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Mindfulness-based cognitive therapy as a treatment for chronic depression: A preliminary study

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ABSTRACT

This pilot study investigated the effectiveness of Mindfulness-Based Cognitive Therapy (MBCT), a treatment combining mindfulness meditation and interventions taken from cognitive therapy, in patients suffering from chronic-recurrent depression. Currently symptomatic patients with at least three previous episodes of depression and a history of suicidal ideation were randomly allocated to receive either MBCT delivered in addition to treatment-as-usual (TAU; $N = 14$ completers) or TAU alone ($N = 14$ completers). Depressive symptoms and diagnostic status were assessed before and after treatment phase. Self-reported symptoms of depression decreased from severe to mild levels in the MBCT group while there was no significant change in the TAU group. Similarly, numbers of patients meeting full criteria for depression decreased significantly more in the MBCT group than in the TAU group. Results are consistent with previous uncontrolled studies. Although based on a small sample and, therefore, limited in their generalizability, they provide further preliminary evidence that MBCT can be used to successfully reduce current symptoms in patients suffering from a protracted course of the disorder.

Introduction

In a significant number of those affected, Major Depression follows a protracted lifetime course with patients suffering from either full episodes or sub-syndromal levels of symptoms over considerable amounts of time (Kessing, Hansen, & Andersen, 2004; Solomon et al., 2000). While views of depression often stress its episodic nature, it has also become clear that in many cases, patients do not recover fully from episodes but continue to show residual symptoms, which themselves have been found to be an important predictor of relapse (Judd et al., 1998; Paykel et al., 1995; Pintor, Gasto, Navarro, Torres, & Fananas, 2003; Pintor, Torres, Navarro, Matrai, & Gasto, 2004). In particular, after severe episodes, sub-syndromal levels of depression are common and persistent (Kennedy, Abbott, & Paykel, 2004). In other patients, symptoms remain relatively stable at the level of full episodes over periods of more than 24 months (Mueller et al., 1996). Recent research has indicated that regardless of their presentation, i.e., whether patients continue to suffer from syndromal levels of the disorder or fluctuate between syndromal and sub-syndromal levels, chronic forms of depression are broadly homogeneous with regard to both their clinical and etiological features, while, at the same time, differing in important regards from episodic forms of the disorder (McCullough et al., 2003). For example, individuals suffering from chronic forms of depression have been found to be more likely to have a familial history of chronic depression (Klein et al., 1995), to be more likely to have suffered from early adversity (Lizardi et al., 1995), to be more likely to suffer from high levels of chronic stress (Klein, Taylor, Dickstein, & Harding, 1988; Ravindran, Griffiths, Waddell, & Anisman, 1995) and neuroticism (Hirschfeld, Klerman, Andreasen, & Clayton, 1986; Weissman, Prusoff, & Klerman, 1978), and to be more likely to suffer from co-morbid disorders, particularly personality (Garyfallos et al., 1999; Pepper et al., 1995) and anxiety disorders (Weissman, Leaf, Bruce, & Florio, 1988). Most importantly, chronic forms of depression have been found to be significantly less responsive to treatment (Thase, Reynolds, Frank, & Simons, 1994) with reports of rates of responders to single modality treatments in trials aimed at chronic depression or based on samples with highly recurrent forms of depression at about 50% (DeRubeis et al., 2005; Keller et al., 2000). There is, thus, an important need for further refinement of treatments for those who have developed a more protracted course of the disorder.

Mindfulness-Based Cognitive Therapy (MBCT; Segal, Williams, & Teasdale, 2002) is a treatment programme that was specifically designed to address latent vulnerability in depression. It combines

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training in mindfulness meditation and interventions from cognitive therapy for acute depression and is delivered in a group setting. 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, & Williams, 2004; Scher, Ingram, & Segal, 2005) and maladaptive ways of responding to negative cognitions and emotions such as rumination (e.g., Watkins, 2008), thought suppression (Wenzlaff & Bates, 1998) and experiential avoidance, i.e., 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). Through the use of mindfulness meditation, participants are taught to develop their ability to recognize and disengage from maladaptive forms of negative automatic and repetitive thinking. In two randomized controlled trials (RCTs), in which previously depressed patients were followed up over a period of one year following the treatment phase, MBCT has been found to reduce risk of relapse by approximately half in patients with three or more previous episodes of depression (Ma & Teasdale, 2004; Teasdale et al., 2000). A recent study has found MBCT to be as effective in reducing relapse over a follow-up period of 15 months as maintenance therapy with antidepressants (Kuyken et al., 2008).

Each of these three previous RCTs of MBCT studied only patients who were in remission or recovery. The use of MBCT in *current* depression had been discouraged because it was unclear whether the cognitive demands of a regular meditation practice would exceed the restricted capacities of depressed patients. However, as factors specifically addressed by MBCT are likely to play an important role not only in recurrence but also in the maintenance and persistence of depression, interest in applying MBCT to a wider range of patients has recently increased. In chronically depressed patients, maladaptive thinking patterns such as rumination and experiential avoidance are likely to have acquired a habitual nature, and mental training using mindfulness meditation may hold particular promise in reversing such tendencies. In line with this, there are now a number of reports that suggest that MBCT can successfully reduce symptoms in currently depressed patients (Finucane & Mercer, 2006; Kingston, Dooley, Bates, Lawler, & Malone, 2007), with two of the studies showing effects in patients who had been found to be resistant to established forms of treatment (Eisendrath et al., 2008; Kenny & Williams, 2007). However, with the exception of the study by Kingston et al. which only included participants with residual symptoms, all of these reports are based on uncontrolled pre–post-comparisons.

The purpose of the current study was to carry out a preliminary study to investigate the effects of MBCT in patients suffering from chronic forms of depression using a randomized controlled design with blind assessments. We compared the immediate effects of MBCT delivered in addition to treatment-as-usual (TAU) to TAU alone. At this stage of knowledge and given the high vulnerability of this group, we offered MBCT to the TAU group as soon as the post-treatment assessments were complete, effectively establishing a waitlist condition. The study focused on patients with a history of suicidality in the past, a group in which cognitive vulnerability has been found to be particularly pronounced (Williams, Barnhofer, Crane, & Beck, 2005; Williams, Van der Does, Barnhofer, Crane, & Segal, 2008), thus, addressing the most severe end of the depressive spectrum. We hypothesized that participants in the MBCT condition would show significant decreases in severity of depressive symptoms, while no such changes were expected in the TAU group, and that number of responders at the end of the treatment phase would be significantly higher in the MBCT than in the TAU condition.

Method

Participants

The study had received full approval by the Mid and South Buckinghamshire Local Research Ethics Committee (Ref: 07/Q1607/2). Participants were recruited through local media advertisements and posters as well as referrals from local mental health practitioners. Interested individuals were screened in a telephone interview and those indicating current presence of core symptoms of depression (feeling sad or depressed, or loss of interest) and a history of chronic or recurrent depression with suicidal ideation were invited for an assessment session at the Department of Psychiatry. In this session, eligibility was assessed using the Structured Clinical Interview for DSM-IV-TR Axis I (SCID; First, Gibbon, Spitzer, & Williams, 2002) and the DSM-IV module for Borderline Personality Disorder, in order to assess presence of habitual self-harming, administered by a trained clinical research psychologist. Inclusion criteria were (a) a history of at least three previous episodes of Major Depression or Chronic Depression, i.e., a full episode of Major Depression lasting for at least two years, (b) a current diagnosis of Major Depression or presence of residual symptoms following a full episode, defined as either meeting DSM-IV criteria for only four instead of at least five symptoms of depression over the last two weeks or suffering from five or more symptoms for at least half of the days, if symptoms had not been present for most of the days over the past two weeks, (c) a history of suicidal ideation (including thoughts of methods of suicide) or suicidal behavior, (d) absence of current mania or hypomania, psychosis, obsessive-compulsive disorder, eating disorder, pervasive developmental disorder or habitual self-harming, substance abuse or dependence that would significantly interfere with the ability to engage in meditation, (e) adequate written and spoken English to complete all study measures, (f) not currently in individual or group psychotherapy and no current ongoing meditation practice, and (g) age between 18 and 65. In addition to our own assessments, we required written confirmation from the participant's GP that there was no contraindication for him or her to take part in the study.

A total of 90 individuals made an initial contact in response to information regarding the study, of which 43 did not participate. The main reasons for people who had made an initial contact not to participate were (a) they were not interested after hearing more about the study or had other commitments that would have interfered with participation in the study (14, 32%), (b) the research team was unable to contact them for a telephone interview after their initial contact (7, 16%), and (c) they did not meet criteria for the study (22, 53%; six current level of depression below inclusion criteria, three not suicidal in the past, four current mania or hypomania, three current eating disorder, two current psychotic symptoms, one severe habitual self-harm, three older than 65 years of age). Of the 47 participants, who were invited for an interview at the Department of Psychiatry, 13 were found not to be eligible (three current level of depression below inclusion criteria, four habitual self-harming, one pervasive developmental disorder, one mania, one hypomania, one alcohol dependence, one eating disorder, one would not have been available at time of classes). Three further participants were lost following the interview: one withdrew before randomization and before completing any measures, for one participant consent from their GP could not be obtained, and with one participant who, during the interview, had displayed significant deficits in orientation, memory and attention, the origin of which was currently unknown but seemed likely to be neurological, it was mutually decided that participation in the classes was too demanding and, therefore, contraindicated. This left