Available online at www.sciencedirect.com
ScienceDirect
Behaviour Research and Therapy 45 (2007) 617–625
BEHAVIOUR RESEARCH AND THERAPY
www.elsevier.com/locate/brat

Shorter communication

Treatment-resistant depressed patients show a good response to Mindfulness-based Cognitive Therapy

M.A. Kenny[a,*], J.M.G. Williams[b]

[a]*The Adelaide Clinic Consuting Suites, 33 Park Terrace, Gilberton, South Australia 5081, Australia*
[b]*University Department of Psychiatry, University of Oxford, UK*

Received 28 September 2005; received in revised form 19 April 2006; accepted 28 April 2006

Abstract

Mindfulness-based Cognitive Therapy (MBCT) is a class-based programme designed for use in the prevention of relapse of major depression. Its aim is to teach participants to disengage from those cognitive processes that may render them vulnerable to future episodes. These same cognitive processes are also known to maintain depression once established, hence a clinical audit was conducted to explore the use of MBCT in patients who were currently actively depressed, and who had not responded fully to standard treatments. The study showed that it was acceptable to these patients and resulted in an improvement in depression scores (pre-post Effect Size = 1.04), with a significant proportion of patients returning to normal or near-normal levels of mood.

Keywords: Mindfulness; MBCT; Depression; Treatment resistance

Introduction

The emotional, social and economic burden of depression for sufferers, their families and society is significant, with 12 month prevalence rates estimated at 2.9–12.6% and lifetime risk estimated at 17–19% (Kessler et al., 1994). The fact that depression is often a chronic relapsing condition, with relapse rates of 50–80% in those who have been depressed before (Judd, 1997) has contributed to the WHO prediction that, by 2020, depression will be the second biggest contributor to ill-health burden world-wide (Murray & Lopez, 1998). Individual CBT has been shown to be effective at treating acute depression and reducing relapse (DeRubeis et al., 2005; Hollon et al., 2005) but waiting lists for individual therapy are lengthy in most healthcare settings.

Even treatment by normally 'effective' means leaves a substantial minority failing to meet criteria for remission. In a trial to examine relapse risk in the 12 months following antidepressant versus cognitive treatment, Hollon et al. (2005) found that, of the patients recruited for the first (acute treatment) phase, only

*Corresponding author. Permanent Address: Centre for the Treatment of Anxiety and Depression, Central Northern Adelaide Health Service, 30 Anderson St, Thebarton, South Australia 5031, Australia. Tel.: +61 08 8222 8100; fax: +61 08 8222 8101.
E-mail address: maura.kenny@nwahs.sa.gov.au (M.A. Kenny).

0005-7967
doi:10.1016/j.brat.2006.04.008

58% of the ADM group and the same proportion of the CT group met predefined criteria for recovery and were able to proceed to the relapse phase of the study. The fact that around 40% did not meet such criteria following an adequate 'dose' of treatment show that there is still a great deal to do to help those patients who are often called 'treatment resistant'.

Moreover, depression has another feature that is a considerable cause for concern: the development of a chronic clinical course, which also resists treatment. In these cases, patients report continuing symptoms of depression and accompanying distress about these symptoms. Some 15–39% of cases still meet criteria for Major Depressive Disorder (MDD) 1 year after symptom onset (Berti Ceroni, Neri, & Pezzoli, 1984; Van Valkenburg, Akiskal, Puzantian, & Rosenthal, 1984), and 22% of cases may continue to do so up to 2 years later (Keller, Lavori, Lewis, & Klerman, 1983). Of particular concern is the risk of suicidal behaviour in such patients. One in seven patients hospitalised for major depression die by suicide (Powell, Geddes, Deeks, Goldacre, & Hawton, 2000) and the Population Attributable Ratio (PAR) for depression in serious but non-fatal suicidal behaviour (that proportion of suicidal behaviour that would be removed if depression were taken out of the picture) is 80 per cent (Beautrais et al., 1996). If suicidal ideation occurs during one episode of depression, it tends to recur in later episodes (Williams, Crane, Barnhofer, van der Does & Segal, 2006), making the question of how best to treat recurrent and persistent depression particularly urgent for such at-risk patients.

What is it that keeps people depressed? Nolen-Hoeksema's Responses Styles Theory (1991) suggests that people who engage in 'repetitive and passive thinking about one's symptoms of depression' tend to prolong the very symptoms they are trying to reduce. Ruminators often hold positive (but erroneous) beliefs that it will help, not realising that they are reducing their capacity to effectively problem-solve (Watkins & Moulds, 2005). Evidence suggests that the cognitive processes that increase vulnerability to future episodes are the same as those that maintain depression. These processes are depressive rumination (Jacobson, Martell & Dimidjian, 2001; Nolen-Hoeksema, 1991, 2000; Watkins & Teasdale, 2004) and high cognitive reactivity to mood shifts, where the experience of low mood more easily triggers negative thinking in previously depressed patients (Segal, Gemar, & Williams, 1999; Teasdale, 1999).

Mindfulness-based Cognitive Therapy (MBCT) arose out of an investigation into the cognitive processes that render depressed individuals vulnerable to repeated relapse and recurrence (Teasdale, Segal, & Williams, 1995) with a view to offering a programme that would target those cognitive vulnerabilities (Segal, Williams, & Teasdale, 2002). The intervention was designed as a class-based intervention to increase accessibility to effective relapse prevention. It incorporates, as a central component, mindfulness training as developed by Kabat-Zinn and his colleagues at the University of Massachusetts Medical Center (Kabat-Zinn, 1990), and adds components of cognitive behaviour therapy for depression (Beck, Rush, Shaw, & Emery, 1979). Two studies have demonstrated this group programme's efficacy in reducing relapse rates of depression at 12 month follow-up compared to treatment as usual (Ma & Teasdale, 2004; Teasdale et al., 2000).

MBCT teaches participants to observe their thoughts and feelings through the repeated practise of intentionally returning attention to a neutral object (e.g. the breath or body sensations) in the present moment. Participants are taught how to cultivate direct experiential awareness, together with an attitude of non-judgmental acceptance, towards whatever is present (including sad mood, which in previously depressed patients is likely to trigger patterns of global negative self-referent thinking). The cultivation of awareness during mindfulness practise enables patients to see more clearly when negative and ruminative responses are being triggered, and allows them to decentre from such patterns of thought, seeing them as mental events, rather than necessarily valid reflections of reality. Unlike standard CBT, where the focus is on changing the content of thoughts, MBCT's focus is on fostering meta-cognitive awareness and the modification of meta-cognitive processes that maintain unhelpful reactive or ruminative mind states. So although MBCT was designed for patients in remission, the above analysis suggests that it might be helpful for symptomatic patients who remain caught in such unhelpful thought processes.

The present article describes a clinical audit of a consecutive series of patients referred for MBCT, focussing on those who had continuing symptoms of depression despite treatment with antidepressant medication (ADM) or CBT or both. The two randomised controlled studies conducted on MBCT had shown that those with three or more episodes had a significant reduction in relapse rates but that those with two or less had a non-significant trend towards an increased risk of relapse in the year of follow-up (Ma & Teasdale, 2004;