

Collaboration in Mindfulness-Based Cognitive Therapy

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In this article, we describe the nature of therapeutic collaboration between psychotherapist and group participants in mindfulness-based cognitive therapy (MBCT), which occurs in a group format and incorporates cognitive therapy and mindfulness practices with the aim of preventing depression relapse. Collaboration is a central part of two components of MBCT: inquiry and leading mindfulness practices. During the process of inquiry, the therapist-initiated questions about the participant's moment-to-moment experience of the practice occurs in a context of curious, open, and warm attitudes. In addition, collaboration is maintained through co-participation in mindfulness practices. We provide a case illustration of collaboration in these contexts and conclude with recommendations for clinical practice. © 2012 Wiley Periodicals, Inc. *J. Clin. Psychol. In Session* 68:179–186, 2012.

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Mindfulness-based cognitive therapy (MBCT) is a relapse prevention intervention that combines the practice of mindfulness meditation with elements of cognitive therapy to target vulnerability among formerly depressed individuals. In this article, we focus on the ways in which MBCT psychotherapists promote and maintain collaboration with participants through two core components—leading mindfulness practices and leading inquiry. Mindfulness practices in MBCT include both informal, daily practices and more extended formal meditation practices. Inquiry is the process by which group therapists engage participants in a conversation about moment-to-moment experience of each mindfulness practice. Inquiry is collaborative by nature, involving joint and interactive participation by therapist and group participants.

A Primer on MBCT

The theory underlying MBCT is that individuals with histories of depression are vulnerable during dysphoric states, during which automatic cognitive patterns that were present during previous episodes are reactivated and can trigger the onset of a new episode (Teasdale, 1988, 1999; Teasdale et al., 2002). MBCT aims to alter one's automatic and reactive relationship to the thoughts, feelings, and sensations that may precipitate relapse (Segal, Williams, & Teasdale, 2002). Specifically, MBCT aims to teach participants to recognize ruminative patterns associated with vulnerability to relapse, to disengage from the automatic “doing” mode of mind, and to access a decentered, “being” mode of mind. *Decentering* has been defined as taking an accepting and nonjudgmental stance toward thoughts, emotions, and sensations (Fresco, Segal, Buis, & Kennedy, 2007), and the ability to identify thoughts as mental events, rather than as veridical representations of reality (i.e., truth with a “capital T”).

Data from six large randomized clinical trials support the efficacy of MBCT among individuals with highly recurrent depression (Bondolfi et al., 2010; Godfrin & van Heeringen, 2010; Kuyken et al., 2008; Ma & Teasdale, 2004; Segal et al., 2010; Teasdale et al., 2000). To date, MBCT research has focused on treatment outcomes. Process and mechanisms of treatment are yet to be examined; however, both the mindfulness practices and process of inquiry are hypothesized as central ways in which therapists help clients to develop the core skills targeted by MBCT.

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The mindfulness practices taught within MBCT include both brief daily mindfulness practices, such as eating mindfully, and extended formal meditation practices, such as breath-focused or body-focused meditation. These practices are designed to foster awareness of the typical ruminative, automatic patterns of thoughts, emotions, and sensations and to teach a way to intentionally switch to a more decentered, nonjudgmental, present-focused mind. The initial four sessions of the 8-week MBCT program focus on teaching participants mindfulness practices focused on paying attention, noticing mind wandering, and intentionally directing attention to a single, relatively neutral focus. The last four sessions of MBCT focus on ways to skillfully handle negative mood shifts with the goal of cultivating sustained wellness and protection from relapse.

Mindfulness practices are led with a spirit of collaboration and mutuality. Collaboration in MBCT is best defined in the context of inquiry. Collaboration is conducted in a dyadic manner within the group setting via a conversation between therapist and participant about the participant's experience of each mindfulness practice. In each session, the therapist is guided by broad goals to link each practice to the prevention of depressive relapse and by specific goals related to the thematic content of each session (described in more detail below). Psychotherapists both guide the practice and pay attention to their experience in a fashion that parallels what they are asking participants to do. Therapists are strongly encouraged to have their own mindfulness practice so that they can guide practices and inquiry from within, rather than responding intellectually to participants' experiences. Additionally, having a mindfulness practice supports therapists in embodying the attitudes they invite participants to adopt. For example, MBCT therapists invite participants to share what they noticed themselves struggling with in the course of practicing mindfulness. By discussing their difficulties, participants gain support both from the therapist and other group members who have experienced similar obstacles. The group format also illuminates universal patterns in habits and patterns of thinking, though thought content may vary. Although perhaps tempting, the MBCT therapist does not attempt to fix or solve participants' difficulties, thereby embodying an important essence of mindfulness of focusing on being with difficulties rather than automatically and ineffectively fixing them. In each of these ways, a context of collaboration frames the leading of mindfulness practices in MBCT.

The process of inquiry also provides a way for participants to learn mindfulness skills and is conducted within a collaborative context. In fact, the groundwork for this collaborative framework is established before the first session of MBCT even begins. During the initial assessment, the participant describes factors that triggered onset and maintenance of depression in the past. The therapist briefly describes the rationale for MBCT and explores with the participant ways in which MBCT might be useful. The therapist conveys that while he or she may be the teacher, the participant is the expert on his or her journey in living with a mood disorder, and that collaboration between the two is the best means of making use of MBCT.

Each of the in-class mindfulness practices is followed by a process of inquiry. During the practice of mindfulness, participants are invited to investigate the patterns of thoughts, emotions, and sensations that may appear in the mind and to see whether they can be approached nonjudgmentally and with curiosity. Once the practice has ended, the therapist asks participants what they noticed during this time and interact with whoever is interested in sharing. In many ways, the type of interaction exemplified by inquiry mirrors participants' internal observing of their experiences, as the therapist investigates with openness, curiosity, and warmth what came up for them. The intention is to connect with the participant in his or her present-moment investigation, conveying the possibility of bringing this quality of awareness to the participant's own life. Although not explicitly framed as such for participants, in effect, the inquiry process is a mindfulness practice in and of itself—inviting therapists and participants to listen and speak mindfully, in contrast to the tendency to either try to fix difficulties or to plan what to say next.

The therapist is consistently involved in the collaborative process of inquiry throughout the MBCT program. However, the co-creative conversation between client and therapist provides the client the direct experience of inquiry in a way that is intended to guide the client in learning to incorporate a similar stance on his or her own internal experience over time. The therapist-participant inquiry process provides an experiential template by which clients relate to their internal thoughts, emotions, and sensations with the aim of moving from a depressive

tendency of self-judgment or criticism to the open, allowing, and curious attitudes of collaboration.

Primary guidance provided to new MBCT therapists for leading inquiry is conveyed in the metaphor of three concentric circles. At the center, where therapists are guided to begin inquiry, questions begin in a very open manner. This “personal” circle highlights the importance of starting with each person’s direct moment-to-moment experience (e.g., “What did you notice?”). In the second, “contextual” circle, the therapist asks how the practice was different from typical, automatic ways of behaving. In the final, “depression-specific” circle, the therapist inquires how the practice may be relevant to the larger mission of preventing depression, thereby tying each participants’ experiences to the session’s key teaching points. Broadly, the therapist collaborates with participants to identify ways in which practice in awareness and attention is a useful tool for relapse prevention.

Across the MBCT intervention, participants are instructed in the intentional narrowing and expanding field of attention. For instance, some practices may invite participants to narrow the field of their attention such that phenomena that previously were experienced as unitary are experienced as multifaceted. A participant may be guided from “I did not like the mindful eating of a raisin exercise” to an exploration of the particular constituents of the experience that were unfavorable (e.g., the flavor, the stickiness, etc.). In other ways, MBCT invites participants to hold a wider focus of attention, with inquiring more broadly what is in the field of awareness.

Case Illustration

Presenting Problem

Anne is a 39-year-old, married, Asian female with two children. Anne was referred by her psychotherapist to the MBCT group to learn depression relapse-prevention skills. Prior to group initiation, the group therapist met individually with Anne for an initial assessment.

Anne met criteria for major depressive disorder, recurrent. In the initial assessment appointment, Anne reported three major depressive episodes, currently in remission. Anne’s first episode occurred after her college boyfriend broke up with her, and lasted 2 months. Anne’s most recent episode had a postpartum onset. Anne was successfully treated to remission with a selective serotonin reuptake inhibitor. Although Anne was initially reluctant to use antidepressant medication while nursing, her physician recommended that she take medication due to the severity of her episode. At the initial assessment appointment, Anne was seeing her psychotherapist a few times per year and had recently tapered off her antidepressant medication. Although Anne was not currently depressed, she feared another depression relapse because of medication cessation, and expressed an interest in learning skills to prevent an all-too-familiar rapid spiral downward into depression.

Anne reported that she tends to see the negative side of things even when not depressed. She reported ruminating about events that happened in the past, like things she should have done or said differently to avoid an argument with her husband or to perform better at work. Anne also reported worrying a lot about things that could happen in the future. Anne reported that her mind always goes to “worst case scenario,” for example, worrying about becoming depressed again, missing work due to depression impairment, getting fired, failing to provide enough financial support for her family, thus forcing them into poverty and homelessness. When queried how thinking this way affected her, Anne acknowledged that she usually felt worse when her mind dwelled on such topics.

After talking to Anne about her depression history and precipitating factors, the group therapist provided a brief rationale for MBCT, and explored with Anne the ways in which MBCT might reduce her ruminative tendencies and how that might prevent future depression.

Case Formulation

Consistent with the MBCT model, Anne experienced vulnerability to cognitive patterns that had been present during previous episodes and that were reactivated by dysphoric states; such

reactivation placed her at risk for the onset of a new episode. Anne ruminated, or focused repetitively on the experiences, causes, and consequences of her problems and symptoms. Anne's belief that thinking planfully (albeit maladaptively) for the future should be helpful aligns with research suggesting that dysphoric participants instructed to ruminate rated themselves more insightful, yet sadder (Lyubomirsky & Nolenhoeksema, 1993). MBCT attempts to alter the automatic, negative thinking patterns associated with rumination and periods of low mood to reduce vulnerability to relapse. Anne was considered an ideal candidate for the group given the recurrent nature of her depression and current experience of reactivation of negative ruminative thinking in the presence of mild sadness.

Course of Treatment

MBCT was administered in a manner consistent with the standard MBCT approach (Segal, Williams, & Teasdale, 2002). Participants met in a group for eight sessions lasting approximately 2 hours per session. The treatment was delivered by a therapist with a PhD in clinical psychology. Each class utilized a combination of didactic and experiential learning incorporating both mindfulness and cognitive-behavioral strategies.

In the following dialogue, the group had just finished practicing the 3-minute Breathing Space for the first time. During this exercise, in the first minute or step, the therapist invited participants to become aware of any thoughts, feelings, and physical sensations that were present. In the second step, the therapist asked participants to bring their attention to their breathing. Finally, in the third step, participants were asked to expand their awareness to include a sense of the breath and body as a whole. The therapist simultaneously led and participated in the practice, so as to guide with her own present moment awareness.

Therapist : What did you notice in your thinking, emotions, or sensations?

Anne : I noticed that I felt really tense. My hands were really cold, and I wanted to warm them up. I felt really tense.

Therapist : So, you noticed the urge to warm your hands. And, did you notice the sense of tightening or tension in any particular place in your body?

Anne : I hadn't really noticed that until you asked, but, yes, actually, I noticed it on my face.

[With the narrowing focus of her questions, the therapist modeled for Anne the ways in which her awareness of her practice may be deepened. In their mutual exploration of Anne's practice, the therapist did not know what would be discovered in advance. Instead, the therapist collaboratively co-created the experience with Anne in real time.]

Therapist : That's very interesting. Did you notice it in any particular part of your face?

Anne : Yes, actually, I felt it in my jaw. I felt that my jaw was clenched. Then, when you first cued us to pay attention to our thoughts, I noticed that I had a lot of background chatter, a lot of thoughts and emotions about an incident that happened at home last night.

[The therapist remained tuned in to Anne's moment-to-moment experience.]

Therapist : So, you're saying you noticed that thoughts and emotions were present.

Anne : Yes, they were very full and present.

Therapist : And you were watching them?

Anne : Right, I was watching it. I felt like I was watching myself rehashing everything that happened last night. Though, at some point, I think I stopped watching the thoughts and emotions and I started to participate in them, and really elaborate on them. I got lost in them for a little while.

Therapist : So, these difficult thoughts and emotions were present in your awareness.

- Anne : Very present.
 [Here and throughout, the therapist conveyed a genuine sense of curiosity and interest in Anne's experience of the practice.]
- Therapist : You're watching them, or they've grabbed your attention. Then you let go, if you could, and came to a focus on the breath at the belly. How did that happen for you?
- Anne : Um. I was able to do it. I'm not exactly sure how it happened, but I was aware when it happened. It was a relief to draw away from the content of my thoughts and emotions. Was that the step where we were doing belly breathing?
- Therapist : Yes.
- Anne : I don't sense my breathing in the belly. I get it much more strongly in the chest. So, I remember I had to consciously make my belly go in and out and have that sensation in order to think about doing.
- Therapist : So, it took some effort?
- Anne : Yes, exactly.
- Therapist : And the third step?
- Anne : The third step felt mildly calming and I had the sense I could do it. But I also had the sense that as soon as my mind could race back to the content, it would go right back to it. It was unfinished. So, it didn't totally stop that.
 [Here, the therapist moved to the second inquiry circle. The participants were given an opportunity to reflect on how the current mindfulness practice differed from more automatic modes of thinking and behaving.]
- Therapist : How is this practice different for you?
- Anne : I often find that my thoughts and emotions get carried away, especially when I've had a hard day or I'm feeling sad. It's like they control my mind. But in this practice, I felt a little bit more in control of my mind, and my thoughts, and feelings. My mind still wandered, but it didn't get so carried away.
 [Here, the therapist moved to the outermost depression-specific inquiry circle, thereby tying it to the session's theme.]
- Therapist : In what ways might this kind of practice be related to preventing depression?
- Anne : I was just wondering, "How is this going to be helpful? How is this going to help me when I'm feeling sad or stressed out?" It dawned on me that it's only 3 minutes. I can really set an intention to be with my breath or be where I am for just 3 minutes, because everything that is stressing me out and bothering me will be there when I'm done. But I can give myself permission to just be here. Without any specific outcome, but just the intention of being with my breath, and not spinning out. It's like I rationalized, "it's only 3 minutes. I can give myself that."

In this next section, we present dialogue from homework review during the sixth session. For homework, group participants were asked to do a daily 45-minute Sitting Meditation. Homework review is a key place for collaboration between therapist and client. By reviewing homework each week, the therapist emphasizes that the core of MBCT depends on routine practice of these new skills. What the client gets out of the class depends not only on therapist-led practices and instruction, but also on the clients' collaborative engagement with the skills over time with the aim of changing long-standing patterns of mind. Here, Anne described a difficulty she faced with the homework and received support from the therapist. In a subtle way, Anne is also demonstrating a progression in the latter half of the eight-session program

toward facing difficulties in a spirit of inquiry, allowing her to cultivate an effective way to reduce unhappiness.

Therapist : Did anyone not do the homework?

Anne : [raises hand]

Therapist : Tell me about that. How did the week go?

Anne : I only did it once. I didn't do it the rest of the days. I just could not find the time to do it. I had too much going on at work, and I was shuttling the kids around every evening to all their activities. By the time I got home each night, I had to make dinner, and then spend time with the family, and then I was exhausted and just went to bed.

Therapist : Did you have the idea of doing the Sitting Meditation in your awareness of the evening? Or did you totally forget?

Anne : No, it was there. At work, and while eating dinner, and when running errands. All throughout the week, I was thinking, "when am I going to do the Sitting Meditation?"

Therapist : What was the quality of that question that kept coming up for you?

Anne : It made me feel anxious.

Therapist : Mm hmm, it sounds like there was a pressure. What was your relationship to the assignment when you were on your way here today?

Anne : I thought, "I didn't do any of the homework." But then, when I was thinking about my week, I was able to let that go. Looking back, I couldn't think of a time when I could have done it at night or early in the morning. I guess I could have woken up earlier, but it felt important to me to get the sleep I needed this week. It felt like I was taking care of myself in a good way. I know that, for me, an hour less of sleep per day can have a profound effect on my mood. On the way here tonight, I decided that it wasn't helpful to be worrying about the homework anymore. I guess I eventually gave permission to myself to let that go.

Therapist : It's interesting what you're describing, though, because I think that life is like that for a lot of us a lot of times. It's dense and packed with a lot of responsibility. I'm interested in the progression you're describing initially of pressure, like "When am I going to do this? How am I going to find time?", to a moment of actually bringing awareness to the assignment in the context of your entire week to be gentle with yourself. There was a sense for you that it was more helpful; it was a way of caring for yourself during your difficult week to not stay up later or wake up earlier.

Anne : Right, exactly.

Outcome and Prognosis

Anne attended all eight group sessions. Though, as illustrated above, she struggled with completing all the homework assignments, she demonstrated a subtle, though profound change in her relationship with her ruminative, negative thoughts, and developed skills to take care of herself more effectively during periods of sadness or stress. "Refresher" sessions are offered to former group participants on a monthly basis, and Anne has attended four. At the most recent "refresher" session, Anne reported that she remained in remission from depression.

Anne reported that the most helpful aspect of the course was learning brief (e.g., 3-minute Breathing Space) and daily mindfulness practices, which were easy to incorporate in her daily routine. Anne recognized that the classes had been helpful in teaching her the foundations of mindfulness practice, but that what really counted for her was incorporating practice into her daily life. For example, she described that when she is stuck in line at the bakery, she will take a deep breath and inhale the aromas of the bread and buns baking. At other times, she has avoided getting into an argument with her husband by noticing a tightening in her neck and recognizing

this as tension. When this happens, she stops and takes a breath before responding. This has been helpful on a number of occasions.

Clinical Practices and Summary

MBCT research has focused on empirical validation of its outcomes, while little research has been conducted on the crucial processes and mechanisms of the treatment. At the same time, both mindfulness practices and the process of inquiry are hypothesized to be central ways in which therapists help clients to develop the core MBCT skills. To summarize, we provide suggestions to develop and maintain a spirit of collaboration in MBCT:

- Begin in the initial assessment session. The participant is provided an opportunity to describe his or her experience of depression. Together, the therapist and participant explore ways in which MBCT may effectively reduce relapse risk.
- By simultaneously guiding and participating in each mindfulness practice, the therapist enhances a sense of mutuality and connection with participants.
- MBCT therapists are strongly encouraged to maintain their own mindfulness practice so that they respond from within to participants' struggles with the practice.
- The process of inquiry should be a genuine exchange during which the therapist uses questions to help the participant deepen awareness of his or her practice, while also embodying the present-focused, open, and warm attitudes of mindfulness.

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