



## The Practical Application of Mindfulness in Individual Cognitive Therapy

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### ABSTRACT

The purpose of this paper is to present a practical framework for the introduction of mindfulness to individual cognitive therapy, which will be exemplified by real case examples. Initially it will integrate information drawn from the literature with the author's clinical experience to present general principles that apply to the application of mindfulness to individual cognitive therapy. It will then attempt to demonstrate how mindfulness can be tailored to the needs of specific clients in individual therapy.

The case studies will demonstrate the application of this technique in the treatment for anxiety, depression and addiction including dual diagnosis. Names and other data that could identify the clients will be changed, disguised or omitted. Finally a case will be presented where mindfulness was used to manage repetitive and tenacious negative automatic thoughts. This process unexpectedly revealed a self-defeating core belief, associated with strong childhood classical conditioning. This in turn was dealt with effectively through mindfulness.

*Key words: mindfulness, meditation, acceptance, cognitive therapy, behaviour therapy*



### INTRODUCTION

Over the last decade a significant body of research has emerged showing the effectiveness of mindfulness in the treatment of a variety of conditions including depression, (Teasdale et al. 2000, J. M. G.) borderline personality disorder, (Linehan M. et al 1991, 1993, 1994, Koons 2001) chronic pain (Kabat-Zinn J et al 1986,) , addiction (Linehan et al 1999, Alterman A.I. et al 2004) and anxiety disorders (Miller J.J. et al 1995)





Mindfulness as a method has come to us through Eastern meditation practices. In the ancient Pali language it was called "*Bhavana*" which literally translates as:

*"Development through Mental Training"*

With such a meaning it is not surprising that mindfulness has become linked to CBT. In fact Hayes (in Hayes, Follette & Linehan 2004 pp 5,6) describes mindfulness and acceptance as the third wave of behavioural therapy. Behavioural conditioning was being the first wave based around the principles of Skinner's operant conditioning and Pavlov's classical conditioning. The second wave was the cognitive therapies which took into account cognitive content. (Ellis 1962, Beck, Rush, Shaw, & Emery 1979) This third wave adds attentional and metacognitive perspectives into the mix. It focuses more on thought processes rather than content.

It could be proposed that a more specific definition of mindfulness would be as follows:

*To be aware of the full range of experiences that exists in the present moment, without judgement. This includes sensory impressions in all sensory modalities as well as emotions and thoughts including visual imagery.*

This is usually done by gently focusing the attention on the breath or a repetitive phrase. When the practitioner notices the attention has wandered he/she brings it gently back. During this process the practitioner notices the contents of consciousness without becoming absorbed by them. (See appendix 1 for more detailed instructions)

## AN EXPLANATORY MODEL OF HOW MINDFULNESS WORKS

Through mindfulness the practitioner becomes less identified with the contents of consciousness. Segal, Williams & Teasdale (2002 p.38, 39) name this process as "decentering". In metaphorical terms it is as if you are watching the stream of consciousness rather than swimming in it and being buffeted by its eddies and currents.

Segal et al (2002 p.38, 39) postulate that this decentering may also be a component of the effectiveness of traditional CBT. Indeed, the importance of such "distancing" or "decentering" had previously been recognised in discussions of cognitive therapy (Beck, Rush Shaw & Emery 1979). Rick Ingram and Steve Hollon (1984 p.272) suggested that "cognitive therapy relies on helping individuals switch to a controlled mode of processing that is metacognitive in nature and focuses on depression-related cognition....typically referred to as 'distancing'....the long term effectiveness of cognitive therapy may lie in teaching patients to initiate this process in the face of future stress".

So it is thought that this decentering allows practitioners to develop a tolerance of unpleasant affect and a concomitant reduction in avoidance behaviour. (Breslin et al 2002, p289)

There is now also a body of evidence that demonstrates the problems created by dealing with unpleasant feelings or thoughts by avoidance. We can now say fairly confidently that suppressing a thought feeling or sensation, including pain ultimately increases it. (Clark Ball & Pape 1991, Gold & Wegner 1995, Wegner, Schneider, Carter & White, 1987, Wegner, Schneider, Knutson & McMahon 1991, Cioffi & Holloway 1993)



For example Wegner et al (1987) compared the thought reports of two groups during a period when each had been instructed to think aloud about a white bear. One group focused on the target (white bear) from the outset, whereas the other first spent a period of time suppressing white-bear thoughts. Compared with the group that thought about a white bear at the outset, the initial suppression group reported a higher rate of target thoughts during a subsequent expression period.

A number of researchers have further validated these findings by addressing methodical issues such as the practicing of the thought that was to be suppressed. (Clark et al 1991, 1993, Harnden et al 1997, Harvey & Bryant 1998, Johnston et al 1997, Kelly & Kahn 1994, Lavy & van den Hout 1994, McNally & Ricciardi 1996, Wegner et al 1991, Wegner & Gold 1995, Wenzlaff et al 1991). This particular issue was addressed by researchers enlisting a modified design where participants engage in a common subsequent expression period after initial expression or suppression, thus eliminating differential effects of practice.

We can all get a taste of the effects of attempted thought avoidance simply by trying not to think of something. For example try not to think of the taste of a lemon in your mouth. Try not to think of its slight acidity and of how it causes your saliva to flow. Of course the paradoxical trap is that in order not to think of something you have to think of it first in order to define what it is that you are going to avoid thinking about.

Unfortunately the news about thought suppression gets even worse. We now know that rebound is greatest in the situational context of the original suppression. (Wegner, et al 1991) So if the desire for a cigarette is suppressed after a satisfying meal, that same desire is likely to return with a vengeance after the next satisfying meal. Moreover, recurrence of the mood alone causes rebound of the suppressed thought. (Wenzlaff et al 1991) So the feeling of satisfaction in a different context would be enough to re-elicite the desire for the cigarette in the above example.

If it happens to be a negative mood that is associated with the repressed thought then we are in double trouble, because thought suppression can stimulate a suppressed mood leading to a self amplifying loop. (Wenzlaff, et al, 1991) So if depressed mood has become associated with cigarette craving, then the simple attempt to put the craving out of your mind will be enough to reactivate depressed mood, which will in turn activate more craving and so on.

Also Prochaska (1992) et al in their study of how people change habitual behaviour, note that most people go through a long contemplative stage before they actually change. This stage is marked by ambivalence. Argumentation usually results in the client completing the other side of the ambivalent equation thus maintaining a state of therapeutic paralysis. It is reasonable to assume that the same problem exists with the client's internal disputation over the ambivalently regarded behaviour.

Mindfulness allows us to bypass these problems associated with avoidance and disputation. Instead of trying to distract from or argue with the unpleasant thoughts, mindfulness simply makes the thought less important. When we use mindfulness we stay exposed to the thought for its natural duration without feeding or repressing it.

Also mindfulness reduces the magical power that we unwittingly give to language. In order to understand this we can do a simple mental exercise where we consider the meaning of the sentence:

“Mindfulness is the opposite of avoidance”?

Using the normal rules of logical language we could deduce from this statement that mindfulness must mean include facing fear. It is a small step then to interpret mindfulness as being counter phobic behaviour – like taking up hang-gliding when you have a fear of heights. This in fact is engaging in an internal struggle





which is not part of mindfulness. Rather, mindfulness is staying with what arises, without trying to control it. Again this statement could be logically misinterpreted to mean that mindfulness means being out of control! In fact people usually feel much more in control when practicing mindfulness. So in mindfulness there is **control of attention** without trying to control the contents of attention, such as thoughts feelings and physical sensations. Mindfulness remains open & non judgemental.

So the above discussion about the nature of mindfulness shows us how language can be used to make fine verbal distinctions. However it also demonstrates some of the limitations of language. Language can lock us into assumptions that we are not even aware we are making. For instance we can now see how through a misapplication of logic that mindfulness could be interpreted as being “counter-phobic” or being “out of control”. So language can trap us into limited conceptual paradigms. Moreover while we are caught up in the internal world of language and intellectualisation we can avoid facing other experiences, such as unpleasant emotions.

The illusion of language is that one is dealing with the world through thought. In fact, one is actively structuring the world through thought.

*It appears to the thinker that one is simply dealing with the structured world, not that one is structuring an ongoing process. Mindfulness and acceptance catch this bird in flight, and like an audience that learns how a magic trick is accomplished, they can profoundly change the effects of the language illusion. (Hayes, S. C. 2002).*

So through a process of non-judgemental awareness (acceptance) that doesn't use the verbal argumentation involved in traditional CBT, mindfulness allows for covert desensitisation without falling into the pitfalls of language.

## SOME OF THE BENEFITS OF MINDFULNESS

Mindfulness produces a number of advantageous outcomes. These include:

- *Development of a stronger “Observing Self” i.e. Decentering.* This is somewhat like the cognitive technique of “Self Monitoring” This in turn allows easier identification of distorted or dysfunctional thoughts. However, unlike conventional cognitive approaches mindfulness stresses disidentification with the thought. This has the interesting outcome that a practitioner can become less self absorbed while becoming more self aware
- *It can be applied in a variety of settings.* It is not restricted to the meditation cushion or closed eyed relaxation or even to low stress environments.
- *We can see thoughts as “Just thinking” without feeding or fighting them.* Disputing a thought can reinforce it. So mindfulness transcends the repression-expression dichotomy in which many people feel caught. Repression simply creates the problems discussed earlier when talking about avoidance. Expression of irrational thoughts can often cause even more problems. Sogyal Rinpoche (1992 p61) expresses this quite eloquently:

*“The practice of mindfulness defuses our negativity, aggression, and turbulent emotions.....Rather than suppressing emotions or indulging in them, here it is important to view them, and your thoughts, and whatever arises with an acceptance and generosity that are as open and spacious as possible.”*



- *Mindfulness allows covert desensitization to negative thoughts and feelings to occur spontaneously.*
- *We can see the temporary nature of sensations, feelings and thoughts.* This allows for the practice described by Allan Marlatt as “Urge Surfing” which he uses as part of “Relapse Prevention”; (Marlatt & Gordon, 1985) a CBT package designed to forestall relapses in individuals treated for substance abuse. The metaphor of “urge surfing” encourages clients to imagine that urges are ocean waves that grow gradually until they crest and subside. The client “rides” the waves without giving in to the urges, thus learning that urges will pass. However, the client also learns that new urges will appear in the normal course of events. Mindfulness skills enable the client to observe the urges as they appear, accept them nonjudgmentally, and cope with them in adaptive ways.

## INITIAL PROBLEMS PRACTISING MINDFULNESS

***Therapists who do not have a regular mindfulness practice themselves have a great deal of difficulty successfully teaching it.*** This even applies to the teaching of a simple process like urge surfing. Indeed the research shows that therapists need to have their own well established mindfulness practice in order to be effective mindfulness trainers. (Segal et al 2002 pp83-84) See appendix 3 for more detail on this point.

***Mindfulness may initially lead to increased awareness of repressed unpleasant feelings such as agitation, grief or boredom.*** Louise had been badly sexually abused for years as a young girl. When she initially came to see me she couldn't remember the last time she had cried. Nonetheless, when Louise began doing regular mindfulness meditation she cried for most of the duration of her daily twenty minute sessions.

I encouraged Louise to allow the crying to happen and to be mindful of the changing physical sensations in her body associated with the grief. This is often a workable way to stay mindful in the presence of intense emotion. In this way Louise began her successful recovery from the abuse and the poorly developed self efficacy that went with it.

***The client needs some pre-existing strength of personality in order to establish a regular mindfulness practice.*** We can see from the above case that some impulse control and distress tolerance are required. It often helps to meditate with the client in therapy sessions. When the therapist can tolerate the client's affect, a message is powerfully communicated that the client's affect is tolerable. This can lead to the rest of the therapeutic session being more grounded and less scattered. Even if the client does not persist with home practice they often benefit by having experienced decentering and the noticing of the automatic flow of the mind and the continually changing nature of mental phenomena. This can provide the basis for later success in therapy with such things as urge surfing or learning distress tolerance.

Sometimes it is better to begin with simple awareness of body sensations rather than breath focussed mindfulness. If it is still too difficult it can be helpful to start with very brief sessions of mindfulness of 5 minutes or less. If even that is too difficult, “mindfulness in action” techniques can be used. (Appendix 2)

***Many people have great difficulty establishing a regular daily practice.*** Usually it is best if a practitioner links the mindfulness practice into their normal daily routine. More details can be found in appendix 1 (Mindfulness Instructions)

## CASE STUDIES



**Coral** is a 26 year old single woman, living in a share house with friends. She has steady employment as a public servant. She has a well documented history of chronic relapsing depression, which has required treatment with ECT in the past. Coral has remained well over the last three years with a combination of antidepressant medication (Cipramil 20- 40 mg daily) and with mindfulness based CBT.

Coral's depression was further complicated by the recreational use of party drugs, such as ecstasy. So Coral needed to become mindful of the connection between her drug use and her mood. She also needed to learn to differentiate between temporary downs and depressive relapse. In addition, she needed to become aware of the contribution that sleep deprivation was making to her post party lows.

Coral was not able initially to make these connections. Her position was in fact that she was "just hopeless" and these explanations were just invalidations of her suffering.

This stance reflected Coral's very powerful core beliefs in her own inadequacy. These proved very resistant to traditional CBT. So I taught her mindfulness, in order to help her to decrease her identification with her thoughts, which of course included these dysfunctional core beliefs. Predictably, Coral believed she was not doing the mindfulness properly. She claimed she could only do it properly in the sessions with me. Otherwise she said would slouch in a chair and her thoughts would go "all over the place". Despite this, she found the practice enjoyable and so was doing it most days for 15 to 30 minutes. Coral did however acknowledge that she would occasionally remember to bring her attention back to her breath. I told her that her imperfect mindfulness practice seemed to be very much on the right track and that I expected it would prove helpful. So I encouraged her to continue.

Soon Coral was spontaneously gaining insight about the connections between her drug use, her sleep deprivation and her moods. This led her to come up with harm minimisation strategies without any prompting by myself. I believe that the mindfulness practice had helped her to bypass her negative core beliefs including her pervasive self doubt. This in turn allowed Coral to apply her own natural intelligence to the problems at hand.

**Carmen** is a 42 year old Latin American woman who migrated to Australia one year before first seeing me, in July 2002. She had symptoms of anxiety and depression but not severe enough to warrant anti-depressant medication. Carmen also had some physical problems with back pain that flared up from time to time and tiredness secondary to anaemia. All these problems seemed to be made worse by an exaggerated sense of responsibility that Carmen seemed to carry for her friends, family and compatriots from Latin America.

Carmen felt very competent in her own country but had an overwhelming sense of vulnerability living in Australia. So most of her early therapy was supportive, consisting of validation of the difficulties she was experiencing as a normal part of adaptation to a foreign culture and language. This process allowed her to reinvigorate her sense of self-efficacy to pre-migration levels. In this way her anxiety and depression quickly began to improve as did her English and understanding of the Australian culture.

However, Carmen continued to exhaust herself, taking on every one else's problems. She could see this was inappropriate. For example she came in one session after seeing a TV programme about the mistreatment of factory hens wanting to become involved in a crusade against this inhumane treatment. In another session she was very distraught about the problems that her Australian partner was having with his ex-wife and their children, and wanted to rescue the children.

At that point I decided that she was ready for a mindfulness technique adapted from Buddhist Vipassana meditation practices. (Kornfield Jack 1993 p83-100) This technique simply involves the labelling of



worrying thoughts as “just worrying” and bringing conscious attention back to the breath or simply changing the subject. (See appendix 4 for more details.)

This can be seen as an application of *Mindfulness “What” Skills* as described by Linehan (1993 p144-146) as part of her *Dialectic Behavioural Therapy*. The first “what” skill is to observe whatever is occurring without avoidance thus resulting in non-reinforced exposure. Next the client describes the experience in words i.e. labelling. This assists with communication and self control. It also helps to distinguish mental events from external reality. Finally the client is encouraged to participate in ongoing events and interactions in the external and real world. Because this is done without being ruled by the labelled experience, this participation can occur without self-consciousness, but mindfully

Carmen adopted this technique and indeed the worrying subsided but she developed a terrible feeling of disorientation and fear. As we explored this response Carmen realised that it was a very familiar feeling that made her feel about 8 years old. She then remembered at that stage of her life she suffered chronic conjunctivitis, which meant that she woke every morning unable to see until her eyes were cleaned by someone else. This would take some time as her parents were usually fighting. So Carmen had been classically conditioned to feel like this blind powerless child when she felt anxious.

Once Carmen identified this childhood feeling as being the same feeling that she had recently experienced, she was able to separate the two. This allowed her to calm down considerably. She was then able to identify the residual anxiety as the feeling of a knot in her abdominal region. It then struck Carmen that she had been carrying these feelings of anxiety in her abdomen most of her life and a lot of her incessant activity and helpfulness was an attempt to distract herself from this chronic anxiety.

Over the next few sessions Carmen became more mindful of this feeling of anxiety in her abdomen without being so afraid of it. She even began to find the variations in intensity of this feeling a useful barometer, which indicated to her when she was experiencing more stress. She therefore learnt to manage her stress much better by using this feeling. Eventually she started to call this feeling her friend. This is the sort of progression we can expect when the mindfulness technique of non judgemental awareness is consistently applied over time. (Baer, R. A. 2003).





## REFERENCES

- Alterman A.I., Kopenhaver J.M., Mulholland E., Ladden L.J. & Baime M.J. (2004) Pilot of the effectiveness of mindfulness meditation for substance use patients. *Journal of Substance Use*, 9(6): 259-268
- Baer, R. A. (2003) Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*, 10(2), 125-143.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- Breslin, F. C., Zack, M., & Mcmain, S. (2002) An information-processing analysis of mindfulness: Implications for relapse prevention in the treatment of substance abuse. *Clinical Psychology: Science and Practice*, 9(3), 275-299.
- Cioffi D. & Holloway J. (1993) Delayed costs of suppressed pain. *Journal of Personality and Social Psychology* 64, 274-282
- Clark D.M., Ball S, & Pape D. (1991) An Experimental Investigation of Thought Suppression *Behaviour Research and Therapy*, 29, 253-257
- Ellis, A. (1970, c1962). *Reason and emotion in psychotherapy*. New York : L. Stuart.
- Gold D.B. & Wegner D.M. (1995) Origins of ruminative thought: trauma, incompleteness, non-disclosure and suppression. *Journal of Applied Social Psychology* 25, 1245-1261
- Harnden JL, McNally RJ, Jimerson DC. (1997) Effects of suppressing thoughts about body weight: a comparison of dieters and nondieters. *International Journal of Eating Disorders* 22:285–90
- Harvey A.G. & Bryant R.A. (1998) The role of valence in attempted thought suppression. *Behaviour Research and Therapy* 36:757–63
- Hayes, S. C. (2002) Acceptance, mindfulness, and science. *Clinical Psychology: Science and Practice*, 9(1), 101-106.
- Hayes S.C. (2004) Acceptance and Commitment Therapy and the New Behavior Therapies In Hayes S.C., Follette V.M. & Linehan M.M. eds. *Mindfulness and Acceptance: Expanding the Cognitive-Behavioral Tradition* New York, London: The Guilford Press
- Ingram R.E. & Hollon S.D. (1986) Cognitive therapy for depression from an information processing perspective. In Ingram R.E., ed. *Information processing approaches to clinical psychology*. Orlando, FL: Academic Press
- Johnston L, Hudson SM, Ward T. (1997) The suppression of sexual thoughts by child molesters: a preliminary investigation. *Sexual Abuse Journal of Research and Treatment*. 9:303–19







- Kabat-Zinn, J., Lipworth, L., Sellers, W., Brew, M., & Burney, R. (1986). Four year follow-up of a meditation-based program for self-regulation of chronic pain. Treatment outcomes and compliance. *Clinical Journal of Pain* 2: 159-173
- Kelly A.E. & Kahn JH. (1994). Effects of suppression of personal intrusive thoughts. *Journal of Personality and Social Psychology* 66:998–1006
- Koons, C.R., Robins, C.J., Tweed, J.L., Lynch, T.R., Gonzalez, A.M., Morse, J.Q., Bishop, G.K., Butterfield, M.I., Bastian, L.A. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy*, 32(2), 371-390.
- Kornfield J. (1993) *A Path With Heart: A Guide Through the Perils and Promises of Spiritual Life* New York: Bantam Books
- Lavy E.H. & van den Hout M.A. (1994). Cognitive avoidance and attentional bias: causal relationships. *Cognitive Therapy Research* 18:179–91
- Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D., Heard, H.L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48, 1060-1064.
- Linehan, M.M., Heard, H.L., Armstrong, H.E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 50, 971-974.
- Linehan M.M., Tutek, D.A., Heard, H.L., Armstrong, H.E. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry*, 151, 1771-1776.
- Linehan, M.M., Schmidt, H., Dimeff, L.A., Craft, J.C., Kanter, J., Comtois, K.A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *American Journal on Addiction*, 8(4), 279-292.
- Linehan, M. M. (1993) *Cognitive-behavioral treatment of borderline personality disorder*. New York: The Guilford Press.
- Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder*. New York: The Guilford Press.
- Marlatt, G. A., & Gordon, J. R. (1985) *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.
- McNally RJ, & Ricciardi JN. (1996). Suppression of negative & neutral thoughts. *Behav. Cognitive Psychotherapy* 24:17–25
- Prochaska, J. O., Diclemente, C. C., & Norcross, J. C. (1992) In search of how people change. *American Psychologist*, 47, 1102-11
- Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-Based Cognitive Therapy for depression: A new approach to preventing relapse*. New York: The Guilford Press.
- Sogyal Rinpoche (1992) *The Tibetan Book of Living and Dying*. Sydney: Random House





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Teasdale, J. D., Williams, J. M., Soulsby, J. M., Segal, Z. V., Ridgeway, V. A., & Lau, M. A. (2000). Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *Journal of Consulting and Clinical Psychology*, 68, 615–623.

Thich Nhat Hanh (1991) *Peace Is Every Step : The Path of Mindfulness in Everyday Life*  
New York: Bantam Books

Wegner D.M. & Gold DB. (1995). Fanning old flames: emotional and cognitive effects of suppressing thoughts of a past relationship. *Journal of Personality and Social Psychology* 68:782–92

Wegner D.M., Schneider D.J., Carter S.R. & White T.L. (1987) Paradoxical Effects of Thought Suppression. *Journal of Personality and Social Psychology* 53, 5-13

Wegner D.M., Schneider D.J., Knutson B. & McMahon S.R. (1991) Polluting the stream of consciousness: The effect of thought suppression on the mind's environment. *Cognitive Therapy and Research* 15, 141-151

Wenzlaff D., Wegner D.M., & Klein S.B. (1991) The role of thought suppression in the bonding of thought and mood. *Journal of Personality and Social Psychology* 60, 500-508





## APPENDIX 1: MINDFULNESS INSTRUCTIONS

### SETTING & POSTURE

Even though we can practice mindfulness in any place and in any posture, some conditions are more conducive. So first we find a relatively quiet place where we are unlikely to be disturbed. We then adopt a relaxed but alert posture. The traditional position is sitting cross legged on a cushion on the floor, but sitting on a chair with the back straight and unsupported and relaxed will do just as well.

### EYES OPENED OR CLOSED

When beginning practice it is better to close the eyes. Ultimately it is very useful to be able to practise mindfulness with the eyes open as it allows us to expand its application to a much broader range of settings.

### THE ANCHOR: BREATH OR MANTRA

We then use the breath as an anchor for our attention. A repeated phrase called a mantra can be used for the same purpose. However, the breath has the advantages of immediately bringing the attention into the body. Moreover, awareness of the breath immediately focuses our attention on a function that is under both conscious and unconscious control. This is a very appropriate place for psychological work to occur. So we focus our attention on the breath without trying to control it. We let the breath breathe itself.

### ALL THOUGHTS ARE "JUST THOUGHTS"

All thoughts including images are regarded as equal while meditating. It does not matter how noble or base they might be; how profound or banal they might be. This is how we cultivate the non-judgemental awareness that is the cornerstone of mindfulness. So for the purpose of mindfulness they are all "just thoughts".

### DEALING WITH DISTRACTION FROM THE BREATH (OR MANTRA)

Soon enough we will realise we have become distracted from our breath and immersed in our thought stream as is our well established habit. When this happens we *gently* bring attention back to the breath without criticism or struggle. We have just been for a dip in our thought stream. So we lightly return to the solid ground of our awareness of our breath. It is this gentle process of moving in and out of the mind-stream that creates the decentering effect described by Segal et al (2002)

Similarly, **sensations** such as sounds, aches itches and tingles are quite acceptable. We can just allow them to be. When these sensations lead to discursive thoughts, such as: "I wish that dog next door would stop barking", then we treat that like any other thought. So we just gently return our attention to our breath.

Strong emotions can sometimes be problematic. They can lead to the practitioner being overwhelmed by a vortex of intense thoughts and feelings. In this case it is often helpful to be mindful of the changing physical sensations in the body associated with the emotion. As the practitioner watches the fluctuations and changing nature of these sensations, the sense of being overwhelmed can often be replaced with interest or even curiosity about the experience.

### ESTABLISHING A REGULAR DAILY PRACTICE

Many people have great difficulty establishing a regular daily practice. Usually it is best if a practitioner links the mindfulness practice into their normal daily routine. Most people have a predictable morning routine into which mindfulness can be slotted. The important thing is that the practice should not





be based on whether a practitioner feels up to it on a particular day or not. Instead it needs to be established as a good habit which is practised without internal disputation, much like brushing your teeth.

Sometimes flexibility and imagination are required to find an appropriate time and place. People with young children often find it easier to meditate at work in their office. Single parents of preschool children often find it very difficult to find time. Sometimes they can fit it in when the children are napping. Some people meditate on the train on the way to work in the morning.

## APPENDIX 2:

### MINDFULNESS IN ACTION TECHNIQUES

These techniques are useful for bring mindfulness into the activities of everyday life. They also are a good place to start with clients who have very low impulse control and distress tolerance. Linehan (2003 pp170-171 & 174-175) describes a number of these techniques as a way of developing distress tolerance in her "Skills Training Manual for Treating Borderline Personality Disorder"

Mindfulness in action techniques include:

**Focussing awareness of an aspect of a physical habit** that previously has largely been outside of conscious awareness e.g.

- Noticing how tight you hold the steering wheel when driving.
- Being aware of what happens to your breathing or voice tone in an argument.

**Focussing awareness on the breath when a specified environmental cue occurs.** This technique has been described in detail by Thich Nhat Hanh (1991 pp22-30). The cues we might use include:

Waiting for phone to be answered  
Waiting at a red traffic light  
Walking  
Listening to Music  
Getting Dressed

**Detailed awareness of the mental phenomena associated with cravings** such as thoughts, physical sensations and feelings. This is different to urge surfing as this technique includes no expectation that the craving will be outlasted.



### APPENDIX 3:

#### WHY MINDFULNESS INSTRUCTORS NEED THEIR OWN REGULAR PRACTICE

Mindfulness is an experiential skill, like swimming, playing a musical instrument, playing chess or rock climbing. Anyone teaching these skills is in fact a coach. To teach an experiential skill (to coach) requires some mastery of that skill. The coach's experience creates an invitational stance because of the continuity between the experience of the instructor and the student. This continuity of experience allows the instructor to tune into the subtleties of the student's mindfulness experience. The instructor can then tailor their coaching to the specific requirements of the student.

Moreover, experiential information is often conveyed non-verbally. This can be done skilfully if the instructor carries the information at an experiential level, within the body. So if instructions about staying non-judgementally with the contents of consciousness are based on the instructor's own experience, then tone of voice, gesticulations and affective expression will all be congruent. This will enhance the verbal message being conveyed.

The student needs to know the instructor has skill and experience. They then sense that their instructor embodies a way of practising mindfulness. This makes it easier to learn by modelling, just as a rock climbing student might do with an instructor. An example of where this might manifest would be the ability of the instructor to competently relate to unpleasant affect.

### APPENDIX 4: THE "JUST WORRYING" LABELLING TECHNIQUE

As a preamble to discussing this technique with a client it is often helpful to differentiate worrying from constructive problem solving. Worrying involves repetitive circular thinking, which is associated with anxiety and produces no enactable practical outcomes.

This technique simply involves a person labelling worry as "just worrying" and then bringing their attention back to their breath or to simply change the subject of their thinking. Every time a person catches themselves worrying they just label it again and change the subject. It doesn't matter if a person does it 10 times in one minute or if they only realise they have been worrying after a period of 2 hours and then apply the technique. The important thing is that the person applies the technique when they realise they are worrying.

This technique involves no criticism or internal struggle, just simple non-judgemental labelling. **Therefore it is important in this regard that the client does not change the label from "just worrying" to "don't worry".**

This technique is very powerful and most people find that their worrying thoughts dissipate almost totally within a few days. Then they usually start worrying about a week later because they have forgotten about the technique through lack of need to use it. At that point a reminder of the technique usually suffices.

The same technique can be applied to other disturbing repetitive mental events using labels such as "just doubting" or "just criticising". This is subtly but significantly different to avoidance. It is not running away from the aversive mental stimulus. Rather it is the non-judgemental labelling which is encapsulated in the word "just"

