Core differences between MBCT and MiCBT

Mindfulness-integrated Cognitive behaviour Therapy (MiCBT) and Mindfulness Based Cognitive Therapy (MBCT) are both evidence-based approaches that inevitably overlap but are also different in several ways. This is because the two methods were originally designed for different purposes, originate from different teachings and teachers of mindfulness training, and incorporate different Western psychological methods. Here is a very brief overview of these techniques, with more information on MiCBT given that it is less well known than MBCT.

MBCT

MBCT uses Mindfulness Based Stress Reduction (MBSR)—which itself combines mindfulness meditation and gentle *asana yoga* exercises—with psycho-education and other aspects from Cognitive Therapy to reduce the probability of relapse in chronic depression once people are at least in remission, and has shown to do this effectively when people are not in crisis or abusing a substance and when they have been clinically depressed at least three times in their life. Two replication studies show that those with less than three major episodes of depression tend to relapse just as much with MBCT as with treatment as usual (about 74% relapse after 2 years).

MBCT is constructed to be delivered 'as a class' in a group format and is typically implemented in this way. When used for what it was designed to do, MBCT is very effective, decreasing the probability of relapse into depression by about 50% over a 2-year period. More recent studies also show that modified versions of MBCT may be effective for other conditions, such as reducing anxiety symptoms. There is abundant outcomes research and more is being published on the content and schedule of implementation. More can be found at: http://mbct.co.uk

MiCBT

MiCBT is a 4-stage systemic model of therapy based on the 'co-emergence model of reinforcement' (Cayoun, 2011) and designed to be implemented across a broad range of disorders to address crisis, chronic conditions, and prevent relapse in both group and individual therapy. The 4 stages are: Personal, Exposure, Interpersonal and Empathic. It is flexible and wide-ranging in its applications for several reasons. MiCBT tightly integrates traditionally delivered mindfulness meditation (in the Burmese Vipassana tradition) with core principles of behaviour modification (such as exposure and assertiveness training) and cognitive restructuring techniques (such as using the downward arrow method to elicit and neutralise core schemas), though it omits disputation techniques.

Stage 1 principally teaches mindfulness meditation. It is called the 'Personal stage', as mindfulness skills are developed to regulate attention (through mindfulness of breath) and emotions (through developing equanimity while scanning the body). People learn 4 central aspects of inner experience first hand. They learn (1) how self-referential processing (thoughts that involve topics of personal importance) 'co-emerge' with corresponding sensations in the body, such that the more identified they are with the topic, the more intense the sensation is. They also learn (2) to witness the linear relationship between the agreeableness of thoughts and the un/pleasantness of body sensations—the more disagreeable the thought is, the more unpleasant the sensation is. They learn that (3) the

need to react is essentially a need to either maximise the experience of pleasant body-sensations (craving) or to minimise the experience of unpleasant ones (aversion/avoidance). Importantly, clients learn that (4) not engaging in craving and aversion reactions (i.e., remaining equanimous) creates desensitisation and eventual extinction of the conditioned response—they learn that body sensations are the locus of reinforcement.

Once people "feel" about 80% of the body following 1 week of mindfulness of breath and 2 weeks of systematic body-scanning, they start 'Stage 2' (the Exposure Stage). Stage 2 builds on equanimity skills developed in Stage 1 to decrease habits of avoidance in specific situations. This is achieved through 'bi-polar exposure', a technique whereby they are initially 'exposed' to problematic experiences in imagery, followed by *in-vivo* exposure (in a real situation). People initially use exposure to body sensations while imagining best and worst case scenarios in these difficult situations, rather than uniquely desensitising from the stimulus. This makes good sense neurologically too, since imagined stimuli engage the same brain pathways. Once reactivity to body sensations has decreased in imagery, people face the difficult situation in real life.

Once a client's confidence in their ability to face difficult situations has increased through Stage 2, s/he progresses to Stage 3 (the 'Interpersonal stage') during which they learn mindfulness-based assertiveness skills and how to not react to others' reactivity. Because of the two previous stages, their awareness, equanimity and confidence allow them to be more objective with and about others. They learn not to be affected by people's emotional reactivity while at the same time remaining aware of the other's suffering (how others, too, react inadvertently to their sensations, rather than to "me", to feel better). This also helps preserve or improve their social network and contributes to preventing relapse.

Stage 3 naturally leads people to understand how they create or maintain unhappiness unnecessarily and gently leads on to Stage 4 (the 'Empathic stage'). Clients begin a more formal compassion training during which they practice loving kindness meditation (after each 30-min of advanced body-scanning session) and engage in a set of 'ethical challenges', presented and understood as 'behavioural experiments'. They learn that they are the first recipient of their emotions and learn to examine the aversive effects created in the body due to harmful speech, thoughts and actions towards themselves and others. This is probably the most powerful stage in terms of shift in consciousness but it is not (or only superficially) accessible unless the previous stages have been completed. Metaphorically speaking, we weed the garden before planting new seeds. The sequencing of the 4 stages is empirically supported and the one-on-one therapy format has been shown to be as beneficial as the group format. More MiCBT research can be found at: http://mindfulness.net.au

This is a very brief overview of the model presented in Dr Cayoun's book for therapists: Cayoun, B. A. (2011). *Mindfulness-integrated CBT: Principles and practice*. Chichester, UK: Wiley-Blackwell. Dr Cayoun has written another book for the general public, which can be used as a self-help book or as a simpler guide for therapists: Cayoun, B. A. (2015). *Mindfulness-integrated CBT for well-being and personal growth: Four steps to enhance inner calm, self-confidence and relationships*. Chichester, UK: Wiley.