

Dismantling mindfulness-based cognitive therapy for recurrent depression implicates lack of differential efficacy for mindfulness training

Eric L Garland

College of Social Work and Huntsman Cancer Institute, University of Utah, Salt Lake City, Utah, USA

Correspondence to Eric L Garland, eric.garland@socwk.utah.edu

WHAT IS ALREADY KNOWN ON THIS TOPIC?

Risk of relapse among patients diagnosed with major depressive disorder is high (>50% of those recovering from a first episode of depression, and approximately 80% of those with a history of two or more episodes),¹ and this risk increases with each successive depressive episode.² Several clinical trials have demonstrated that mindfulness-based cognitive therapy (MBCT) significantly reduces relapse risk among patients with three or more prior depressive episodes.³ Yet, MBCT contains multiple therapeutic elements, and the specific efficacy of the mindfulness training element in MBCT is unknown.

WHAT DOES THIS PAPER ADD?

- ▶ This is the largest investigation of MBCT to date, and the first to use an active psychological treatment group as a control. By employing a dismantling design that compared MBCT to cognitive psychological education (CPE) and treatment-as-usual (TAU) control groups, this study sought to disentangle the specific effect of mindfulness training from psychoeducation and non-specific therapeutic factors.
- ▶ The use of a dismantling design with a well-matched CPE control group comprised all of the elements of MBCT except for mindfulness training represents a critical advance over previous studies.⁴
- ▶ MBCT, CPE and TAU demonstrated comparable efficacy, in contrast to prior studies, which demonstrated a clear advantage of MBCT over TAU. In a prespecified analysis, MBCT was shown to be significantly more efficacious than the other two conditions for individuals with high levels of childhood trauma.

LIMITATIONS

- ▶ Owing to the implementation of evidence-based guidelines in the UK, the strength of the TAU control condition may have contributed to the null results on depression relapse.
- ▶ The use of a dichotomous outcome measure, though clinically valid, may have limited sensitivity to detect between-group differences.

ABSTRACT FROM Williams JM, Crane C, Barnhofer T, *et al.* Mindfulness-based cognitive therapy for preventing relapse in recurrent depression: a randomized dismantling trial. *J Consult Clin Psychol* 2014;**82**:275–86.

Patients/participants Two hundred and seventy-four adults (aged 18–70 years) with a history of major depression (at least three episodes) who had been in remission for the past 8 weeks. Participants were recruited via referrals from primary care and mental health clinics, and community-based advertisements. All participants were assessed using the structured clinical interview for DSM-IV (SCID) at baseline.

Setting Oxford, England; Bangor, North Wales.

Intervention *Mindfulness based cognitive therapy (MBCT)*: eight weekly, 2-h group sessions comprising the psychological education components of cognitive-behavioural therapy for depression, with the meditation elements within mindfulness based stress reduction. An additional two sessions were held 6 weeks and 6 months post-treatment. *Cognitive psychological education (CPE)*: eight weekly, 2-h group sessions including all components of the MBCT intervention except the elements involving meditation practice. Participants in both intervention groups received a pretreatment interview, designed to maximise treatment engagement and develop a treatment plan to target MBCT or CPE to their individual needs.

Comparison Treatment as usual (TAU), which was also given to the two intervention groups. TAU involved maintaining current medication, other treatments and appointments.

WHAT NEXT IN RESEARCH?

- ▶ Studies of other multimodal mindfulness-based interventions (eg, Mindfulness-Oriented Recovery Enhancement⁵) should employ dismantling designs to parse out the therapeutic effects of mindfulness meditation from other intervention components, such as compassion meditation, yoga, psychoeducation and group support.
- ▶ Double-blinding in psychological treatment studies can be extremely difficult. At minimum, future studies should conceal the identity of experimental and control treatments and use perceived treatment credibility/therapeutic expectancy as a covariate in outcome analyses.

COULD THESE RESULTS CHANGE YOUR PRACTICES AND WHY?

Yes. On the whole, mindfulness training appears to be no more efficacious than psychoeducation or other common empirically supported interventions for preventing depressive relapse. That said, clinical trials examine the overall average effect of a treatment, and significant individual differences exist with regard to treatment response, depending on clinical presentation and underlying biobehavioural vulnerabilities. Clinicians and researchers should attend to predisposing characteristics (such as childhood trauma, as identified in the present trial) that might moderate treatment effects.

Competing interests None.

doi:10.1136/eb-2014-101856

REFERENCES

1. **Burcusa SL**, Iacono WG. Risk for recurrence in depression. *Clin Psychol Rev* 2007;**27**:959–85.
2. **ten Doesschate MC**, Bockting CLH, Koeter MWJ, *et al.* Prediction of recurrence in recurrent depression: a 5.5-year prospective study. *J Clin Psychiatry* 2010;**71**:984–91.
3. **Piet J**, Hougaard E. The effect of mindfulness-based cognitive therapy for prevention of relapse in major depressive disorder: a systematic review and meta-analysis. *Clin Psychol Rev* 2011;**31**:1032–40.
4. **Garland EL**. Mindfulness research in social work: conceptual and methodological recommendations. *Soc Work Res* 2013;**37**:1–10.
5. **Garland EL**, Manusov EG, Froeliger B, *et al.* Mindfulness-oriented recovery enhancement for chronic pain and prescription opioid misuse: results from an early-stage randomized controlled trial. *J Clin Consult Psychol* 2014;**82**:448–59.

Patient follow-up Three, 6, 9 and 12 month follow-up (255 participants, 93% at 12 months).

Allocation Unclear.

Blinding Single blind (assessors).

OUTCOMES

Time until relapse to major depression (meeting SCID criteria at least 2 weeks since previous assessment) The relapse rates were 46% for MBCT, 50% for CPE and 53% for TAU. There was no significant difference in time to relapse between treatment groups: the HR for MBCT versus CPE was 0.88 (95% CI 0.57 to 1.34); the HR for MBCT or CPE versus TAU was 0.73 (95% CI 0.47 to 1.13); the HR for MBCT versus TAU was 0.68 (95% CI 0.42 to 1.12).

Effect in those with childhood trauma MBCT significantly reduced risk of relapse compared with TAU in people scoring above average on the Childhood Trauma Questionnaire (HR=0.43, 95% CI 0.22 to 0.87). The relapse rates for high childhood trauma scorers were 41% with MBCT, 65% for TAU and 54% for CPE. The difference in relapse rates was non-significant for MBCT versus CPE (HR=0.61, 95% CI 0.34 to 1.09) and CPE versus TAU (HR=0.72, 95% CI 0.39 to 1.32).