MINDFULNESS-BASED
COGNITIVE THERAPY
FOR PREVENTION OF
DEPRESSIVE RELAPSE

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INTRODUCTION: DEPRESSION AND RELAPSE

Mindfulness-based cognitive therapy (MBCT) (Segal, Williams, & Teasdale, 2002) is an 8-week group protocol developed for the prevention of relapse of major depressive episodes. Major depressive disorder (MDD) is among the most common and severe causes of ill health and functional impairment (Murray & Lopez, 1998), with lifetime prevalence in community samples ranging from 10% to 25% for women and 5% to 12% for men (American Psychiatric Association, 2000). An important issue in the treatment of depression is the high risk of relapse or recurrence. At least 60% of individuals who experience a single episode of MDD are likely to have a second episode, and this risk increases with the number of previous episodes. Those with three previous episodes have a 90% chance of suffering
a fourth episode. Judd (1997) suggests that the average individual with MDD will experience four episodes during his or her lifetime.

The most common approach to relapse prevention is the continued use, after recovery, of the antidepressant medication with which the episode was treated. Unfortunately, this approach is effective only as long as the medication is continued, and noncompliance rates are reported to be about 30–40% (Basco & Rush, 1995). Some patients, such as pregnant women, should not use such medications, while others cannot tolerate the side effects or are unwilling to take them for extended periods (Segal et al., 2002). Research also suggests that cognitive behavioral therapy (CBT) is effective both for treating acute episodes of depression and for reducing risk of relapse (Blackburn, Eunson, & Bishop, 1986; Evans et al., 1992; Kovacs, Rush, Beck, & Hollon, 1981; Shea et al., 1992; Simons, Murphy, Levine, & Wetzel, 1986). However, provision of CBT or other empirically supported psychotherapies to all depressed individuals probably is not feasible, given the prevalence of depression, shortage of adequately trained clinicians, and low rates at which depressed individuals seek such treatments (Segal et al., 2002; Segal, Teasdale, & Williams, 2004). MBCT was designed to provide a cost-effective approach to relapse prevention in patients whose previous episode was successfully treated with antidepressant medication. The group format reduces the resources required for delivery of treatment, while the skills taught are designed to reduce the likelihood of relapse without reliance on extended use of medication.

THEORETICAL AND CONCEPTUAL BACKGROUND OF MINDFULNESS-BASED COGNITIVE THERAPY

MBCT is based on a theoretical model that describes factors contributing to vulnerability to relapse and recurrence of major depression and how cognitive therapy reduces this vulnerability.

VULNERABILITY TO RELAPSE OF DEPRESSION

The cognitive model of depression specifies that depressed individuals generally experience sad moods and negative thoughts regarding the self, the world, and the future. After recovery from the depressive episode, individuals’ thoughts may become less negative and distorted. In fact, Haaga, Dyck, and Ernst (1991) found that levels of dysfunctional attitudes in recovered depressed patients do not differ from levels in never-depressed individuals. However, according to the model underlying MBCT, individuals who have experienced one or more depressive episodes have developed associations between sadness and negative thought patterns, and therefore
they differ from never-depressed individuals in the negative patterns of thinking triggered by the ordinary sad moods that are unavoidably part of life. That is, in previously depressed individuals, these sad moods trigger patterns of thinking that are similar to those present during the previous depressive episode. During times of sad mood, these thoughts are much more negative, global, and self-critical than those reported by never-depressed individuals. This difference has been shown empirically in several studies in which previously depressed and never-depressed individuals are experimentally induced to experience a temporary sad mood (e.g., through listening to sad music). While in this sad state, their thoughts and attitudes are measured. Previously depressed individuals are much more likely to endorse global, negative self-judgments and other dysfunctional attitudes, whereas those who have never been depressed show few such changes in thinking when feeling sad (e.g., Ingram, Miranda, & Segal, 1998; Miranda & Persons, 1988; Miranda, Persons, & Byers, 1990; Segal, Gemar, & Williams, 1999; Segal & Ingram, 1994). In summary, the evidence suggests that for previously depressed individuals, small increases in sadness are associated with significant increases in depressive thought content, whereas for never-depressed individuals, such increases in negative thoughts do not occur.

In addition to increases in negative thought content, for previously depressed individuals, sadness or dysphoria also reactsactivates a ruminative style of thinking, which includes analyzing why they feel sad and thinking about their shortcomings and how these lead to problematic situations. Although ruminateive individuals often express the belief that dwelling on their problems and trying to understand their inadequacies will yield important insights about their moods and how to improve them, empirical data suggest that ruminative thinking perpetuates depressed mood (Nolen-Hoeksema, 1991). Thus, the model underlying MBCT suggests that in previously depressed individuals, ordinary sad moods are likely to reactivate both depressive thought content and a ruminative style of thinking, leading to a vicious cycle in which sad moods escalate into episodes of depression.

**HOW COGNITIVE THERAPY REDUCES RELAPSE**

Early descriptions of cognitive therapy for depression suggested that vulnerability to relapse would be reduced by changes in the content of dysfunctional thoughts and attitudes. However, the empirical literature has shown that both cognitive therapy and antidepressant medication produce equally strong reductions in dysfunctional attitudes (Barber & DeRubeis, 1989; Simons, Garfield, & Murphy, 1984). Thus, it is unlikely that these changed attitudes are responsible for the superior protection against relapse
afforded by cognitive therapy. More recent conceptualizations (Segal et al., 2002; Segal et al., 2004; Teasdale, 1999a; 1999b) suggest that cognitive therapy, in addition to changing the content of thoughts, also leads to a change in individuals’ perspective about, or relationship to, their thoughts and emotions. This changed perspective, often called distancing or decentering, leads individuals to see their thoughts and feelings as mental events that come and go, that do not necessarily reflect important truths about their worth or adequacy as human beings, and that do not necessitate specific reactions or behaviors.

Traditional cognitive therapy is hypothesized to encourage this perspective by repeatedly asking participants to observe and identify their thoughts. In the past, these tasks were assumed to be important because they led to evaluation, disputing, and change of thought content. However, several researchers have suggested that decentering alone might be a central process by which cognitive therapy achieves its effects (Ingram & Hollon, 1986; Teasdale, Segal, & Williams, 1995). By allowing individuals to see their thoughts as “just thoughts,” rather than as valid reflections of reality, cognitive therapy may reduce the reactivity to negative thoughts that can lead to rumination and depressive relapse.

MINDFULNESS TRAINING AND RELAPSE

Mindfulness training is directly concerned with teaching people to decenter from their thoughts and emotions without avoiding, denying, or suppressing them. It teaches close observation of these phenomena and thus discourages experiential avoidance. It also teaches nonjudgmental acceptance and nonreactivity to these phenomena. According to the MBCT model, intentionally focusing undivided attention on thoughts, emotions, and sensations in this way uses much of the individual’s capacity for attentional processing, so that little capacity remains for rumination.

Segal et al. (2002; 2004) distinguish between doing and being modes of mind. The doing mode includes recognition of discrepancies between how things are and how we wish them to be. Such discrepancies trigger negative emotions, as well as thought patterns designed to find ways of reducing the discrepancy. When constructive actions can be implemented, this mode of mind is adaptive and can lead to the achievement of many important goals. However, when nothing can be done to change a problematic situation (e.g., when grieving the loss of a spouse or partner), this mode of mind can become unproductive, ruminative, and depressogenic. Much of the individual’s attention will be focused on analyzing the past, reviewing what is wrong with the present, anticipating the future, and seeking solutions; however, if solutions are not found, a pervasive sense of dissatisfaction can result. Ruminating in this way, as previously noted, is likely to perpetuate negative mood states.
In contrast, Segal et al. (2002; 2004) describe mindfulness as a being mode. In MBCT the central skill learned in mindfulness practice is disengaging from doing mode, especially from the self-perpetuating, negative, ruminative thought patterns that are part of doing mode. In being mode the focus is on accepting and allowing whatever is present as it is, without any goal or effort to change it. In being mode, no efforts are made to analyze the future consequences of possible problem-solving strategies or to review past attempts to solve similar problems. Rather than thinking about problems or situations, being mode is characterized by direct observation and acceptance of whatever is happening in the present moment—including thoughts and feelings that urge immediate action. Instead of acting on such thoughts or feelings, the participant simply observes and notes them. No attempt is made to evaluate the rationality of observed thoughts or to dispute or change their content.

This mindful approach to thoughts and feelings slows reactivity to mood, increasing time and ability to choose new responses. It also decreases rumination and strengthens acceptance of thoughts and feelings, reducing the tendency to see them as necessarily accurate representations of the truth about the self or the world. Adopting the observant and nonjudgmental stance of being mode increases the likelihood that individuals will notice phenomena indicative of an approaching relapse (such as fatigue or irritability) and refrain from maladaptive attempts to suppress or ignore them. In this way, they provide themselves with much better opportunities to act skillfully and intentionally in coping with early signs of relapse and taking adaptive steps to prevent it.

The aim of MBCT, then, is to teach skills that will allow individuals, in times of sadness, to interrupt their old habitual patterns of thinking or behaving so that these moods remain mild or transient and do not escalate into more serious affective states. It is not essential, or even desirable, that the treatment aim to eliminate the experience of sadness. However, these new skills can allow the experience of sadness without automatic escalation to depression. Segal et al. (2002) state that a central aim of MBCT is "to help participants be able to choose the most skillful response to any unpleasant thoughts, feelings, or situations that they meet" (p. 86). MBCT is conducted with recovered depressed patients, for whom the negative, ruminative thought patterns characteristic of depressive episodes have become infrequent. However, doing mode is a pervasive element of most individuals’ daily experience in Western culture and is likely to arise during the practice of meditation exercises used in the program (body scan, sitting meditation, yoga, walking). Thus, these exercises provide ample opportunity to practice observing and disengaging from doing mode. In addition, although participants are not depressed, the ordinary unpleasant emotions of daily life are welcomed as valuable opportunities for practicing this core skill.
EMPIRICAL SUPPORT

RANDOMIZED CLINICAL TRIALS

Two randomized clinical trials have provided strong empirical support for the efficacy of MBCT in reducing relapse of major depressive episodes. The first (Teasdale et al., 2000) included 145 patients who had experienced two or more major depressive episodes but were currently in recovery or remission. All had been treated with antidepressant medication but had discontinued the medication at least 3 months before beginning the study and had remained in remission since that time. Patients were randomly assigned either to treatment as usual (TAU) or to TAU plus participation in MBCT. All patients then were followed for 1 year. For those with only two previous episodes, participation in MBCT had no significant effect on likelihood of relapse over the next year. However, for those with three or more previous episodes, likelihood of relapse was substantially reduced for participants in MBCT. Among patients receiving TAU, 66% relapsed, whereas only 37% of patients receiving MBCT relapsed. This difference was not related to differences in use of antidepressant medication, as the MBCT group used less medication than the TAU group.

The results of this trial were replicated by Ma and Teasdale (2004), who studied 75 formerly depressed patients. These authors also found that for participants with only two previous episodes, MBCT and TAU groups did not differ in rates of relapse. However, for those with three or more previous episodes, participation in MBCT substantially reduced the risk of relapse (78% for the TAU group versus 36% for the MBCT group). These two studies show that for patients with three or more previous depressive episodes, MBCT is likely to reduce the risk of relapse by half. Moreover, because MBCT is administered in groups of up to 12 participants, these substantial effects can be attained cost-effectively.

POPULATIONS FOR WHOM MINDFULNESS-BASED COGNITIVE THERAPY MAY NOT BE EFFECTIVE

It should be noted that MBCT does not appear to be effective for individuals with only two previous episodes of depression. Several hypotheses have been proposed to account for the lack of efficacy of MBCT among such patients. Segal et al. (2002) suggest that for these individuals, relapses may be triggered more often by the occurrence of major life events, such as the breakdown of relationships, rather than by reactivation of depressive thinking patterns during periods of sadness. Post (1992) has suggested that as the number of previous episodes increases, the severity of environmental stress required to provoke another episode decreases. For individuals with more previous episodes, associations between sadness and
negative thinking may be stronger, so that reactivation of depressive thinking patterns occurs more readily in the face of even mild environmental stressors. The strong emphasis in MBCT on preventing the reactivation of depressogenic thinking patterns associated with sadness, and its relative lack of attention to coping with major life events, may help to explain why the treatment is efficacious only with individuals with several previous episodes.

It is also possible that different types of depression tend to have different triggers. Some may be triggered by life events, whereas others are triggered by prolonged rumination. Individuals may be more prone to one type or the other. If so, then it is important for future research to clarify ways to prevent relapse in individuals who are susceptible to relapse during stressful life events. Finally, it is possible that individuals with fewer previous episodes are less motivated to engage fully in the treatment regimen; in contrast, individuals with more previous episodes may have learned through bitter experience the importance of sustained effort to prevent future depressive relapse and therefore may be more likely to comply with treatment expectations, which include extensive meditation practice and other homework exercises.

It is also important to note that the efficacy of MBCT has not been evaluated in patients in the midst of a depressive episode. Segal et al. (2004) suggest that the program may not be effective for these individuals. The intensity of negative thinking and the poor concentration typical of depressive episodes might make it difficult for currently depressed patients to participate in mindfulness exercises and to acquire the necessary attentional control skills. Moreover, the nature of some of the formal mindfulness practices taught in MBCT (e.g., sitting meditation) may not be consistent with efforts to activate depressed patients that are typical of cognitive and behavioral treatments for acute depression.

CASE STUDY

CONTEXT AND CLIENT BACKGROUND

The individual described in this case study was a participant in an MBCT group co-led by two of the authors (S.C. and S.D.). Participants in the group were referred primarily by psychotherapists in independent practice who work with depressed clients. Therapists were asked to refer clients who were interested in learning skills to prevent depressive relapse. Potential participants were mailed an intake packet with several assessment instruments, including the Beck Depression Inventory II (BDI-II) (Beck, 1996) and an information form that asked their primary reasons for taking the course. They were also asked to describe any current psychotherapy or
pharmacotherapy and any current significant health problems. Those who completed and returned these materials along with an initial fee were invited to a brief screening interview. Applicants were assessed for current depressive severity, current Axis I psychopathology, and any interpersonal difficulties that might interfere with group learning. They were also asked to commit to daily meditation practice and other homework, and any reservations were explored. Several potential participants who appeared to be too depressed to complete the groups’ substantial homework requirements were screened out at this point.

The client chosen for this case study, who we shall call Suzanne, was part of a group of seven participants. All group members had experienced previous episodes of major depression. Some were not completely recovered from their current episode of depression but had made significant progress in combating it and were judged to be able to complete the homework required by the group. Several group members also had current anxiety disorder diagnoses.

Suzanne was a 38-year-old graphic artist, referred by her previous therapist. She was eager to begin the group treatment, as she had suffered from both depression and anxiety for many years. She had experienced some relief as a result of previous psychotherapy and medication but had also suffered several relapses. A busy professional also raising a family, she feared that time to meditate and do other homework would be scarce but was motivated to enroll in the group in order to minimize the chance of future relapse.

COURSE OF TREATMENT

The group followed the MBCT manual (Segal et al., 2002) with slight modifications as warranted by specific group participants. The group met for 2 1/2 hours per session for 8 weeks. The first week focused on the introduction to the metaphor of “automatic pilot” as a method to begin discussion of doing and being modes of mind. The first exercise in the program was mindful eating, in which participants were led through a process of eating a raisin mindfully, paying close attention to sights, sounds, texture, taste, etc. The exercise was intended to give participants a direct experience of moving from the automatic pilot of doing mode to being mode. (See Chapter 1 in this volume for more detailed discussion of the meditation exercises used in MBCT.)

Following the mindful eating practice, the instructors co-led a period of inquiry, a core component of each session. The aim of inquiry is to teach through experiential learning, modeling an open and accepting response to direct experience. Leading inquiry often requires maintaining awareness of one’s own tendency to rush to fix or solve problems. Using questions, the leader instead helps participants explore their own internal experience,
observing connections between thoughts, feelings, and sensations. Leaders often invite discussion and reflection with questions such as the following: How long did the experience last? Did it stay the same or did it change? Were there any other accompanying thoughts, feelings, or body sensations? What happened next? In general, inquiry begins with a focus on the practice just conducted in the group and then moves to a discussion of the weekly homework assignment.

Suzanne responded very positively to the mindful eating practice. She easily grasped the metaphor of automatic pilot and during inquiry described the multiple ways in which she felt on automatic pilot, both at work and when interacting with her husband and two sons. The early sessions of MBCT are typically both challenging and exciting for group members, and Suzanne was no exception. Although extremely busy with work, parenting, and travel, she quickly began to practice mindfulness of daily activities, concentrating on eating mindfully whenever possible. Suzanne was easily able to identify both thoughts and feelings, although several other group members struggled with this task, especially when first introduced into the second session. She commented, “After rushing home and cooking dinner with my husband, I noticed heaviness in my body when I finally sat down to eat. I felt anxious whenever I wasn’t listening to the kids, even though I wanted to concentrate on my food and had explained this to them and they had agreed not to talk for the first five minutes.”

The body scan also is introduced in session 1. Suzanne found this exercise meaningful and incorporated it into an evening routine with her husband, who began to practice with her as they both listened to the body scan tape. In fact, Suzanne expressed some embarrassment during the homework review in session 2, which focused on a discussion of the many barriers that participants encountered as they practiced the homework assignments from the previous week. Suzanne, by contrast, reported how pleasurable she had found the body scan to be and how few barriers she encountered in her practice.

An important task for group leaders is to create a group culture or expectation in which the full range of participant reactions to the homework can be comfortably expressed. For this reason, it was important to respond to Suzanne’s positive experience with the body scan practice while, at the same time, teaching that unpleasant mindfulness practice is no “less” of a mindfulness practice. In addition, it was important to highlight the presence of judgments, including the categorizing of experiences as “pleasant” and “good,” as well as “unpleasant” and “bad.” Adopting a nonjudgmental stance was important for the other group members during that session and would become important to Suzanne as she worked with the following week’s homework.

Session 3 introduced participants to the practice of sitting meditation, using the breath as an anchor of attention. Like several of the other group
members, Suzanne found it very difficult to develop a formal sitting practice outside of the class sessions. Sometimes she found it difficult to stay awake; at other times her focus seemed to be everywhere except on her breathing, and she became discouraged. During inquiry, the group leaders normalized the experience of mind wandering as an inherent part of the practice of mindfulness for most practitioners and shared with Suzanne the common instruction, “If the mind wanders a hundred times, then simply bring it back a hundred times” (Segal et al., 2002, p. 168).

In addition, the group leaders invited Suzanne to notice the judgments that arose in response to her experience of her wandering attention and to practice accepting each sitting as it was, letting go of expectation or demands. Both group leaders, as well as the other group participants, described the challenge of meeting experience nonjudgmentally, which Suzanne found helpful. She continued to work with judgmental thoughts by noticing and inviting an attitude of acceptance throughout the course; however, she frequently described feeling discouraged, wishing for more experiences of competency during her sitting practice.

By contrast, the 3-minute breathing space introduced in week 3 was easily incorporated into Suzanne’s daily practice. She reported that this short exercise in breathing brought her back into the present and interrupted her tendency to ruminate, either about missed opportunities in the past or about future unknowns. She initially paired this breathing exercise with brushing her teeth for practice and later reported using it spontaneously, especially in an increasingly tense work situation.

Mindful walking and stretching were less compelling to Suzanne. She became very self-conscious and distracted as she tried to attend to carefully placing each foot on the ground. Although she tried this practice several times, she never found it useful. Group leaders responded evenly to Suzanne’s reaction to mindful walking, encouraging her to experiment with the weekly assignments while observing her judgmental responses. The leaders reminded the group that one aim of the course was to introduce participants to a range of practices, with the hope that some (but perhaps not all) would be incorporated into a long-term daily routine.

Similarly, the stretching led to much self-criticism about her lack of flexibility and strength. Additionally, her children often jumped on her as she tried to stretch. Thus, while other class members found the yoga tapes and practice extremely useful, Suzanne did not. Again, there was the problem of finding time and space in her hectic life. Eventually she was able to adopt a somewhat playful attitude toward the walking and stretching practices but did not integrate either into a daily routine after the conclusion of the course, whereas she regularly practiced the body scan. Other group members, however, found that mindful walking and stretching became their primary modes of meditation practice. Interestingly, this proved true for both participants who struggled with current anxiety symptoms.
In week 4, Suzanne participated actively in the discussion of the definition of depression. She was able to describe with great detail the vegetative symptoms that felt like a profoundly heavy weight when she was depressed. She was also very moved by the mindfulness-based stress reduction (MBSR) videotape shown during this session, which shows Jon Kabat-Zinn working with chronic pain patients at the University of Massachusetts. Like others in the class, she was encouraged to see that these patients found the mindfulness practices extremely helpful in improving their quality of life. She was also touched by the kindness and empathy of Kabat-Zinn and said she would like to adopt this kind of attitude with her own struggles with depression, as opposed to the self-critical dialogue she so often repeated to herself.

The theme of week 6 (i.e., thoughts are not facts) also resonated deeply for Suzanne. In the class discussion, she was able to identify alternative viewpoints (to her typical negative thoughts) and readily saw the usefulness of the breathing space as a first step to viewing her life through a wider lens. Quickly grasping the connection between negative predictions and anxiety, she began using alternative, more accurate predictions when she thought about the future, at work and at home. She also described the negative impact on her mood and behavior of anxious thoughts about her children’s welfare whenever they were apart. Instead, she now began focusing on the importance of attachment, separation, and reunion as necessary learning experiences for both parents and children.

At this point in the course of the class, Suzanne was able to interrupt the beginning of a depressive relapse. Several external events were related to this relapse. The winter holiday schedule resulted in a break of 2 weeks between mindfulness meetings, and the holidays themselves increased demands on Suzanne’s time and made practicing more difficult. Moreover, these events coincided with the shortest days of the year and especially gray, dark weather. As Suzanne’s mood began to slip, she responded with familiar negative self-talk, criticizing herself for not accomplishing more each day. She felt guilty about exercising and seeing her friends, and so eliminated these necessary parts of her self-care. This decrease in exercise and social contact resulted in decreased energy and a feeling that she wasn’t doing anything right, accompanied by the thought that she wasn’t “good enough.” When her new boss demanded more attention to tasks she had previously seen as of limited importance, she interpreted this as further evidence in support of her internal self-critical thoughts.

When the class began again in the new year, Suzanne was relieved to hear that other members had also found it difficult to maintain a steady mindfulness practice. The inquiry discussion avoided any stance of blame and focused instead on the costs and benefits of a flexible relationship to practice. Other members discussed using the 3-minute breathing space and mindful walking, eating, and driving. During inquiry, Suzanne began to
bring awareness to some of her patterns of negative, self-critical thought. She commented, in particular, on the frequency of all-or-nothing thinking. For instance, she discussed feeling that there was "no point" to maintaining her meditation practice, because it was not possible to do the full 40 minutes, and how she subsequently felt guilty and worthless.

During inquiry, the group leaders invited Suzanne to observe the presence of such judgments when they arose and to experiment with a more flexible and nonjudgmental approach to her practice and herself, perhaps using a briefer period of practice (e.g., 10 minutes) if a longer period was not feasible. She felt motivated by this discussion and began to practice again. Suzanne realized that her judgmental thoughts were contributing to her relapse and she began to bring awareness to such judgmental thoughts during her practice, in family life, and at work. She began to experiment with a more accepting and compassionate stance to these domains. Putting these new mindful skills into practice reversed the downward slide in her mood and prevented a full-blown relapse of depression. This increased her confidence in the model and inspired other group members to stick with their practice. Suzanne also found it helpful to create a routine for her practice. Initially she had paired practice of the 3-minute breathing space with brushing her teeth. As she added new skills, she also tied them to existing daily routines and this helped her maintain consistency in her practice.

In week 7, Suzanne struggled with the knowledge that she needed to focus on her own needs instead of caring always for others. She saw clearly that her mood improved when she and her husband had time alone, even though this was hard to schedule. Similarly, she benefited mightily from time with women friends and from time alone. Exercise and adequate sleep at times seemed like remote memories from a life before motherhood, but she acknowledged the importance of beginning to work these basics of self-care back into her life. Consequently, she included earlier bedtimes and increased exercise, pleasure, and social contact in her action plan to reduce relapse.

Because she had experienced a short relapse during the group, Suzanne was well aware of her personal relapse signature. She recognized the sadness, lethargy, and worry that often presaged a rapid decline in pleasure and mood. At this point, critical self-talk and harsh judgments about not performing well enough quickly surfaced. Subsequent irritability and withdrawal triggered more self-criticism about her mothering skills and her performance at work. Instead of asking her willing husband for help, she withdrew further and became more depressed. Identifying the steps in the relapse process, although painful, presented the opportunity for quick intervention. Attention to the basics of self-care (sleep, social contact, adequate nutrition and exercise) would help her focus on her own needs in the moment. Suzanne's use of the 3-minute breathing space remained a key component of bringing attention to the onset of her relapse signature,
providing an opportunity to make different choices. In addition, regular daily practice of the body scan provided an ongoing practice of disengaging from the automatic pilot paths toward judgment and criticism. Adding yoga and sitting meditation to the body scan were also now available options. Developing alternative self-talk, in contrast to her typical critical dialogue, could help her to develop more accurate viewpoints of the present and to hold a more accepting and accurate view of herself.

Not unlike several participants, Suzanne was both sad that the group was ending after session 8 and hopeful about the future. Although she expressed some concern that she might lose her focus on the daily body scan, Suzanne was also excited to try to maintain her practice on her own and to regain an evening with her family. She was effusive in her praise of the class and the accepting stance of the leaders and materials. She was open to the idea of a future get-together or workshop but also felt hopeful about her ability to do the body scan and sitting meditation on her own. As she was more accepting of herself, she was also better able to support the other participants who had developed very different ways to bring mindfulness to their everyday activities. We were all moved by the description of how one participant, who had struggled throughout the class, now begins her day walking very mindfully to the bus and then continuing mindful awareness of each moment on the bus ride to work.

ISSUES THAT AROSE DURING TREATMENT

Like several other class members, Suzanne struggled with various forms of thinking errors common to people with depression, such as perfectionist standards and all-or-nothing thinking. Although these errors were less rigid than when Suzanne had previously experienced a full-blown depressive episode, these ways of thinking still made it a challenge for Suzanne and other class members to build skills, including the skills of acceptance and the attitude of mindfulness. For example, skill building requires making mistakes and feeling both uncomfortable and incompetent. Suzanne, a very bright and successful professional, was used to feeling quite competent in many areas of her life. Our class asked her to stretch herself, both physically and emotionally. Although the leaders and the materials modeled and encouraged the importance of simply accepting experience, this was not easy for Suzanne.

The fact that she did not easily develop a daily practice of meditation initially seemed another example of her “badness” or failing; a problem that could potentially trigger a relapse was therefore explored in our work together. Each week, this issue arose for Suzanne or for another class member, and each week we would all practice together and process the difficulty in simply being in the moment, experiencing acceptance of the present.
Addressing these thinking errors became part of the practice of mindfulness and also preparation for life problems. For example, midway through the class, Suzanne encountered conflicts and criticism with a new, difficult boss at work. The previously described relapse into depression also resulted in negative future predictions about her workplace. This, in turn, negatively affected her work performance. She became tense and irritable and had a hard time getting an accurate picture of her excellent work skills, forgetting previous positive evaluations and feedback, as well as frequent promotions.

When Suzanne returned her attention to the moment and took a 3-minute breathing space, she brought awareness to the ways in which she was increasing tension in her body (e.g., shoulders, abdomen) and in her thoughts (e.g., “I can’t do this; this is impossible”). This increased awareness allowed her to shift her relationship with these experiences and to employ other strategies that would more effectively address the challenges at work. Each evening she listened to the body scan tape, and this reminded her of the power of staying focused on the moment. She also experienced increasing mastery of this skill. Mindfulness of cooking also enriched her experience of the moment and bought her new, accurate information about herself and the world.

When she was anxious, Suzanne typically tried to take control of a situation, and this tendency was also manifested in the group. Initially she was quick to say positive things about the practice and to respond to questions. As the class progressed, she was gradually able to sit with silence and let others express misgivings or difficulties. She trusted the leaders more to handle discomfort and to guide the group. Some of her old assumptions were tested, and new, more flexible ones developed about the necessity, costs, and benefits of overresponsibility. She realized how this stance increased anxiety, and she therefore began to reduce her attempts to control the future, instead accepting and enjoying the present.

Suzanne originally harbored the hope and expectation that mindfulness meditation would result, preferably immediately, in an increased state of relaxation. So she was somewhat disappointed in the hard work entailed in learning to practice mindfulness meditation and yoga stretches. As the sessions continued, Suzanne accepted the reality that relaxation might be an occasional by-product of mindfulness practice but was not the goal. This concept helped her to reduce her perfectionist strivings, bring greater awareness to her frequent judgmental thoughts, and begin to accept each imperfect moment.

OUTCOME OF SUZANNE’S TREATMENT

In the class, Suzanne developed mindfulness skills that included daily use of the body scan and mindfulness of everyday activities, such as eating and
cooking. She began to use the 3-minute breathing space when she was anxious, such as in difficult interactions with her boss at work or with her children at home. She reported a heightened awareness of the present, as well as decreased rumination about the future and self-criticism about the past. She developed the skill of noticing her patterns of self-judgment and demands for very high standards for her own performance at work and as a parent. Over time, she experimented with becoming more realistic about what she could accomplish in difficult and demanding environments. She grew to appreciate her own strength and resilience and the support of her husband and family in facing challenges at work and at home, enriching her gratitude for her current life. She successfully foreshadowed the beginning of a depressive relapse during the group and reported confidence about the skills learned to help manage similar times in the future.

PRACTICAL ISSUES

A wide range of practical issues arises in the course of developing and leading an MBCT group. These issues generally fall within three broad categories: (1) the background and role of group leader; (2) responding to participant reactions; and (3) managing logistical and financial issues. These are addressed in the following section.

BACKGROUND AND ROLE OF GROUP LEADER(S)

MBCT requires that leaders maintain an active meditation practice (Segal et al., 2002). Clearly the therapists’ ongoing meditation practice and resulting attitude of mindfulness and acceptance help set the tone for the groups and the meditation experiences within the group. Previous experience with simple yoga postures and principles is also useful. Some basic knowledge of the principles of cognitive behavioral therapy is necessary, as these principles are embedded through the treatment and made explicit in the second half of treatment. Finally, clinical experience with mood disorders, specifically depression and anxiety, is useful. Experience with leading groups may also prove helpful.

Having a co-leader, while not required or even discussed in the manual, provides a depth of experience and attention that, in our experience, enriches the group for both leaders and participants. It is also easier to learn new skills without the pressure of leading each session alone. The co-leaders met and talked each week before and after each group session. Planning before sessions and debriefing afterward strengthened their confidence in the presentations and allowed for coordination and division of labor. Subsequent groups required briefer planning, but debriefing continued in order to adapt the teaching to each particular group and to adapt to the
specific needs of each participant. Assisting an experienced group leader is another way to gain skill in leading MBCT groups and is a format commonly used in centers providing MBCT.

An important aspect of the role of group leader is to tie mindfulness practices and inquiry to the prevention of depressive relapse. The aim of the course is not to teach mindfulness for the sake of mindfulness; there is an explicit mental health agenda, in contrast to the teaching of similar practices in retreat settings. Group leaders can use their expertise in treating depression and providing CBT techniques to provide psychoeducation about the symptoms of depression and anxiety and how mindfulness skills can help to both strengthen nondepressed states and alert the class members to early signs of relapse. For example, mindfulness of mood and feelings of minor sadness may provide early warning signs of relapse. Attentiveness to and acceptance of the moment can also increase awareness of positive and neutral mood, further opening the previously negative lens of depression and so strengthening awareness of small pleasures and gratitude in living.

In addition, it is important for group leaders to maintain a balance between teaching through experiential exercises and imparting information. This balance requires clinical experience and a willingness to dance with the tension of differing needs of different classes and class members. MBCT demands a subtle ability to weave information into the class while maintaining the overall emphasis on experiential learning. Moreover, as in good CBT, the agenda is adjusted to meet the needs of the group. For example, the 3-minute breathing space can be used in any session if the focus is becoming overly didactic or leading away from experiential learning and knowing. Similarly, as a leader, one needs to move constantly back and forth from doing mode to being mode. Examples of this back and forth movement include leading inquiry and mindfulness practices, a dance that emerges in each session. Beginning leaders may at times refer to the treatment manual, or preferably preparation notes, to keep on task. However, the intention of the treatment is to teach and guide from one’s own moment-to-moment experience; therefore, excessive reliance on the manual is strongly discouraged. Planning in advance the time allowed for each task may prove helpful, especially initially. With experience, it becomes more possible to lead from one’s immediate experience, while monitoring time constraints and attending to class members’ needs. This is an enriching and increasingly elegant experience, enhanced by the leaders’ mindfulness practice and clinical expertise and sensitivity.

Finally, it is of paramount importance that leaders protect time and space for adequate preparation for group. Experience teaches that it does not work to run in from a hectic day and lead the group. Instead, leaders need time to access being mode in order to function well as leaders.
Ideally, leaders would arrive early enough to meditate in the room before the class begins.

**RESPONDING TO PARTICIPANT REACTIONS**

A number of common reactions or difficulties frequently arise during treatment. The following discussion outlines some guidelines for group leaders for responding to such reactions:

1. In general, it is often helpful to maintain the intention to provide corrective feedback in a manner consistent with the model; this includes staying present in the moment, not shying away from participants' misconceptions or misuse of strategies, and maintaining openness and curiosity. For example, class members often confuse the intent of the 3-minute breathing space and may use it as a distraction or way of tuning out. A mindful response will often include questioning and inviting reflection as a way of giving feedback.

2. Leaders should be prepared for participants to voice strong negative reactions to practices. It is common to hear the following: “I hate the body scan,” “I can’t stand the physical discomfort or pain from sitting,” or “I always fall asleep when I meditate or listen to the tapes.” In response to such experiences, it is often helpful to model a calm, accepting stance that provides a mindful, curious response while also conveying the importance of continuing to practice and accept the experience that arises.

3. It is important to maintain a nonjudgmental stance when responding to confusion about what mindfulness practice is and/or hopelessness and discouragement about one’s practice (e.g., “I can’t do this; my mind keeps wandering”). Be prepared to keep making the point that bringing back your attention is the practice.

4. It is helpful for leaders to be thoughtful in responding to participants not completing homework and/or not sharing openly about homework. It can be hard to assess homework compliance in MBCT classes. The leader does not want to create a “school” environment but does need to emphasize the importance of doing the work and practice. There are no formal mechanisms for checking on practice other than providing a weekly time for reporting back to the group. It is particularly important to model acceptance and also to encourage increased effort, an ongoing dialectic.

5. Leaders should be prepared to respond thoughtfully to participants changing the homework practices based on personal preference, either because they did not like the assigned practice or because they prefer to do their “own” practice (especially for people with meditation experience).
MANAGING LOGISTICAL AND FINANCIAL ISSUES

The MBCT manual sets an ambitious course for each 2-hour group session. At times, it can be challenging to give adequate attention to each agenda item in each session; this is particularly the case in week 3. Possible remedies include extending sessions to 2.5 hours (as we did) or extending the course to 9 weeks. Another practical solution would be to decrease the time allowed for the opening mindfulness practice (e.g., reducing a 45-minute meditation to 30 minutes). However, given the emphasis on learning through direct and immediate experience, this option may be problematic.

Finding an adequate space can also present challenges for therapists providing MBCT outside of a research trial or institutional setting. A room with available table and chairs is helpful for the initial sessions (and for clients who prefer chairs for the mindfulness practices); however, the room also needs large open space, preferably carpeted, for yoga, body scan, and sitting meditation. Windows are ideal for seeing meditation and general comfort, yet privacy is also ideal for confidentiality. A space of beauty may also add to the spirit of mindfulness and invite group attentiveness and cohesiveness. In our experience, many of these features can be hard to find in traditional independent practice settings. Although a strong leader and motivated participants would likely be successful in an unheated, dark basement, it is often worthwhile to seek an environment that is sufficiently inviting and spacious.

In independent practice settings, it is often important to consider how to work with managed care and insurance reimbursement. Because the treatment is described as a class, and not as group psychotherapy, in our experience insurance payments were not possible. However, practitioners and/or clients in other settings may find it advantageous to advocate with insurance companies to cover this service. Since insurance reimbursement was not possible for our clients, we maintained a few sliding scale spots if payment would have precluded individuals from attending the group.

SUMMARY

MBCT is an 8-week group treatment that combines mindfulness strategies with traditional cognitive behavioral strategies. It is designed to help patients with histories of depression develop core skills that will help to prevent the relapse and recurrence of depression in the future. This chapter has reviewed the rationale and background of the model, as well as relevant research. A case illustration has been presented to provide additional detail about the use of common treatment strategies and client responses, describing the experience of one client who benefited tremendously from the treatment. In our experience, leading these classes presents both
challenges and opportunities for the instructors: Staying mindfully in the moment while also running a group and teaching new approaches to experience blends many clinical and personal skills.

As described in other chapters in this volume, current efforts to apply this model to a range of other disorders are under way. In the group described herein, participants also reported that the skills were of assistance in managing anxiety. We eagerly await ongoing clinical reports and research investigations to increase the applicability and future directions of mindfulness-based therapies.

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REFERENCES


