Notes from presentation on Mindfulness-Based Cognitive Therapy (MBCT)

BHH GP/LUNCHTIME EDUCATIONAL LECTURES WINTER TERM

(11th January 2016 – 21 March 2016)

Monday 11th January 2016	Subject: Mental Health Mindfulness for GP's Speaker: Richard Hawkins, Cognitive Behavioural Therapist BSMHFT

Mindfulness-Based Cognitive Therapy (MBCT)
Case Study: Jane

Stage in Treatment	PHQ9	GAD7	WASA
At referral	27 (3)	18	34
End of counselling	18 (2)	8	33
Start of MBCT	27 (3)	12	19
End of MBCT	9 (1)	4	?
Follow Up	4 (0)	1	8

PHQ9 Score in brackets is for Q9 "Thoughts that you would be better off dead, or of hurting yourself"

"I have found the course very useful. When I first started I felt very angry, upset, unable to reason and blamed myself for everything. After a couple of weeks I wasn't sure if the course was for me, but before I knew it working with the practices has helped me hugely to realise that I cannot control life and have started to accept things how they are and live with things in a more healthy way. Also relaxing and sleeping and paying attention to what is happening around me in the real world, not just what is happening in my head constantly."

What is Mindfulness?

Mindfulness is the awareness that emerges through:
paying attention
on purpose,
in the present moment,
and nonjudgmentally,
to things as they are.

—Williams, Teasdale, Segal, and Kabat-Zinn (2007)

Mindfulness Learning Outcomes

Reduced rumination.

Stress reduction.

Boosts to working memory.

Focus.

Less emotional reactivity.

Greater cognitive flexibility.

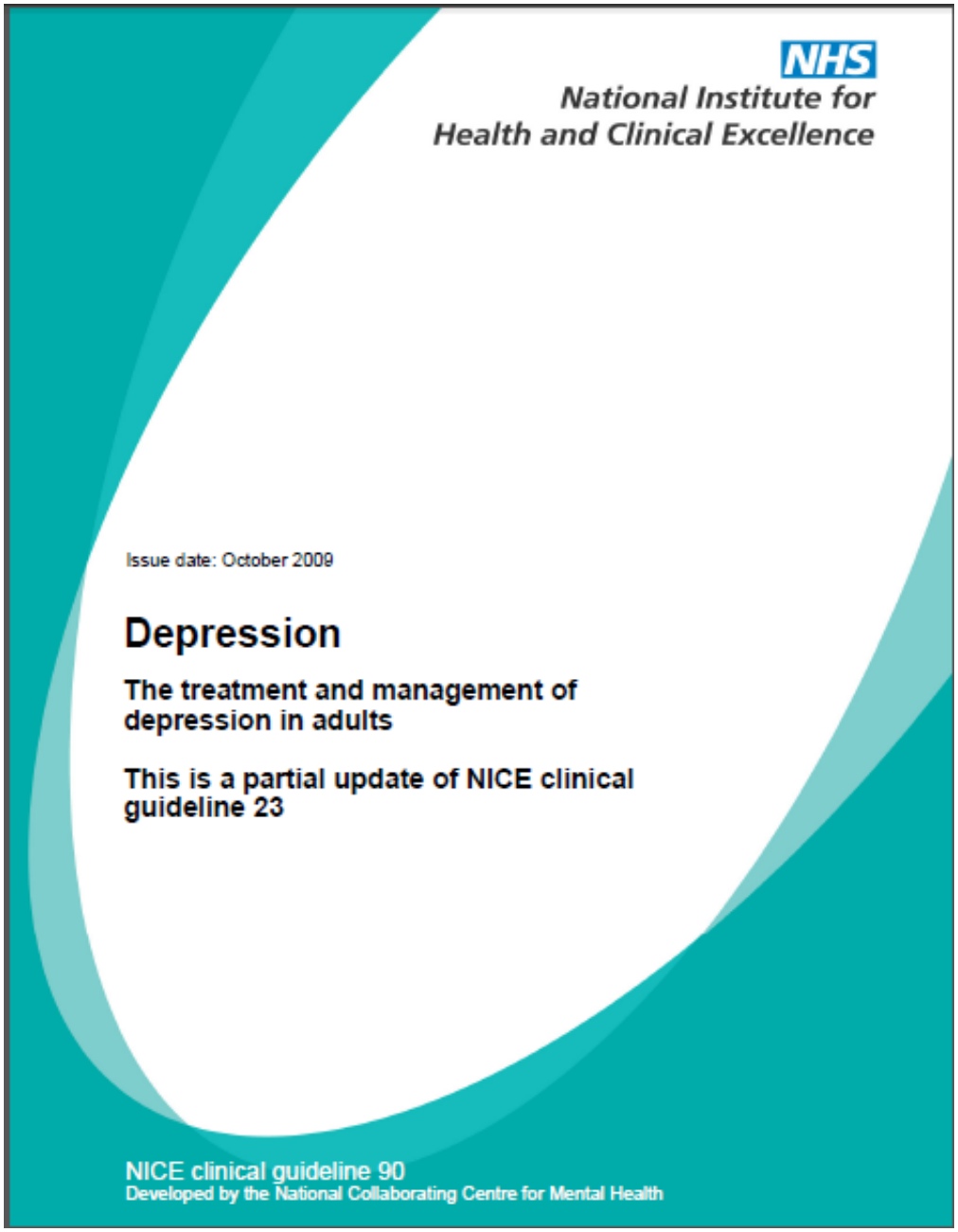
Relationship satisfaction.

Source: "*What Are the Benefits of Mindfulness? A Practice Review of Psychotherapy-Related Research*", American Psychological Association.

NICE Recommendation

2009 - NICE guidelines [CG90] recommends MBCT as a treatment for relapse prevention of depressive episodes:

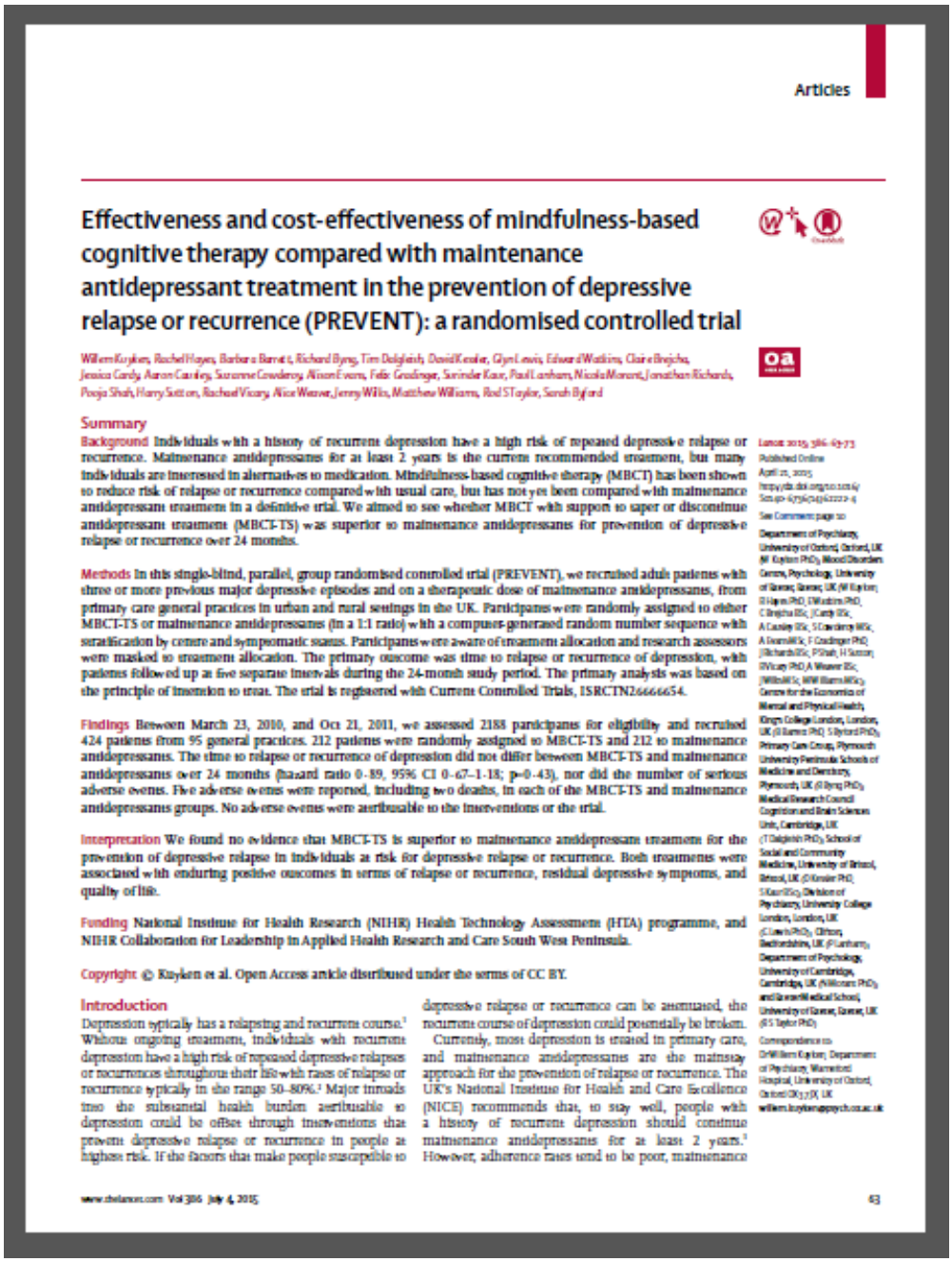
> ***"Psychological interventions for relapse prevention***
> *1.9.1.8*
> *Mindfulness-based cognitive therapy for people who are currently well but have experienced three or more episodes of depression."*



Comparison of MBCT with maintenance anti-depressants

2015 – A RCT study reported in *The Lancet* concluded that there is no evidence that MBCT is superior to maintenance antidepressants, but both are associated with enduring positive outcomes.

MBCT is more cost effective and, as the NICE guidelines state, people with depression, including those who relapsed despite anti-depressant treatment or who are unable or choose not to continue antidepressant treatment, should be offered psychological interventions – CBT or MBCT.



Articles

Effectiveness and cost-effectiveness of mindfulness-based cognitive therapy compared with maintenance antidepressant treatment in the prevention of depressive relapse or recurrence (PREVENT): a randomised controlled trial

Willem Kuyken, Rachel Hayes, Barbara Barrett, Richard Byng, Tim Dalgleish, David Kessler, Glyn Lewis, Edward Watkins, Claire Brejcha, Jessica Cardy, Aaron Causley, Suzanne Cowderoy, Alison Evans, Felix Gradinger, Surinder Kaur, Paul Lanham, Nicola Morant, Jonathan Richards, Pooja Shah, Harry Sutton, Rachael Vicary, Alice Weaver, Jenny Wilks, Matthew Williams, Rod S Taylor, Sarah Byford

Summary

Background Individuals with a history of recurrent depression have a high risk of repeated depressive relapse or recurrence. Maintenance antidepressants for at least 2 years is the current recommended treatment, but many individuals are interested in alternatives to medication. Mindfulness-based cognitive therapy (MBCT) has been shown to reduce risk of relapse or recurrence compared with usual care, but has not yet been compared with maintenance antidepressant treatment in a definitive trial. We aimed to see whether MBCT with support to taper or discontinue antidepressant treatment (MBCT-TS) was superior to maintenance antidepressants for prevention of depressive relapse or recurrence over 24 months.

Methods In this single-blind, parallel, group randomised controlled trial (PREVENT), we recruited adult patients with three or more previous major depressive episodes and on a therapeutic dose of maintenance antidepressants, from primary care general practices in urban and rural settings in the UK. Participants were randomly assigned to either MBCT-TS or maintenance antidepressants (in a 1:1 ratio) with a computer-generated random number sequence with stratification by centre and symptomatic status. Participants were aware of treatment allocation and research assessors were masked to treatment allocation. The primary outcome was time to relapse or recurrence of depression, with patients followed up at five separate intervals during the 24-month study period. The primary analysis was based on the principle of intention to treat. The trial is registered with Current Controlled Trials, ISRCTN26666654.

Findings Between March 23, 2010, and Oct 21, 2011, we assessed 2188 participants for eligibility and recruited 424 patients from 95 general practices. 212 patients were randomly assigned to MBCT-TS and 212 to maintenance antidepressants. The time to relapse or recurrence of depression did not differ between MBCT-TS and maintenance antidepressants over 24 months (hazard ratio 0·89, 95% CI 0·67–1·18; p=0·43), nor did the number of serious adverse events. Five adverse events were reported, including two deaths, in each of the MBCT-TS and maintenance antidepressants groups. No adverse events were attributable to the interventions or the trial.

Interpretation We found no evidence that MBCT-TS is superior to maintenance antidepressant treatment for the prevention of depressive relapse in individuals at risk for depressive relapse or recurrence. Both treatments were associated with enduring positive outcomes in terms of relapse or recurrence, residual depressive symptoms, and quality of life.

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Introduction

Depression typically has a relapsing and recurrent course.[1] Without ongoing treatment, individuals with recurrent depression have a high risk of repeated depressive relapses or recurrences throughout their life with rates of relapse or recurrence typically in the range 50–80%.[2] Major inroads into the substantial health burden attributable to depression could be offset through interventions that prevent depressive relapse or recurrence in people at highest risk. If the factors that make people susceptible to depressive relapse or recurrence can be attenuated, the recurrent course of depression could potentially be broken.

Currently, most depression is treated in primary care, and maintenance antidepressants are the mainstay approach for the prevention of relapse or recurrence. The UK's National Institute for Health and Care Excellence (NICE) recommends that, to stay well, people with a history of recurrent depression should continue maintenance antidepressants for at least 2 years.[3] However, adherence rates tend to be poor, maintenance

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