

# Introduction

Our world today is filled with violence. Even those who specialize in working with trauma victims can be stunned by the stories they hear of childhood abuse, family violence, sexual assaults, and the atrocities of war. Such events can leave lasting scars for those who experience them, whether or not the residual effects lead to full-blown clinical disorders like posttraumatic stress disorder (PTSD).

Inevitably, no matter what kind of clinical work one does, all therapists will encounter clients with some history of trauma. Therefore, we believe that all competent clinicians should have an understanding of PTSD, and at least some level of working knowledge of the principles involved in the treatment of individuals with trauma histories.

Clients are often reticent to seek out treatment, and even our best evidence-based practices for PTSD, such as Cognitive Processing Therapy (CPT; Chard, 2005; Resick et al., 2008) and Prolonged Exposure (PE; Foa et al., 1999), may not be effective at reducing symptoms to a sub-clinical level more than 70% of the time (Resick, Nishith, Weaver, Astin, & Feuer, 2002). Hence, tools to enhance current treatments, and to decrease residual symptoms, are continually being sought. This need resulted in the authors collaborating on a feasibility study to adapt mindfulness-based cognitive therapy (MBCT) for the treatment of individuals with PTSD.

MBCT is an eight-session program, meeting once per week with regular home practice assignments, which teaches the skills of mindful awareness and the principles of cognitive-behavioral therapy. It was first developed in the 1990s by Zindel Segal, Mark Williams, and John Teasdale (Segal, Williams, & Teasdale, 2013), adapted from mindfulness-based stress

## 2 *Mindfulness-Based Cognitive Therapy*

reduction (MBSR), developed in the 1970s by Jon Kabat-Zinn, Saki Santorelli, Elana Rosenbaum, and their colleagues (Kabat-Zinn, 2013).

MBCT was originally designed to help individuals with a history of major depressive disorder prevent future recurrences. The more episodes a person experiences, the higher the risk for depression coming back again. After two major depressive episodes, the chance of having yet another recurrence rises to 70–80% (Keller, Lavori, Lewis, & Klerman, 1983; Kupfer, 1991).

A major focus of MBCT is teaching mindfulness skills, which fosters our capacity to pay attention to present moment experiences. Becoming aware of automatic reaction patterns opens up the possibility of making more adaptive choices. By noticing, rather than avoiding, unpleasant thoughts, emotions, and body sensations, clients can learn to relate to them differently. One of the techniques clients practice is known as “decentering” (Piaget, 1950; Piaget & Morf, 1958; Segal, Williams, & Teasdale, 2013), which involves recognizing thoughts as mental events, rather than getting overly caught up in them as if they were always perfect representations of reality. Learning to stay present with strong emotions and body sensations counteracts maladaptive avoidance patterns. By noticing the warning signals of rising levels of stress, depression, anxiety, or pain, clients can be proactive to take care of themselves, instead of ignoring those signals until they become overwhelming and more difficult to handle.

The evidence base for MBCT is strong, demonstrating significant reductions in depressive relapse rates, especially for those who have suffered three or more previous episodes (Chiesa & Serretti, 2011; Hofmann, Sawyer, Witt, & Oh, 2010; Kuyken, Crane, & Dalgleish, 2012; Ma & Teasdale, 2004; Piet & Hougaard, 2011; Segal, Teasdale, & Williams, 2004; Teasdale, Segal, & Williams, 1995; Teasdale, Segal, Williams, Ridgeway, Soulsby, & Lau, 2000; Williams & Kuyken, 2012). MBCT has also been shown to be as effective as maintenance antidepressant pharmacotherapy in preventing depression from returning (Kuyken, Byford, Byng, Dalgleish, Lewis, et al., 2010; Segal, Bieling, Young, McQueen, Cooke, et al., 2010).

Inspired by its success in preventing depressive relapse, clinicians and researchers have continued to study and adapt MBCT for a variety of populations and presenting issues, such as addictions (Bowen, Chalwa, & Marlatt, 2010), bipolar disorder (Deckersbach, Hölzel, Eisner, Lazar, & Nierenberg, 2014), cancer (Bartley, 2011), children and adolescents (Semple & Lee, 2011), eating disorders (Kristeller & Wolever, 2011), generalized anxiety disorder (Evans, Ferrando, Findler, Stowell, Smart, & Haglin, 2008; Roemer & Orsillo, 2002; Roemer, Orsillo, & Salters-Pedneault, 2008), health anxiety (Surawy, McManus, Muse, & Williams, 2014; Williams,

McManus, Muse, & Williams, 2011), stress (Rimes & Wingrove, 2011; Sears, 2015), and tinnitus (Sadler, Stephens, & Kennedy, 2008).

Given the frequent comorbidity of depression and PTSD, the usefulness of decentering from intense thoughts and emotions, and the importance of working with avoidance, investigating the potential benefits of using MBCT for PTSD holds much promise. Later in this book, we will discuss the preliminary results of studies like those done by the authors at the Cincinnati VA PTSD clinic, by Anthony King and colleagues at the Ann Arbor VA (King, Erickson, Giardino, Favorite, Rauch, Robinson, Kulkarni, & Liberzon, 2013), and Louanne Davis and Brandi Luedtke at the Indianapolis VA (Davis & Luedtke, 2013). We will also share clinical experiences from work we have done in private practice, medical agencies, and other settings.

Interest in mindfulness among clinicians has quickly grown in popularity in the last decade, inspired by the personal benefits, the brain imaging studies, and the explosion of clinical research. However, as is all too common in clinical work, sometimes enthusiasm for an intervention precedes the evidence for how best to use it. A recent meta-analysis reviewed 18,753 mindfulness research citations, and found only 47 studies (with 3,515 subjects) that were randomized, clinical trials with active controls for placebo effects (Goyal, Singh, Sibinga, Gould, Rowland-Seymour, Sharma, Berger, et al., 2014).

The best empirical evidence to date comes from well-trained clinicians who utilize carefully developed interventions, such as MBSR, MBCT, dialectical behavior therapy (DBT; Linehan, 1993, 2014), and acceptance and commitment therapy (ACT; Hayes, Strosahl, & Wilson, 2012).

Sometimes individuals with their own personal meditation backgrounds make assumptions about how mindfulness can be used clinically. While a personal practice provides an important foundation, mindfulness is simply a tool, and as such, must be used wisely, with an understanding of the populations and the presenting issues for which it is being used. Mindfulness should be used to enhance, and never to replace, good clinical training and competence.

By definition, people with PTSD have experienced something so terrible they do not want to continually remember it (APA, 2012). Yet, a part of their brain does not want them to forget, perhaps because it may be crucial to future survival. Much of the distress they experience comes from an ongoing battle with their own intrusive memories, thoughts, feelings, and body sensations. Hence, asking them to pay more attention to thoughts, emotions, and sensations will be uncomfortable at best, and if not done carefully, could even exacerbate their symptoms.

#### 4 *Mindfulness-Based Cognitive Therapy*

Our purpose is not to take away what we know works well for PTSD. It is important to be trained in best practices for the treatment of trauma. Rather, our purpose is to provide more tools and perspectives. After all, mindfulness is simply awareness. Given how complicated posttraumatic stress can be, paying more attention to the dynamics of what is going on is very important for both clients and clinicians.

Sometimes knowing what *not* to do is as important as knowing what to do, as lack of awareness can actually harm clients, despite the therapist's best intentions. At one extreme, we as clinicians may be so uncomfortable or fearful of upsetting clients that we become shaped by them to avoid processing anything related to the trauma. A participant in an MBCT workshop at a national convention once asked, "Did you say you were doing research on mindfulness for PTSD? Wouldn't paying more attention make clients with PTSD feel worse?"

"It certainly can, so it must be done very carefully," I replied.

"Well, I have a client with PTSD," he informed me. "And whenever anything comes up that reminds her of the trauma, she starts to get upset, so we talk about something else." Not surprisingly, he went on to say that they had not made any progress in their work together.

At the other extreme, we can cause harm if we attempt to treat individuals with trauma histories without proper training. A Vietnam veteran once reported that he had been asked to participate in a psychodrama in which everyone acted out an experience from his tour in Vietnam. The veteran flashed back, reliving his Vietnam experience as if he were there again, and ended up attacking and choking the perhaps well-meaning but ill-equipped therapist.

Segal, Williams, and Teasdale (2013) were depression researchers looking for ways to prevent relapse, which led to the development of MBCT. They did not begin with an agenda for how they could promote mindfulness. Once developed, they were concerned about finding clinicians to support its implementation, since it requires both solid CBT clinical skills and experience, as well as a commitment to an ongoing personal mindfulness practice.

Likewise, we are not proselytizers for a particular intervention for its own sake, but are continuously seeking better ways to help the trauma survivors we serve, and believe that MBCT for PTSD offers unique potential to help at least certain subpopulations. We also are concerned about implementation, since it requires competence in CBT, mindfulness, and trauma interventions, but we feel it is important to begin promoting awareness, engaging in critical dialogue, and investigating its potential through carefully controlled empirical research.

Just as an ethical clinician would not work with a new clinical population or intervention after reading only one book on the subject, this book is not meant to be a stand-alone guide for using MBCT for individuals with PTSD. Though admittedly somewhat ambitious, we have six goals in mind for clinicians who read this book:

1. To increase general understanding of the nature of trauma and PTSD.
2. To raise awareness of the principles of evidence-based treatments for PTSD.
3. To provide an overview of the principles of mindfulness as it is used in clinical contexts.
4. To outline the principles and techniques of MBCT and how it can be adapted for use as a component in the treatment of trauma.
5. To highlight the importance of building both personal and professional competence in mindfulness techniques as a foundation for intervention delivery as well as for clinician self-care.
6. To inspire future research on trauma and more efficacious interventions that are informed by established principles and clinical expertise.

This book is also not meant to be an authoritative treatise on the best and only way to do this work, as there are many variables that still need to be more thoroughly tested. For instance, some clinicians find it important to first use a treatment like Cognitive Processing Therapy or Prolonged Exposure first, allowing for more stability before working with an intervention like MBCT. Others have found that some basic mindfulness training first can be helpful for clients to better manage the emotions that come up with more traditional trauma interventions. Building one's knowledge base and supervised training experiences in using both mindfulness and PTSD treatments allows one to more confidently rely on clinical judgment for when and how to integrate and apply these interventions, in careful consideration of the individual's history, symptoms, and diversity variables.

The next chapter will begin with the nature of trauma and PTSD, including its etiology, risk factors, and the processes that contribute to continuation of posttraumatic symptoms. Current evidence-based treatments, including Cognitive Processing Therapy and Prolonged Exposure, will also be discussed. In Chapter 3, the nature of mindfulness and mindfulness-based interventions will be discussed, including ways they have been used to augment existing gold standard PTSD treatments. The mechanisms and principles related to the efficacy of mindfulness-based approaches will then be discussed, including the underlying neurological processes involved. Chapter 4 will provide an overview of the principles and curriculum of the

## 6 *Mindfulness-Based Cognitive Therapy*

eight-week MBCT protocol, along with considerations for adapting the material for working with trauma survivors. Chapter 5 will discuss delivery of MBCT for PTSD in individual and group formats, provide practical considerations for implementation, and explore possible future directions. The final chapter will provide suggestions and resources to help therapists build their personal and professional competence in practicing mindfulness and providing mindfulness-based interventions for trauma survivors.

There are countless human beings suffering from posttraumatic stress, and we as clinicians can give our clients real and concrete tools to help them make the shift from surviving to living. This work requires specialized knowledge, training, and dedication, for those with whom we work as well as for our own self-care and professional development. If we pay attention, there is always more to learn, even for those of us who have been in the field for decades. Are you ready to begin?