

Editorial

Mindfulness-based cognitive therapy:
a promising new approach to preventing
depressive relapse

J. Mark G. Williams and Willem Kuyken

**Summary**

Mindfulness-based cognitive therapy (MBCT) was developed as a psychological approach for people at risk for depressive relapse who wish to learn how to stay well in the long-term. In this article we set out the rationale for MBCT, outline the treatment approach, overview the efficacy research to date and look to future challenges.

Declaration of interest

J.M.G.W. is Director of the Oxford Mindfulness Centre,

author of the original treatment manual and subsequent patient self-help manuals, Chief Investigator of the Wellcome Trust-funded Staying Well After Depression Trial and teaches MBCT internationally. W.K. is Co-Director of the Mood Disorders Centre, Chief Investigator of the National Institute for Health Research funded PREVENT Trial, is Programme Director of the Exeter MBCT MSc and teaches MBCT internationally.

Mark Williams (pictured) is a clinical psychologist whose research over 35 years has focused on psychological models and treatment of depression and suicidal behaviour. Willem Kuyken is a clinical psychologist specialising in recurrent depression. He is Co-Founder of the Mood Disorders Centre, established to develop and disseminate psychological treatments (www.exeter.ac.uk/mooddisorders).

Why develop a psychosocial group treatment to prevent depressive relapse?

Although substantial progress has been made in the treatment of many chronic conditions in psychiatry, recurrent depression continues to cause significant disability and human suffering. An outstanding challenge remains developing cost-effective approaches to prevent depression from turning into a recurrent, relapsing condition.¹ The current mainstay approach to preventing depressive relapse is maintenance antidepressants and many patient groups have advocated for accessible psychosocial approaches to help people at risk for depression. Mindfulness-based cognitive therapy (MBCT) was developed by Zindel Segal, one of us (J.M.G.W.) and John Teasdale, with the aim of helping people vulnerable to repeated episodes of depression stay well in the long term.² The intention was to use a psychological understanding of depressive relapse to develop a targeted approach to relapse prevention for people with recurrent depression.

So what is the theoretical rationale for MBCT? During an episode of depression, low mood coexists with negative thinking, other painful emotions and unpleasant body sensations. Once the episode is past, and mood has returned to normal, the constellation of negative thinking, emotions and body sensations tends to go into abeyance. However, there is evidence that, even after recovery from an episode of depression, people remain vulnerable in that a relatively small change in mood can result in a large escalation of negative thoughts, including self-judgement (such as 'I am worthless'), negative views of experience (such as 'Everything is just too difficult') and hopelessness (such as 'There is nothing I can do to escape my situation'). Negative thoughts are accompanied by other powerful emotions in addition to low mood (e.g. anxiety, guilt, anger, frustration, shame), and by

physical symptoms and body sensations such as weakness, fatigue, tension and pain. These thoughts and feelings may seem overwhelming, not least because they can seem out of proportion to the trigger situation. Individuals who thought they had recovered may feel as if now they are 'back to square one', and fear that this is the start of an inevitable slide into depression. In an attempt to understand what is going on and to find a solution, they begin to analyse their experience, and may end up inside a constantly circling ruminative loop, plagued by questions such as 'What has gone wrong?', 'Why is this happening again?' and 'Where will it all end?' Ironically, when people try to think their way out of depression in this ruminative way, it may have the effect of prolonging and deepening the mood disturbance.

In summary, there is good evidence that (a) how easily the constellation of negative thoughts and feelings remain ready for activation is a marker for vulnerability to relapse and recurrence, (b) psychological interventions can reduce this reactivity, and (c) reductions in cognitive reactivity are associated with lower risk for depressive relapse.³

The MBCT approach

Mindfulness-based cognitive therapy is based on Jon Kabat-Zinn's stress reduction programme at the University of Massachusetts Medical Center, which was developed to help people with chronic physical pain and disease.⁴ It includes meditation techniques to help participants become more aware of their experience in the present moment, by tuning into moment-to-moment changes in the mind and the body. Participants learn the practice of mindfulness meditation through a course of classes held weekly for an 8-week period, and through daily mindfulness practice supported by audiotaped CDs. Mindfulness-based cognitive therapy also includes basic education about depression and a number of exercises derived from cognitive therapy that demonstrate the links between thinking and feeling and how participants can care for themselves, especially when they notice a downturn in their mood. Unlike cognitive therapy, the mindfulness approach does not try to change the content of negative thinking. Rather, it encourages participants to change their relationship to thoughts, feelings and body sensations, so that they have an opportunity to discover that these are fleeting

events in the mind and the body that they can choose to engage with – or not. That is, repeated practice in noticing, observing with curiosity and compassion, and shifting perspective helps participants to realise that their thoughts, emotions and sensations are just thoughts, emotions and sensations, rather than ‘truth’ or ‘me’. They learn to see more clearly the patterns of the mind, and to recognise when mood is beginning to dip without adding to the problem by falling into analysis and rumination – to stand on the edge of the whirlpool and watch it go round, rather than disappearing into it. This helps break the old association between negative mood and the negative thinking it would normally trigger. Participants develop the capacity to allow distressing emotions, thoughts and sensations to come and go, without feeling that they have to suppress them, run away from them or fight them. They learn to stay in touch with the present moment, without being driven to ruminate about the past or worry about the future. Some first-person accounts of MBCT are available at www.bemindful.co.uk/.

Does MBCT work?

In the 10 years since the publication of the MBCT manual, research has primarily been focused on addressing MBCT’s effectiveness. Data from six randomised controlled trials ($n = 593$) indicate that MBCT is associated with a 44% reduction in depressive relapse risk compared with usual care for patients with three or more previous episodes, and in head-to-head comparisons with antidepressants, MBCT provides effects comparable with staying on a maintenance dose of antidepressants.⁵ For people looking for a psychosocial approach to staying well, MBCT appears to be accessible, acceptable and cost-effective. Based on this evidence, the National Institute for Health and Clinical Excellence 2009 depression guideline⁶ recommended MBCT for people who are currently well but have experienced three or more episodes of depression.

How does MBCT work?

Even though we know that MBCT works, it does not follow that it works through its hypothesised mechanism. Understanding mechanisms can help therapists and treatment developers improve MBCT’s outcomes by emphasising key processes. Research embedded in one trial comparing MBCT with maintenance antidepressants showed that MBCT does indeed cultivate both mindfulness and self-compassion, and it was precisely these changes in mindfulness and compassion that explained the changes in depressive symptoms 15 months later. Crucially, when people are able to be more self-compassionate at times of low mood, this breaks the link between reactivity and poorer outcomes a year later.⁷ This provides promising evidence that MBCT is indeed working through its hypothesised mechanism.

Developing MBCT: the next 10 years

The original MBCT manual² published in 2002 had a clear focus on preventing depressive relapse based on a theoretical account of cognitive reactivity and depression and has acquired a robust evidence base. The situation is developing rapidly. In the UK, many National Health Service (NHS) mental health services are beginning to offer MBCT within their care pathway, the Mental Health Foundation issued a report in 2010⁸ advocating for steps to improve the accessibility of MBCT, there are now three training programmes in the UK at the Universities of Bangor, Exeter and Oxford, and MBCT has taken root in North America, Germany,

the Benelux counties, Scandinavia and Australia. In recent years, one of us (J.M.G.W), with several colleagues, has increased the accessibility of MBCT by producing a self-help manual that supports people with depression learning mindfulness for themselves.⁹ Some of the largest depression and mindfulness trials to date are underway to definitively address outstanding questions concerning MBCT’s efficacy, mechanism and acceptability, particularly in relation to the current treatment of choice, maintenance antidepressants.^{10,11} Future research needs to establish why MBCT is effective only for those with three or more prior episodes and assess its broader acceptability in real-world settings. In the past 10 years, theory development and treatment research has extended to people with chronic fatigue, current depression, bipolar disorder, parenting stress and suicidality. Most recently, *Mindfulness: A Practical Guide to Finding Peace in a Frantic World* sets out a psychological account of human stress and how MBCT can enhance people’s resilience.¹² Outstanding challenges will be examining the translational gap from efficacy to implementation in the NHS, training sufficient MBCT therapists and extending the evidence base for these newer MBCT developments.

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