



The association between meditation practice and treatment outcome in Mindfulness-based Cognitive Therapy for bipolar disorder



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ABSTRACT

This study aimed to examine the impact of quantity of mindfulness meditation practice on the outcome of psychiatric symptoms following Mindfulness-based Cognitive Therapy (MBCT) for those diagnosed with bipolar disorder. Meditation homework was collected at the beginning of each session for the MBCT program to assess quantity of meditation practice. Clinician-administered measures of hypo/mania and depression along with self-report anxiety, depression and stress symptom questionnaires were administered pre-, post-treatment and at 12-month follow-up. A significant correlation was found between a greater number of days meditated throughout the 8-week trial and clinician-rated depression scores on the Montgomery-Åsberg Depression Rating Scale at 12-month follow-up. There were significant differences found between those who meditated for 3 days a week or more and those who meditated less often on trait anxiety post-treatment and clinician-rated depression at 12-month follow-up whilst trends were noted for self-reported depression. A greater number of days meditated during the 8-week MBCT program was related to lower depression scores at 12-month follow-up, and there was evidence to suggest that mindfulness meditation practice was associated with improvements in depression and anxiety symptoms if a certain minimum amount (3 times a week or more) was practiced weekly throughout the 8-week MBCT program.

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Introduction

According to Cahn and Polich (2006), meditation affects individuals at two levels. The first is through their immediate subjective state which occurs during the meditation practice itself and includes subjective experiences of calmness, peacefulness, a slowing or cessation of thoughts and increased perceptual clarity (Cahn & Polich, 2006). The second is at the trait level, which comprises accrued benefits of meditation practice over time. This includes changes in relationships to thoughts, feelings and internal experiences which, in turn, lead to the experience of a deeper sense of calm, sense of comfort and heightened sensory awareness outside the meditation practice (Cahn & Polich, 2006).

Mindfulness meditation is one of the main components of Mindfulness-based Cognitive Therapy (MBCT) which was originally designed to treat patients with recurrent depressive episodes in

order to prevent relapse (Segal, Williams, & Teasdale, 2002). MBCT comprises an 8-week group therapy program that combines cognitive therapy with the principles, concepts and mindfulness meditation exercises of the Mindfulness-based Stress Reduction (MBSR) program, originally developed by Kabat-Zinn (1990). Mindfulness meditation involves concentrating on the breath or body while maintaining a non-judgmental stance towards thoughts and feelings (Kabat-Zinn, 1990; Segal, Williams, et al., 2002). Mindfulness meditations in MBCT and MBSR include the Body Scan Technique – involving the non-judgmental observation of bodily sensations; the Sitting Meditation – observation of breathing in the abdominal region and any thoughts or feelings that arise; and the 3-min breathing space – a short meditation focussing on observing physical sensations, the breath and the body, in a non-judgmental way (Kabat-Zinn, 1990; Segal, Williams, et al., 2002).

Greater frequency of practice of the Body Scan meditation has been found to be associated with lower anxiety and interpersonal sensitivity scores after an MBSR program (Carmody & Baer, 2008). Others examining MBSR have also noted correlations between greater time spent in meditation and lower somatization symptoms, higher self-rated health and lower psychological distress scores for pain patients (Rosenzweig et al., 2010).

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However, a review of twenty-four studies that assessed mindfulness meditation, home practice indicated that almost half of the studies did not find any associations between meditation practice and treatment outcomes (Vettese, Toneatto, Stea, Nguyen, & Jing Wang, 2009). For example, Ramel, Goldin, Carmona, and McQuaid (2004) found that quantity of meditation practice was unrelated to improvements in depression and anxiety symptoms following MBSR, whilst Carmody, Reed, Kristeller, and Merriam (2008) noted no relationship between frequency of home meditation practice and improvements in state or trait mindfulness, medical symptoms or psychological distress (Carmody et al., 2008).

The assumption in many of these previous studies has been that greater quantities of meditation practice will be associated with greater improvements in psychiatric symptoms. An alternative hypothesis is that there is a minimum amount of meditation practice which is required to effect symptom improvements. One study has reported that participants who had engaged in a minimum of 3 days of mindfulness meditation practice a week during a modified MBSR program demonstrated significant increases in trait mindfulness scores compared to those who meditated for 2 days a week or less, at post-treatment and at 3-month follow-up (Schenstrom, Ronnberg, & Bodlund, 2006). However the relationship between meditation practice and other outcome variables such as overall well-being was not assessed (Schenstrom et al., 2006).

Although some studies have examined the efficacy of MBCT as an adjunctive treatment for bipolar disorder (Weber et al., 2010; Williams et al., 2008), as yet no studies have examined the relationship of the quantity of mindfulness meditation practice to symptom improvements. This study aimed to assess the relationship of mindfulness meditation practice to symptom improvements following MBCT training in a sample of participants with bipolar disorder over a 12-month follow-up period. Full details of the methodology and results of this trial have been reported elsewhere (Perich, Manicavasagar, Mitchell, Ball, & Hadzi-Pavlovic, 2013). It was hypothesized that the more days engaged in meditation practice would be associated with corresponding increases in mindfulness (state and trait), lower hypo/mania, depression and anxiety scores at post-treatment and at 12-month follow-up. This study also aimed to replicate the results of Schenstrom et al. (2006) by examining the impact of a minimum amount of meditation practice per week (minimum of 3 days) on trait mindfulness and treatment outcome. It was hypothesized that those practicing meditation for a minimum of 3 days per week would return lower scores on depression and anxiety and higher scores on trait mindfulness than those who practiced 2 days a week or less.

Method

Participants

Participants were recruited through local newspapers, general practitioner and psychiatrist mail-outs and the Sydney Black Dog Institute Research Register to participate in a randomized-controlled trial comparing MBCT to Treatment-as-usual (TAU). Participants were included in the study if they: (i) met criteria for a lifetime DSM-IV diagnosis of bipolar I or II disorder, (ii) were able to be maintained on a mood stabilizing medication for the duration of treatment, (iii) were currently under the care of a GP or psychiatrist who would review medication as necessary, (iv) experienced at least one bipolar disorder episode (hypo/mania, depression, mixed episode) over the past 18 months, and (v) had a lifetime incidence of at least 3 bipolar episodes. Additional criteria were: (i) at least 18 years of age, (ii) at least secondary school education, (iii) able to provide informed consent, (vi) fluent in written and spoken

English, (vii) currently under the care of a GP or psychiatrist who would review medication as necessary.

Participants were excluded from the study if they were: (i) currently experiencing a bipolar episode, (ii) had been given a diagnosis of schizophrenia or schizoaffective disorder, current substance abuse disorder, organic brain syndrome, antisocial or borderline personality disorder, (iii) had a concurrent significant medical condition which impeded their ability to participate, or (iv) were currently receiving other psychological therapy. Participants were also excluded if they currently practiced meditation or if they had previously participated in a formal course involving mindfulness, such as Dialectical Behaviour Therapy, MBCT or MBSR. The study was approved by the University of New South Wales Human Research Ethics Committee (HREC approval number 08039) and registered with the Australian and New Zealand Clinical Trials Registry (ACTRN12610000414011; UTN 1111-1115-0862).

Measures

Clinician administered

1. Young Mania Rating Scale (YMRS) (Young, Biggs, Ziegler, & Meyer, 1978). A clinician administered 11-item scale which assesses symptoms of mania. It has reported good inter-rater reliability (Young et al., 1978).
2. Montgomery-Åsberg Depression Rating Scale (MADRS) (Montgomery & Åsberg, 1979). A clinician administered 10-item scale designed to assess depression symptoms. It has good internal consistency ($\alpha = .85$) (Hermens et al., 2006) and good inter-rater reliability (0.76) (Davidson, Turnbull, Strickland, Miller, & Graves, 1986).
3. Composite International Diagnostic Interview (CIDI) (WHO, 1997). An interviewer-administered schedule covering the anxiety disorder modules of the CIDI – AUTO (Peters & Andrews, 1995) and has reported as having fair validity for the anxiety disorder sections (Kappa = 0.40) (Peters & Andrews, 1995).
4. Structured Clinical Interview for DSM-IV-TR Disorders (SCID-I) (First, Spitzer, & Williams, 2002). A researcher administered interview schedule that assesses diagnostic criteria for bipolar disorder (mania, hypomania, depression and psychotic episodes). Diagnostic reliability of the SCID-I is high with a kappa value of 0.74 for DSM-IV criteria for bipolar disorder (Gunderson et al., 2006).

Self-report measures

1. Depression Anxiety Stress Scales (DASS) (Lovibond & Lovibond, 1995). A 42-item measure comprising subscales of depression, anxiety and stress. The DASS has reported adequate reliability ($\alpha = .93$ for stress, $\alpha = .90$ for anxiety and $\alpha = .95$ for depression) (Crawford & Henry, 2003).
2. State/Trait Anxiety Inventory (STAI) (Spielberger, 1983). A two dimensional measure of state and trait anxiety with both subscales comprising 20 items. The STAI has good internal consistency, with the state anxiety subscale ranging from $\alpha = .90$ to $\alpha = .91$ and the trait anxiety subscale, ranging from $\alpha = .86$ to $\alpha = .85$ (Spielberger, 1983).
3. Mindful Attention Awareness Scale (MAAS) (Brown & Ryan, 2003). An uni-dimensional measure of trait mindfulness comprising 15 items. It has good internal consistency ($\alpha = .87$) with test-retest reliability at 4 weeks reported as 0.81 (Brown & Ryan, 2003).
4. Toronto Mindfulness Scale (TMS) (Lau et al., 2006). A state measure of mindfulness comprising 13 items. It comprises 2

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