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Research report

Mindfulness-based cognitive therapy vs cognitive behaviour therapy as a treatment for non-melancholic depression

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ABSTRACT

Aim: To examine the comparative effectiveness of Mindfulness-Based Cognitive Therapy (MBCT) and Cognitive Behaviour Therapy (CBT) as treatments for non-melancholic depression.
Method: Participants who met criteria for a current episode of major depressive disorder were randomly assigned to either an 8-week MBCT (n = 19) or CBT (n = 26) group therapy condition. They were assessed at pre-treatment, 8-week post-group, and 6- and 12-month follow-ups.
Results: There were significant improvements in pre- to post-group depression and anxiety scores in both treatment conditions and no significant differences between the two treatment conditions. However, significant differences were found when participants in the two treatment conditions were dichotomized into those with a history of four or more episodes of depression vs those with less than four. In the CBT condition, participants with four or more previous episodes of depression demonstrated greater improvements in depression than those with less than four previous episodes. No such differences were found in the MBCT treatment condition. No significant differences in depression or anxiety were found between the two treatment conditions at 6- and 12-month follow-ups.
Limitations: Small sample sizes in each treatment condition, especially at follow-up.
Conclusions: MBCT appears to be as effective as CBT in the treatment of current depression. However, CBT participants with four or more previous episodes of depression derived greater benefits at 8-week post-treatment than those with less than four episodes.

1. Introduction

Of all the psychological therapies, Cognitive Behaviour Therapy (CBT) has become the treatment of choice for patients with depression with numerous efficacy and effectiveness studies attesting to its benefits (Beck, 2005). The goals of most CBT approaches for depression have focused on instructing patients about a cognitive approach to understanding the aetiology and maintenance of mood disorders, applying specific skills to identify and modify dysfunctional and automatic thoughts, as well as understanding maladaptive assumptions and beliefs judged as reflecting enduring cognitive structures or schemas (Beck, 2005). CBT may be conducted with individual clients or by using a group-based format. Group-based CBT approaches have been found to be cost effective and therapeutically equivalent to individual face-to-face approaches, thus further contributing to the popularity of CBT as an acute treatment for depression (Oei and Dingle, 2008; Tucker and Oei, 2007).

Mindfulness-Based Cognitive Therapy (MBCT) was specifically developed to prevent relapse amongst those in remission from depression and for those with a chronic, unremitting depressive history (Segal et al., 2002a). MBCT comprises an 8-week group therapy program with sessions (each lasting approximately 2 to 2.5 h) teaching a 'mindful'

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approach to thoughts and feelings, characterized by non-judgmental awareness of internal experience, including a significant meditation component (Segal et al., 2002a). It combines elements of cognitive therapy, such as psychoeducation about depression, within this framework. Mindfulness is thought to assist in distancing from automatic and self-perpetuating negative thoughts which characterize depressogenic thinking (Segal et al., 2002a). In contrast to conventional CBT—which encourages patients to examine the accuracy of their beliefs—MBCT encourages patients to recognize the occurrence of dysfunctional thoughts without emotionally responding to them.

Three studies have evaluated the effectiveness of MBCT in reducing relapse and recurrence in major depression. In the first study, Teasdale et al. (2000) randomly allocated 145 patients who had recovered from recurrent depression to a treatment as usual (TAU) or an MBCT condition. Their results indicated that, compared to TAU, MBCT significantly reduced the risk of relapse within a 60 week period in patients with a history of three or more previous episodes of depression (66% vs 37%). These findings were replicated in a later study by Ma and Teasdale (2004) who found that those with two prior episodes had a relapse rate of 50% compared to 33% for those with three episodes, and 38% for those with four or more episodes. However, Michalak et al. (2008) reported that relapse rates were reduced (to 37.5%) following treatment with MBCT at a 12-month follow-up, while the number of previous episodes of depression did not predict relapse rates.

In addition to preventing depressive relapse, other studies using MBCT have noted improvements for those experiencing current or residual depression (Eisendrath et al., 2008; Barnhofer et al., 2009; Kenny and Williams, 2007; Kingston et al., 2007). Kenny and Williams (2007) investigated the effects of MBCT in 46 participants with treatment resistant depression (categorized as those who had undertaken previous treatment—either current medication or previous CBT within the past 10 years, had 3 or more past episodes of depression and who were still currently symptomatic). Those who undertook the MBCT program demonstrated significant reductions in mean depression scores following treatment. These authors also found that participants allocated to the 'severe' category on the Beck Depression Inventory (BDI) demonstrated greater pre- to post-treatment change compared to those allocated to the 'moderate' category (Kenny and Williams, 2007). A randomized-controlled trial comparing MBCT to TAU with 14 participants in each condition found that MBCT was effective in treating current depression (Barnhofer et al., 2009). Participants who had completed an MBCT group showed a significant decrease in mean Beck Depression Inventory II (BDI-II) scores compared to TAU, with scores dropping to the moderate range. These authors also found that fewer participants in the MBCT condition met diagnostic criteria for depression after treatment (Barnhofer et al., 2009). Eisendrath et al. (2008) examined the effects of MBCT on 55 participants with treatment resistant depression and also noted reductions in depression scores following an MBCT program. Mean BDI-II scores at baseline in the 'moderate' to 'severe' range dropped to the 'mild' to 'moderate' range post-treatment. These studies suggest that, in addition to reducing relapse to depression, MBCT may be used as an active treatment for current depression.

The number of prior episodes of depression has also been found to influence CBT outcome for those currently depressed (Conradi et al., 2008). These authors conducted a 2-year follow-up of participants diagnosed with depression who were randomly allocated to CBT plus psychoeducation, psychoeducation only or TAU. Individuals who received CBT plus psychoeducation demonstrated the greatest improvements in depression. In addition, those who received CBT plus psychoeducation and had 4 or more previous episodes of depression returned significantly lower depression scores than those with less than 4 prior episodes at 2-year follow-up (Conradi et al., 2008).

No studies have, as yet, compared MBCT to another psychological treatment. Given that CBT is widely researched in treating current depression, we have compared MBCT to CBT to address this issue. We also sought to determine whether there were any differences in treatment outcome for those with fewer (less than four) and multiple (four or more) previous episodes of depression as previously reported by Conradi et al. (2008). Less than four vs four or more prior episodes of depression was determined a priori in accordance with the findings of Conradi et al. (2008) where an effect was seen on treatment outcome for those with current depression receiving CBT. The impact of previous episodes of depression on MBCT treatment outcome for those currently depressed was also explored.

We hypothesized that both MBCT and CBT would be effective in reducing depression amongst those experiencing a current episode. Furthermore, based on prior research, we hypothesized that both MBCT and CBT would be equally effective in reducing depression in those with a history of four or more previous episodes.

2. Method

2.1. Participants

Participants were recruited from the general community through referral by general practitioners (GPs) and community advertisements (local newspapers and locally distributed flyers). Inclusion criteria were: (a) aged 18 years or over, (b) meeting DSM-IV criteria for major depressive disorder on the computerized version of the Composite International Diagnostic Interview (CIDI-AUTO) (described below) (WHO, 1997), (c) scoring 20 or more on the BDI-II (Beck Depression Inventory II) state depression measure (Beck et al., 1996) at telephone screening in order to establish probable caseness for current depression, (d) reporting low mood for at least three preceding months, (e) being proficient in English, (f) not having engaged in CBT, mindfulness or meditation/relaxation (operationalized as more than four sessions of regular meditation/relaxation) over the preceding 12 months, (g) being under supervision of a case manager/clinician, (h) not commencing antidepressant medication or, if medicated, not changing their antidepressant medication regime over the preceding three months, and (i) preparedness to commit to an 8-week group program.

Exclusion criteria were: (a) a current diagnosis of melancholic depression or bipolar disorder, (b) a history of any psychotic illness, (c) dementia, (d) current active suicidal ideation, (e) being hospitalized, (f) concurrent treatment using