

## Mindfulness Training and Problem Formulation

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**Evidence suggests mindfulness-based clinical interventions are effective. Accepting this, we caution against assuming that mindfulness can be applied as a generic technique across a range of disorders without formulating how the approach addresses the factors maintaining the disorder in question. Six specific issues are raised: mindfulness has been found to be unhelpful in some contexts; where mindfulness has been found to be effective, instructors have derived and shared with clients a clear problem formulation; there may be many dimensions of effectiveness underlying the apparent simplicity of mindfulness; mindfulness was developed within a particular "view" of emotional suffering that implies wider changes that go beyond meditation practice alone; professionals need to match the different components of mindfulness with the psychopathology being targeted; nonetheless, mindfulness may affect processes common to different pathologies.**

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**B**aer (2003; this issue) provides a very helpful and thoughtful overview of the current status of mindfulness training as a clinical intervention. The literature Baer reviews suggests that the apparently simple procedure of teaching people to pay attention "in a particular way" has benefits across a wide range of disorders. Further, it seems that, in some situations, these benefits can be obtained when patients are seen in large groups, with mixed diagnoses, and in situations in which it may appear that the training is not tailored to specific formulations of particular conditions but, rather, is offered in much the same

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way to all. In such situations, a generic form of mindfulness training apparently yields clinically useful effects. From such evidence it might seem that mindfulness training offers a cheap, general-purpose, therapeutic technology that can be successfully applied without the need for clients or instructors to understand the problems being treated, or the way that change occurs: All that is required is to apply the appropriate training, and await the positive results.

Can it really be this simple? Does mindfulness training offer to a wide range of clinical problems a single answer that can be applied without any need to formulate the nature of these problems or the way they are to be changed? We suggest that this is unlikely. Further, we believe that attempts to apply mindfulness training indiscriminately, as if it were a simple, general-purpose therapeutic technology, are unlikely to yield results as promising as those reported in the literature reviewed by Baer. This is because, we would argue, the research that suggests positive effects for mindfulness training has focused on instructors who were not just proficient technicians in the delivery of certain forms of attention training. Rather, these instructors also embodied, sometimes implicitly, quite specific views of the nature of emotional distress and of the ways to reduce that distress. Focusing on the more obvious aspects of attentional training, while neglecting the need for such formulations, is likely to lead to enfeebled and misplaced applications of mindfulness training. In this brief commentary, we describe our reasons for making this assertion, noting their congruence with views previously expressed elsewhere (e.g., Hayes, 2002).

There are a number of considerations that suggest to us that mindfulness training, if it is to be effective in treating clinical problems, is best conducted by practitioners who have adequately formulated views of the disorders that they seek to treat and of the ways that mindfulness training can be helpful to clients with those disorders. We summarize each of these considerations here and then describe them in further detail below. (1) The profession already knows that mindfulness training can be unhelpful in certain situations, so clearer understanding of when and how it is helpful is important if we are to focus the therapeutic potential of this training effectively. (2) Research demonstrating the effectiveness of mindfulness training has involved instructors using that training in tandem with particular ways of understanding emotional disorder and its

remediation. We cannot assume that equivalent effects will be achieved without such contexts of understanding. 3) Relatedly, mindfulness training is a basically simple procedure, but the way in which it is delivered may be as important as the content of what is delivered. Style of delivery will reflect instructors' ways of understanding. (4) Within the tradition in which mindfulness training was developed, mindfulness was never seen as an end in itself, but as one part of a comprehensive, multifaceted path to resolve a clearly formulated problem. The same is likely to be true of effective clinical use of mindfulness training. (5) Mindfulness training is multifaceted, and certain components may be more relevant to some clinical conditions than others. Effectiveness may depend on the appropriate problem-component match. (6) Although mindfulness training may modify processes common to a range of psychopathologies, awareness of those common effects, rather than indiscriminate application of techniques, is likely to enhance clinical outcomes. We now consider each of these points in turn.

#### **MINDFULNESS TRAINING CAN BE UNHELPFUL**

In our research demonstrating the effectiveness of mindfulness-based cognitive therapy (MBCT) in reducing risk of relapse in patients with a history of three or more episodes of depression (Teasdale et al., 2000), we found that the same training was unhelpful to patients who had experienced only two previous episodes. Exactly the same pattern of results was observed in a subsequent trial (Ma, 2002). It is not simply that the benefits for those with only two episodes failed to reach statistical significance. Rather, in both trials, patients with only two previous episodes showed a nonsignificantly greater tendency to relapse following MBCT than patients who continued with treatment as usual. By contrast, in patients with three or more episodes, relapse rates after MBCT were halved when compared to those rates of patients with treatment as usual. Such results suggest, very interestingly, first, that we can identify distinct relapse-related psychopathologies in terms of differential response to MBCT, and, second, that MBCT may be relevant to only one of those psychopathologies. Extrapolation from these particular findings suggests that, more generally, mindfulness training may be helpful only in certain situations, and clinicians should take care to apply mindfulness-based interventions to clinical conditions in terms of analyses both of these conditions and of what mindfulness training can offer.

#### **SHARING A CLEAR FORMULATION WITH CLIENTS**

In our own work with MBCT (Segal, Williams, & Teasdale, 2002), mindfulness training is conducted in the context of an explicit analysis of the processes involved in depressive relapse and of the relevance of mindfulness to changing those processes. The same is true of the use of mindfulness in the dialectical behavior therapy program for treating borderline personality disorder, developed by Linehan (1993a, 1993b), and in a more recent acceptance-based treatment of generalized anxiety disorder (Roemer & Orsillo, 2002). Research on the mindfulness-based stress reduction (MBSR) program (Kabat-Zinn, 1990) has also shown that, in the clinical setting where this program was developed and initially evaluated, use of specific mindfulness training techniques is embedded in a coherent context of understanding. It is important to note that this understanding (formulation) is communicated by instructors to clients in many different ways in the interchanges that occur around the specific techniques that are being taught (Wizer, 1995). The demonstrated effectiveness of mindfulness training when, as in these programs, it is linked to coherent alternative views of clients' problems, views that are shared with clients and reinforced by the mindfulness practices, cannot necessarily justify use of such training in isolation from those shared formulations. Indeed, within our analyses of the effects of MBCT (Teasdale, Segal & Williams, 1995) and of cognitive-behavioral treatments more generally (Teasdale, 1993, 1997) we see the lasting effects of psychological interventions as critically dependent on the creation of such alternative views, rather than on the repeated use of coping behaviors alone.

#### **THE APPARENT SIMPLICITY OF MINDFULNESS APPROACHES**

As Baer notes, mindfulness has been defined as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994, p. 4). Such a brief definition might suggest that mindfulness training is simple. It is. But it is also difficult, and the full significance of each characteristic of mindfulness and, in turn, adequate training of mindfulness may be realized only when the relevance of each aspect of mindfulness to a particular problem is formulated. For example, our analysis of the ruminative thinking that underpins depressive relapse (Segal et al., 2002, pp. 64–77) suggests that this thinking reflects a more general goal-based mode of processing, in which judgments and evaluations of discrepancies between

actual and desired states are central. One way in which mindfulness is seen as helpful is in allowing individuals to switch out of goal-based processing into an alternative, incompatible, mode of processing that is not, itself, goal based. However, the ease with which individuals learn to access that alternative mode will depend crucially on the *way* that attentional training is conducted. It is all too easy for instructors and clients alike to focus on the task of paying attention on purpose and in the moment in a way that is, itself, goal oriented. From the perspective of our analysis, this way of training would be counterproductive. And yet, without a formulation that emphasizes why a shift from such goal-based processing may be central to therapeutic efforts, it is only too natural for instructors to fall into a goal-oriented mode in delivering what is intended to be the training of mindfulness.

#### **INTEGRATING MINDFULNESS INTO A "WHOLE VIEW" OF EMOTIONAL SUFFERING AND DISORDER**

Baer notes that Western researchers and clinicians who have introduced mindfulness practice into mental health programs usually teach these skills independently of the religious and cultural traditions of their origins. We believe that this is quite appropriate. However, although clinicians teach mindfulness independently of the specifically religious and cultural aspects of these traditions, we would suggest (as above) that those instructors whose effectiveness has been assessed by research have been guided by the analysis of emotional suffering and its resolution that is at the heart of these traditions. For this reason, it is relevant to note that, in these traditions, mindfulness has always been used as only one of a number of components of a much wider intervention, or path, itself grounded in a clear formulation of the origins and cessation of suffering, rather than as an end in itself. The separate components of the path are integrated and informed within an overarching analysis of suffering. As a result, the effects of these components interact in ways that allow the impact of the whole path to become more than the sum of its parts. We suggest that contemporary clinical applications of mindfulness training would similarly benefit from theory-driven integration within a wider intervention.

#### **THE CHALLENGE OF UNDERSTANDING AND EVALUATING A MULTIFACETED APPROACH**

Mindfulness training is multifaceted, and Baer notes a number of ways in which it has been suggested that such

training may be helpful: exposure, cognitive change, self-management, relaxation, and acceptance. Although these separate aspects are interrelated, training often emphasizes one or more of them over others. It is likely that the overall impact of mindfulness training will be enhanced if the relative emphasis given to different components reflects the relative importance, in particular instances, of the psychopathological processes that they target. Such matching of intervention to problem will be assisted by a clearly formulated analysis of both problem and intervention. For example, disengagement of attention from ruminative processing (Nolen-Hoeksema, 1991), and its redeployment to a neutral focus, such as the movement of the breath, may be particularly relevant to skilled self-management of depressed moods (Teasdale et al., 1995), whereas the reduction of experiential avoidance may be more appropriate in a number of anxiety-related disorders (Hayes, Wilson, Strosahl, Gifford, & Follette, 1996).

#### **THE POSSIBILITY OF COMMONALITY OF EFFECTS**

Although clinicians need to match intervention to problem, they also need to be aware of the possibility that mindfulness training may have widespread beneficial effects because it targets processes that cut across a range of disorders. An example of such a generically useful skill is the training of individuals to switch out of habitual, relatively automatic, patterns of reaction into more intentional, considered choice of response. Another example is the cultivation of an attitude of "acceptance" and "allowing" towards difficult and unpleasant experiences so that the negative impact of such experience is not compounded by self-induced aversion. Such benefits may accrue to some degree if mindfulness is trained relatively mechanically as a general-purpose psychological technique. However, these effects are likely to be considerably enhanced if mindfulness training is offered by instructors who are themselves aware of the rich variety of processes that are subsumed within this apparently simple procedure and who, as a consequence, attune the way that the training is delivered in the moment to the needs of the moment.

#### **CONCLUSION**

As Baer notes, mindfulness training is conceptually consistent with cognitive-behavioral treatment procedures but also differs from them in important ways. We regard the possibility of a synergistic relationship between mindfulness training and cognitive-behavioral therapy, each comple-

menting the other, as one of the most exciting and potentially productive avenues for future exploration. We suggest that the full fruits of this relationship are most likely to be realized if the integration of these approaches is guided by adequate conceptualizations both of the nature of the problems to be addressed and of the respective contributions of the two approaches to resolution of those problems.

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