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Review Article

Mindfulness-Based Cognitive Therapy for Depression

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ABSTRACT

Depression is an illness that restricts an individual's ability to work, eat, sleep, or enjoys a pleasurable event. WHO identifies depression as one of the largest illness in terms of morbidity with statistics reporting higher incidence of depression in women than men. Factors related to depression in India have not been different from the other parts of the world. A major shift is to develop promising brief interventions that would have high potential to expand under real life conditions is the need of the hour. Mindfulness-Based Cognitive Therapy (MBCT) is one such approach with promising effects as compared to other psychotherapies. Studies report MBCT efficaciously increases self-awareness, self-reflection, emotional wellbeing and functioning by equipping one with skills like acceptance, exposure, non-judgmental observation, cognitive flexibility, relaxation, and self-management. Thus, a client is helped to change depressive states. This therapy modality teaches the clients the necessary skills to disengage from habitual patterns of dysfunctional cognitive routines and help them to adapt a healthy behaviour.

Keywords: MBCT, Depression, Cognitive Therapy, Meditation-based therapy, Behaviour-Cognitive Models.

INTRODUCTION

WHO estimates depression to be the second largest illness in terms of morbidity with higher incidence among women than men (Waraich, 2004). Interestingly, about 2% of children and 5% of teenagers with depression do not get identified (Kessler, 1994) owing to lack of awareness in the society. It was found that South Asian women experience greater incidence of depression, approximating three times more than men owing to exposure to domestic and sexual violence, adverse childhood experiences and poverty(Patel, 1999&2006; Piccinelli, 2000).The prevalence among both genders is about equal in boys and girls, in fact slightly more in boys than girls(Kessler, 2001). However, during adolescence, depression seems to engulf a higher proportion of girls than boys and continues into adulthood and beyond, irrespective of countries, cultures but the difference decreases in old age (Rao, 2009).

Factors relating to depression in India have not been different from the other parts of the world. The differences in symptoms among age groups, however differ; children expressing irritability as against sadness expressed in adults and dysfunction as poor scholastic performance in children and poor work performance in adults (Bhargava,2005).The most common symptoms co-manifesting with depression reported in Indian studies are unexplained signs such as insomnia, clinical anxiety, suicidal ideation, and retardation, loss of insight, hypochondriasis, and gastro-intestinal. There are also cultural differences in exhibiting the symptoms of depression. A comparative study of depression in North and South India reported joylessness, disruption in social functioning, lack of self-confidence, disturbed appetite and sleep, restlessness, memory loss, and guilt in North India, whereas South Indian studies mainly reported hypochondriasis along with other symptoms. Similarly, other parts of the country reported heightened lack of interest and reduced self-confidence,

delusions and suicidal ideation was observed in comparison to South India (Bhugra, 1997).As regard to symptoms of depression in elderly population noted were sadness, low mood, somatic symptoms and signs, suicidal thoughts, early awakening, lack of energy, anxiety and tension, hopelessness and irritability with inability to fall asleep and disturbed sleep patterns (Rao, 1983).

Depression is one of the major mental health concerns of people and there are many therapy models are available based on different approaches. This paper highlights the Mindfulness-Based Cognitive Therapy. This research is done based on secondary data and the objective of this paper is to elaborate the causes, kinds, diagnostic criteria and to explain Mindfulness-Based Cognitive Therapy for depression.

Diagnostic criteria: Diagnostic and Statistical Manual (DSM) and International Classification of Diseases (ICD) as the two standard manuals for identifying and classifying mental disorders from the diagnostic symptoms. The DSM-5 gives the following criterion as the major symptoms to diagnose depression. The client should have five or more symptoms for 2-week time. The symptoms must cause some impairment in social, occupational, and other areas of functioning. In diagnosing this, the therapist needs to rule out substance abuse or another medical condition as the cause of the problem. ICD-10 also attributes similar symptoms and classifies further into mild depression (four symptoms) moderate depression (five to six symptoms) and severe depression (seven or more symptoms, with or without psychotic symptoms).

1. Depressed mood most of the day, nearly every day
2. Fatigue or loss of energy nearly every day.
3. Diminished interest or pleasure in all, or almost all, activities most of the day.
4. Disturbed sleep
5. Poor appetite leading to significant weight loss or increased appetite and weight gain.
6. Low self-confidence
7. A slowing down of thought and reduced physical movement observable by others.
8. Feelings of worthlessness or excessive or inappropriate guilt and self-blame.
9. Diminished ability to think or concentrate and indecisiveness.
10. Suicidal ideation without a specific plan, or a suicide attempt.

Causes of depression: Although there are various factors that contribute to depression among different category of people, for convenient sake it is presented in four categories: biological, cognitive, relationship and accidents.

1. Biological Factors: Some people are prone to depression biologically due to genetic conditions (Wells, 1992). Additionally, biological changes during puberty, pregnancy, childbirth, and menopausal transition increase the risk of depression due to hormonal fluctuation during these periods of growth and exposure to stressors. Puberty marks biological, psychological, and social challenges along with significant physical changes. Here, pressure from parents and peers, academics and career uncertainties serve as existing stressors. Pregnancy and childbirth increase vulnerability to pre and post-partum depression which when untreated may lead to major depressive disorders. Similarly, menopausal transition (MT) period is again a critical period for developing depression.

2. Cognitive Factors: Cognitive vulnerability is the way an individual responds to circumstances that greatly depends on his/her cognitive style, underlying individual differences, thinking processes, perception, knowledge, past experiences and expected outcomes. Cognitions such as low self-esteem, negative automatic thoughts, dysfunctional attitudes, cognitive distortions(Beck 1967), decreased self-control(Bandura, 1978) or

self-efficacy(Nolen-Hoeksema, 2000) are all attributed to a negative cognitive style(Abramson,1989) that exacerbate when an individual is exposed to constant unsupported stressors eventually dragging the individual to deep seated depression.

3. Relationship Factors: Problems with attachment, communication, conflicts, cohesion, and poor child rearing practices, rejection by family members, teachers and peers contribute to interpersonal problems that increase the vulnerability to depression (Rao, 2009). Added to that, childhood difficulties that arises from the world of children when they are emotionally fragile, their difficulty to understand and adjust with adults, sexual, emotional or physical abuse, dysfunctional upbringing, parental divorce/ death/ separation and many more which eventually shapes the child's temperament into adult personality (Simon, 1995).

4. Accidental Factors: A lot of social and psychosocial stressful incidents, acute psychological trauma, or exposure to childhood trauma, all increases the risk of clinical depression (Berk, 2013). When an individual experiences pressures such as discouraging life events on a daily basis, his/her past experiences influence his/her perceived thoughts and the emotion he/she attaches to it and tune his/her behaviour in response to the situation. Traumatic events like loss of a loved one, serious illness, divorce, bereavement, financial loss renders emotional instability and loses control of him/her (DA, 1993). Natural and catastrophic disasters like earthquakes, tsunamis, hurricanes, or manmade disasters like wars are major sources/causes of depression overruling age, gender, environment, genetics, or any other source.

Types of depression: Depression is a mental condition that restricts an individual's ability to work, eat, sleep, or enjoy a pleasurable event. It is the combination of heterogeneous symptoms that interfere with an individual's capacity to act (Iyer, 2012) but not all types of depression need medications. Some minor forms of depression can be treated with counselling and psychotherapies while severe ones such as MDD, mania, BPD, melancholia or TRD may need both pharmacotherapy and psychotherapies. The following are some of the classified common types of depression that can be easily helped by counselling and psychotherapy without medication. Though the given list of depressive disorders is not exhaustive, these may be considered as the major and most common ones.

Dysthymia is persistent depressive disorder, though less severe, does not disable an individuals' capacity to function but prevents the individual from functioning fully, resulting in a long-term condition with chronic symptoms (Iyer, 2012). This chronic form of depression can be diagnosed when the mood disturbance continues for at least 2 years in adults or 1 year in children (APA,2013). This kind of people may be described as having a low-spirited personality, constantly complaining or incapable of having fun.

Neuroticism is a personality type on the emotional extremes that wax and wane in response to some situations and positively linked to depression. Anxiety is the major defining feature of this depression. Hypersensitivity and hyper-vigilance to unfamiliar threats in a real/ perceived environment is a characteristic of this depressive neuroticism. Since neuroticism is not an illness, it cannot be effectively managed through counselling and psychotherapy (Charlton, 2000).

Malaise is a general feeling of being unwell and a symptom often associated with the condition of physical pain, psychological exhaustion, fatigue, prolonged tiredness, drained sensations. This is due to altered neurotransmitters and hormones that trigger sleep disruption/disturbance/ deprivation and unpleasant painful physical states (Charlton,2009). Some of these causes are more serious than others while a person with malaise is having trouble determining

the cause. If any physical symptoms are ruled out, it can be treated for depression.

Anhedonia otherwise called demotivated depression is caused by reduced ability to experience pleasure and positive emotions. The individual will have diminished interest in pleasurable activities like going on an outing, adventure, friendly gathering almost every day. This will further lead to loss of interest in life, its opportunities, its pleasure that results in lack of vitality. Introvert personality type people are more prone to this demotivated depression.

Seasonal Affective Disorder (SAD) is characterized by low mood that exacerbates at higher latitudes. As the name suggests, this is a type of depression that comes and goes in a seasonal basis. Individuals with SAD sleep excessively, may be tired after waking, sleepy throughout the day, increased appetite and sometimes resulting in weight gain. People with this depression are often asked to exposure themselves to sunlight especially in the early morning light (Charlton, 2009). Together with it, counselling and psychotherapy can help a lot to prevent relapse/ recurrence.

There following types of depression may need both pharmacotherapy and psychotherapies. Pharmacotherapy is the treatment of mental illness with the help of drugs whereas psychotherapy is done through verbal assistance.

Major depressive disorder that is characterized by discrete episodes of at least 2 weeks' duration or longer involving clear-cut changes in effect, cognition, and neuro-vegetative functions and inter-episode remissions (APA, 2013).

Maniac Depression or Bipolar Disorder where the suffering individual's mood switches from cycles of depression, elation, or mania with rapid dramatic episodes. The individual also suffers from affective processing cognitions such as thinking and judging, and in social behaviour that may sometimes be embarrassing (Iyer, 2012).

Melancholia is a form of endogenous depression with psychotic features such as hallucination, thought disorder, catatonia, delusion, and psychomotor retardation. It could be an unconscious reaction to loss which is marked by decreased self-esteem or a feeling of guilt (Charlton, 2009).The individual show diminished self-care and suicidal tendencies with profound sadness, despair, emptiness and guilt, slowed speech and movement.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

Mindfulness is defined as the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmental to the unfolding of experience moment by moment. Mindfulness therapy is built on the philosophy that all human beings have an inherent capacity for mindfulness. This inherent tendency of humans are not fully utilised due to the daily demands of life in keeping up specific standards, face values, stressors, and exposure to unforeseen events; added to that greed, hatred and ignorance too inhibit the natural capacity (Hofmann, 2017). When humans focus on the internal self, realize the truth of unnecessarily engaging in self-critical, ruminative, worrying, negative thoughts and emotions. Therefore, mindfulness therapy is focused on understanding the phenomenological nature of mind, emotions and sufferings that lead to potential release in the form of maladaptive behaviours and endorses a compassionate quality that enables one to cultivate and refine our inherent capacity of being mindful in all aspects of life (Kabat-Zinn, 2003).

Mindfulness therapy: Mindfulness based interventions (MBI) in psychotherapy or counselling model that integrates the eastern concepts of meditation and western concepts of cognitive and behavioural practices. For example, interventions like the Dialectal Behaviour Therapy (type of cognitive behavioural therapy) uses

mindfulness as a component of intervention. The most researched mindfulness intervention that was presented with empirical evidence was Mindfulness-Based Stress Reduction (MBSR) developed by Jon Kabat-Zinnin 1980. Similarly, mindfulness-based relapse prevention (MBRP) is used for drug and addiction and mindfulness-based relationship enhancement (MBRE) to address conflicts in relationships (Bowen, 2014; Carson, 2004).

Mindfulness and CBT are similar in the sense that both work on reducing psychopathology using combination of cognitive and behavioural exercise. They both work on desensitize conditioned fear responses. They view one's internal experiences of thoughts, feelings and sensations to identify the maladaptive behaviour and work on relaxation and improve self-regulation (Baer 2003). Both focus on changing one's perspective of unpleasant thoughts, feelings and sensations (Hofmann, 2017).However, there are differences between the two. Mindfulness works on sustained attention to desensitize conditioned fears, CBT directly severe conditioned responses through exposure-based processes (Hofmann, 2008). Instead of challenging the maladaptive cognitions, mindfulness focuses on accepting the thoughts, feelings, emotions, and sensations even if they are painful and full of misery (Ellis,1980; Longmore, 2007). CBT is goal oriented to strive reduce maladaptive behaviour whereas mindfulness works on cultivating an attitude of non-striving to achieve goal. (Baer, 2003)

Mindfulness training was initiated as a group therapy with 8-12 people in a group attending a 2-hour session across 8 sessions by Kabat-Zinn. He combined the psycho-educational aspects of CBT and integrated with mindfulness meditation that originated from the eastern tradition (Kabat-Zinn, 1990). Segal, (2002) designed an eight 2-hour session. During the course, the first hour of the 2-hour session, is dedicated to meditation techniques and a one hour to structured Cognitive and Behavioural practices along with daily homework.

Themes of therapy: Both Zinn and Segals's approach towards using MBCT focused on four overarching themes, they are: 1. Control. 2. Acceptance. 3. Relationship. 4. Struggle. In the case of depression, control describes the perception and evaluation of thought and feelings as a personal agency that makes the client feel helpless. MBCT teaches to discern such views and facilitates an individual from a helpless passive self to an active effective self, enabling one to identify triggering sources and warning signs signalling remediation thus changing focus intentionally and deliberately plan action. As far as acceptance is concerned, the clients are taught that depressive thoughts and feelings as not their thoughts, they are due to a treatable illness and not their fundamental self. Instilling a non-judgmental attitude towards depressed mood as a temporary state that would pass, the clients are provided rationale to accept self-worth. By encouraging relationship client is given awareness in interpersonal relationships and a sense of legitimacy to reduce self-blame, self-devaluation, and guilt. This concept of improved interpersonal relationship helps the clients to have better bonding, improved communication and empathy with family and friends enhancing positive thought process. It is a real struggle for a client to come out of strong associations with low moods and belief systems that they have developed in the curse of time. Mindfulness practice enables them to shift to a neutral focus to step out of the mind-churning maps, acting and plan effective problem solving. Thus, mindfulness based therapies have reported increased self-awareness, self-reflection, emotional wellbeing and functioning altering depressive states by equipping one with skills like acceptance, exposure, non-judgmental observation, cognitive flexibility, relaxation and self-management reduced psychological and /or

cognitive dysfunction and/ or impairment and reduced depressive states and changed behaviour.

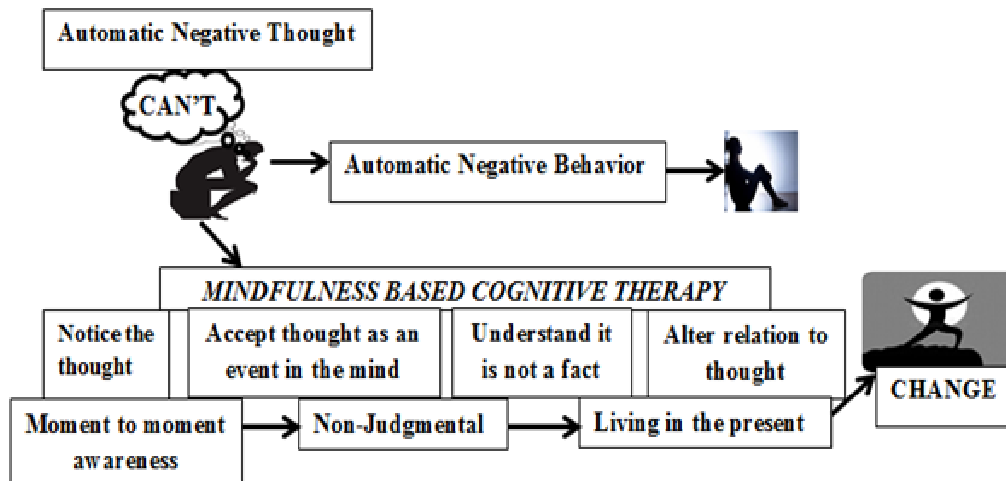

Figure 1: MBCT therapy process (Rizwana, A., 2020)

Benefits of MBCT: Individuals realize the effect of mindless, habitual, automatic wandering thoughts that have become chronic leading to depression. The therapy enhances the quality of consciousness with clarity and vividness of current experiences and functioning. The clients are made to disengage from chronic ruminating, mindless thoughts by engaging in informed self-endorsed behavioural regulations. They are made aware that thoughts are mere mental events rather than self-evident truth bringing into an individuals' awareness that thoughts are not facts. The clients are trained in restructuring and disputing thoughts and cognitions by acquiring new functional ways to deal with negative thoughts, emotions, and feelings.

The mindfulness meditation in MBCT help clients to interrupt ruminative cognitive-affective processes that underlie depression and Treatment resistant depression by training them to change the relationship to one's thoughts and dealing transiently through conscious/ intentional attention and reasoning, as against CBT's approach of challenge one's thoughts and working on ways through cognitive restructuring.

Limitations of MBCT: The limitations of MBCT are it requires a sizable commitment from patient and therapist. Also, the method and skill that cannot be sustained unless practiced for a long period. Though mindfulness state is difficult to achieve, once achieved, it equips one with high cognitive flexibility, insight, self-regulation (Brown, 2003).

CONCLUSION

Human beings perceive the world constantly through our senses, thoughts and actions incarnating a conscious self. Therefore, it is common to feel sad, have mood swings, disappointments, negative thoughts, leading to depression. MBCT was popularised by two groups of psychologists, Kabat-Zinn and Zindel Segal, John Teasdale and Mark Williams. The focus was to address vulnerabilities to depression. MBCT was developed from a model of cognitive susceptibility of individuals who have different patterns of negative thinking. MBCT is a therapy model focused as a group-therapy program. MBCT encourages individuals to become more aware of their thoughts, feelings, and bodily sensations and to change the ways in which they relate to these thoughts. In therapy, individuals are encouraged to view their thoughts as passing events in the mind, rather than treat them as reality so that they can easily come

out of their depressive thought pattern. The supportive meditation helps the clients to concentrate and focus their mind on the thought process. MBCT is easy to learn and practice with promising effects as compared to other psychotherapies.

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