

Maintenance Version of Cognitive Therapy

Mindfulness Based Cognitive Therapy
=•NEE•E1®II

- Background: Relapse and recurrence in depression
- Previous approaches to maintenance of treatment gains
- Modelling cognitive risk
- Development of MBCT
- Description of MBCT

Images of bad
 Pleasant Events
 Depression
 Memory Bias
 negative things
 6-9 months
 Reappears

Morbidity
MMMENNE1161

- Workers with depression lose 5 times more days off work than average
- WHO predicts that by 2020 depression will present second largest burden of ill-health in the world
- Much of this burden due to relapse/recurrence

Depression recurrence
~MMMEENN1®III

- Lifetime risk estimates 6%-17%
- For 5-10%, full episode persists > 2 years
- Greater proportion (20-25%) attain only partial recovery between episodes
- More than 50% who do recover will have at least one further episode
- Those with history of 2 or more episodes have 70-80% chance of recurrence

Trigger life event
 first time
 then anything
 autonomous
 "binding"
 "sensitive"

Previous approaches o preventing
relapse - 1

- r. Continue treatment beyond initial 'response'
 - antidepressant medication
 - a continue patients at dosage used to achieve remission (see Frank, et al., 1990)
 - ti psychotherapy
 - a Interpersonal Psychotherapy (IPT-M) following IPT & hnipramine combination treatment (Frank, et al., 1991)

Frank et al

12 weeks
relapse
stay on drugs
or risk recur
Not permanent

Previous approaches- 2

Use acute treatments that give long-term protection

- r. best evidence is when CBT has been used in acute phase
 - Evans, et al., 50% to 20% (over 24 months)
 - Simons, et al., 66% to 20% (over 12 months)
 - Blackburn, et al., 78% to 23% (over 24 months)
 - Shea, et al., 50% to 36% (over 18 months)

CBT reduces

r

Previous approaches - 3

Cross-mode approach

- r. different treatment for prophylaxis than that used during acute stage
 - a Lithium treatment (see Souza & Goodwin, 1991, meta-analysis)
 - m no evidence for use of psychotherapy following acute treatment with antidepressants (i.e. for patients in remission)

Beck Dysfunctional Attitude Scale

Cognitive risk factors

~==NNNEE®1B1

- CBT Model - Dysfunctional attitudes represent high risk
 - "I cannot find happiness without being loved by another person"
 - "People who have the marks of success/ good looks/ fame/ wealth are bound to be happier than people who do not"
 - "I should be happy all the time"
 - "Turning to someone else for advice or help is an admission of weakness"
- BUT: Most show DAS back to normal when patient has recovered

A life event
ruminates

Symptoms
Depression

Modelling risk reduction

Priming studies

- Ingrain, Miranda & Segal, 1998
 - n review 16 studies (including 13 with remitted patients)
 - 12/16 showed evidence of cognitive vulnerability following priming

Priming studies

- typical examples

-MMONEEM®®OI

- sample
 - formerly depressed women
 - never depressed women
- task
 - Dysfunctional Attitude Scale
- manipulation
 - mood induction (e.g. negative film)

Lower mood
- activate
dysfunctional
attitudes

Priming studies (2)

- outcome measure
 - change in DAS scores following mood induction
- Typical results
 - negative mood leads to increased DAS in formerly depressed patients only

Priming studies (3)

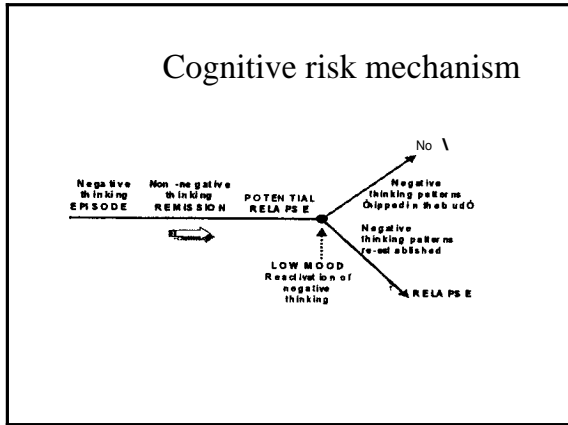
- Segal et al (J)
 - CBT vs Pharmacotherapy
 - Patients in remission
 - DAS before & after mood priming
- Results
 - Priming affected DAS more in pharmacotherapy than CBT patients
 - "primed" DAS predicted relapse and recurrence

Relapse predicted
by DAS change
after priming

Cognitive risk

- These studies suggest that relapse/recurrence = retriggering of old patterns of information processing
- Ruminative response style compounds the picture (Nolen-Hoeksema, 1991)
- Need to design intervention that prevent retriggering and escalation of depression-related thinking

life event
↓
low mood



- ### Development of MBCT
- Need to retain effective component of CBT
 - 'decentering' from negative thoughts interrupt ruminative response cycles
 - Need to train patients to be aware of low-level symptoms
 - Need to use skills that can increase positive well-being, not just reduce negative symptoms

Based

through behaviour

- ### Development of MBCT: Constraints
- Since patients have not received CBT before, cannot deal with relapse by 'rehearsing' what was learned in acute therapy
- CBT designed to focus on negative thoughts/affect; less suitable for patients in remission

Body scan

stress reduction tapes on

Development of MBCT

- Need treatment that
 - shares with CBT the aim of helping patients to 'step back', but
 - develops this ability in absence of negative thought streams
- MBCT has explicit focus on training in attentional control
 - uses any thoughts, feelings or sensations as object of attention
 - positive, negative or neutral

Mediation
out for
depression
thoughts from
incident
pain

Description of MCBT

B Eight weekly classes plus 4 follow-up sessions. Each 2-hours in length.

B Pre-class interview with instructor to explain, motivate and point out the commitment that will be necessary

B Up to 12 in each class

B Homework, up to one hour per day, 6 days a week - mostly audiotapes of mindfulness practice + generalisation practice

allow things
to be as they
are
Bill Mowers

Description of MBCT:2

- Aim: to prevent consolidation of self-perpetuating patterns of negative thinking that may escalate negative thinking into depressive relapse.
- Core skill: how to step out of the self-perpetuating cognitive routines, by
 - being mindful
 - 'letting go' of tendency to continually work towards escaping unhappiness and achieving happiness (safety signals).

Healing + the
mind
Healing from
Walter
Pam Wagner

Description of MBCT: Themes

- IdAutomatic pilot vs Becoming aware
- IdNoticing tendency to monitor current state and compare it to desired state (judgement)
- IdExperiential learning: Practising concentration
 - Noticing the way we relate to experience

Description of MBCT: Themes -

2



- IdRadical acceptance
- IdDifferentiating thoughts from reality
- IdTaking mindful action
 - Education about depression, relapse and recurrence

Similarities with CBT

- n Commonalities in underlying models
 - close links between thoughts and feelings
 - m important aim of therapy is "decentring", to be able to `step back' and view experience from a wider perspective
 - thoughts are not facts

Similarities with CBT

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Common techniques

- education about depression and how symptoms cooccur and "come with the territory"
- use of Pleasant Events and Unpleasant Events Calendar (Weeks 2 and 3)
- use of Automatic Thoughts Questionnaire to
 - explain about frequency of selftalk and offering degrees of belief in such thoughts
 - explain how degree of belief fluctuates depending on mood
- use of "being ignored in the street" story
- explanation about differences between Mastery and Pleasure

Steve Holland
Automatic
Thoughts
Questionnaire

Differences from CBT

III

- Assumptions about current practice of therapist.
- Progression within therapy
- Focus of homework assignments
- Presence of explicit 'Thought catching'
- Presence of Socratic questioning.
 - Focus: on negative thoughts versus all mental contents
 - Engagement with particular content themes.
- 'Answering back' vs 'noticing' such thoughts

frequency
of beliefs

FM S-IV
Diagnostic
Criteria

MBCT: generic approach

~MMWNE•NNNOI

MBCT assumes that what is damaging is

- combination of non-awareness (so old habits can be initiated) plus
- judgement (the constant wish for things to be different) which gives rise to ruminative attempts to problem-solve.

It focuses, therefore,

- on awareness and modification of these processes
- not on changing contents.

Dangers of MBCT

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Increasing self-focus may increase rumination for some patients

Some patients have problems distinguishing between "self" and "problem".

Symptoms of depression (negativity and hopelessness) may too easily undermine motivation to do the practice necessary to step out of negative cognitive patterns.

MBCT requires persistence despite apparently little change for some.

Informal feedback (from Session 8 Questionnaires)

I have discovered an inner strength

I now have tactics when I sense a low mood/depression starting

A sense of the value of ordinary everyday life has given me a different perspective on life after leaving a rewarding, if demanding, job

It has removed a sense of shame about having been depressed in the past, therefore greater self-acceptance

I have discovered a way of moving into an inner place of calm/centredness

It helped me cope with my father's death when I was in a potentially isolated and difficult situation

MBCT Outcome Trial

- Cambridge, Toronto, Bangor
- N = 145 (110 women, 35 men)
- N = 132 completed at least 4 wks treatment ("per protocol")
- Previously depressed patients (At least 2 previous episodes of Major Depression)
- Stratified by Number of previous episodes (2 vs >2)
- Randomly allocated to Treatment as Usual (TAU) or MBCT (+TAU)

MBCT Outcome Trial

Primary Outcome Variable

- Relapse/recurrence to DSM MR Major Depression
- Inter-rater agreement: 88% (blind)

"Intention to treat" analysis:

- Data on relapse status on 137 out of 145 patients at 12 months follow-up (95%)

"Per protocol" analysis:

- on 128 out of 132 patients (97%)

Outcome trial:results

m For patients with only 2 previous episodes (23% of sample) - No effect of MBCT on relapse

For patients with 3 or more previous episodes (77% of sample) - Significant effects

- TAU: 66% relapsed in 12 months
- MBCT: 37% relapsed in 12 months

Survival Curve (for patients with 3 or more previous episodes)

Dangers of MBCT

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Medication differences?

Percentage using antidepressant medication at any point during 12 month follow-up

- Controls: 46% (20/44)
- MBCT: 33% (14/42)

Baseline differences between patients with 2 vs 3+ previous episodes

- Age
 - 2 episodes: 38.9
 - 3+ episodes: 44.6 ($p < 0.01$)
- Age at first onset of depression
 - 2 episodes: 33.4
 - 3+ episodes: 25.0 ($p < 0.001$)
- "History"(years)
 - 2 episode: 5.5
 - 3+ episode: 19.6 ($p < 0.001$)

Outcome trial: results

- No difference in use of Antidepressant medication over 12 month follow-up period
- Risk of relapse in TAU **determined by history:**
- No. previous episodes in TAU:
 - If 2: $p(\text{relapse}) = 31$
 - If 3: $p(\text{relapse}) = 56\%$
 - If 4+: $p(\text{relapse}) = 72\%$
- In MBCT: Effect of previous episodes removed

Outcome trial: summary

- n First multi-centre RCT of clinical intervention based on mindfulness
 - m For more serious patients (history of >3 episodes), M13CT almost halves chances of relapse
 - MBCT may be effective for "autonomous" relapse processes
- Highly cost effective (because class-based approach): Clinician time per patient = 5 hours on average



Mindfulness-Ease! Cognitive Therapy (MBCr17)

Mindfulness-based Stress reduction (MBS9V)

Resources

If you are a therapist or counsellor, and want to learn more about the use of a mindfulness approach in your work with people who are vulnerable to depression, the approach is described in *Mindfulness-based Cognitive Therapy for Depression: a new approach to preventing relapse.* Written in a practical and accessible manner, the authors tell the story of how they came to develop MBCT. They use illustrative clinical transcripts that bring to life the challenges and promise of this innovative approach.

An additional 'way in' is to look at the video of the Bill Moyers' documentary "Healing from Within," describing the Mindfulness Based Stress Reduction (MBSR) Program at the University of Massachusetts Medical Center. This gives a very direct, accessible, and interesting view of what actually happens in that program (we use it with our own program in Sessions Four and Five). As well as seeing what goes on within sessions, case histories are presented, and interviews with Jon Kabat-Zinn present the thinking behind the program. This video is available from Ambrose Video Publishing, 1290 Avenue of the Americas #2245, New York, NY 1014; telephone : educational orders: 1-800-526-4663 (\$89.95), individual orders: 1-800-345-2690 (\$29.95); website: www.ambrosevideo.com.

Whether a therapist or not, Jon-Kabat-Zinn's own book, *Full Catastrophe Living*, describes the UMass MBSR program in a very accessible and engaging way. It is an excellent introduction to clinical applications of mindfulness training for instructors and the general public, and is essential reading for anyone wishing to explore this approach further. Again, this book is an important resource that we use in the MBCT program.

Jon Kabat-Zinn has also written "Wherever you go there you are" (published in the UK as "Mindfulness Meditation for Everyday Life"). This is a wonderful book that conveys beautifully the spirit of bringing mindfulness to everyday experience, together with suggestions for practice. Another excellent source for a more detailed description of *insight meditation*, the tradition from which clinical applications of mindfulness are most directly derived, is "Seeking the Heart of Wisdom: The Path of Insight Meditation" by Joseph Goldstein and Jack Kornfield". These two books are highly recommended.

And if you decide you would actually like directly to taste the practice of mindfulness? The best way is to be taught face to face by an experienced meditation teacher (details of how to find one, below). However, you might like, first, to "do it yourself" using audiotapes of

guided meditation instructions. For our mindfulness program we used the tapes (two series), recorded by Jon Kabat-Zinn. Series One consists of two 45 minute tapes (which are also used on the UMASS MBSR program) that narrate a guided body scan, a guided meditation on the breath, body, sounds, thoughts, and choiceless awareness, together with two different sessions of guided mindful hatha yoga. Series Two consists of five tapes (each from 10 to 30 minutes long) specifically designed for those with a more general (rather than clinical) interest in learning mindfulness meditation. Both series can be ordered from: Stress Reduction Tapes, P.O. Box 547, Lexington, MA 02173, USA; or through the website: www.stressreductiontapes.com.

Ideally, one learns meditation from personal contact with an experienced meditation teacher. There are many different forms of meditation. If you want to explore the type of meditation that we have found beneficial for helping with difficult emotions, it is important to choose a tradition and teacher that are compatible in spirit and form with the MBSR and MBCT programs. In practice, this is likely to mean exploring the teachings offered by centres related to the westernised insight meditation tradition. Information about these centres can be obtained from the following: in North America: Insight Meditation Society, 1230 Pleasant Street, Barre, MA 01005, or Spirit Rock, PO Box 909, Woodacre, CA 94973; in Europe: Gaia House, West Osgwell, Newton Abbot,

Devon, TQ12 6EN, England. Further information on each of these centres is available, directly or via links, from the following website: www.dhartna.org. Although there is no equivalent retreat centre in Western Australia, from time to time various teachers of this approach do visit Australia.

Meanwhile, if you would like to begin seriously on a "do-it-yourself" basis, an excellent comprehensive distance learning package, "Introduction to Insight Meditation," has been prepared by two of the most respected Western meditation teachers in this tradition, Sharon Salzberg and Joseph Goldstein. This twelve month course includes 12 audio cassettes (each with a talk on one side and a guided meditation on the other), a workbook, and personal guidance (by e-mail, mail, or cassette correspondence) from an experienced meditation instructor. This course is available from: Sounds True, P. O. Box 8010, Dept. V6, Boulder, CO 80306-8010, USA.

Mark Williams

'Segal, Z.V., Williams, J.M.G., & Teasdale, J.D. (2002) *Mindfulness-based Cognitive Therapy for Depression: a new approach to preventing relapse*. New York, Guilford Press.

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