Unsettling Care: Intersubjective Embodiment in MBCT

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SUMMARY   *Focusing on the place of "embodiment" for therapists in mindfulness-based cognitive therapy, this paper reveals that care often requires an on-going commitment to "being with" forms of uncomfortable self-experience. This work challenges the valorization of caregiving (as "natural," "good," or "rewarding") in anthropology by revealing the unsettled nature of lived experience, replete with difficult and changeable affective relations. Care emerges as a necessarily unsettled practice.* [care, embodiment, mindfulness-based cognitive therapy, mental health, unsettled]

Introduction

We sat in the sun in front of the university, in a small city in the Southwest of England near where I grew up. The city is built on the eastern bank of a river, stretching up a steep hill on the spine of which sits the cathedral at one end and the university at the other. It was a fine day, and from where we sat, it was possible to see across to the high and wild moorland at the heart of the county. We were on a lunch break from a day of training on the two-year therapist training program for mindfulness-based cognitive therapy (MBCT), and six of us variously sat or lounged on the grass, eating our pack lunches and mulling over the morning's work. It was one of the first times that year that it felt like summer, and I chose to ignore the damp of the grass in favor of the sun on my face. Leslie, sitting opposite me, had rolled her trousers up to the calf. "I used to think that 'shared humanity' and 'embodiment' didn't really mean anything," she mused. "Now I see that they're central. How do you *teach* that?"

"I guess it has to be something that you *are*, not something you *do*," responded Barbara from the other side of our circle. "Shit!" exclaimed Leslie, and we all laughed. We had spent the morning rehearsing leading mindfulness practices with peers and receiving feedback, and there was a clear sense that the practice made people anxious. Tessa, a National Health Service therapist, spoke for the group when she said, "I feel a huge sense of responsibility for delivering MBCT in a clinical setting. I'm scared of feeling out of my depth … I know it's important to develop my own authenticity."

The two-year therapist-training program in MBCT is taught at master's level at three universities in the United Kingdom. This account is informed by two and a half years of ethnographic fieldwork with two cohorts on the therapist training program at one of these universities. In my research I attempted to understand trainee therapists' perspectives and everyday experiences as they moved from the beginning of the training to qualification as mindfulness-based cognitive therapists. I conducted participant observation in the weekly sessions of the course throughout this period, and I sought to embed myself in training: participating in training sessions, joining MBCT courses led by therapists in training, completing course work, attending silent retreats and out of school activities. This work aimed to understand the perspectives of therapists in training through research methods, which included interviews, life histories, participant observation, and hours of informal conversation. Semi-structured interviews and formal life histories were conducted with therapists during and after training. Interviews and life histories were recorded and transcribed verbatim, and ethnographic fieldnotes and interviews were coded for themes and key words. Therapists were enthusiastic and excited about my research. With their consent I sought to understand the struggles that they faced in training, and subsequently in practice, and to make sense of the ways in which an experience of both commitment and ambivalence informed their approaches to care over the course of years.

In this article I focus on "embodiment" as a practice of care in MBCT, a therapeutic intervention for the prevention of depressive relapse, to argue that care itself may be an "unsettled" practice. In developing a theory of "unsettled care" I seek to contribute to the growing anthropological literature on care. Anthropologists have provided insights into the ways in which practices of care may be hampered or co-opted by political structures within which care is incorporated and gendered, racial or class-based inequalities are reproduced. For example, anthropologists have criticized the application of capitalist and neoliberal ideologies of autonomy in care contexts (Han 2012; Stevenson 2014). They have highlighted that care may be bound up with state violence and disenfranchisement (Biehl 2007; Jervis 2001; Glenn 2010), that unequal practices of care may be sustained through wider political and economic infrastructures (Street 2014; Ticktin 2011). Anthropologists have done the important work of revealing that healthcare professionals must often come to terms with their efforts being thwarted or compromised by either the structural challenges that they face, the lack of resources at their disposal, or the contradictions of care in practice, requiring them to make tragic choices between incommensurate values (Lester 2009; Brodwin 2013). At the same time, care has been theorized as a "moral experience" (Kleinman 2012), or a morally appropriate feeling for others (see Tronto 1998), associated with forms of altruism or self-sacrifice, characterized by a "selfless attitude" (Margalit 2002), reflecting "devotion to the other" (Kleinman and Van der Geest 2009), as a "fundamentally creative and deeply human endeavor" (Taylor 2014).

As Catherine Trundle and I argue in the introduction to this Special Section, although this scholarship has done the valuable work of highlighting the ways in which morally valued care is located in and constituted by wider political, economic, and gendered forces, "care" itself has often remained under

theorized. Care is interpreted as a humanizing force, which is obscured by an over emphasis on structure and technical competence. It is the longed for and always out of reach antidote to the dehumanizing effects of proceduralism, "care" itself acting as a powerful emblematic counter to the totalizing logics of biopolitics (see Biehl 2012). What is called for is more, different, or better kinds of care. However, framing care as the basis of intimate, affective life risks passing over the untidy or negative affective dimensions of caring relations in favor of a "sincere" emotion of care that emanates from within (see Aulino 2016). In response to this, we seek to highlight the "unsettled" nature of care in practice. Rather than seeing care as a morally valorized basis for intimate, affective life, we seek to examine the emotional ambivalences experienced in caring relationships.

In this article I consider the role of embodiment in unsettled intersubjective care relationships in MBCT. "Embodiment" is understood by therapists to be the capacity to inhabit an on-going awareness of thoughts, physical sensations, and emotions. It is a morally valued ability, which is modeled by therapists and learned by participants in the therapeutic encounter. Embodiment is intended to provide forms of shared experience and exemplarity. At the same time, however, embodied awareness of experience requires an unsettled openness and exposure—a willingness on the part of the therapist to "be with" difficult emotions within him or herself and a willingness to "be with" others in the shared recognition of vulnerability. This is a source of anxiety for therapists who know that their skill in caring for others rests on their ability to embody the awareness that they wish to impart. Therapists worry that they are not embodied enough, that they too suffer from suboptimal mental health and that they carry a responsibility to "be with" these experiences if they are to help others.

My aim in describing subjective and intersubjective fluctuations of care is to argue that care itself is a relational activity, which is necessarily and profoundly unsettled. Therapists understand care for others to be a morally virtuous practice that rests on a subjective experience of often uncomfortable emotions. Embodying mindful awareness is rarely experienced as a feeling of authentic beneficence. Instead, therapists are aware of a host of fluctuating emotional and bodily responses to their care for others, some of which are loving and altruistic, others of which are anxiety ridden and unstable. Learning to "be with" such feelings is understood to be the on-going work of the therapy, for therapists and participants alike. Focusing on MBCT therapists' aspirations to embodiment, I describe how care requires an on-going commitment to forms of uncomfortable self-experience in therapists' efforts to care for others. Care is both unsettled and unsettling.

Settled Embodiment

Mindfulness-based cognitive therapy is a psycho-social, group-based intervention for people who have had three or more depressive episodes but are currently well (Segal et al. 2002). In Britain, it has been available on the National Health Service (NHS) since 2001 and provides an alternative to maintenance antidepressants for those most at risk of depressive relapse. It is taught over an eight-week course that is heavily practice based. In addition to a two-hour

15-minute group session once a week, participants also complete daily mindfulness practices at home. MBCT draws on mindfulness meditation and components of cognitive behavioral therapy (CBT), through which participants learn to develop an awareness of their thoughts, feelings, and emotions conditioned by an attitude of "friendly curiosity." This ability to "step back" from internal experiences is understood to disrupt the negative automatic thinking patterns associated with depressive relapse and to enable the participant to relate to him or herself with a greater sense of compassion than is usual for people with a history of depression (Ma and Teasdale 2004).

Mindfulness-based interventions reflect a broader shift to preventative mental healthcare and positive framings of mental health in Britain. Successive governments since the millennium have viewed the development of preventative, people-centered healthcare services as an approach by which the NHS might address the healthcare challenges of the twenty-first century. Increasing emphasis has been placed on preventative medicine (Rose 2008), patient empowerment (APPG Report 2014), and behavior change (NICE 2014) to encourage people to moderate behaviors linked to chronic illness and disease (see, for example, Abraham and Michie 2008). In such approaches, emphasis is placed on empowering people to make better decisions for themselves and change their behavior in ways that improve long-term health outcomes, which will lead to improvements in health overall at both an individual and a population level. In preventative interventions we see a slide from the management of risk in targeted populations to the universal promotion of positive health in everyday life.[1.] MBCT is a secondary prevention approach. It is a targeted intervention aimed specifically at supporting those at a high risk of depressive relapse. But the universalist theory of mind on which it is based makes mindfulness an appropriate practice in "universal" primary prevention campaigns that seek to stop mental health problems before they occur and promote good mental health for everyone. Mental health has altered from being thought of as an either/or categorization of those who do and do not suffer from mental ill health, to a presentation of mental ill health affecting one in four people, to an understanding of mental health and illness as fluctuating conditions of all human life. Sometimes described as a changing landscape, sometimes as a scale, location on which changes, mental health has come to be thought of as something that affects all people to a greater or lesser extent at different points in their lives, and something that they can actively support. This is echoed in approaches to mental health, which emphasize the promotion of health rather than the prevention of illness, reflecting national and international medical policies that define mental health in positive terms.

In contrast to the genetic nosology of depression examined by Dumit (2002) in which people vulnerable to relapse are understood as "inherently ill," the framing of mental health here is far more optimistic. MBCT practitioners understand the suffering caused by depression in a universalist register, which they refer to as a "common humanity": all people experience mental health and illness by virtue of their humanity, and health and flourishing can be cultivated. Participants have a history of depression and the likelihood that they will relapse is high, but at the time of the intervention they are not in an acute depressive episode and would not qualify for a mental health diagnosis. They

engage in MBCT as a preventative intervention. The therapist and the participants experience a form of connection through the recognition of a shared experience of both the universalism of mental health and ability to cultivate and embody mindful awareness.

The cultivation of embodied reflective awareness is central to the intervention. Through ongoing training in returning the attention to the body, participants learn to develop awareness of the relationship between their thoughts, feelings, and emotions. As Pagis writes of embodiment cultivated through meditation, developing awareness of embodied sensations through conscious practice "offers a channel through which the relation of the self with the social world can be monitored" (Pagis 2009:280). Awareness of the body enables the practitioner to recognize visceral responses to experiences, and this provides a "gap" before he or she reacts, for example to feelings of fear, doubt, or anxiety (cf. Cook 2017). This is taught explicitly in each weekly session, and it is "modeled" through the behavior of the therapist. Participants first witness the qualities that they will be encouraged to develop through the example of the teacher leading the course.

Mindfulness therapists ideally offer an example of mastery to MBCT participants: the therapist's own embodiment of mindfulness and compassion and the extent to which he or she can create a supportive and calm environment are recognized as significant in the MBCT program (Hopkins and Kuyken 2012). Mindfulness is intended to extend beyond formal practice and to infuse therapists' experiences, both professional and personal, and enhance their own well-being. As Feldman and Kuyken state, "The teacher needs first and foremost to have through their own mindfulness practice cultivated compassion in relation to his/her life and experience. This experiential learning is a prerequisite to teaching others and is experienced by participants as an embodied teacher who 'walks the walk'" (Feldman and Kuyken 2011:153; see also Crane 2009; Crane et al. 2010).

Psychological approaches place a strong emphasis on therapist training, including the therapist undergoing the therapy herself in order to help others (for example, psychoanalysts undergoing a mandatory period of psychoanalysis).[2.] But mindfulness-based interventions have a distinctive aspect to them in their developmental process: the therapist's "embodiment" of the key "therapeutic ingredients" (Crane et al. 2010:76) and their own personal mindfulness practice in support of this. As well as developing technical competence in the delivery of the content of the therapy program (which is highly routinized), therapists are expected committedly to engage in a developmental process of mindfulness training, which is ongoing and daily. Through embodying mindful awareness, the teacher communicates to the participant what it is to bring mindful attention to personal experience (see Crane 2009; Kabat-Zinn 1990; McCown et al. 2010; Segal et al. 2002). For therapists, as for participants, learning is ongoing; each must have an ongoing and engaged commitment to mindfulness. This includes daily formal and informal personal mindfulness practice and regular silent retreat. It also includes, for the therapist, regular supervision and peer supervision, and inquiry into personal practice by an experienced therapist.

Unsettled Embodiment

Therapists learn to work with vulnerability through teaching and embodying the quality of mindful awareness and curiosity about experience that they wish to impart. This is a form of care that "works" through an emphasis on "being with"; participants learn to "be with" difficult experiences through the guidance of a therapist who models this through an exemplary embodiment of mindful awareness. Thus, mindfulness interventions interpret mental health as based on a sense of shared humanity between therapists and participants, and the intervention rests on the embodiment of a progressively shared quality of awareness. For both therapists and participants, a successful course involves attending mindfully to experiences of stress, depression, or anxiety as they arise. This requires a willingness to experience vulnerability on the part of the therapist; he or she must model an embodied mindful awareness of his or her emotional experiences, including the experiences of anxiety or stress that are generated through the therapeutic encounter, in order to support participants. As the course teacher told the trainees in response to their anxiety, "You are learning to be an embodiment of mindfulness and this equalizes the relationship with the participant because it's about the common humanity of mental health, while also holding space. Make a commitment to ground yourself, and if you're not grounded, be aware that you're not."

But therapists, during and after training, worried that they were not sufficiently mindful to support the needs of others, knowing that the efficacy of the intervention rested in part on the extent to which they were able to embody mindfulness themselves. This was reflected in my relationship with Judith during her training and once she had qualified as a therapist. Judith, like many others, had experienced a couple of brief spells of depression when she was in her twenties. Now in her fifties, she had spent her career as a family therapist and social worker, a job that she characterized as "dealing with difficult people, threat, fear, aggression and hostility." She had also been into meditation since the 1980s, and she joined the therapist-training course with the intention of creating a bridge between her experience of meditation and her professional life. Judith divided her time among palliative care for her elderly mother, her work as a social worker, and the training program. She excelled at the academic components of the training but struggled to lead groups during supervised training, preoccupied with the responsibility of leading the group and worry for her mother.

Toward the end of a supervised course she told me, "There's nothing between me and most of the people in that group. I could be on either side of that line. I'm currently well, I am well, for me, and they are currently well for them. But relapse into depression is something that they've come to the group for, and this is something I know." Judith's vulnerability highlighted for her the place of embodiment in the therapy. She felt that her own awareness of thoughts, feelings, and emotions was an important component of leading the group, and at the same time, she felt that her vulnerability made it challenging to maintain her perspective as a therapist: "There's just something about the level in which my thinking, body sensations, emotions, are both relating to me and they're the content of the course. They are within the teaching. And there's no other subject matter." Judith describes the necessary tension, heightened by the

circumstances of her mother's care, that therapists feel between the awareness of personal anxiety and the professional responsibility to model an embodiment of mindfulness.

This tension was addressed explicitly in training, and the "inner critic" was a topic to which we repeatedly returned. During a session toward the end of the training the teacher asked the group, "Imagine that it is after the first exercise in the first week and a participant throws a ton of doubt at you. What do you feel?"

"Well, anxiety would go up!" responded Leslie. "My inner critic would kick in," commented Barbara, "I'd try to give them answers, I guess." The teacher told us that in preparation for scenarios such as this the therapist was to develop awareness of his or her embodied anxiety and then refocus awareness on the breath. As he said, "Doubt is a common experience for all of us, so keep that kindness, starting with yourself, when the inner critic rages."

"I'm aware of it," responded Barbara. "But when I'm anxious I go into 'waffle mode,' so I need to know that I'm working within my own ability. You know, you feel like you have to put on a bit of a front. I'm good at pretending a role and doing a good job of what people expect, when that drops away its much better." As is clear from Leslie's and Barbara's recognition of their own anxiety, care in MBCT occurs through therapists' willingness to cultivate awareness of experiences of ambivalence and vulnerability. In exploring the dynamics of care in practice we are able to problematize the affective labor of self-experience in caregiving and highlight the unsettled moral emotions of care for others (cf. Cubellis 2018).

Conclusion: Unsettling Care

What does it mean to care for another? Although care has been productively associated with expectations of positively valued emotional support, attention, or affection (Mol et al. 2010) and has been framed as a morally valorized practice (Kleinman 2012), such readings risk masking the ways in which practices of care necessarily entail forms of emotional ambivalence and labor. In the context of MBCT, care occurs through embodied intersubjectivity and is bound up with wider experiences of unsettled emotional states. MBCT is premised on an understanding of mental health as an aspect of "common humanity," which necessitates the recognition of vulnerability, ambivalence, and uncertainty on the part of both therapists and participants.[3.] The requirement for therapists to model an attitude of "being with" difficulty for participants requires forms of experience, exposure, and awareness of emotion on the part of the therapist for care to work. The recognition that care is unsettled in therapists' efforts to embody mindfulness provides an insight into what has been referred to by others as an emotional "backstage" to care work (Dragojlovic and Broom 2017). It points to the ways in which care work is informed by the concerns of life outside caregiving and that care work occurs within intersubjective or relational moments. It is located in situated and evolving therapeutic relations and incorporates the "moral, ethical and affective struggles that *being in* and *being with* suffering may induce" (Dragojlovic and Broom 2017:4).

In this article I have sought to contribute to the anthropology of care by examining the ways in which the moral value of care becomes unsettled in care encounters. Attending to therapists' subjective labor in caring for others offers a provocation to anthropology. For therapists, to care for others requires developing an awareness of intersubjective embodied experience, and this requires personal affective labor. Embodied awareness on the part of the therapist is recast as a vehicle for therapeutic connection at the same time that therapists experience leading a group as generating doubt, self-criticism, and insecurity. This requires a sense of openness to forms of vulnerability, which is unsettled and often unsettling. Care is experienced as a relationally unstable practice. As such, understanding the ongoing work of care requires resisting a categorization of care as unambiguous or morally resolved. The unsettled care that this suggests is not easily categorized as a positively valued affective experience or an effect of wider political forces. This shifts our focus from care as a positive internal state or an absent object to an unsettled on-going intersubjective experience. This work challenges the valorization of caregiving (as "natural," "good," or "rewarding") by revealing the unsettled nature of lived experience, replete with uncomfortable and changeable affective relations. Care emerges as an inherently unsettled practice.

Notes

1. This is reflected in a paradigm shift underpinning research in psychology, epidemiology social sciences, and informing policy focused on positive mental health, psychological resilience and well-being rather than disorder or dysfunction (see Huppert et al. 2005; Layard 2005).

2. The word "embodying" is used specifically in the mindfulness training but is paralleled in other forms of cognitive therapy training, in which therapists are required to "model" the stance that they are encouraging patients to adopt in relation to themselves. In CT this is non-judgmental interest, curiosity, and open-mindedness; and this "modeling" facilitates effective cognitive-behavioral interventions (Fennell and Segal 2011:130).

3. Cf. Myers 2015 for a different therapeutic interpretation of "common humanity."

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