Mindfulness-Based Cognitive Therapy: A Potential New Alternative to Medication for Recurrent Depression

Kuyken W, Byford S, Taylor RS, et al. Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. J Consult Clin Psychol 2008;76:966–78.

Study Overview

Objective. To determine whether mindfulness-based cognitive therapy (MBCT) is therapeutically comparable to maintenance antidepressant medication (m-ADM) for the treatment of recurrent depression.

Design. Randomized controlled trial.

Setting and participants. Patients were recruited from primary care offices in Devon, England. Eligible patients were aged ≥ 18 years with a history of ≥ 3 previous episodes of depression treated with m-ADM over the previous 6 months and whose most recent depressive episode was in full or partial remission. Of 1469 patients assessed for eligibility, 362 were ineligible, 451 did not communicate with investigators, and 533 declined to participate (main reasons: time commitment, satisfaction with m-ADM, aversion to group therapy), leaving 123 patients for inclusion. Patients were randomized to either (1) MBCT, which consisted of 8 weekly group sessions lasting 2 hours each plus 4 follow-up sessions in the following year, and m-ADM taper or (2) continuation of m-ADM for the study duration. Participants were assessed every 3 months for 15 months.

Main outcome measures. The primary outcome measure was time to relapse/recurrence of depression, as defined by DSM-IV criteria. Secondary outcome measures included severity and duration of relapse/recurrence, residual depressive symptoms, quality of life, and overall costs (including direct treatment costs, other medical costs, and costs associated with time away from work).

Main results. 61 patients were randomized to MBCT and 62 to m-ADM. Among patients receiving MBCT, 75% were able to discontinue m-ADM over the first 6 months of treatment. The 15-month rate of relapse/recurrent major depression in the MBCT group was 47% compared with 60% in the m-ADM group (hazard ratio, 0.63; $P = 0.07$). There was no significant difference between the treatment groups in the severity or duration of relapses/recurrences. Patients receiving MBCT reported significantly fewer residual depressive symptoms (on 2 validated scales) and better quality of life (on physical and psychological scales) as compared with patients receiving m-ADM. Average annual costs did not significantly differ between the 2 groups ($2767 for MBCT vs. $2340 for m-ADM; $P = 0.79$).

Conclusion. MBCT may represent a valuable new tool in the treatment of recurrent depression. However, the newness of this treatment modality, the small scale of its employment to date, and the low rate of enrollment in this trial warrant further study prior to widespread adoption.

Commentary

Like other conditions predominantly seen in the primary care setting, depression is a common, debilitating, and chronic disease plagued by frequent relapses [1]. For patients who develop recurrent major depression, the rate of future relapse reaches 80% without long-term treatment [2]. Currently, m-ADM constitutes the predominant means of treatment for recurrent depression [3]; however, due to medication side effects and low m-ADM adherence, new approaches to treating recurrent major depression are needed [4].

MBCT is a new psychotherapeutic technique developed specifically for patients with recurrent depression, with the goal of preventing relapses [5]. MBCT is an 8-week program led by a trained therapist with 8 to 15 patients per group; each weekly group session lasts 2 hours. In prior studies, MBCT had been added to standard m-ADM with apparent benefit (ie, lower depression recurrence rates) for patients with 3 or more prior episodes of depression [6]. However, MBCT has not previously been studied as a substitute for m-ADM.

The current investigation by Kuyken and colleagues is the first randomized trial to compare the effectiveness of MBCT alone to standard treatment with m-ADM among patients with recurrent depression. Over 15 months of follow-up, patients receiving MBCT had a lower rate of relapse than those receiving m-ADM, although this difference did not reach statistical significance. Aside from lower residual depressive symptoms (as measured by the Hamilton Rating Scale for Depression and Beck Depression Inventory) and higher quality of life in the MBCT group, there were no significant differences in secondary outcomes between the 2 treatment groups. Total costs were similar between

the groups, and the authors estimated a greater than 50% probability that MBCT would be more cost-effective than m-ADM—if society would be willing to pay in excess of $1000 for preventing 1 additional relapse.

This study has some important limitations. First, the very low patient enrollment rate (11% after excluding known ineligible patients) suggests that study enrollees may not accurately represent the overall patient population with recurrent depression. Because they consented to participate in the trial when so many of their peers did not, enrollees may have had a special affinity for visit-based therapy (or a special aversion to m-ADM). Future trials with higher enrollment will be necessary to confirm the study's findings. Second, assessment of residual depressive symptoms was interview-based, and treatment could not be blinded. Third, because MBCT is such a new treatment modality, the therapists who employed MBCT were trained and supervised by the British team that developed MBCT. Because this level of expertise in training and supervision may not be reproduced in other settings, it is unclear whether MBCT would be of similar quality with widespread implementation (including in the United States).

Applications for Clinical Practice

For patients with recurrent depression, MBCT presents a potentially promising alternative to m-ADM, the problematic current standard of care. However, primary care physicians, mental health providers, and the health systems managers should wait for confirmatory, large-scale studies before using this treatment modality to prevent depression relapse.

—Review by Mark W. Friedberg, MD, MPP

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