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Effectiveness of Mindfulness-Based Cognitive Therapy for Co-Morbid Depression in Drug-Dependent Males

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A B S T R A C T

The present study aimed at examining the effect of Mindfulness-Based Cognitive Therapy (MBCT) in decreasing depression symptoms in dully diagnosed males (drug dependent males with co-morbid depression).An experimental research design with pre- and post-tests and a control group was used. The sample of the study comprised 33 drug-dependent men who also endorsed depression symptoms on the Beck Depression Inventory II (BDI-II). All the selected individuals were assigned randomly to either the intervention group or control group (16 to the intervention and 17 to the control group). The intervention group experienced eight 2-h sessions of training in MBCT. At the end of the training, the subjects were once again evaluated using the BDI-II. Analysis of co-variance was used to analyze the data. The results suggested that MBCT did contribute to a significant decrease in the depression symptoms of the dully diagnosed individuals. It is recommended that the MBCT be used for treating depression in drug-dependent males undergoing detoxification and treatment for their drug dependence.

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Substance abuse is a major public health problem that affects millions of people and imposes substantial financial and social burdens on society. According to DSM-5, the essential characteristic of a substance use disorder is a set of cognitive, behavioral and psychological symptoms indicating that the individual continues using the substance despite experiencing significant problems arising from the continued consumption (American Psychiatric Association, 2013). Substance use disorders are chronic and recurrent with a longitudinal recovery. Therefore, despite the documented efficacy of several psychological and behavioral interventions for substance use disorders (Anderson, 2004), client compliance is generally poor and relapse to problematic substance use is a common occurrence (Rotgers, Keller, and Morgenstern, 1996). There are many risk factors for relapse. Some of the reasons mentioned by addicts for their relapses include, apart from social pressure, adverse life events, work stress, and marital conflict, co-existing psychiatric problems like depression, and anxiety disorders (Billings & Moos, 1983; Cummings, Gordon, & Marlatt, 1980; Littman, Stapleton, & Oppenheim, 1983). Mental illness can greatly increase the risk of addiction relapse if left untreated.

Many patients seeking treatment or patients referred to addiction therapy centers manifest comorbid depression in addition to the diagnosis of substance use disorder (Beck, Wright, Newman, & Liese, 1993).To help these substance-dependent individuals gain relief from their dependence, one solution is to consider therapy for comorbid psychological disorders. Depression is one such disorder with a high frequency of co-morbidity with drug addiction (Crum, Cooper-Patrick, & Ford, 1994). The co-existence of even a few symptoms of depression in substance-dependent individuals is sufficient to impair their functioning and to increase the possibility of their developing Major Depression. Depression symptoms in substance-dependent individuals can interfere with or prevent the initiation or the regular attendance of psychotherapy (Charney, Paraherakis, Negrete, & Gill, 1998).

An intervention proposed recently for many mental disorders including depression is Mindfulness-based cognitive therapy (MBCT). Mindfulness means to consider the present time purposively and with no judgment (Kabat-zinn, 1990). In other words, mindfulness means maintaining a moment-by-moment awareness of our thoughts, feelings, bodily sensations, and surrounding environment, without judging them. That is, experiencing absolute reality without giving any explanation (Segal, Williams, & Teasdale, 2002).With roots in Buddhist meditation, mindfulness is now considered to be an inherent quality of human consciousness, that is, a capacity of attention and awareness oriented to the present moment that varies in degree within and between individuals, and can be assessed empirically and independent of religious, spiritual, or cultural beliefs (Black, 2011). Mindfulness is considered not only a dispositional characteristic (a relatively long-lasting trait), but also an outcome (a state of awareness resulting from mindfulness training), and a practice (mindfulness meditation practice itself). Mindfulness has associations

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and influences on psychological, biological, behavioral and social variables, and as pointed out by Baer, mindfulness has to do with particular qualities of attention and awareness that can be cultivated and developed through meditation. In other words, as mindfulness involves intentionally bringing one's attention to the internal and external experiences occurring in the present moment, it is often taught through a variety of meditation exercises. Mindfulness training increases the capacity for attention and constant, intellectual awareness which is beyond thinking. Meditation practices and mindfulness increase consciousness and self-acceptance. Interventions based on training in mindfulness skills are becoming increasingly popular as evidence mounts pointing to the utility of mindfulness-based interventions in the treatment of several disorders (Baer, 2006).

Mindfulness research has found that people with higher natural levels of mindfulness report feeling less stressed, anxious and depressed, and more joyful, inspired, grateful, hopeful, content, vital, and satisfied with life (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Brown & Ryan, 2003; Cardaciotto, Herbert, Forman, Moitra, & Farrow, 2008; Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007; Walach, Buchheld, Buttenmuller, Kleinknecht, & Schmidt, 2006). In addition to these mental health benefits of meditation practice and cultivating mindful awareness, simply being in a mindful state momentarily is associated with a greater sense of well-being (Lau et al., 2006).

Research also suggests that people with higher levels of mindfulness are better able to regulate their sense of well-being by virtue of greater emotional awareness, understanding, acceptance, and the ability to correct or repair unpleasant mood states (Baer et al., 2008; cf. Brown, Ryan, & Creswell, 2007; Feldman et al., 2007). The ability to skillfully regulate one's internal emotional experience in the present moment may translate into good mental health long-term.

Cultivating greater attention, awareness and acceptance through meditation practice is associated with lower levels of psychological distress, including less anxiety, depression, anger, and worry (cf. Baer, 2003; Brown et al., 2007). Mindfulness training reduced distress in persons with a history of depression by decreasing rumination, a cognitive process associated with depression and other mood disorders (Jain et al., 2007; Ramel, Goldin, Carmona, & McQuaid, 2004). Such findings indicate that the mechanism of mindfulness appears to involve reshaping ways of thinking that engender improved emotional well-being.

Teasdale (1988) presented a distinct but related model of cognitive vulnerability to depressive relapse, the differential activation hypothesis (DAH). The DAH makes three general assumptions. First, it is hypothesized that depressed mood negatively biases information processing thereby increasing the accessibility of depressogenic interpretations of experience. Second, as a result of these mood effects on cognitive processing, increased negative interpretations of events would produce further depression. Third, this theory assumes individual differences regarding the nature of thinking patterns activated by depressed mood are related to differences in the experiences, and their interpretations, which have previously produced depressed mood. In other words, links between dysphoric mood and negative thinking patterns will be stronger among individuals with a history of depression than those who have never experienced depression (Lau, Segal, & Williams, 2004). Therefore, Teasdale, Williams, Segal, and Soulsby (2000) assert that skills learned for controlling attention can be useful in preventing the relapse of Major Depression episodes. Based on Jon Kabat-Zinn's Mindfulness-Based Stress Reduction program, Segal, Williams and Teasdale designed the Mindfullness Based Cognitive Therapy (MBCT) to prevent relapse by increasing metacognitive awareness without any explicit attempt to change negative thinking itself. MBCT combines the ideas of cognitive therapy with meditative practices and attitudes based on the cultivation of mindfulness. Individuals are trained to become acquainted with the modes of mind that often characterize mood disorders while simultaneously learning to develop a new relationship to them. In this method, depressed individuals are trained to observe their thoughts and feelings without judging them. Instead of viewing them as a part of themselves or as a reflection of reality, they view their thoughts and feelings as simple mental events which pass. This kind of attitude prevents negative thoughts and intellectual rumination from being intensified (Teasdale et al., 2000).

In this paper, evidence regarding the effectiveness of MBCT in decreasing depression in dually diagnosed individuals is presented. Various studies have suggested that short term therapy has a positive influence on reducing depression disorders in substance-dependent individuals (Levkovitz et al., 2000; Shwartz et al., 2004). However, few studies have focused on the influence of MBCT on dually diagnosed individuals who are simultaneously undergoing detoxification and treatment for their substance-dependence. Most studies in Iran have considered the influence of MBCT on the relapse of substance use and dependence after afflicted individuals have undergone detoxification and treatment (Kaldavi, Barjaali, Falsafinejad, & Sohrabi, 2012). The intent of the present paper is to present findings regarding the influence of mindfulness-based cognitive therapy in alleviating symptoms of depression in drug-dependent males. It is hoped that findings of the present study indicating the influence of MBCT on symptoms of depression in drug-dependent individuals will facilitate the treatment of dually diagnosed individuals and eliminate some of the existing barriers to their recovery, thereby preventing relapse.

METHOD

Participants

The study was experimental and used a pretest–posttest control group approach (Kazdin, 1999). The study sample comprised male drug-dependent individuals who also suffered from symptoms of depression. The study was conducted in the following way. After receiving permission from one of the addiction treatment centers affiliated to the ministry of health and treatment, the Beck Depression Inventory II-2 (BDI-II) was administered to 62 drug-dependent males. Those scoring 14 or higher on the BDI-II were recruited for the study. Using this inclusion criterion, 35 individuals were chosen and randomly assigned to the intervention (18 individuals) and control groups (17 individuals). In this study, two sessions of absence were permissible and absence on more than two sessions was considered as a criterion of failure. As 2 individuals failed to attend therapy sessions on 2 occasions, they were excluded from the study. Therefore, the intervention group consisted of 16 individuals, with a total sample of 33 drug-dependent males. All subjects were dependent either on opium or heroin, and were being treated with methadone during the study. The subjects ranged in age from 17 to 43 years, with mean age being 29.5 years. The intervention group received 8 sessions of mindfulness-based cognitive therapy while the control group received no therapy. After the 8 sessions, the BDI-II was administered to both the intervention and control groups.

Measures

The Beck Depression Inventory (BDI-II)

The Beck Depression Inventory (BDI-II) is a widely used tool in line with the depression criteria of DSM-IV. The BDI-II consists of 21 items to assess the intensity of depression in clinical and normal patients. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. Items on this scale explore agitation, worthlessness, concentration difficulty, loss of energy and increases and decreases in sleep and appetite (Beck, Steer, & Brown, 1996). The administration of the BDI-II on an Iranian sample of 94 subjects revealed the internal consistency of the instrument to be 0.91 and a test–retest correlation coefficient of 0.89 (Fati, 2003).

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