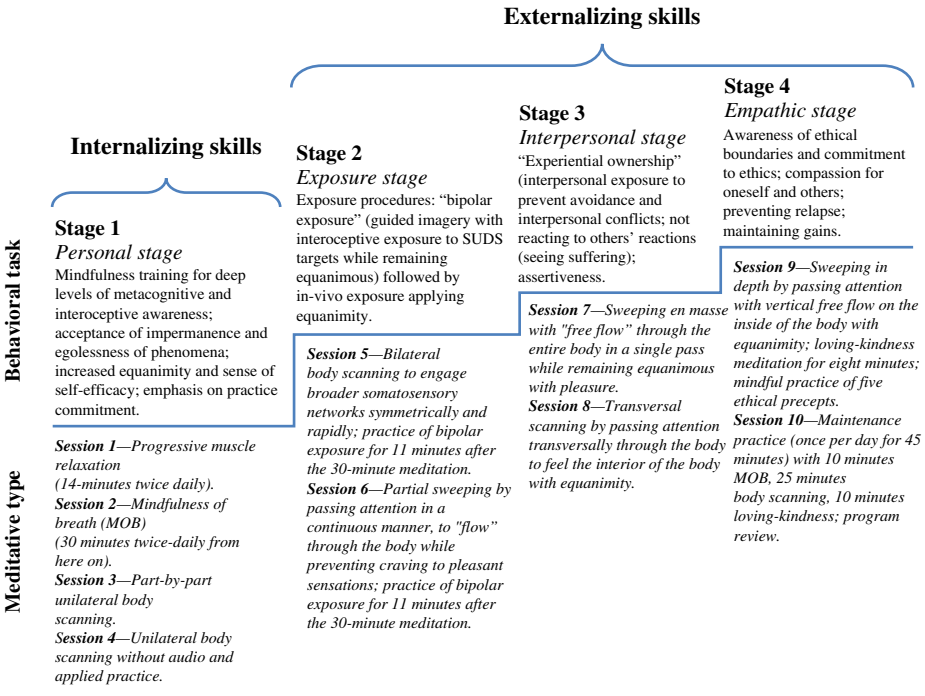

Figure 1.1 The four-stage model of Mindfulness-integrated Cognitive Behavior Therapy. (Adapted from Cayoun, 2011.)

severe personality disorders—though there are no controlled studies confirming the ideal program duration and long-term efficacy of MiCBT for personality disorders. Let us now examine the stages in some detail. Figure 1.1 summarizes the four stages of MiCBT within a typical 10-session format, which is also the delivery model through which you will be guided in Part 2 of this book. Note that this schedule is only an approximate indication of standard delivery. Each stage can be extended for a longer duration, depending on the patient's needs and requirements for progressing to the next stage.

Stage 1: Personal Stage: Attention and Emotion Regulation

In Stage 1, mindfulness meditation training is taught to internalize attention in a way that decreases emotional reactivity and promotes deep levels of experiential awareness and acceptance. An emphasis is placed on the internal context of experience to equip clients with an increased sense of agency and self-efficacy in handling thoughts and emotions before addressing the life difficulties for which they sought therapy.

Following standard intake assessment and contractual agreement on therapeutic goals (described in Session 1; see Part 2 of the book), clients begin with the practice of progressive muscle relaxation (PMR) and mindfulness of body posture and movement. Besides its potential relaxing effect, PMR provides an initial and reassuring sense of agency over stress-related muscle tension, which assists in

reinforcing the client's initial effort to commit to a daily practice. However, PMR is only used for the first week in most cases, as a preparatory measure. This is because clients can inadvertently use relaxation as a means of experiential avoidance, which is incompatible with the aims and acceptance-based features of mindfulness. Mindfulness of body (posture and movements) in daily actions introduces the notion of present-moment awareness, which is a relatively easy introduction to mindfulness principles and practice, as commonly used in other integrations, such as Dialectical Behavior Therapy (Linehan, 1993).

Clients are then taught to practice mindfulness of breath (described in Session 2) for one to two weeks and basic (unilateral) body scanning for the following two weeks (described in Session 3 and Session 4). People who use these methods show an increased ability to detect and withstand distress, which leads progressively to brain reorganization in just a few weeks, both in grey matter (Hölzel et al., 2011) and white matter (Tang, Lu, Fan, Yang, & Posner, 2012). Increased efficacy of self-regulation networks produced by neuroplasticity provides an invaluable biological apparatus to facilitate emotion regulation during exposure tasks implemented in the following stages (exposure and interpersonal stages).

For instance, imaging research using functional MRI shows that mindfulness of breath can produce a generalized reduction in amygdala response to emotional stimuli that is maintained during non-meditative states (Desbordes et al., 2012). Anatomical MRI also shows rapid decrease in grey matter volume of the right basolateral amygdala during a standard eight-week MBSR program (Hölzel et al., 2010). The emphasis on interoception as the locus of reinforcement places body-scanning methods at the heart of twice-daily MiCBT practice. This is partly because interoceptive awareness and acceptance are central to the Vipassana approach to mindfulness training (Hart, 1987; Kerr et al., 2013), and partly because the last 15 years of affective and cognitive science have reliably shown that people with emotional disorders have impaired interoceptive capacity; i.e., a reduced ability to feel common body sensations (Khalsa et al., 2017). The effort to decrease the habit of identifying with moment-to-moment experience trains clients to process information in a less self-referential, more objective manner (Farb et al., 2010), as will be discussed in the next chapter.

To maximize training efficacy, clients learn to adhere to three fundamental practice principles: *sufficient frequency* (usually twice daily), *sufficient duration* (usually 30-minutes per session) and *sufficient accuracy* of practice (conscious effort to decrease identification with, and reacting to, emerging experiences). MiCBT research shows that clients who adhere to this protocol benefit most (e.g., Scott-Hamilton & Schutte, 2016). The first two principles permit the third, which specifically increases equanimity by reducing the need to react with craving or aversion, irrespective of the type of experience. Generalizing awareness and acceptance of thoughts and body sensations in everyday situations occurs as a spontaneous consequence of neuroplasticity.

In addition, clients are taught to apply equanimity in daily life. They learn to monitor body sensations as continually as possible in everyday situations and identify typical patterns of sensations experienced during stressful events while increasing their capacity to prevent learned responses (i.e., via increased equanimity). Hence, interoceptive awareness, developed during formal meditation practice, becomes a skillful means for preventing the reinforcement of unhelpful reactive