Mindfulness-Based Cognitive Therapy (MBCT) for Depression-Review and Current Trends

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ABSTRACT

Depression is a major public health problem, in terms of its prevalence, dysfunction, morbidity and economic burden. Mindfulness-based cognitive therapy (MBCT) was developed as a psychological intervention for relapse prevention of major depression. This review provides an overview of current trends in MBCT research, including efficacy, mechanisms of change, limitations, and gaps in literature. The article concluded that MBCT may be used as adjunct psychological intervention to pharmacotherapy; however efficacy of MBCT alone is inconclusive.

Keywords: Mindfulness-based cognitive therapy, depression current trends

INTRODUCTION

Depression is a major public health problem, in terms of its prevalence, dysfunction, morbidity and economic burden. The essential feature of a major depressive episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. The individual must also experience at least four additional symptoms that includes changes in appetite or weight, sleep, and psychomotor activity, decreased energy, feelings of worthlessness or guilt, difficulty thinking, concentrating, or making decisions, or recurrent thoughts of death or suicidal ideation or suicide plans or attempts. (DSM-5). Recurrent depressive episode is characterized by at least two episodes should have lasted a minimum of 2 weeks and should have been separated by several months without significant mood disturbance and without any history of independent episodes of mood elevation and over-activity that fulfil the criteria of hypomania or mania.

EPIDEMIOLOGY

The report on Global Burden of Disease estimates the point prevalence of unipolar depressive episodes to be 1.9% for men and 3.2% for women, and the one-year prevalence has been estimated to be 5.8% for men and 9.5% for women.

According to NMHS, 2015-16 was conducted on a nationally representative sample of 39485 individuals, sampled from 12 states of India using uniform and standardized methodology. The lifetime prevalence of depression in India was 5.25% among individuals aged 18+ years and the current prevalence was 2.68%, highlighting the fact one out of 20 adult individuals have suffered from depression in the past with half of them suffering at present.

MINDFULNESS-BASED COGNITIVE THERAPY

Mindfulness-Based Cognitive Therapy (MBCT) is an eight week manualized treatment programme that was developed by Zindel Segal, John Teasdale, and Mark Williams specifically designed to address latent vulnerability in depression. The rationale of the treatment is based on findings from cognitive research on vulnerability that has linked relapse to mood-related reactivation of negative thinking patterns (Lau, Segal, and Williams, 2004; Scher, Ingram, and Segal, 2005) and maladaptive ways of responding to negative cognitions and emotions such as rumination (Watkins, 2008), thought suppression (Wenzlaff and Bates, 1998) and experiential avoidance. This is an unwillingness to remain in contact with one's private experiences, leading to attempts at altering experience so that it is less aversive (Hayes et al., 2004). The major difference

between MBCT and CBT is that the emphasis in MBCT is on changing the relationship to one's thoughts (Segal, Williams and Teasdale, 2002) whereas the emphasis of cognitive-behavior therapy is on challenging thought content (Teasdale, 2002).

MINDFULNESS

Mindfulness has its origins in Buddhist tradition, and has been adopted in psychology as an approach to respond adaptively to mental events that contribute to emotional distress. The basic premise underlying mindfulness practice is that the experience of the present moment in a non-judgemental and purposeful way can effectively counter the effects of negative thoughts about the past and the future, which tend to occur in depression (Hoffman, Sawyer, Witt, and Oh, 2010).It has been described as "bringing one's complete attention to the present experience on a moment-to-moment basis" (Marlatt and Kristeller, 1999) and as "paying attention in a particular way: on purpose, in the present moment, and non judgmentally" (Kabat-Zinn, 1994). The ability to direct one's attention in this way can be developed through the practice of meditation, which is defined as the intentional self-regulation of attention from moment to moment. 'Mindfulness' refers to a process that leads to a mental state characterized by non-judgmental awareness of the present moment experience, including one's sensations, thoughts, bodily states, consciousness, and the environment, while encouraging openness, curiosity, and acceptance (Bishop et al. 2004). Mindfulness practices can effectively counter the effects of stressors, because excessive orientation toward the past or future when dealing with stressors can be related to feelings of depression and anxiety (Kabat-Zinn, 2003). It is further believed that by teaching people to respond to stressful situations more reflectively rather than reflexively, MBCT can effectively counter experiential avoidance strategies, which are attempts to alter the intensity or frequency of unwanted internal experiences (Hayes, Luoma, Bond, Masuda, and Lillis, 2006). These maladaptive strategies are believed to contribute to the maintenance of many emotional disorders (Bishop et al., 2004; Hayes, 2004). In addition, the slow and deep breathing involved in mindfulness meditation may alleviate bodily symptoms of distress by balancing sympathetic and parasympathetic responses (Kabat-Zinn, 2003).

EFFICACY OF MBCT ON DEPRESSION

There is consistent empirical evidence in support of using MBCT to decrease the risk of depressive relapse. Beginning with the initial trial of this intervention in 2000, 145 individuals who were in remission or recovery from major depression were randomized to either an 8-week course of MBCT or treatment as usual (TAU). Participants were followed for 1 year, and the results indicated that only 40% relapsed during the follow-up period in MBCT group compared to 66% of those in the TAU group (Teasdale et al., 2000). In 2008, a follow-up study of 123 patients in remission or recovery from major depression who were randomized to either maintenance antidepressant medication or medication plus MBCT showed that the MBCT group had a significantly lower relapse rate (47%) over 15 months than the medication-alone group (60%). MBCT was also associated with a reduction in depressive and comorbid symptoms and an increase in quality of life (Kuykenet al., 2008). Similar results were replicated more recently in 2010 by Segal et al. A systematic review conducted by Coelho et al, in 2007 evaluated the results of four studies that compared MBCT plus TAU to TAU alone. The results of this review concluded that for individuals who have experienced three or more depressive episodes, MBCT is a positive adjunct to TAU. The authors did qualify this conclusion by noting that there may be issues with control groups, so this conclusion should be interpreted with caution.

The trials compared MBCT to TAU, which can only indicate whether some kind of additional treatment action results in a positive change. The trials did not compare MBCT to other non pharmaceutical treatments or similar group settings, making it difficult to identify any specific effects of MBCT. Specifically, a systematic review and meta-analysis, Clarke et al., 2015 examined the effects of non pharmacological interventions on depressive relapse prevention. Their review culminated in the conclusions that at 12 months, MBCT, CBT, and interpersonal psychotherapy were each associated with a significant reduction in relapse compared to active and inactive controls. However, the authors concluded that

MBCT's efficacy may be limited to participants who had recovered from their depression via pharmacological means and a nonspecific effect of treatment.

One of the new trends in the study of MBCT is the extension of examining depressive relapse as the primary outcome variable to examining depressive symptoms as an outcome variable. In 2014, Strauss et al conducted a meta-analysis of 12 randomized controlled trials evaluating mindfulness-based interventions for individuals with current anxiety or major depression. The findings demonstrated a significant effect associated with MBCT compared to control conditions. This particular meta-analysis provides strong evidence for the effectiveness of MBCT with individuals who are currently experiencing a major depressive episode, in addition to the strong evidence in support of MBCT for those who are currently in remission.

A randomised controlled trial aimed to see whether MBCT with support to taper or discontinue antidepressant treatment (MBCT-TS) was superior to maintenance antidepressants for prevention of depressive relapse or recurrence over 24 months. Authors found no evidence that MBCT-TS is superior to maintenance antidepressant treatment for the prevention of depressive relapse in individuals at risk for depressive relapse or recurrence. Both treatments were associated with enduring positive outcomes in terms of relapse or recurrence, residual depressive symptoms, and quality of life (Kuyken et al., 2015).

An individual patient data meta-analysis from 9 Randomized Trials studies comprising 1258 participants showed that patients receiving MBCT had a reduced risk of depressive relapse within a 60-week follow-up period compared with those who did not receive MBCT. Furthermore, the study revealed that comparisons with active treatments suggest a reduced risk of depressive relapse within a 60-week follow-up period. Socio-demographic (ie, age, sex, education, and relationship status) and psychiatric (i.e, age at onset and number of previous episodes of depression) variables showed no statistically significant interaction with MBCT treatment. However, there was some evidence to suggest that a greater severity of depressive symptoms prior to treatment was associated with a larger effect of MBCT compared with other treatments (Kuyken et al., 2016).

INDIAN STUDIES

In India, a preliminary study from NIMHANS examined the effectiveness of mindfulness based cognitive therapy in patients with depression. A single case design with pre and post assessments was adopted. The sample consisted of five patients with depression. Four patients completed therapy. Three patients showed clinically significant improvement on depression, work and social adjustment and QOL. Changes in dysfunctional beliefs were not significant, suggesting that beliefs take a longer time and more sessions to change (Sharma, 2013). Another study examined the effects of Mindfulness-based Cognitive Therapy (MBCT) on mindfulness skills, acceptance and spiritual intelligence in patients with depression. Sample consisted of five patients with a diagnosis of Recurrent Depressive Disorder as per ICD-10. A single case design with pre- and post-intervention assessment was adopted. Quantitative analysis revealed clinically significant reduction in the severity of depression and considerable to significant improvements in acceptance, improvement in mindfulness skills and spiritual intelligence. Qualitative analysis revealed themes of 'awareness', 'acceptance' and 'enhanced coping' (Nangia and Sharma, 2012).

A single case design with pre- and post-assessment case series in 5 patients with late-life. Depression consisted of 8 sessions over 8 weeks indicated clinically significant improvement in the severity of depression, mindfulness skills, acceptance, and overall quality of life in all 5 patients. Eight-week MBCT program has led to reduction in depression and increased mindfulness skills, acceptance, and overall quality of life in patients with late-life depression (Mathur et al; 2016).

MECHANISM OF CHANGE

The existing research examining mechanisms of change in MBCT have concluded that changes in cognitive variables, such as mindfulness, worry, meta-awareness, and self-compassion, are associated with reductions in relapse risk and depressive symptoms, and thus may be mechanisms of action for the positive effects of MBCT. In a following study, Hepburn et al. (2009) tested the hypothesis that MBCT training could have an effect on thought suppression in formerly depressed patients

with a history of suicidality. The authors observed that MBCT did not reduce thought suppression; however, it significantly reduced self-reported attempts to suppress thoughts in the previous week. The authors interpreted this finding as suggestive of an effect of MBCT on the reduction of ruminations which, in turn, could lead to a reduction of depression. In accordance with this finding, Kingston et al. (2007) observed a significant reduction of ruminative thinking in patients who practiced MBCT as compared with those who did not, even though the limited sample size and the absence of randomization suggest considering such finding with caution.

The current research examining mechanisms of change in MBCT have provided strong evidence that increased mindfulness and decreased negative repetitive thought (i.e., rumination) are processes that mediate the association among mindfulness-based interventions and treatment outcome. There is also support for such mechanisms as meta-awareness, self-compassion, and cognitive reactivity (Gu et al., 2015).

Three studies have examined the metacognitive mechanisms of MBCT and found that MBCT is an effective intervention that increases metacognitive awareness to negative thoughts and feelings including rumination, and significantly decreases relapse of major depression (Scherer-Dickson, 2004; Teasdale, Segal, and Williams, 1995; and Kingston, Dooley, Bates, Lawlor, and Malone, 2007). In a 2015 review, van der velden et al reviewed 23 clinical trials of MBCT for the treatment of recurrent MDD. Studies were included if they were clinical trials examining meditation or mechanisms in MBCT for MDD, the participants were 18 years or older, and MBCT was conducted in accordance with the manual. Of the 23 studies included, 12 trials showed that MBCT-treatment outcome was associated with or predicted by changes in mindfulness, rumination, worry, self-compassion, decentring, and/or meta-awareness.

LIMITATIONS OF MBCT

According to Segal et al. (2002), although MBCT is effective with patients with three or more episodes, it is not with those having only two previous episodes. A study by Ma and Teasdale (2004) showed that relapse rate for those receiving MBCT and that for the ones receiving TAU are the same. It also indicate that the reduction rate in relapse/recurrence with MBCT is highest if there are no major life events reported as onsets of depression, while no difference is shown between MBCT and TAU for onsets preceded by significant life events. MBCT is effective in reducing relapse/recurrence related to autonomous and ruminative type of negative thinking patterns that are provoked internally, but ineffective in reducing relapse associated with severe life events (Ma and Teasdale 2004).

MBCT does not target patients who are acutely depressed because poor concentration and higher intensity of negative thinking among those patients would affect their focus and attention required to develop the core skills for MBCT. On the contrary, findings from a study by Kenny and Williams (2007), most actively depressed participants of MBCT showed improvement in their depression scores. Therefore, the effectiveness of MBCT on acutely depressed patients is still inconclusive.

GAPS IN LITERATURE

The effectiveness of MBCT on acutely depressed patients is still inconclusive. There is a lack of research on "the unique contribution of mindfulness meditation to the outcome of MBCT" (Lau and McMain, 2005). There is limited research in this area and very few studies in India. Manual or module not available according to Indian Culture. MBCT have not been actively researched on acute and severe depression. According to Coelho et al. (2007), MBCT research is in its early stage and it is premature to attempt to draw definitive conclusions about its effectiveness. However, review of literature suggest that the MBCT can be considered an adjunct to pharmacotherapy treatment but MBCT alone as a treatment is still inconclusive. Considering the homogeneity of the trials in this review (i.e. the structure, content, and delivery of MBCT) and that the majority of participants were individuals who responded well to pharmacological treatment for depression, the literature could be further developed by testing MBCT with diverse patient populations and varying the treatment delivery.

CONCLUSION

Studies find that MBCT has shown significant effectiveness in preventing relapses/recurrences for patients in certain categories, for example, three or more episodes and non-life event (i.e., death in family) onsets. It also effectively increases metacognitive awareness to negative thoughts and feelings including rumination, and significantly decreases relapses of major depression. MBCT is considered a highly cost-efficient group-based approach. However, conclusive research studies are still lacking to support the unique role mindfulness plays in MBCT and its effectiveness in acute phase and relapses/recurrences of depression. Further research is needed to show how MBCT might shift therapeutic practices.

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How to cite this article: Sachdeva, D., Kaur, H., & Avasthi, A. (2018). Mindfulness-Based Cognitive Therapy (MBCT) for Depression- Review and Current Trends. *Journal of Disability Management and Rehabilitation*, 5(1), 49-54.