Mindfulness-Based Interventions in Practice

THE TALKING THERAPIES UK PRACTITIONER SERIES



Mindfulness-Based Interventions in Practice

Integrating mindfulness into individual therapy: choosing, adapting and troubleshooting practices.

Practitioner level · 10 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Mindfulness-Based Interventions in Practice course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

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A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

A practice that helps one client can destabilise another, and the difference is rarely in the practice itself: it is in the match between practice and formulation. This course teaches mindfulness-based work at that clinical standard, for practitioners integrating it into individual therapy rather than delivering a fixed programme.

You will learn to select and adapt practices by formulation: which practices suit which presentations, where breath-focus misleads, when body-based work needs titration, and how to adapt length, posture and anchor for real clients including those with trauma histories. You will study inquiry, the teaching conversation that follows practice, as the place where the learning actually happens. The second module works with difficulty: sleepiness, restlessness, distressing experience and doubt treated as the curriculum itself rather than obstacles to it, and the boundaries question answered honestly, including what depth of practice a therapist can responsibly lead without further training.

Substantial written lessons with key points and applied practice tasks, supported by a study tutor. Ten hours of CPD with around nine months of access, a final assessment, and a personalised certificate on passing. For clinicians who want their mindfulness work to be as formulated as the rest of their practice.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at practitioner level and carries 10 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Deliver the core practices of MBSR and MBCT with skilled guidance and inquiry
- Conduct inquiry after practice: opening experience, normalising, and drawing the learning
- Teach the cognitive component of MBCT, including the relationship between mood and thought
- Adapt practices for anxiety, rumination and low mood in individual therapy
- Work with common obstacles: sleepiness, restlessness, doubt and striving
- Hold group process in mindfulness-based courses without losing the practice thread

PART 1

Foundations of Mindfulness Practice

This module covers adapting mindfulness practices for diverse clinical presentations and contexts.

CHAPTER 1

Matching practice to formulation

Lesson “Matching practice to formulation”:

In the intermediate stage of mindfulness-based clinical work the pivotal competence is not the ability to lead a generic eight-minute breath meditation, but the capacity to align a specific mindfulness practice with the client’s formulation. Formulation, understood in the tradition of the cognitive-behavioural model (Beck, 1976) and enriched by contemporary relational and neurobiological perspectives, is the clinician’s hypothesis about the client’s presenting problem, the maintaining mechanisms, and the contextual triggers that sustain distress. When the therapist can read that hypothesis and select an anchor – breath, body, sound, feet, or movement – whose mechanistic profile directly addresses the identified maintaining process, the intervention becomes a precision tool rather than a blunt instrument.

The notion of an “anchor” in mindfulness practice refers to the sensory or perceptual object that the client repeatedly returns to when attention wanders. The classic breath anchor, popularised by Kabat-Zinn (1990) and later refined in Mindfulness-Based Cognitive Therapy (Segal, Williams & Teasdale, 2002), stabilises the attentional network by providing a continuously available, internally generated stimulus. The body scan, as described in the original Mindfulness-Based Stress Reduction (MBSR) protocol, expands interoceptive awareness by guiding the client through a systematic, non-judgmental exploration of somatic sensations. Auditory anchors – for instance a gentle bell, a piece of ambient music, or the sound of a ticking clock – recruit the auditory cortex and can be less threatening for clients who experience heightened anxiety around internal cues. The tactile sense of the feet on the floor or the weight of the hands on the thighs offers a grounding stimulus that is external to the breath yet still embodied. Finally, movement-based anchors such as mindful walking, gentle yoga, or slow stretching engage the proprioceptive and vestibular systems, providing a dynamic form of attentional training that can be especially useful for hyper-aroused nervous systems.

Choosing an anchor by mechanism against the formulation begins with a clear articulation of the client's maintaining cycles. For a client whose formulation highlights rumination as the central driver – for example, a patient with recurrent depressive episodes whose cognitive model identifies a pattern of "thought-looping" that reinforces negative self-schemas – the therapist should favour practices that interrupt the loop early and repeatedly. Brief, frequent noticing practices, such as the three-minute breathing space of MBCT (Segal, Williams and Teasdale, 2002) or a quick auditory cue that prompts the client to label the current mental content, act as a train-stop for rumination. The brief duration prevents the client from becoming absorbed in a prolonged focus on the content of thoughts, which could otherwise become a new form of rumination.

In contrast, a formulation that foregrounds avoidance – for instance, a client with social anxiety who habitually disengages from internal sensations to escape perceived threat – requires a graduated exposure to sensation. Here the therapist might begin with a very short, external anchor such as the feeling of the feet on the floor, perhaps for thirty seconds, and then slowly lengthen the duration as tolerance builds. The language used to introduce the practice is crucial: framing the exercise as "noticing what is here, as much as feels workable" provides permission and reduces the likelihood of a defensive shutdown.

When the formulation identifies self-attack or self-criticism as a core maintaining factor – a pattern often observed in individuals with borderline personality features or chronic shame (Gilbert, 2005) – the therapist should select anchors that can be infused with a compassionate tone. A body scan that is paced slowly, with frequent invitations to "softly notice" rather than "hardly notice" can reduce the risk of back-draft, a phenomenon described in Mindful Self-Compassion teaching (Germer and Neff, 2013) where the sudden emergence of previously suppressed affect leads to an overwhelming surge of grief or anger. In such cases, the therapist may also incorporate loving-kindness phrases, but only after the client has demonstrated sufficient stability to tolerate the affective shift.

High-arousal presentations – for example, a client with post-traumatic stress disorder (PTSD) who experiences hyper-vigilance and a dominant sympathetic response – demand an entry point that down-regulates the autonomic nervous system before any open awareness is invited. Longer

exhalations, tactile grounding through the feet, and gentle movement such as slow walking may support autonomic down-regulation, including vagal pathways, in some clients (Porges, 2011). Only after a period of physiological calm should the therapist introduce a more subtle internal anchor, perhaps a soft auditory cue, to begin cultivating present-moment awareness.

The therapist must also be mindful of the potential destabilising effect of deep interoceptive focus in clients with unprocessed trauma. The body scan, while valuable for many, can, for some individuals with unresolved trauma, lead to activation of somatic memories that have not been negotiated within a trauma-informed framework (van der Kolk, 2014). When a formulation flags unresolved trauma, the clinician should assess the client's tolerance and may choose to postpone intensive body-focused work or to use a very limited, external anchor, while closely monitoring the client's affective response. If the client demonstrates safety and regulation, the therapist can then titrate the depth of interoceptive exposure, always maintaining a clear safety plan and grounding strategies.

Adaptation is the second half of the skill. Every parameter of a mindfulness practice is a lever that can be turned to suit the formulation: length, posture, anchor, language, and setting. A three-minute practice can be a complete therapeutic dose if it is precisely matched to the client's current capacity; a twenty-minute practice is not inherently superior. Posture can be adjusted – eyes open, standing, or walking – to accommodate the client's comfort and to align with the chosen anchor. Language must be trauma-sensitive; for a client with a history of coercive control, instructions that imply obedience ("you must focus on your breath") can be re-phrased as invitations ("you may notice the breath if that feels safe"). The physical setting, even down to whether the door is open, can be a subtle but powerful factor for clients whose formulation includes claustrophobia or a fear of confinement.

The clinical integration of these decisions is best illustrated through a worked example. Consider Maya, a 32-year-old woman referred for mindfulness support following a recent episode of panic disorder and a long-standing pattern of self-critical rumination. Her formulation, constructed collaboratively with her, identifies three maintaining mechanisms: (1) interoceptive hypersensitivity to breath-related sensations, (2) a habitual rumination loop that amplifies catastrophic predictions about

bodily sensations, and (3) a deep-seated shame narrative that fuels self-attack when she perceives herself as “out of control”.

The therapist begins by mapping each mechanism to a potential anchor. For mechanism (1), the breath may be avoided as a primary anchor if it reliably amplifies the panic cascade for this client; instead, the therapist selects the tactile sensation of the feet on the floor as an external grounding anchor. For mechanism (2), the therapist introduces a brief, frequent noticing practice – a two-minute “pause and label” exercise – that can be deployed whenever Maya notices the rumination train departing the station. The practice involves silently naming the content of the thought (e.g., “worry”, “catastrophe”) and then gently returning attention to the feet anchor. For mechanism (3), the therapist integrates a compassionate language component, inviting Maya to notice the self-critical voice with a tone of “soft curiosity” rather than confrontation.

The first session proceeds with Maya seated, feet flat on the mat, eyes gently open. The therapist guides her through a 60-second grounding of the feet, describing the pressure, temperature, and texture of the floor. The therapist then models the “pause and label” sequence, demonstrating how to notice a thought, label it, and return to the feet. Maya practices this three times, each time the therapist checks her physiological state, noting that her heart rate remains within a calm range. The therapist explicitly defers any breath-focused meditation for the next several weeks, noting in the treatment plan that the breath anchor will be revisited only when Maya demonstrates stable interoceptive tolerance.

Over the next six weeks, Maya reports a reduction in panic frequency, attributing the change to the external grounding and the brief labelling practice. When the therapist re-evaluates the formulation, the interoceptive hypersensitivity has diminished, and the client now expresses curiosity about the breath rather than fear. At this point, the therapist introduces a short, breath-anchored practice – a three-minute “soft breath awareness” – but only after a brief grounding of the feet, thereby providing a transitional safety net. Maya successfully incorporates the breath practice into her daily routine, reporting that it now feels like a gentle tide rather than a storm.

A second vignette demonstrates the opposite polarity of prescription. Alex, a 45-year-old man with chronic complex PTSD, presents with a formulation that highlights a body-based trauma memory network, hyper-vigilance, and

dissociative episodes when internal attention is prolonged. The therapist recognises that a full body scan would be destabilising. Instead, the therapist selects an auditory anchor – a low-frequency gong that fades in and out – combined with a very brief, three-minute mindful walking practice. The walking is performed in a safe, open corridor, with the therapist encouraging Alex to notice the sensation of each foot making contact with the floor, while simultaneously listening to the gong. The therapist also teaches Alex a "safe-place" visualisation that can be activated if dissociation begins. Over eight weeks, Alex reports increased tolerance for brief internal focus and a reduction in dissociative episodes, illustrating how the careful matching of anchor and formulation can transform a potentially risky practice into a therapeutic asset.

The prescription mindset that underlies these examples is simple in principle but demanding in execution: right practice, right dose, right sequence, continuously reviewed against the client's response. The clinician must hold the formulation as the north star, allowing it to guide decisions about which anchor to employ, how long to sustain the practice, and what language to use. This approach respects the individuality of each client and avoids the pitfall of treating mindfulness as a one-size-fits-all protocol.

In summary, the intermediate mindfulness clinician must move beyond the comfort of a pre-packaged curriculum and develop the nuanced skill of matching practice to formulation. Anchors differ not only in sensory modality but also in the neurocognitive mechanisms they engage. Breath anchors stabilise attentional networks but can amplify interoceptive threat in panic-prone clients; body anchors deepen interoception but may destabilise unprocessed trauma; auditory and tactile anchors provide external safety nets for clients with heightened internal threat; movement anchors regulate arousal in hyper-vigilant nervous systems. By selecting the anchor whose mechanism directly counters the client's maintaining factors, and by adjusting length, posture, language, and setting to the client's current capacity, the therapist creates a precision-matched mindfulness intervention. This precision is the hallmark of competent, evidence-based practice and the essence of the lesson on matching practice to formulation.

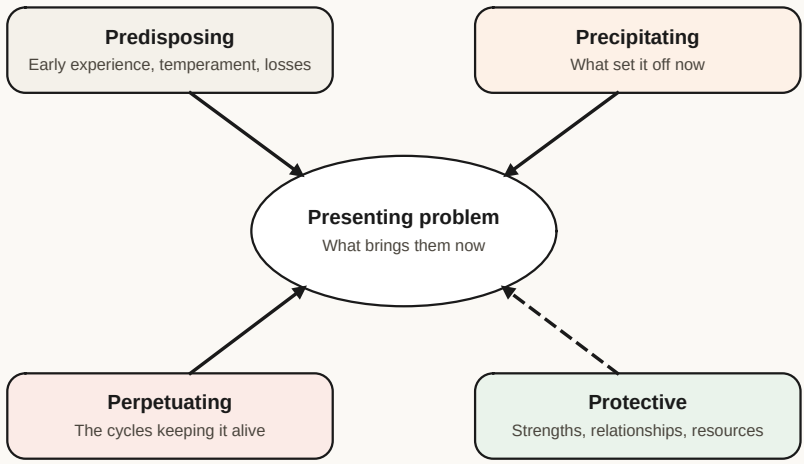


FIGURE 1.1 The five Ps of formulation

A shared map of how a difficulty came to be and what keeps it going: the presenting problem at the centre, with predisposing vulnerability, the precipitating trigger, perpetuating cycles, and protective strengths around it. A good formulation is provisional, collaborative, and rewrites itself as understanding deepens.

Points worth keeping

- Anchors differ: breath, body, sound, feet, movement
- Choose by mechanism against the formulation
- Body-focused depth can destabilise unprocessed trauma

PRACTICE TASK

For a panicky, interoceptively fearful client, name your first anchor choice and the reason in one sentence.

CHAPTER 2

Inquiry: the teaching conversation

Inquiry in Mindfulness-Based Interventions is the moment when the practice moves beyond the mere training of attention and becomes a therapeutic encounter. The practice itself supplies a concrete specimen of the client's lived experience; the subsequent conversation is the laboratory in which that specimen is examined, its meaning uncovered, and the client's relationship to experience transformed. This conversation, often called the teaching conversation, is a disciplined craft that emerged from the pioneering work of Jon Kabat-Zinn in the Mindfulness-Based Stress Reduction (MBSR) programme and Zindel Segal, Mark Williams and John Teasdale in Mindfulness-Based Cognitive Therapy (MBCT). It is now a core skill for clinicians who wish to integrate mindfulness into individual therapy, group work, or supervision. The structure of the teaching conversation can be described as three concentric layers – what was noticed, how it was met, and how the pattern mirrors broader life – each layer moving from concrete observation towards increasingly abstract insight. The relationship to experience, rather than the content of experience, is the therapeutic target; the clinician's role is to harvest the client's own discovery before offering any explanatory teaching.

The first layer, often termed the "noticed" layer, asks the client to stay with the raw phenomena that arose during the practice. The language is deliberately concrete: "What did you observe?" "Where in the body did you feel it?" "Was the sensation steady or changing?" By keeping the client at the level of sensations, thoughts, emotions and urges as events, the clinician prevents premature summarising or judgement. For example, a client might say, "I felt a tightness in my chest," rather than "I am anxious." The clinician gently invites the client to describe the tightness without attaching a label, because labelling can re-introduce the narrative mind that mindfulness seeks to observe with equanimity. This layer is rooted in the phenomenological stance championed by Kabat-Zinn, who taught that attention must be cultivated on the present moment, and in the cognitive-behavioural emphasis on precise description before interpretation.

The second layer, the "met" layer, explores the client's relationship to the

experience that has just been noticed. Here the clinician asks, “What happened after you noticed the tightness?” “How did you respond to the wandering of the mind?” “What attitude did you adopt towards the restlessness?” This is the therapeutic centre because it reveals habitual patterns of reacting – fighting, fleeing, grading, or despairing – that are the very targets of mindfulness training. In MBCT, Segal and colleagues described how a “decentering” stance – seeing thoughts as mental events rather than truths – can interrupt the chain of rumination that fuels depressive relapse. In the teaching conversation, the client’s own description of their reaction becomes the data from which insight can emerge. If a client reports that they judged themselves as “useless” when the mind wandered, the clinician does not immediately label this as self-criticism; instead, the clinician invites the client to stay with the feeling of judgment, noticing its quality, duration, and the impulse it generates. This invites the client to experience the judgment as a passing mental event, thereby loosening its grip.

The third layer, the “mirrors life” layer, invites the client to consider how the micro-pattern observed in the brief practice reflects broader behavioural or emotional patterns in their everyday life. Questions such as “Is this pattern familiar in other situations?” “Where else do you notice a tendency to push away experience?” or “What does this tell you about the way you relate to difficulty in general?” are posed. Crucially, the clinician seeks to let the client arrive at this connection rather than imposing it. The aim is to enable the client to see the practice as a microcosm of their lived experience, thereby fostering a sense of agency and self-directed learning. This mirrors the MBCT principle that the practice is a laboratory for testing and observing habitual mental habits, with learning arising from direct experience rather than from instruction (Segal, Williams and Teasdale, 2013).

The stance of the clinician throughout the three layers is as important as the structure. A curious, unhurried, non-fixing stance mirrors the mindfulness attitude of non-judgmental awareness. The clinician receives whatever the client reports – boredom, resentment, a sense of “nothing” – with genuine interest, because grading the practice as successful or failed re-instates the very evaluative mind that mindfulness aims to observe. The classic error, often observed in novice teachers, is to jump to instruction as soon as a teaching point is identified. For instance, a client may describe a vivid mental narrative of catastrophe; the clinician, spotting an opportunity to teach

decentring, might launch into a brief lecture about “thoughts are just thoughts.” While well-intentioned, this interrupts the client’s own process of discovery. The disciplined approach is to “harvest” first: the clinician continues to ask into the experience until the client’s own observation yields the insight. Only after the client has articulated the phenomenon does the clinician add a gentle frame, preferably as a question, such as “What do you make of the fact that the thought announced a catastrophe and then simply passed?” This question respects the client’s agency and encourages the insight to become part of their own experiential repertoire, rather than a piece of external knowledge that must be remembered.

The importance of harvesting before teaching is supported by empirical work on the mechanisms of change in mindfulness interventions. A meta-analysis of mediation studies by Gu and colleagues (2015) found strong evidence that MBCT and MBSR work through reduced cognitive and emotional reactivity, and moderate evidence for increased mindfulness and reduced rumination and worry. Moreover, an early controlled study found increases in grey matter concentration in the hippocampus and other regions after an MBSR course (Hölzel et al., 2011), although a larger trial with an active control found no such structural changes (Kral et al., 2022).

A concrete worked example illustrates how the three layers operate in practice. Consider a client, Maya, who has been attending an eight-week MBCT programme for recurrent depression. In a one-to-one session, she completes a three-minute breathing meditation. After the practice, Maya reports, “I felt a knot in my stomach, and then a flood of thoughts about my upcoming presentation at work, and I started to feel panicky.” The clinician begins with the first layer, asking, “Where exactly did you feel the knot?” Maya replies, “Just below my ribs, like a tight band.” The clinician follows, “What did the thoughts feel like?” Maya describes them as “sharp, like needles, jumping from one worry to another.” By staying at the level of sensation and quality, the clinician avoids premature interpretation.

Moving to the second layer, the clinician asks, “When you noticed the knot and the thoughts, what did you do next?” Maya answers, “I tried to push the thoughts away, telling myself not to think about the presentation, but the knot tightened even more.” The clinician then gently probes, “What was your attitude towards that tightening?” Maya reflects, “I felt frustrated with myself, like I was failing at the meditation.” Here the client reveals a habitual stance

of self-criticism and avoidance. The clinician refrains from labelling this as “negative self-talk”; instead, they invite Maya to stay with the frustration, noticing its texture and the impulse to push it away. This sustains the client’s experiential contact with the reaction, allowing the decentering process to unfold naturally.

In the third layer, the clinician asks, “Does this pattern of tightening when you try to push thoughts away remind you of anything in your daily life?” Maya pauses, then says, “Yes, at work I often feel that same knot when I try to ignore emails that I think will be stressful, and then I end up feeling even more anxious.” The clinician simply holds this observation, saying, “So the brief practice has shown a miniature version of a larger pattern you’ve been dealing with for months.” No further explanation is offered. Maya, having arrived at the insight herself, later reports that she can now notice the knot early and choose to sit with it rather than push it away, a shift that aligns with the decentering skill taught in MBCT.

The teaching conversation, therefore, is not a didactic lecture but a collaborative inquiry that respects the client’s capacity to generate their own therapeutic insight. The clinician’s role is to facilitate a safe space where the client can explore the raw data of experience, observe their habitual responses, and recognise the broader relevance of the pattern. This process embodies the core principle of mindfulness that the relationship to experience, rather than the experience itself, is the target of change. By harvesting discovery before delivering teaching, the clinician ensures that any conceptual framing is anchored in the client’s lived reality, enhancing retention and fostering a sense of ownership.

In practice, clinicians should remember several practical guidelines. First, allocate sufficient time after the practice for the three layers; rushing through them often leads to premature instruction. Second, maintain an attitude of genuine curiosity, allowing the client’s narrative to unfold without interruption. Third, use open-ended, phenomenological questions that keep the client at the level of concrete observation. Fourth, when a teaching point does arise, frame it as a question that invites the client to test the idea against their own experience, rather than as a statement that imposes an external model. Finally, be mindful of the therapist’s own inner dialogue; if the clinician feels the urge to “fix” or “explain,” they should pause, notice that impulse, and return to the stance of non-judgmental curiosity.

The evidence for MBCT as a whole is strong, although inquiry itself has rarely been studied on its own. An individual patient data meta-analysis of randomised trials found that MBCT reduced the risk of depressive relapse over 60 weeks compared with not receiving it, and compared with active treatments (Kuyken et al., 2016). The lived, moment-to-moment discovery that inquiry facilitates is thought to be one route to the reduced reactivity through which MBCT works.

In summary, the teaching conversation in mindfulness-based interventions is a structured yet fluid inquiry that proceeds through three layers: noticing the raw phenomena, exploring how the client meets that experience, and linking the micro-pattern to broader life contexts. The clinician's stance of curiosity, patience, and non-fixation, combined with a disciplined commitment to harvest discovery before offering instruction, transforms a simple practice into a therapeutic encounter that respects the client's agency and aligns with the evidence base for mindfulness. By mastering this craft, clinicians can help clients move from merely experiencing moments of awareness to integrating a lasting, self-directed capacity for compassionate, non-reactive engagement with the full spectrum of human experience.

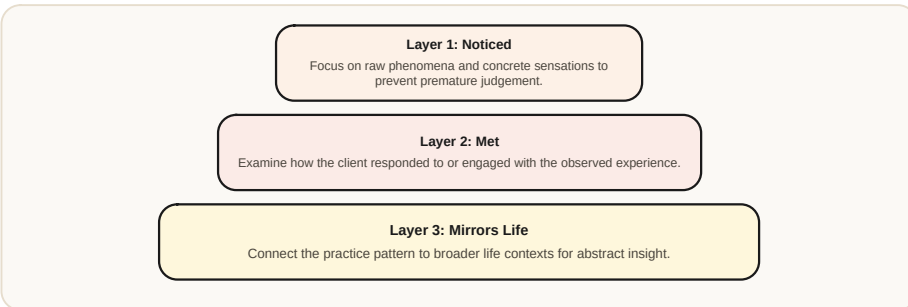


FIGURE 2.1 The Three Layers of Inquiry

The teaching conversation moves from concrete observation to abstract insight through three concentric layers. The clinician harvests the client's discovery at each stage before offering teaching.

Points worth keeping

- Inquiry layers: noticed, met, mirrors life
- The relationship to experience is the target
- Harvest discovery before delivering teaching

PRACTICE TASK

Write the three questions, one per inquiry layer, you would ask after a client's first breathing space.