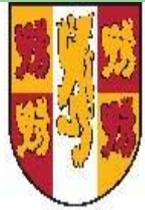


MBCT: the evolving story



PRIFYSGOL
BANGOR
UNIVERSITY

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Centre for Mindfulness Research
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Bangor University

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Research Lead
Sussex Mindfulness Centre
Sussex Partnership NHS Foundation Trust
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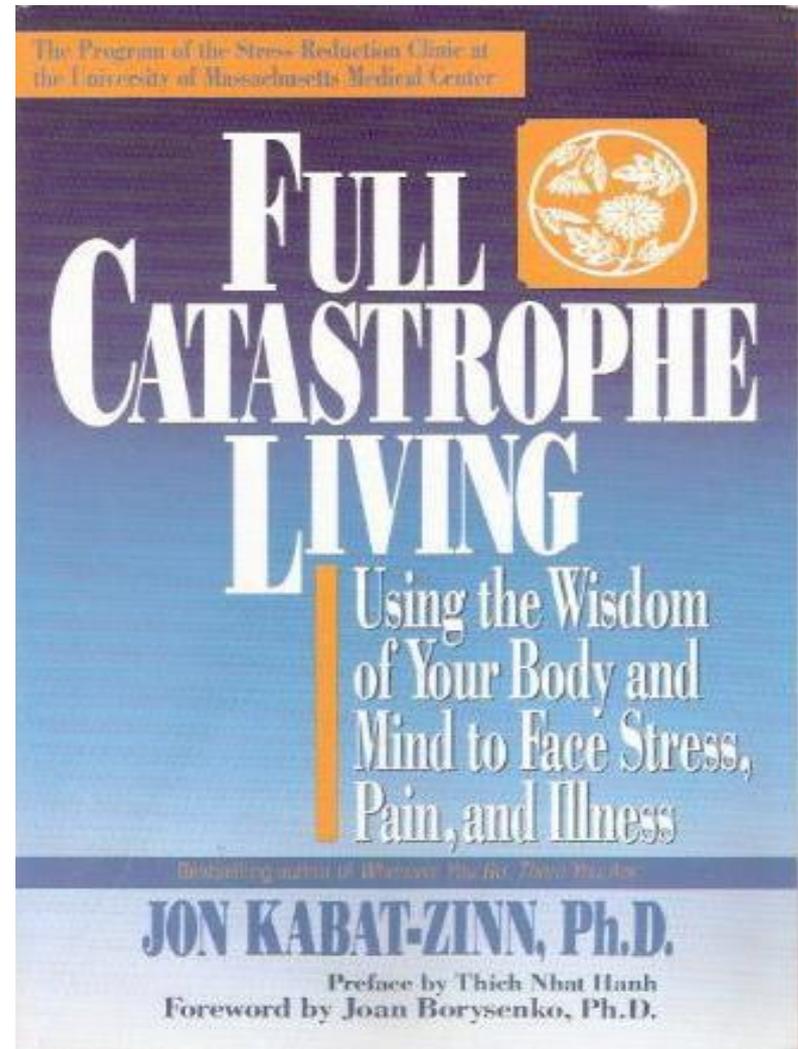
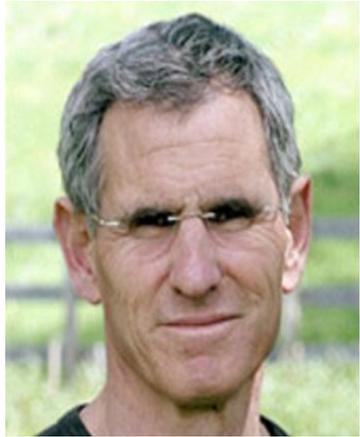


Our hopes...

- To build understanding of the MBCT research journey
- Through this to heighten clarity about current MBCT clinical practice
- To explore MBCT clinical questions & dilemmas
- To reconnect with our mindfulness practice
- To experience yourself as an active participant in the evolving story!

Plan for the day

- Origins of MBCT – the first steps
- The MBCT research journey – an overview
- How does MBCT work?
- MBCT implementation – research and practice





Buddhist
philosophy

Experiential
learning

**Mindfulness-
based stress
reduction**

Group-
based
learning

Stress
physiology

Yoga/
mindful
movement

Stories/
poetry/
Metaphors

Mindful-
ness
medita-
tion
practice

Mindfulness-Based Stress Reduction (MBSR)

For....

- Chronic Pain
- Anxiety
- Psoriasis

Relevance to major depression?



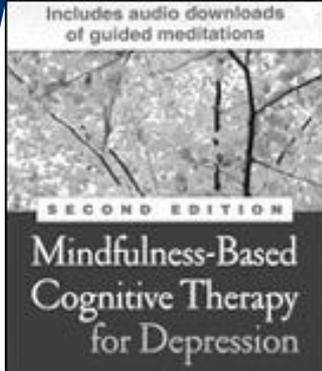
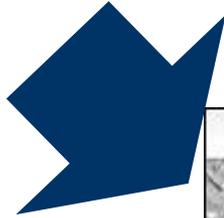
The Scale of the Problem:

Population Health and Mental Well-being

- WHO - mental illness = biggest health burden by 2030
- Mental illness = biggest single cause of morbidity across the world (40% of the total in Britain)
- Depression = leading cause and increasing year by year
- Use of anti-depressants in the UK increased from 9m prescriptions in 1991 to 47m in 2011
- Much of the burden from physical ill health comes from the stress that such illnesses cause the sufferer
- Cost of depression and anxiety to UK economy is estimated at £17 billion or 1.5% of GDP
- In the most deprived areas of the UK, 9 -10% of population are on (often long-term) antidepressant prescriptions.

COGNITIVE THERAPY OF DEPRESSION

AARON T. BECK
A. JOHN RUSH
BRIAN F. SHAW
GARY EMERY

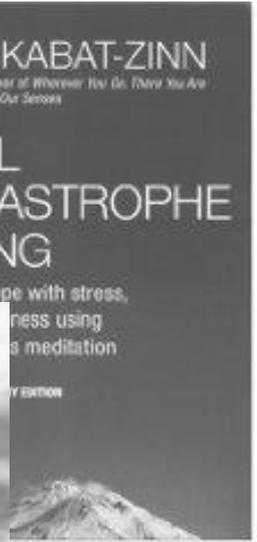


JON KABAT-ZINN

Bestselling author of *Wherever You Go, There You Are*
and *Come to Your Senses*

FULL CATASTROPHE LIVING

How to cope with stress,
anxiety, and depression using
mindfulness meditation

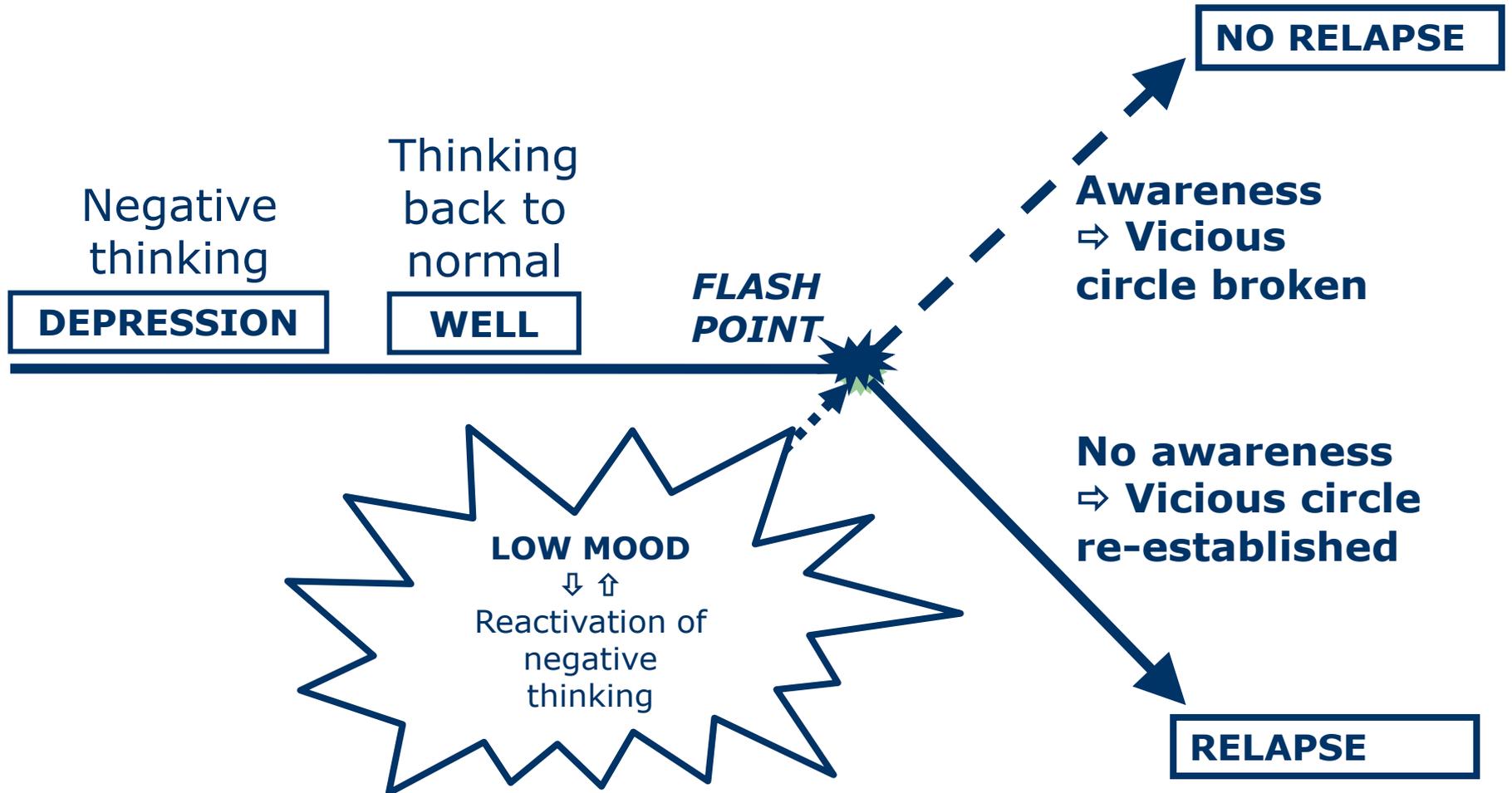


Zindel V. Segal
J. Mark G. Williams
John D. Teasdale





The Rationale for MBCT



This integration...pioneered a new possibility → wider interest:

- the central processes on which MBCT is thought to have its effects (rumination and experiential avoidance) are trans-diagnostic
- the skills that MBCT trains (attentional focus, self-awareness and self-compassion) have wide applicability
- The MBCT manual published in 2002 made the programme form and its rationale explicit and accessible.

(see Teasdale, Segal & Williams 2003)

Each discipline offers:

- A map of the mind
- A sophisticated investigative tool

Each acknowledges:

- Universal processes
- Common humanity

Following a trail.... cognitive approaches to understanding and treating major depression



Heightened vulnerability to depression...

- Connections between changes in body, mood and thoughts become much closer so that even small shifts in these can trigger a depressive response.
- Memories/images become re-accessed and feel current
- Characteristic pattern of :
 - Over use of conceptual mode (rumination)
 - Attempts to stop rumination and aversive experience (avoidance)(using 'doing mode' to suppress or elaborate emotional expression)
- Hopelessness and despair

Low mood activates whole *mode of mind* (*driven doing-mode*)

- Discrepancy-based (wanting things to be different, matching to standard, judgmental thinking about self, goals, etc)
- Mainly verbal
- Thoughts taken as real
- Thinking often relates to past or future
- Urge to 'get away from' – avoidance patterns
- Automatic/ habitual – keeps going over old ground – 'mental groove'

Universal and specific vulnerability (Williams 2008)

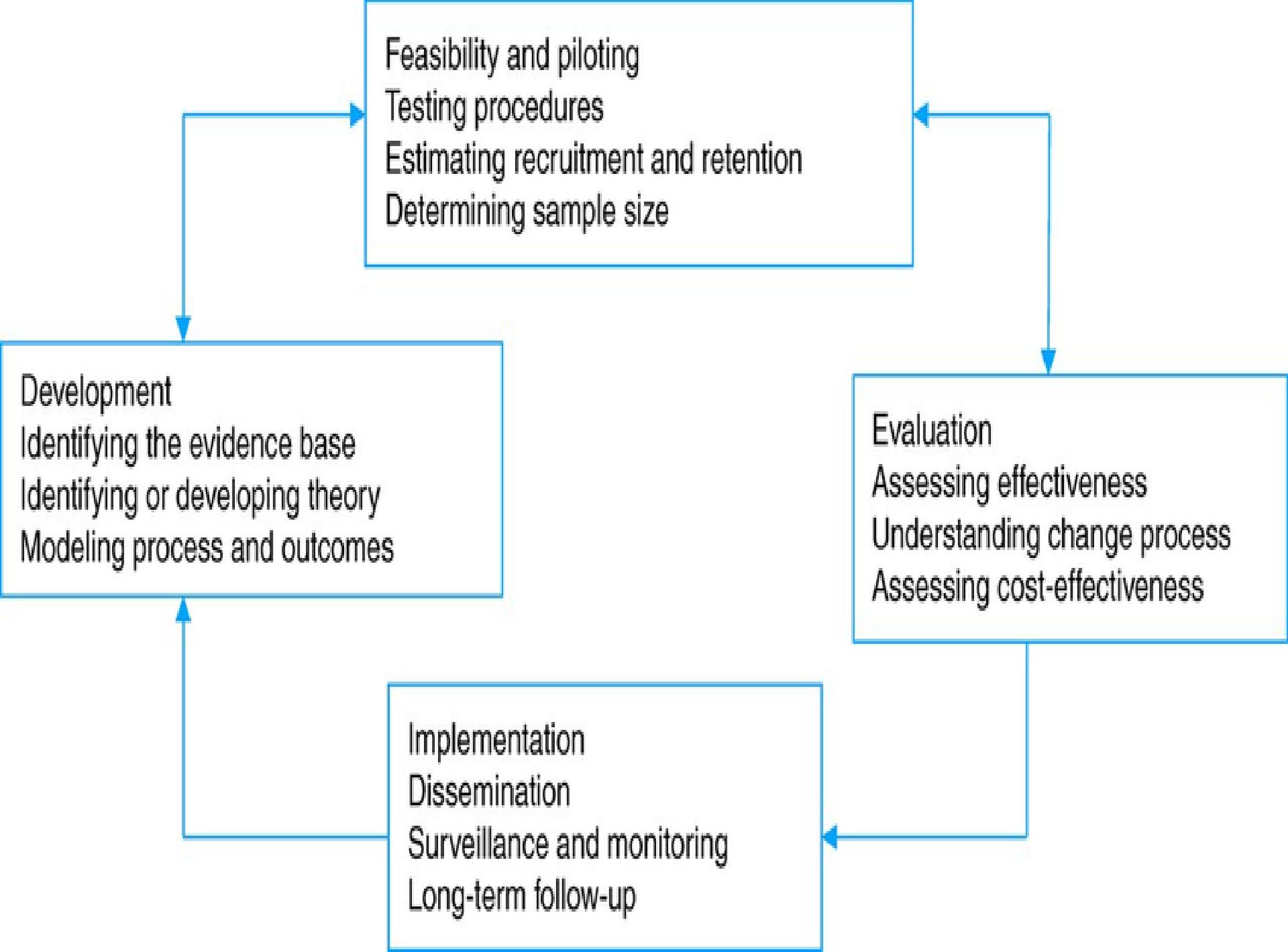
Universal:

- traits shared by all humans that tend us towards suffering

Specific:

- patterns, traits, tendencies, particular sensitivities created by our conditioning, life events, environmental influence, illness, genetic makeup etc.

MBCT research journey



Phases of the MBCT research journey

1. Preliminary trials
2. Replications in other contexts/other teachers
3. MBCT for other populations
4. How does MBCT work?
5. Evaluation of implementation

First MBCT Clinical Trials

- 3 centre study (Teasdale et al, 2000)
- Single centre replication study (Ma & Teasdale, 2004)

Summary of results of both trials:

MBCT approximately halved the likelihood of depressive relapse in patients who had had three or more episodes of depression

National Institute for Health and Clinical Excellence (NICE) Recommendation for Depression Relapse Prevention (2009)

8.10.8 Psychological interventions for relapse prevention

8.10.8.1 People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment) or who have residual symptoms, should be offered the following psychological interventions:

- individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment
- mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression. [Key priority]

NICE Guidance on Depression: Review 2019

NICE Guidelines

NICE have recommended MBCT should be offered as a **relapse prevention intervention for people currently well with a history of 3+ episodes of depression** since 2004 (and updated in 2009)

NICE do not currently recommend MBCT/other MBIs elsewhere

But do NICE guidelines matter?

MBCT in IAPT

IAPT (Improving Access to Psychological Therapy) services offer NICE-recommended psychological therapies for anxiety and depression in England

Over 1 million adults are referred to IAPT services each year

MBCT is now mandated in IAPT

Health Education England have funded training for 72 MBCT teachers to work in IAPT in 2018-2020 and are funding 128 places for 2021



What's changed since 2009?



⇒ Stronger evidence for relapse prevention

Original Investigation | META-ANALYSIS

Efficacy of Mindfulness-Based Cognitive Therapy in Prevention of Depressive Relapse An Individual Patient Data Meta-analysis From Randomized Trials

Willem Kuyken, PhD; Fiona C. Warren, PhD; Rod S. Taylor, PhD; Ben Whalley, PhD; Catherine Crane, PhD; Guido Bondolfi, MD, PhD; Rachel Hayes, PhD; Marloes Huijbers, MSc; Helen Ma, PhD; Susanne Schweizer, PhD; Zindel Segal, PhD; Anne Speckens, MD; John D. Teasdale, PhD; Kees Van Heeringen, PhD; Mark Williams, PhD; Sarah Byford, PhD; Richard Byng, PhD; Tim Dalgleish, PhD

IMPORTANCE Relapse prevention in recurrent depression is a significant public health problem, and antidepressants are the current first-line treatment approach. Identifying an equally efficacious nonpharmacological intervention would be an important development.

OBJECTIVE To conduct a meta-analysis on individual patient data to examine the efficacy of mindfulness-based cognitive therapy (MBCT) compared with usual care and other active treatments, including antidepressants, in treating those with recurrent depression.

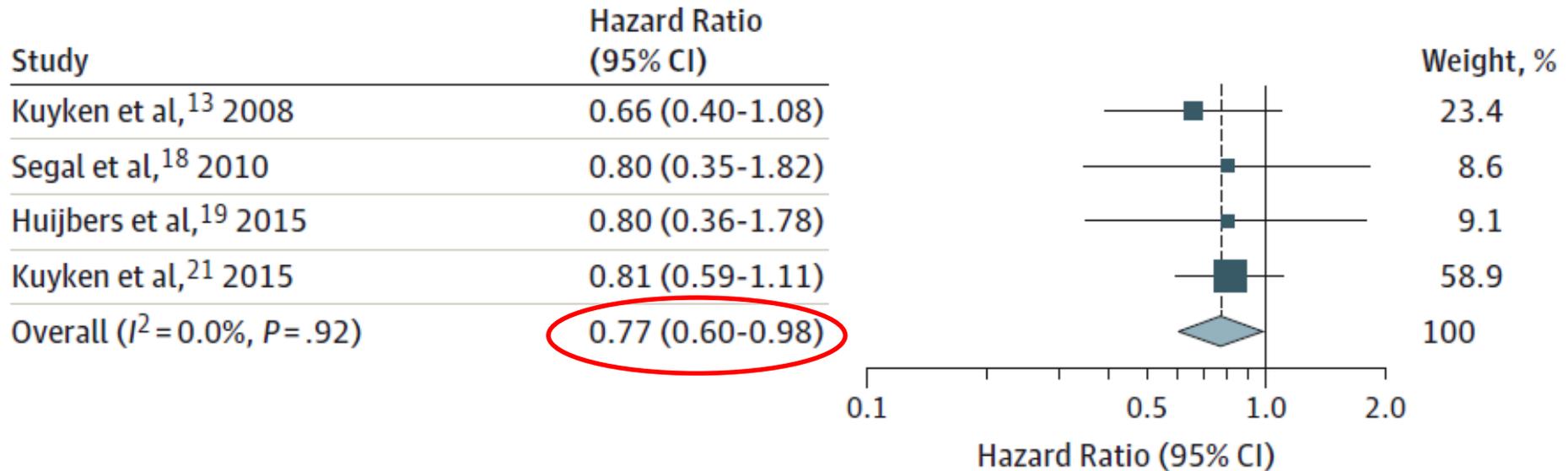
DATA SOURCES English-language studies published or accepted for publication in peer-reviewed journals identified from EMBASE, PubMed/Medline, PsycINFO, Web of Science, Scopus, and the Cochrane Controlled Trials Register from the first available year to November 22, 2014. Searches were conducted from November 2010 to November 2014.

← Editorial page 547

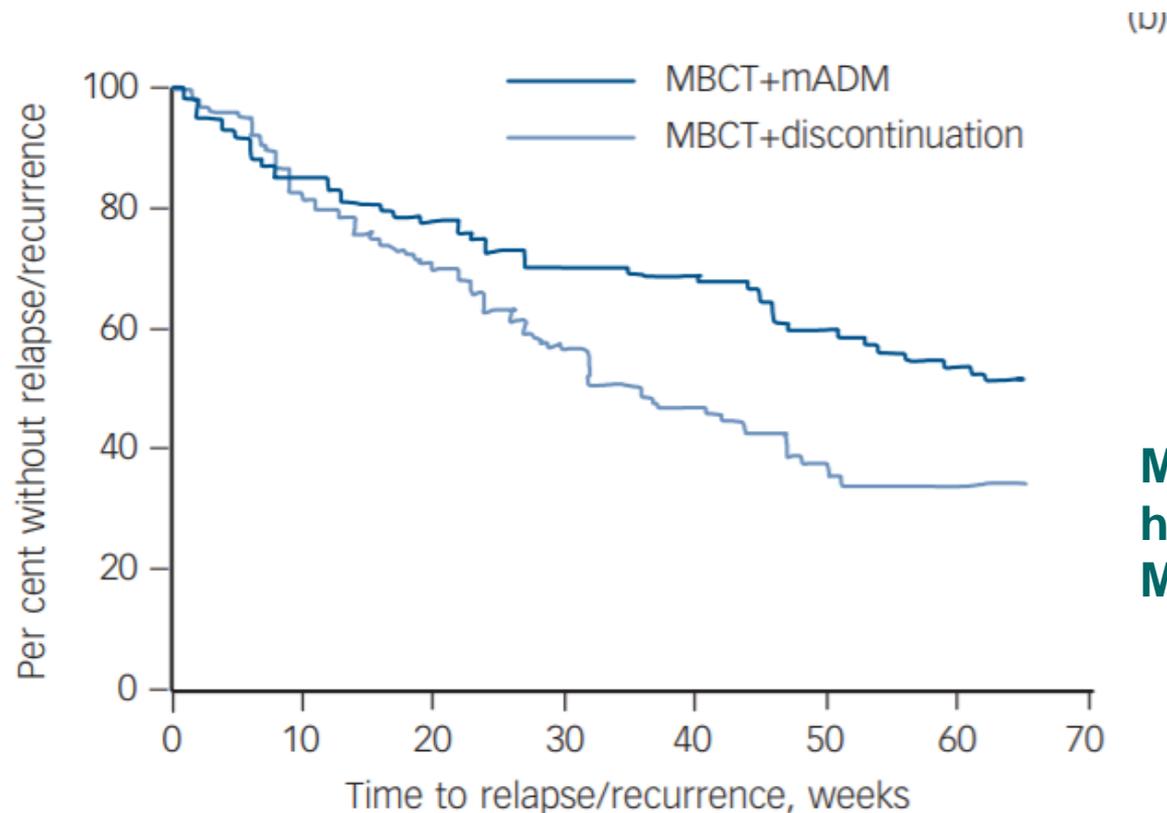
+ Supplemental content at
jamapsychiatry.com

MBCT has **23% lower risk of relapse** over two years compared with anti-depressant medication

C MBCT vs antidepressants



MBCT followed by anti-depressant medication versus discontinuation



**MBCT+discontinuation
higher relapse rate than
MBCT+mADM**

Farb et al, 2018

Journal of Consulting and Clinical Psychology

© 2017 American Psychological Association
0022-006X/17/\$12.00 <http://dx.doi.org/10.1037/ccp0000266>

BRIEF REPORT

Prevention of Relapse/Recurrence in Major Depressive Disorder With
Either Mindfulness-Based Cognitive Therapy or Cognitive Therapy

Norman Farb
University of Toronto–Mississauga

Adam Anderson
Cornell University

Arun Ravindran
University of Toronto

Lance Hawley
Sunnybrook Hospital, Toronto, Ontario, Canada

Julie Irving and Enza Mancuso
Centre for Addiction and Mental Health, Toronto,
Ontario, Canada

Tahira Gulamani, Greg Williams, Amanda Ferguson,
and Zindel V. Segal
University of Toronto–Scarborough

Risk of relapse similar for MBCT and group Cognitive Therapy

	Intention To Treat	Per Protocol
MBCT	22%	20%
CT	21%	24%

Decentring improved to a similar degree in both arms,
with non-relapsers showing greatest improvement

⇒ Strong evidence for current depression



Contents lists available at ScienceDirect

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journal homepage: www.elsevier.com/locate/clnpsychrev



Review

Mindfulness-based interventions for psychiatric disorders: A systematic review and meta-analysis

Simon B. Goldberg^{a,b,c,*}, Raymond P. Tucker^d, Preston A. Greene^a, Richard J. Davidson^{b,e}, Bruce E. Wampold^{c,f}, David J. Kearney^a, Tracy L. Simpson^{a,g}

^a VA Puget Sound Health Care System, Seattle, WA, USA

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^f Midam Bad Psychiatric Center, Vikersund, Norway

^g Center for Excellence in Substance Abuse Treatment and Education, VA Puget Sound Health Care System, Seattle, WA, USA

HIGHLIGHTS

- We examined the relative efficacy of mindfulness-based interventions on clinical symptoms of psychiatric disorders.
- 142 randomized clinical trials were included (N = 12,005 participants). Control conditions were coded on a five-tier system.
- At post-treatment, mindfulness interventions were equivalent to evidence-based treatments and superior to other comparisons.
- At follow-up, mindfulness interventions were equivalent to minimal and evidence-based treatments and superior to others.
- The most consistent evidence for mindfulness-based interventions was seen for depression, pain, smoking, and addictions.

ARTICLE INFO

Keywords:
Mindfulness
Meditation
Meta-analysis
Psychiatric disorders
Relative efficacy

ABSTRACT

Despite widespread scientific and popular interest in mindfulness-based interventions, questions regarding the empirical status of these treatments remain. We sought to examine the efficacy of mindfulness-based interventions for clinical populations on disorder-specific symptoms. To address the question of relative efficacy, we coded the strength of the comparison group into five categories: no treatment, minimal treatment, non-specific active control, specific active control, and evidence-based treatment. A total of 142 non-overlapping samples and 12,005 participants were included. At post-treatment, mindfulness-based interventions were superior to no

For people experiencing current depression, MBIs have **similar outcomes to evidence-based treatments** (mostly CBT)

Comp	Diagnosis	k	Tx n	Cont n		d 95% CI
EBT	Depression	10	528	536		-0.01 (-0.19-0.16)

⇒ Growing evidence for ‘treatment resistant’ depression

Mindfulness-based cognitive therapy vs. psycho-education for patients with major depression who did not achieve remission following antidepressant treatment



Alberto Chiesa^{a,b,*}, Vittoria Castagner^a, Costanza Andrisano^a, Alessandro Serretti^a, Laura Mandelli^a, Stefano Porcelli^a, Fabio Giommi^c

^a Department of Biomedical and Neuromotor Sciences, University of Bologna, Viale Carlo Pepoli 5, 40123 Bologna, Italy

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Keywords:
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Major depression
Response

ABSTRACT

Mindfulness-based cognitive therapy (MBCT) showed efficacy in most of the available studies but suffers from important methodological limitations, such as inadequate control groups. The present study aims to compare MBCT with a group designed to be structurally equivalent to the MBCT “active ingredient” of MBCT (i.e., mindfulness meditation) in patients with major depression (MD) who did not achieve remission following antidepressant treatment. Out of 106 screened subjects, 43 were randomized to MBCT or the active ingredient group. MD severity was assessed using the Hamilton Depression Rating Scale (HAM-D) and the Beck Depression Inventory-II (BDI-II) and quality of life were also included. All assessments were performed at baseline and at 26 weeks. Both HAM-D and BDI scores, as well as quality of life improvements, which were particularly evident over the 26 weeks, were significantly greater in the MBCT group compared to the psycho-education group. Although limited by a small sample size, the results suggest the superiority of MBCT over psycho-education for non-remitters with MD. © 2015 Elsevier B.V.

Psychotherapy
and Psychosomatics

Regular Article

Psychother Psychosom 2016;85:99–110
DOI: 10.1159/000442260

Received: April 27, 2015
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Published online: January 26, 2016

A Randomized Controlled Trial of Mindfulness-Based Cognitive Therapy for Treatment-Resistant Depression

Stuart J. Eisendrath · Erin Gillung · Kevin L. Delucchi · Zindel V. Segal · J. Craig Nelson · L. Alison McInnes · Daniel H. Mathalon · Mitchell D. Feldman

Department of Psychiatry, University of California, San Francisco, Calif., USA

Key Words

Cognitive therapy · Depression · Major depressive

disorder. MBCT showed significantly greater mean percent reduction in the HAM-D₁₇ (36.6 vs. 25.3%; $p = 0.01$) and a significantly higher rate of treat-

NICE Depression Guideline Update



NICE Guidance for Depression is currently under review

MBCT beyond depression:

- Adolescents with ADHD
- Health anxiety
- Psoriasis
- Respiratory conditions
- Healthcare professionals
- Insomnia
- Cancer
- OCD
- Binge eating
- Headache pain
- Tinnitus
- Veterans with PTSD
- etc

Summary

- Evidence for depression prevention is compelling – particularly in those who have heightened relapse vulnerability
- MBCT appears to be safe when (carefully) offered to people with current depression, anxiety, PTSD and a range of other conditions

Implications for our work

In small groups consider if/how research evidence and NICE guidelines inform who we offer MBCT to, and how we offer MBCT

How does MBCT work?

How does MBCT work?

In small groups consider:

What changes during an MBCT course?

How does MBCT facilitate these changes?

How does MBCT work?

Research evidence



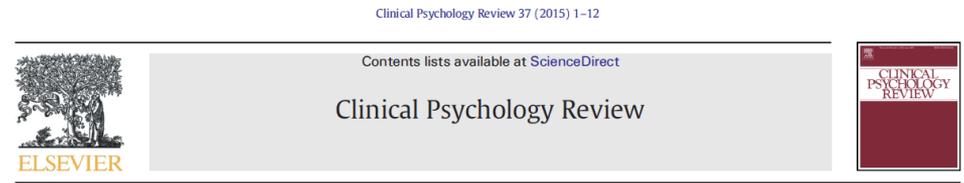
A systematic review of mechanisms of change in mindful cognitive therapy in the treatment of recurrent major depressive disorder

Anne Maj van der Velde
Jesper Dahlgaard^f, Lone

^a Danish Center for Mindfulness at the
^b Department of Psychology, Copenhagen
^c Mood Disorders Centre, University of Ex
^d Department of Psychiatry, University of
^e Watar Gruppen, Kognitiv Center, Coper
^f Department of Psychology and Behavior

HIGHLIGHTS

• Mindfulness based cognitive therapy



How do mindfulness-based cognitive therapy and mindfulness-based stress reduction improve mental health and wellbeing? A systematic review and meta-analysis of mediation studies

Jenny Gu^{a,b}, Clara Strauss^{b,c}, Rod Bond^a, Kate Cavanagh^{a,b,*}

^a School of Psychology, University of Sussex, Falmer, East Sussex, BN1 9QH, UK
^b Sussex Mindfulness Centre, Research and Development Directorate, Hove, BN3 7HZ, UK



Review

Mechanisms of action in mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR) in people with physical and/or psychological conditions: A systematic review

Modi Alsubaie^a, Rebecca Abbott^b, Barnaby Dunn^a, Chris Dickens^c, Tina Frieda Keil^d, William Henley^b, Willem Kuyken^{e,*}

^a Mood Disorders Centre, Exeter University, Exeter, UK
^b Medical School, Exeter University, Exeter, UK
^c Psychology, Medical School, Exeter University, Exeter, UK
^d Psychology Department, Exeter University, Exeter, UK
^e Psychiatry Department, Oxford University, Oxford, UK

How does MBCT work?

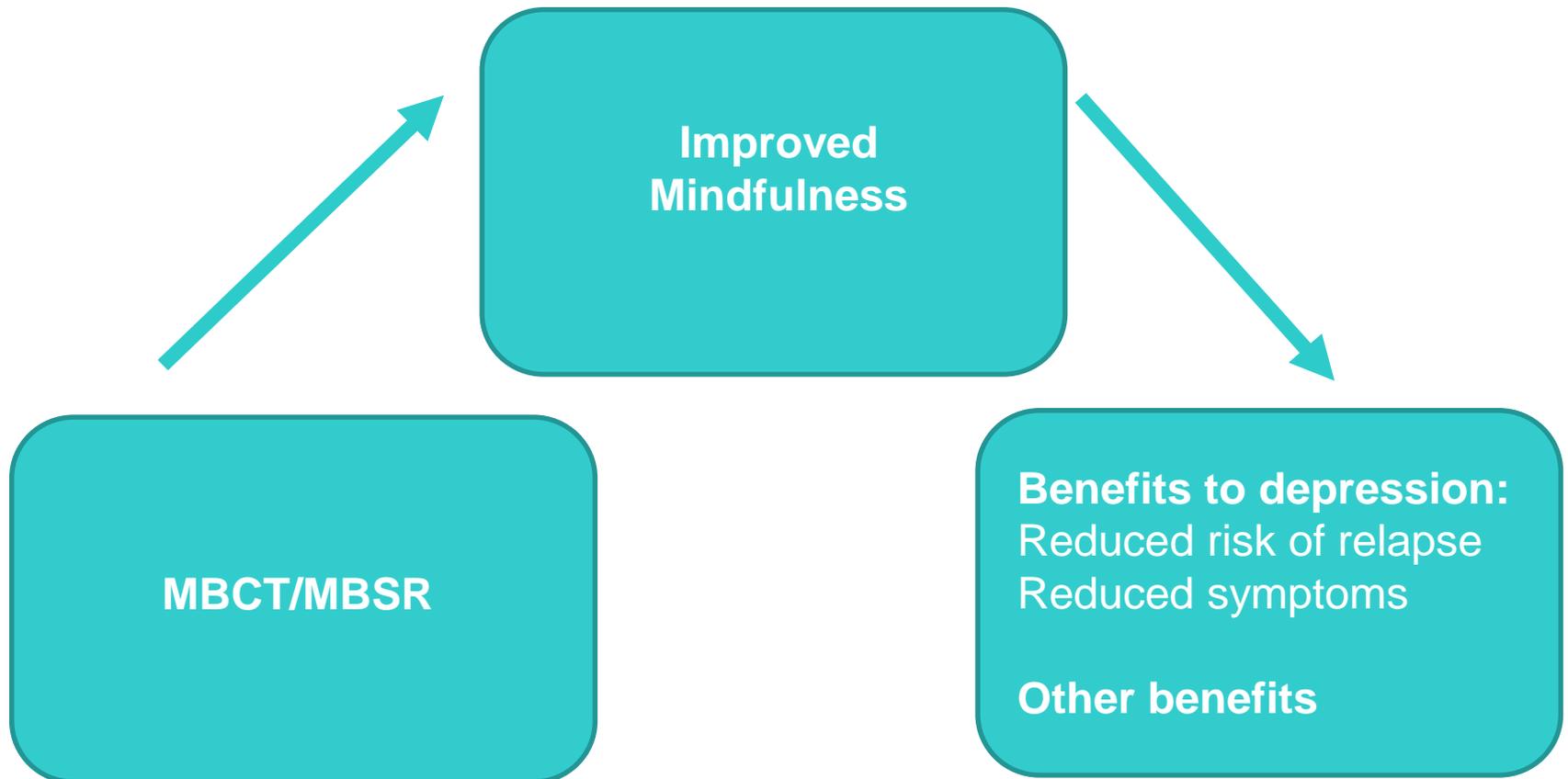
MBCT

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Reduced risk of relapse  
Reduced symptoms  
  
Other benefits"]; style A fill:#00A09A,color:#fff; style B fill:#00A09A,color:#fff; linkStyle 0 stroke:#00A09A,stroke-width:2px; linkStyle 0 stroke-dasharray:none;
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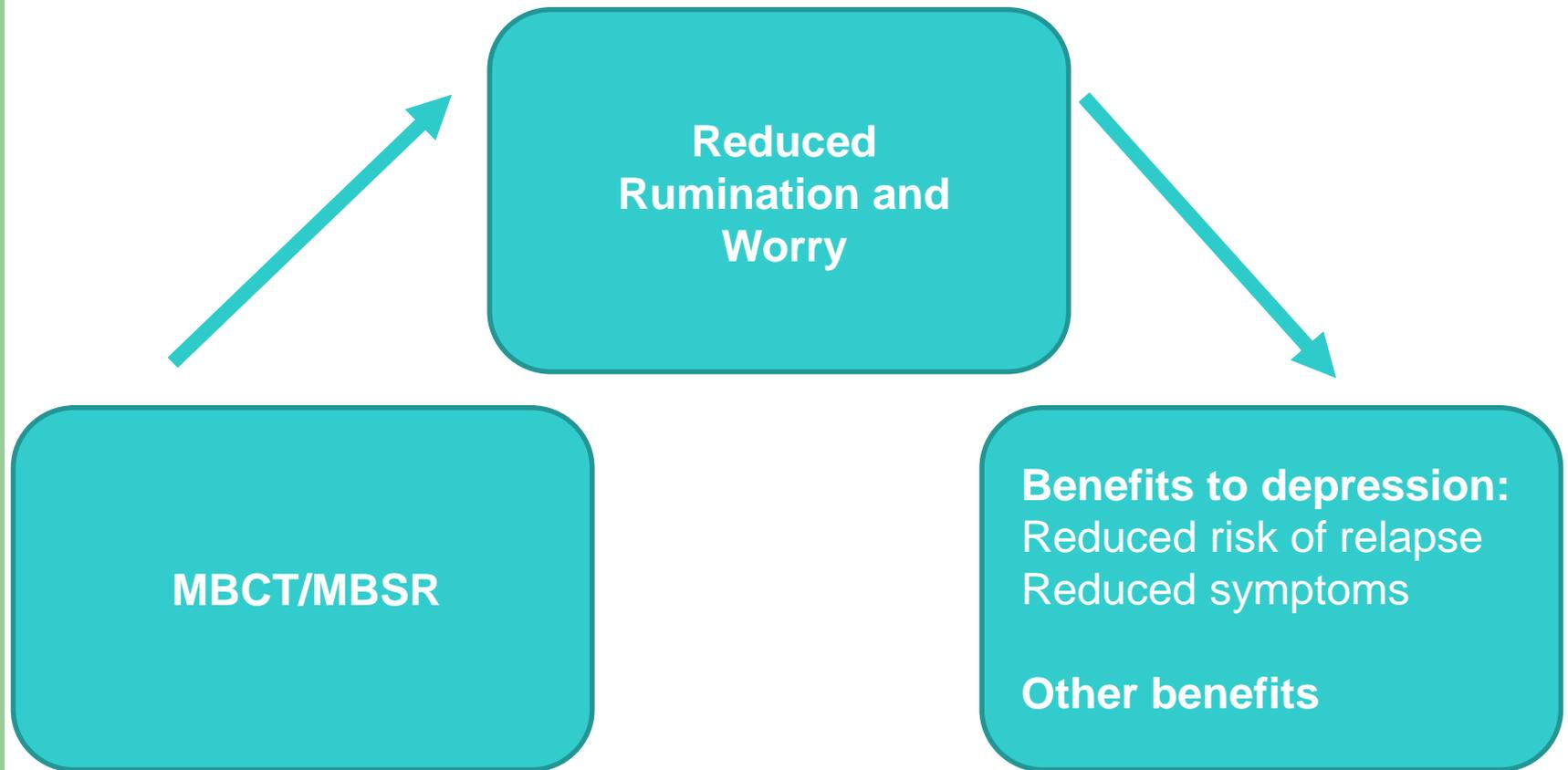
Benefits to depression:
Reduced risk of relapse
Reduced symptoms

Other benefits

Strongest evidence



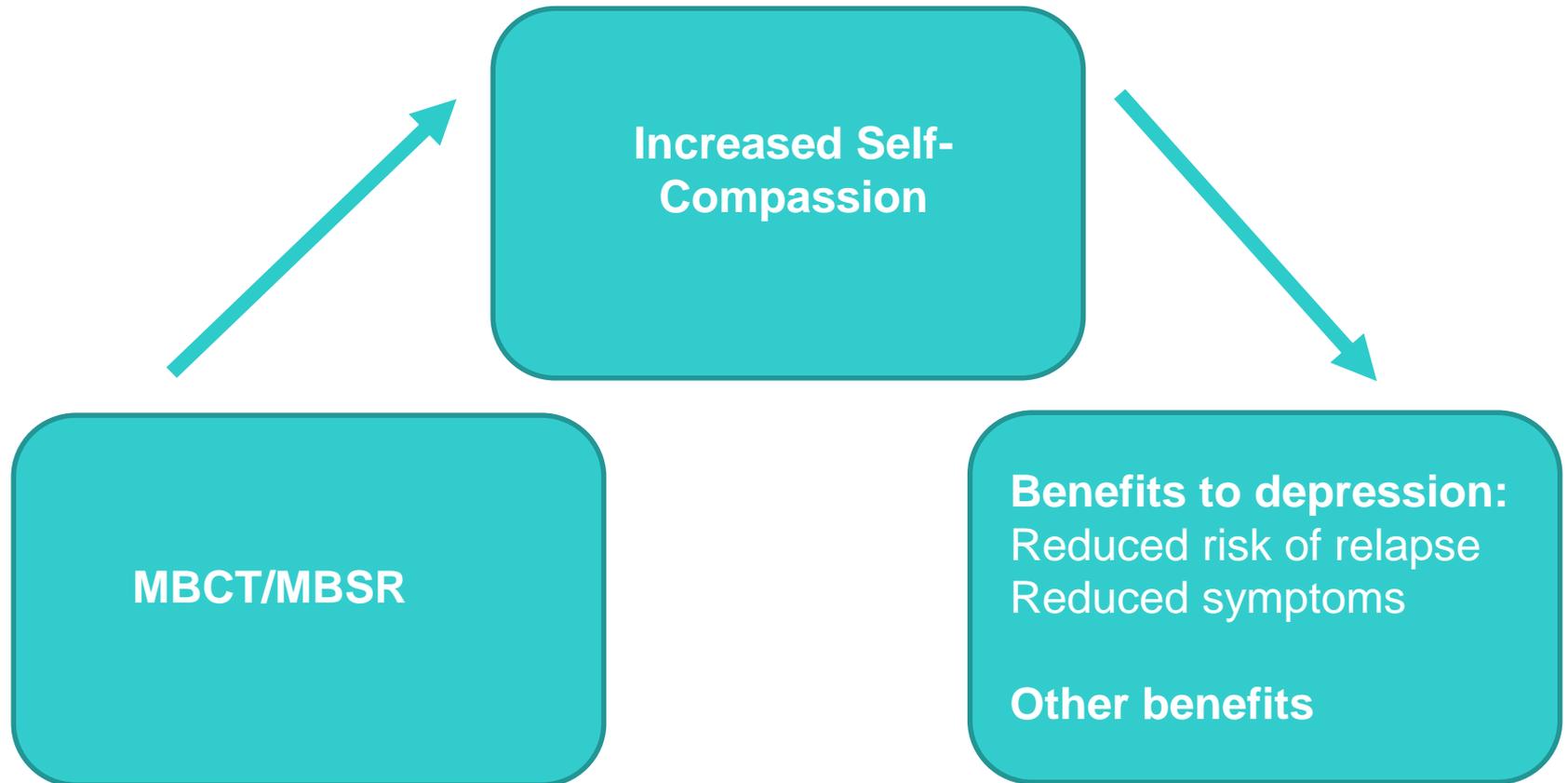
Strongest evidence



Rumination and Worry

- Rumination: “**repetitive and passive thinking** about one’s symptoms of depression and the possible causes and consequences of these symptoms” (Nolen-Hoeksema, 2003, p. 107)
- Worry: “**a chain of thoughts and images**, negatively affect-laden and relatively uncontrollable ... [that] represents an attempt to engage in mental problem-solving on an issue whose outcome is uncertain but contains the possibility of one or more negative outcomes” (Borkovec, Robinson, Pruzinsky, & DePree, 1983, p. 10).

Limited evidence



How does MBCT work?

The role of mindfulness practice

Home practice in Mindfulness-Based Cognitive Therapy and Mindfulness-Based Stress Reduction: A systematic review and meta-analysis of participants' mindfulness practice and its association with outcomes



Christine E. Parsons, PhD ^{a,*}, Catherine Crane, PhD ^b, Liam J. Parsons, MA ^c, Lone Overby Fjorback, PhD ^d, Willem Kuyken, PhD ^a

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Mindfulness-based stress reduction

Treatment engagement

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Homework

Adherence

Mindfulness practice

Meditation practice

ABSTRACT

Mindfulness-Based Cognitive Therapy (MBCT) and Mindfulness-Based Stress Reduction (MBSR) emphasize the importance of mindfulness practice at home as an integral part of the program. However, the extent to which participants complete their assigned practice is not yet clear, nor is it clear whether this practice is associated with positive outcomes.

For this systematic review and meta-analysis, searches were performed using Scopus and PubMed for studies published through to the end of 2015, reporting on formal home practice of mindfulness by MBSR or MBCT participants.

Across 43 studies ($N = 1427$), the pooled estimate for participants' home practice was 64% of the assigned amount, equating to about 30 minutes per day, six days per week [95% CI 60–69%]. There was substantial heterogeneity associated with this estimate. Across 28 studies ($N = 898$), there was a small but significant association between participants' self-reported home practice and intervention outcomes ($r = 0.26$, 95% CI 0.19, 0.34).

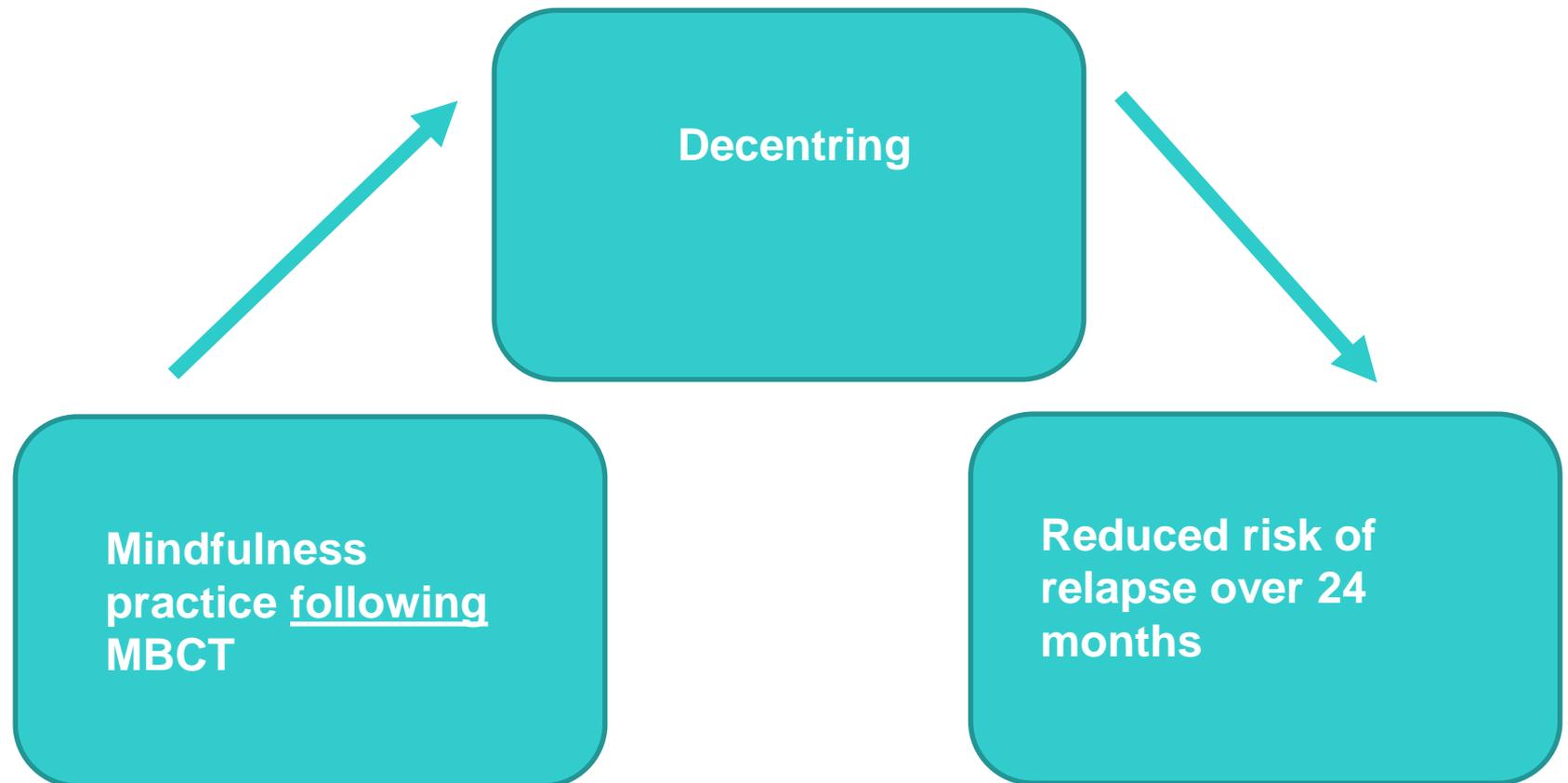
MBSR and MBCT participants report completing substantial formal mindfulness practice at home over the eight-week intervention, albeit less than assigned amounts. There is a small but significant association between the extent of formal practice and positive intervention outcomes for a wide range of participants.

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MBCT and MBSR: Meta-analysis of relationship between mindfulness practice and outcome

- 43 studies (n=1427)
- On average 64% of assigned practice completed during the course
- A significant association between amount of self-reported home practice during MBCT/MBSR and intervention outcomes – 7% of variation in outcome was accounted for by the amount of home practice

The role of sustained mindfulness practice



Segal et al, 2018

MBCT in Action

Whilst watching the video consider:

1. What patterns are the participants bringing that are implicated in depression?
2. How does the MBCT teaching process train new ways of relating to these patterns?
3. What is the teacher doing? How is she doing this?

The Implementation of Mindfulness-Based Cognitive Therapy: Learning From the UK Health Service Experience

Rebecca S. Crane • Willem Kuyken

“Even if a psychosocial intervention has compelling aims, has been shown to work, has a clear theory-driven mechanism of action, is cost-effective and is recommended by a government advisory body, its value is determined by how widely available it is in the health service.”

Implementation Guidance

<http://www.implementing-mindfulness.co.uk/>

Implementing MBCT

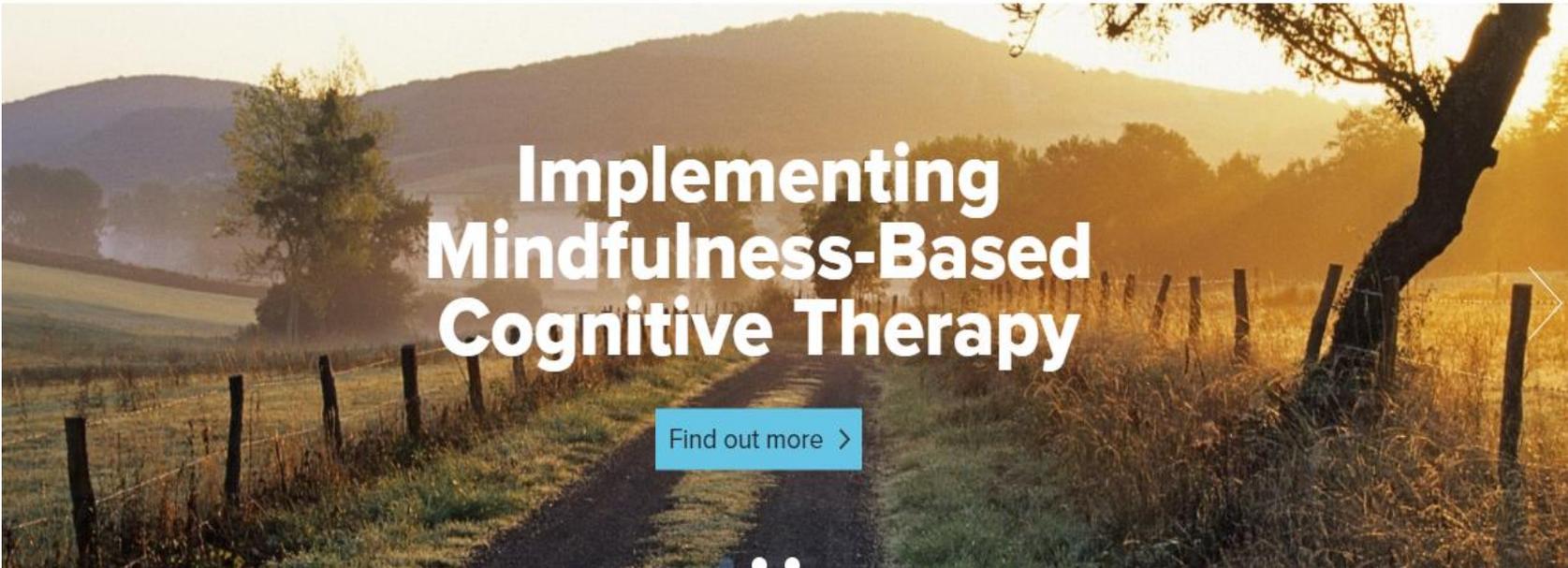
Home

Overview

Resources

Training, Mentoring and Supervision

Feedback



Implementing Mindfulness-Based Cognitive Therapy

Find out more >



MINDFUL NATION UK

Report by the Mindfulness All-Party
Parliamentary Group (MAPPG)

October 2015

Health care

Education

Criminal Justice

Work place

Thank you!

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