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Brief report

Mindfulness-based cognitive therapy for seasonal affective disorder: A pilot study

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ABSTRACT

Background: The best available treatment for seasonal affective disorder (SAD) is light therapy. Yet, this treatment does not prevent recurrence of depression in subsequent seasons. The aim of the study is to gain preliminary insight in the efficacy of Mindfulness Based Cognitive Therapy (MBCT) in the prevention of SAD recurrence.
Methods: This is a randomized controlled pilot study, in which SAD patients in remission were randomly allocated to an individual format of MBCT or a control condition (i.e. treatment as usual). MBCT was given between May and June 2011, when there was no presence of depressive symptoms. The Inventory for Depressive Symptomatology Self-Report (IDS-SR), which patients received on a weekly basis from September 2011 to April 2012, was used to assess moment of recurrence (≥ 20) and severity at moment of recurrence.
Results: 23 SAD patients were randomized to MBCT and 23 to the control condition. Kaplan–Meier survival curve showed that the groups did not differ in moment of recurrence ($\chi^2(1).41$, $p=.52$). *T*-tests showed no group difference in mean IDS-SR scores at moment of recurrence ($t(31)=-.52$, $p=.61$).
Limitations: The results are limited by small sample size ($n=46$) and missing data of weekly IDS-SR assessments.
Conclusion: The findings of this pilot RCT suggest that individual MBCT is not effective in preventing a SAD recurrence when offered in a symptom free period (i.e. spring).

1. Introduction

Seasonal affective disorder (SAD winter type) is a recurrent depression characterized by the seasonal pattern in the onset (autumn or winter) and spontaneous remission (following spring or summer) of the depressive episodes (Rosenthal et al., 1984). In the Netherlands, 3% of the population meets the criteria for the diagnosis of SAD (Mersch et al., 1999). SAD can be treated effectively with bright light (Golden et al., 2005), with remission rates up to 80% (Meesters et al., 1995; Gordijn et al., 2012) when remission is defined as improvement of at least 50% and a post-treatment score of 8 or below on the Structured Interview Guide for the Hamilton Depression Rating Scale-Seasonal Affective Disorder (Wirz-Justice et al., 2013).

There are, however, some limitations to light therapy (LT). First, at least 20% of SAD patients do not remit with LT (Terman et al., 1996; Terman et al., 1989). Second, 70% of patients have a recurrence of depression in subsequent autumn and winter seasons (Thompson and Isaacs, 1988). One challenge is, thus, to develop interventions with enduring effects in the prevention of SAD recurrence (Rohan et al., 2009). From research in the field of non-seasonal major depressive disorder (MDD) we know that Mindfulness-based Cognitive Therapy (MBCT;(Segal et al., 2002)) is particularly effective in the prevention of recurrence in patients with recurrent MDD in remission (Piet and Hougaard, 2011). If such outcomes could be generalize to SAD, MBCT could represent a solution to long-term SAD management.

The primary objective of this pilot study is to gain preliminary insight in the efficacy of MBCT in the prevention of recurrence of depression in SAD patients in the following winter. We hypothesize that SAD patients who receive MBCT (i.e. treatment condition), as compared to those who receive treatment as usual (i.e. TAU condition) will differ in:

1. Moment of recurrence of SAD. We expect patients in the treatment condition to have a later (if any) onset of SAD than patients in the TAU condition

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2. Severity of recurrence of SAD. We expect that patients in the treatment condition will experience a less severe recurrence (if any) than patients in the TAU condition

2. Methods

2.1. Participants

For this randomized controlled trial patients were recruited through the SAD outpatient clinic of the University Medical Center Groningen (UMCG), the Netherlands. Eligible patients were patients ≥ 18 years, with a formal diagnosis of winter SAD (based on the criteria of the DSM-IV as assessed by means of a M.I.N.I. interview (Sheehan et al. 1998)), who received LT in the winter of 2010–2011 at the UMCG. Patients known to have a psychiatric comorbidity (e.g. schizophrenia, autism) were not approached. The following exclusion criteria were checked during the recruitment procedure: presence of depressive symptoms (IDS-SR ≥ 15; (Rush et al. 1996)), receiving psychological treatment at the time of the study, experience with mindfulness meditation, and not being able to read and/or write Dutch.

2.2. Procedure

Because the MBCT training is developed to prevent recurrence of depression, the training was planned for the spring time (April 1–June 30 2011). In March 2011, 152 potentially eligible patients received a letter inviting them to participate in the study. In the letter it was explained that half of the patients would be randomly allocated to MBCT, and half to TAU. An informed consent form and a pre-paid return envelope were included. Patients were asked to provide consent for (1) study participation and (2) use of the data on their depressive symptoms in the coming winter (i.e. from August 29 2011 (week 35) – April 15 2012 (week 15)). These data are collected by the SAD outpatient clinic as part of standard care, in order to monitor the development of depressive symptoms in their patients during the winter season (see for further information the description of the TAU condition).

It was asked to return the completed informed consent form within two weeks. Patients who returned an informed consent expressing their interest in participation were further screened for eligibility via a short (5–10 min) standardized telephone interview. During this interview, patients were asked specifically whether they (1) received psychological care at that moment and, (2) whether they had experience with mindfulness meditation. Thirdly, the interview was used to check whether patients had sufficient command of the Dutch language. Patients found eligible during the telephone interview were send the IDS-SR (including return envelope). Patients who scored ≥ 15 were excluded from participation.

Eligible patients were randomised by means of a computerized randomization program. After randomization, patients were notified by telephone. Participant recruitment and flow throughout

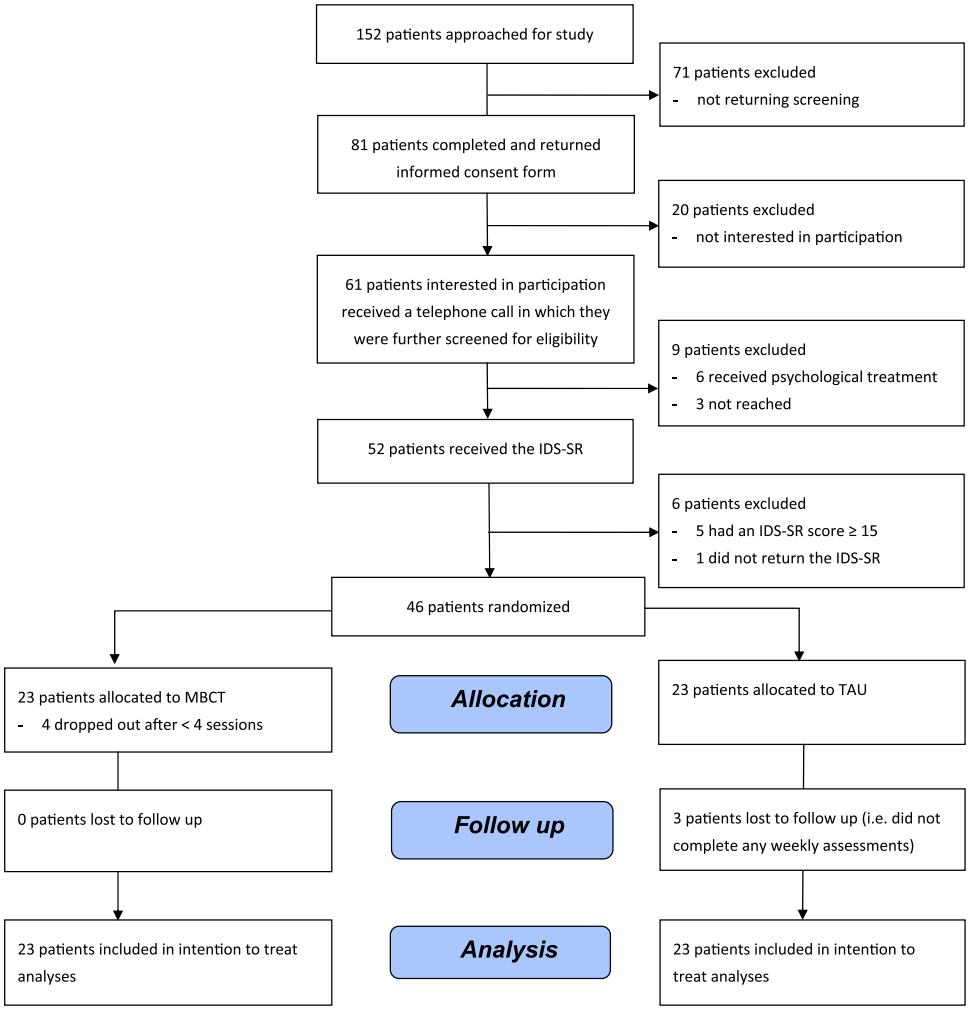

Fig. 1. Participant flow throughout the study.