Mindfulness-based therapies for the treatment of depression

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Abstract

The purpose of this paper is to explore the published research on the efficacy of mindfulness-based therapeutic interventions in the treatment of depression. Growing amounts of clinical trials support the hypothesis that mindfulness, which is described as paying attention in a particular way, on purpose, in the present moment, and nonjudgmentally, is an effective treatment for psychological mood disorders and their recurrence and relapse. These treatments promote the use of various meditative practices to increase present-moment awareness of conscious thoughts to manage negative experiences more effectively and offer an alternative to antidepressant medications within the context of such psychosocial interventions as cognitive-behavioral therapy. Analysis of the research exploring the efficacy of mindfulness-based interventions in the treatment of depression and depressive symptoms has shown it to be effective for adults, older populations (over the age of 65), adolescents, and children.

The Prevalence of Depression

Mental disorders are common in the United States with an estimated 26.2 percent of Americans over the age of 18 suffering from a diagnosable mental disorder annually (Kessler, Chiu, Demler, & Walters, 2005). Of the various types of mental disorders diagnosed each year, 9.5 percent or 20.9 million Americans age 18 or older, have a mood disorder (Kessler, Chiu, et al., 2005), with the median age of onset being 30 years (Kessler, Berglund, Demler, Jin, & Walters, 2005). Unipolar mood disorders include Major Depressive Disorder (MDD) and Dysthymic Disorder. Bipolar mood disorders are distinguished from unipolar depressive disorders by the presence of manic (e.g., elevated mood) episodes and include Bipolar I Disorder, Bipolar II Disorder, and Cyclothymia Disorder. MDD, also known as major depression, affects approximately 14.8 million, or 6.7 percent, of American adults annually (Kessler, Chiu, et al., 2005); is more prevalent in women than in men (Kessler et al., 2003); and has a median age of onset of 32 years (Kessler, Berglund, et al., 2005), although it can develop at any age (The National Institute of Mental Health, 2008). While most people feel sad from time to time, these feelings generally subside within a few days of onset. When these feelings persist beyond a few days and begin to interfere with a person’s functioning in daily life, that person may have a depressive disorder.

The Criteria and Associated Features of Depression

The Diagnostic and Statistical Manual of Mental Disorders (4th Edition, Text Revision; DSM-IV-TR; American Psychiatric Association, 2000) provides
specific criteria that must occur most of the day, nearly every day, for a person to be diagnosed with MDD that include: the person being in a major depressive episode; the person experiencing either markedly depressed moods or a loss of interest in pleasurable activities for at least two consecutive weeks; significant weight loss (when not dieting) or weight gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; and recurrent thoughts of death or suicide, or recurrent suicidal ideation without a plan, or a suicide attempt or plan. In addition, the DSM-IV-TR specifies that the person’s major depressive episode is not better accounted for by another disorder and that there has never been a manic episode experienced by the person. One of the key features of major depression is its high rate of recurrence.

Like many other chronic health conditions, depression has an elevated rate of recurrence and, for those who go without proper treatment, relapse rates can reach as high as 80% (Kuyken et al., 2008). The increased risk of recurrence in persons suffering from depression has contributed to the World Health Organization predicting that, by 2020, depression will be the second biggest contributor to illness world-wide (Kenny & Williams, 2007). In addition, depression often takes a chronic clinical course that may be very resistant to treatment with antidepressant medication (ADM) and various cognitive behavioral therapies, with only 58% of one study group meeting the predefined criteria for meeting the recovery threshold (Kenny & Williams, 2007). These facts reveal the need for effective interventions that will minimize the risk of recurrence and relapse for those who suffer from MDD and various other depressive mood disorders. Many patients would prefer not to use ADM in the treatment of their depressive symptoms because of unwanted side effects and have expressed a preference for psychosocial interventions (Kuyken et al., 2008).

Cognitive Behavior Therapy

Butler, Chapman, Forman, and Beck (2006) state that one of the most extensively researched forms of psychotherapy, with 325 published outcome studies as of 2006, is cognitive-behavioral therapy (CBT). CBT is defined as a therapeutic practice that helps patients recognize and remedy dysfunctional thought patterns. In CBT the therapist directly challenges the patient’s irrational thinking that leads to maladaptive behavior (Singh, Lancioni, Wahler, Winton, & Singh, 2008). CBT is a short-term, and therefore generally affordable, treatment and is commonly used to treat a wide range of disorders, including depression. Individual CBT has been shown to be effective at treating acute depression and reducing the incidence of relapse of depressive symptoms. (Kenny & Williams, 2007). In a recent review of 16 meta-analyses, the authors found CBT to be a highly effective treatment for adult unipolar depression, adolescent unipolar depression, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, post traumatic stress disorder, and childhood depressive and anxiety disorders (Butler et al., 2006). The same study also found that the effects of CBT are maintained for substantial periods beyond the cessation of treatment and that significant evidence was found that shows the long-term effectiveness of CBT for depression, generalized anxiety, panic, and social phobia. Butler et al. also found robust and convergent meta-analytic evidence that CBT showed superior long-term persistence of effects and relapse rates.
half those of pharmacotherapy. It was through a continuing effort to prevent the high rates of relapse in patients with depression that a new group of therapeutic techniques and interventions based on something called mindfulness were developed.

Mindfulness Defined

Mindfulness is an English translation of the Pali word sati, meaning awareness, attention, and remembering (Germer, 2005). In the various Buddhist meditative traditions, mindfulness is a central component and refers to a careful awareness of one’s own thoughts and feelings. Mindfulness meditation is a tool that allows thoughts to appear as they will, observing them without judgment (Cefus, 2009). This sense of mindful awareness is a skill developed to help a person to be less reactive to what is happening in any given moment, whether that experience is perceived as positive, negative, or neutral. Most of us are caught up in distracting and often conditioned thoughts about what is happening in the moment. This is mindlessness. Examples of mindless behaviors may include: rushing through activities without being attentive to them; breaking or spilling things because of carelessness, inattention, or thinking of something else; failing to notice subtle feelings of physical tension or discomfort; or finding ourselves preoccupied with the future or the past (Brown & Ryan, 2003). Our sense of suffering seems to increase as our minds stray away from the present moment. A great many people who are preoccupied with the past or the future are in psychotherapeutic treatment for depression or anxiety (Germer, 2005). Depressed patients often feel regret, sadness, or guilt about the past and patients who are anxious fear the future. Mindful awareness is, in essence, a way of being, or a way of inhabiting one’s body, mind, and moment-to-moment experiences (Shapiro & Carlson, 2009). Mindfulness is largely experiential and can be difficult to define clearly. In order for it to be properly integrated into Western psychology, mindfulness is defined as the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment (Kabat-Zinn, 2003). Because mindfulness is about attention, it is universal and there is nothing particularly Buddhist about it. It is an inherent human quality and we are all mindful to some degree from moment to moment. Over the past 25 years, clinical research has documented the effectiveness of one mindfulness-based therapy, Mindfulness-Based Stress Reduction (MBSR), as an effective intervention for reducing distress and enhancing well-being in persons with a variety of medical and psychiatric conditions (Shapiro et al., 2008).

Mindfulness-Based Stress Reduction

MBSR was developed in 1979 by Jon Kabat-Zinn and his colleagues at the University of Massachusetts Medical Center as an alternative treatment for patients who were falling through the cracks of the traditional medical system. As described by Shapiro and Carlson (2009), MBSR involves an 8-week program of up to 35 participants who meet weekly for 2½ to 3 hours, with a 6 hour silent retreat occurring on a weekend between the 6th and 7th class. MBSR offers a variety of both formal and informal programs that involve intensive training techniques in sitting meditation, body scan (a guided meditation exercise in which attention is directed through body parts, usually from feet to the head), walking meditation, gentle yoga, and other informal daily mindfulness practices. Participants are
required to practice meditation and gentle yoga at home for 45 minutes, 6 days a week for the duration of the program. A didactic approach to teaching occurs each week with participants having time to process their experiences, group discussion of challenges to practice and other insights that may arise, and feedback from facilitators (Shapiro & Carlson, 2009). The facilitators encourage the application of the mindfulness attitudes of non-judging, patience, non-striving, acceptance, beginner’s mind, trust, letting go, and nonattachment. Because MBSR has a strong and research-supported history of effectiveness in reducing distress, a group of researchers decided to investigate the efficacy of mindfulness as a possible program for preventing the high incidences of relapse and recurrence in persons suffering with depression.

Mindfulness-Based Cognitive Therapy

In the late 1990s, cognitive therapists John Teasdale, Mark Williams, and Zindel Segal, experts in the field of CBT, investigated why people who recovered from a major depressive episode were likely to have more depressive episodes in the future. While there were effective treatments for acute episodes of depression, no therapy had been developed that was effective at preventing the high rate of relapse. With the growing interest and extensive research supporting the efficacy of MBSR, and with the help of Jon Kabat-Zinn, Teasdale and his colleagues integrated CBT with MBSR and developed a formal, manualized therapy called Mindfulness-Based Cognitive Therapy (MBCT; Shapiro & Carlson, 2009). The focus of MBCT is on fostering meta-cognitive awareness and the modification of meta-cognitive processes that maintain unhelpful reactive or ruminative mind states (Kenny & Williams, 2007). These processes enable a person to see more clearly when negative and ruminative responses are being triggered, which enables them to decenter from these thought patterns. Decentering, which is sometimes referred to as reperceiving, is the capacity to take a detached or objective stance on one’s own thoughts and emotions (Fresco et al, 2007). Processes such as decentering help to foster a person viewing their negative thought patterns as mental events rather than valid reflections of a permanent reality. In MBCT, patients are taught how to cultivate direct experiential awareness, along with an attitude of non-judgmental acceptance, toward whatever is present at this moment, which may include a sad or ruminative mood (Kenny & Williams, 2007). The didactic focus of MBCT is more about understanding the nature of depression than on stress and the stress response as in MBSR, which provides a model of understanding the futile nature of attempting to logically argue away negative thoughts (Shapiro & Carlson, 2009). The patient is instructed to see these negative thoughts as just thoughts, which will arise and pass in time if they are not believed to be a static reality that represents the way things will always be. MBCT is typically conducted in groups of up to 12 participants over the course of 8 weeks and is similar to MBSR in that both utilize the practices of sitting meditation, body scan, walking meditation, and various informal daily practices (Shapiro & Carlson, 2009). Examples of informal daily mindfulness practices include mindful eating, communication with others, grooming, and even washing the dishes. By consciously bringing awareness and acceptance to our experiences in the present moment, we are better able to use a more adaptive range of skills in coping or attending to the task at hand (Shapiro, Carlson, Astin, & Freedman, 2006). MBCT was developed in order to explore a potential avenue to reduce, or possibly
prevent, the high rate of relapse and recurrence in persons suffering from depressive episodes, and there are growing amounts of research that investigate this claim.

The Research: Investigating Mindfulness

As previously stated in the study by Kuyken et al. (2008), people suffering with recurrent depression experience relapse at rates as high as 80%. Studies exploring the efficacy of mindfulness-based interventions are showing great promise at reducing this statistic. One of the risk factors for recurrent depression is the residual symptoms that occur after treatment of an acute depressive episode, with 32% of patients suffering residual symptoms 12-15 months after the resolution of the acute episode; and these persons were at a much higher risk of relapse (76%) than those who did not experience the residual symptoms (Kingston, Dooley, Bates, Lawlor, & Malone, 2007). In a study exploring whether or not MBCT would improve depressive symptoms versus treatment as usual (TAU) for psychiatric outpatients by the end of the treatment and at a 1-month follow-up, Kingston et al. (2007) found residual symptoms reduced during the program and clinical gains were maintained at follow-up. TAU consisted of regular outpatient visits to their psychiatric clinic and pharmacotherapy. While the sample size of the study was small, their initial results show that MBCT may reduce the risk of residual symptoms, and therefore, reduce the risk of recurrent depressive symptoms. In addition to these findings, the study also found that patients liked having another option for treating their depressive symptoms and that the treatment was both time and cost-effective.

In another study exploring the efficacy of MBCT, Kuyken et al. (2008) sought to determine if MBCT provides an effective alternative approach to maintenance antidepressant medication (m-ADM) in preventing depressive relapse and recurrence. One hundred twenty-three participants were randomly selected to receive either a traditional m-ADM treatment or an 8-week MBCT therapy class that included support to taper/discontinue their m-ADM. The study aimed to compare MBCT and m-ADM in terms of cost-effectiveness, quality of life, residual depressive symptoms, and comorbid psychiatric diagnoses. This study further attempted to determine if MBCT enabled patients to taper/discontinue their ADM. Kuyken et al. found that, for recurrent depression, MBCT produces comparable outcomes to those for people using m-ADM in terms of relapse/cost effectiveness and superior outcomes in addressing residual depressive symptoms, psychiatric comorbidity, and the physical and psychological domains of quality of life. Quality of life was measured by way of a self-report measure that assesses subjective quality of life (e.g., "How much do you enjoy life?"). Reductions in ADM usage in the MBCT group were substantial, and 75% of patients in the MBCT group completely discontinued their ADM (Kuyken et al., 2008). Additionally, MBCT showed promise as an alternative approach to m-ADM, with over 50% of the people participating in the MBCT group staying well through the 15 month follow-up period, compared with 40% of those in the m-ADM group. MBCT produced additional gains in the physical and psychological domains of life and may produce incremental benefits in quality of life compared with m-ADM. In addition to the challenge of treating recurrence and relapse in persons suffering from depressive disorders, researchers have investigated the efficacy of mindfulness-
based therapies in addressing the needs of patients who are treatment-resistant.

Kenny and Williams (2007) suggested that depressed persons, described as treatment-resistant, tend to engage in repetitive and passive thinking about their symptoms of depression and, therefore, tend to prolong the symptoms they are trying to reduce. The processes of depressive rumination and high cognitive reactivity to mood shifts, when an experience of low mood facilitates triggers negative thinking in previously depressed patients, have been shown to increase vulnerability to future depressive episodes and are the same as those that maintain depression (Kenny & Williams, 2007). MBCT cultivates awareness and enables patients to see more clearly when these negative and ruminative responses are being triggered, allowing the individual to decenter from such thought patterns and accept that the thoughts are merely mental events rather than valid reflections of reality. In a study of 79 treatment-resistant patients suffering with depressive episodes, Kenny and Williams found that MBCT was an acceptable treatment for patients who have only had a partial response to ADM, standard individual CBT, or both; MBCT appears to be significantly effective at reducing levels of depression, even in those who start with a more severe depressive episode, including suicidal depression.

As the above studies indicate, the growing evidence for the efficacy of mindfulness-based interventions is promising, even for those who suffer from recurrent and treatment-resistant depression. Studies are beginning to investigate specific populations to determine if mindfulness-based therapies are as effective in elderly and younger patients as they are among adult populations.

Relatively few studies have emerged that address the question as to whether or not mindfulness-based interventions are effective in addressing the needs of special populations (e.g., adolescents, children, elderly) diagnosed with depressive disorders. One population of concern is those over the age of 65 who suffer from recurrent depression. Smith, Graham, and Senthinathan (2007) found that research has emerged showing the efficacy of CBT for depression, with the potential need for some slight modifications that allows for more socialization into the model of cognitive therapy for older persons (a cohort effect) and an allowance for more therapy sessions to accommodate slower processing and other factors, in populations over the age of 65. In an exploratory study of 30 older adults suffering from recurrent depression, the participants reported benefits from a course that integrated mindfulness meditation with cognitive therapy and reported confidence in their ability to maintain the program after their initial therapy, which was validated by follow-up conducted by the researchers 1 year later (Smith, Graham, & Senthinathan, 2007). This initial research indicates the appropriateness of mindfulness-based cognitive interventions for older populations.

Additional populations of concern in the treatment of depressive disorders are adolescents and children, with the prevalence of adolescent psychiatric disorders rising substantially over the past 50 years (Collishaw, Maughan, Goodman, & Pickles, 2004). Of the psychiatric disorders diagnosed in these younger populations, anxiety and mood disorders, particularly depression, are the most frequently reported, with combined prevalence rates ranging from 9% to 15% in adolescence (Biegel, Brown, Shapiro, & Schubert, 2009). In a study of 74 adolescents age 14-18, Biegel et al. found that MBSR was well tolerated by adolescents, with 75% of the participants
completing the intervention, and the most pronounced change occurring among the MBSR participants with mood disorders. For this study group, the prevalence at a 90-day follow-up was less than half of that seen at pretest in both samples. This number is significant due to the reported difficulty in administering psychotherapeutic treatments to adolescents with mental health problems, who often do not view psychotherapy as a beneficial treatment option, and the relatively low (35% - 40%) number of adolescents that show diagnostic remission after receiving psychotherapeutic interventions (Biegel et al., 2009). The results of this study suggest that MBSR for adolescents may have positive effects on both self-reported psychological experience and clinically significant outcomes that can be sustained over time.

Conclusion

Evidence for the efficacy of mindfulness-based interventions for the treatment of depression is growing. Patients in treatment for depression and other mood disorders have expressed a desire to move away from ADM, primarily due to unwanted side effects, and toward more productive and cost-effective psychosocial therapies. With the high rate of recurrence, relapse, and rising levels of prevalence world-wide in persons suffering from depressive symptoms, the need for effective interventions is self-evident. Building on the long history of efficacy in treating depression with CBT and the stress reducing methods of MBSR, the development of MBCT has shown tremendous promise in bringing sustained relief to persons of all ages who suffer from depressive disorders. Although the various mindfulness-based techniques have demonstrated great potential, the investigation of mindfulness remains in its infancy and requires great sensitivity and a range of theoretical and methodological perspectives to highlight the richness and complexity of this intervention (Shapiro et al., 2006). Frewen, Evans, Maraj, Dozois, and Partridge (2008) suggest that future researchers should investigate the connection between mindfulness and how the ability to let go of distressing negative conscious cognition may result in an increased sense of control over negative cognitive and emotional experiences, such as those associated with clinical depression and anxiety disorders. Shapiro et al., (2006) have begun to investigate what the mechanisms behind mindfulness are (intention, attention, and attitude) by attempting to provide axioms, or fundamental building blocks out of which other things emerge, that will increase our understanding of how the interwoven and cyclic processes of mindfulness work. The cyclic process of mindfulness suggests that intention, attention, and attitude are interwoven aspects of a simultaneous process, rather than a linear, stage-like process. Clinical trials suggest that the mechanisms behind mindfulness not only involve relaxation, but important shifts in cognition, emotion, biology, and behavior that work in concert to improve health (Greeson, 2009). A review of the research to date points toward a position supporting mindfulness as an intervention that helps to foster greater attention, acceptance, awareness, and compassion; and that these aspects help to free individuals from suffering, promoting a state of improved health and well-being.

References


