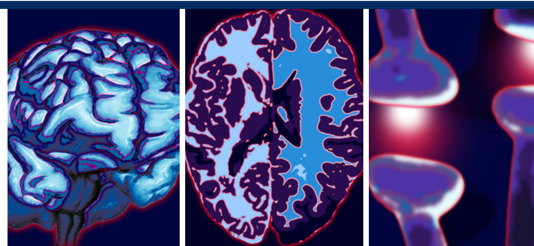
EDITORIAL



Is it medication versus mindfulness in prevention of depression relapse?

“When trying to help patients decide what strategies they can use to stay well, the data suggest MBCT and maintenance medication should be in our mental formulary. Are those choices mutually exclusive? The answer is no, and probably emphatically no.”

Peter J Bieling†

Mindfulness-based cognitive therapy (MBCT) is still a relatively new, standalone treatment for the prevention of relapse in depression. Combining about equal parts of mindfulness (Vipassana) meditation and cognitive behavioral principles, the treatment is 8 weeks of 2 h sessions for a group of remitted participants that can range in size (8–15 would be typical). The group itself involves the experience of meditation, a certain amount of ‘chalk-board’ talk, and discussion of participants’ experiences with meditating. Those experiences are considerable; it is expected that people in the group meditate for an hour a day as part of homework by listening to instructions and writing down their experiences. For some patients the foregoing is a recipe for hopefulness in tackling their own problems, for others it can seem like a daunting challenge. This will be discussed in more detail later.

Since 2000 there have been four randomized controlled trials (RCTs) to test the efficacy of this approach for relapse prevention; two early studies suggested a 50% reduction in relapse for patients receiving MBCT compared with treatment as usual [1,2]. A more recent study found no difference in relapse outcomes when MBCT was compared with maintenance pharmacotherapy. The design of this larger study was as much about real-world effectiveness as it was efficacy [3]. Finally, a recent trial, in which the author was a team member, compared maintenance antidepressant medication to MBCT, as well as placebo, after patients had been treated for an acute episode of depression within the study. Only participants who stayed remitted for 6 months were randomized to one of the three study ‘prevention’ arms and we followed those participants for another 18 months to track the study’s main outcome – relapse. This then was a rigorous head-to-head test of these treatments, under very tight experimental control. Our group found that patients who had an unstable remission showed a 73%

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reduction in relapse risk in both the MBCT and antidepressant groups compared with placebo, with no differences between the MBCT and antidepressant groups [4]. These results encourage us in suggesting that MBCT is a reasonable alternative to maintenance medication for keeping people well. We are also finding, similar to other groups with similar study designs, that people who are treated with MBCT develop capacities to see their thoughts in a different, 'wider' way and that growth in self-compassion seems to mediate the efficacy of MBCT [Bieling PJ, Hawley L, Bloch R *et al.*, Unpublished Data] [5,6].

Antidepressants versus MBCT: what is at stake?

It has been particularly important that MBCT subject itself to the scrutiny of the head-to-head RCT with the gold-standard treatment for a number of reasons. The obvious one is that the RCT is the only design that proves the stand-alone efficacy of a treatment in producing an outcome and allows us to compare the size of the outcome. This is arguably even more important when a treatment has the word meditation in its title. At worst, that word conjures ontological themes that will make both providers and patients shy away from 'going there'. At best, meditation is associated with alternative medicine, faith healing, spas and supplements. For MBCT to be taken seriously and shed some of the stigma that comes with the concept of meditation, it needs to compete in the trial arena and fight it out. However, if the question of efficacy starts to be settled, does a fight need to continue?

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Before getting to the answer, consider another reason that the community of depression clinicians can sometimes feel vulnerable and concerned about recommending new treatments. Any serious reader of the entire body of data and opinion on the efficacy of antidepressant medication cannot avoid the debate about the efficacy of these medications. We can be plagued with doubts. Why is the placebo effect in treatment studies for depression so strong? Why do the medications not beat this placebo effect convincingly or soundly in any trial we read (let alone those that do not get published)? We know that nonspecific factors are probably an important part of changes in symptoms we see in studies, and that effect is not confined to antidepressants. When it comes to treating acute depression, there is evidence that a number of psychotherapies, some of which are very different from one another, are almost equally effective for symptom reduction [7]. This should worry the academic and clinical community, it is a huge conundrum facing our field and collectively we would probably agree that finding a treatment that would beat all other current treatments would be an important breakthrough.

Meanwhile, the world goes on. Every day, the epidemiology suggests that the burden of depression grows larger. We need to help our patients make choices today, about what treatments to pursue and what not to pursue, and we cannot ignore the evidence in making those recommendations. When trying to help patients decide what strategies they can use to stay well, the data suggest MBCT and maintenance medication should be in our mental formulary. Are those choices mutually exclusive? The answer is no, and probably emphatically no. The one versus the other line of thinking is a carry over from the RCT and it is not necessary. Our center, a tertiary mood disorders clinic, runs a regular MBCT program in which a good 90% of participants come to us on an antidepressant regimen. For many, the dosage and types of medications have been years in the making. Most patients are grateful to be on a combination of medicine that their provider feels is as effective as possible. And patients have often done their own form of work to accept some of the inevitable compromises of a long-term medication regimen. In our groups they learn on the first day that MBCT is hardly 'anti' antidepressants. Quite the opposite, we describe the strategies we use as working at a different kind of level within an interconnected system. So, to a great extent, the issue of this or that is settled before it even begins, it is both.

However, there are two other scenarios to consider and these are more complex than the combination camp. There will always be a group of patients, it seems, who are reluctant about taking medication for an extended period, perhaps owing to reservations regarding side effects, costs or the desire to simply be drug free if possible. For these people, we can say that at least in very carefully screened populations, MBCT offers as much protection as maintenance antidepressants for 18 months. As the case gets more complicated, and the time-frame increases, we have less information. Sometimes the best one can hope for in these scenarios is the 'MBCT alone' strategy, but have the patient accept that,

if the protective effect begins to wane, they need to be open to restarting medications. This would seem to be a reasonable balance between self-determination and clinical responsibility, but it is not an easy scenario.

For others, 'both' is not going to be an option because of the commitment that MBCT requires. We, of course, do not see these people in our MBCT service by definition, but their concerns are understandable. The time required is fairly extensive, arguably more than most other 'talking therapies' when one considers the at home practice. Moreover, reluctance around the concept of meditation needs to be taken seriously and at the very least talked through. In our experience, strong invocations to 'just give it a try' by enthusiastic referrers have not led to great compliance, the modality must meet the person at some stage of readiness and openness. In this scenario, our colleagues sometimes tell us that a patient could really use the techniques and they know this because, at least in part, the patient is so reluctant to consider meditation. We know what they mean, but have no easy answers. We always keep the door open to meet with potential group participants to informally discuss the pros and cons. However, in the real world it must be acknowledged that MBCT will not be for everyone.

Big challenges remain before us, for example, would a combination of MBCT and maintenance medication perform better than either treatment alone in preventing relapse? However, the news is fundamentally good. For us and our patients, we now have two good choices of intervention types for prophylaxis. Furthermore, the two types of intervention are different enough and appealing in different ways that it seems certain that more and more people will have the chance to undertake a treatment that we know will help keep them well.

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Bibliography

1. Teasdale JD, Segal ZV, Williams JM, Ridgeway VA, Soulsby JM, Lau MA: Prevention of relapse/recurrence in major depression by mindfulness-based cognitive therapy. *J. Consult. Clin. Psychol.* 68, 615–623 (2000).
2. Ma SH, Teasdale JD: Mindfulness-based cognitive therapy for depression: replication and exploration of differential relapse prevention effects. *J. Consult. Clin. Psychol.* 72, 31–40 (2004).
3. Kuyken W, Byford S, Taylor RS *et al.*: Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. *J. Consult. Clin. Psychol.* 76, 966–978 (2008).
4. Segal ZV, Bieling PJ, Young T *et al.*: Antidepressant monotherapy versus sequential pharmacotherapy and mindfulness-based cognitive therapy, or placebo, for relapse prophylaxis in recurrent depression. *Arch. Gen. Psychiatry* 67, 1256–1264 (2010).
5. Green SM, Bieling PJ: Evaluating mindfulness-based cognitive therapy in a mood and anxiety service. *Cogn. Behav. Pract.* (2011) (In Press).
6. Kuyken W, Watkins E, Holden E *et al.*: How does mindfulness-based cognitive therapy work? *Behav. Res. Ther.* 48, 1105–1112 (2010).
7. Cuijpers P, van Straten A, Andersson G, van Oppen P: Psychotherapy for depression in adults: a meta-analysis of comparative outcome studies. *J. Consult. Clin. Psychol.* 76, 909–922 (2008).