

Mindfulness-Based Cognitive Therapy and Emotion Focused Therapy as Treatments for Major Depression

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INTRODUCTION

In this paper, I summarise the symptomology and treatment options for Major Depressive Disorder (MDD), and then examine two specific treatment approaches: Mindfulness Based Cognitive Therapy (MBCT) and Emotion Focused Therapy (EFT). I will compare the evidence base and efficacy of each model, and reflect on their relative strengths and weaknesses in treating MDD.

MAJOR DEPRESSIVE DISORDER (MDD)

The symptoms of MDD are identified in the Diagnostic and Statistical Manual (5th Edition) as a markedly depressed mood and/or a loss of interest or pleasure in life, nearly all day, every day, for at least two weeks (American Psychiatric Association 2013). In addition, patients will have at least four of the following seven symptoms: a significant change in appetite or weight; significant change in sleep pattern; observable psychomotor agitation or retardation; fatigue; feelings of worthlessness or inappropriate guilt; loss of ability to concentrate; and recurrent thoughts of death or suicide (American Psychiatric Association 2013).

For the diagnosis to be valid, the symptoms must be significant enough to cause impairment in the person's functioning, and not attributable to another medical condition, substance use, or mental disorder, such as bipolar disorder or psychosis (American Psychiatric Association 2013).

Some patients with MDD present with a bright façade, or experience a temporary lift in mood during positive events (World Health Organisation 2004/2010, p146), but most of the time they experience a significantly lowered mood and negative outlook. Depression may be classified as mild (4-5 symptoms), moderate (6-7 symptoms) or severe (8-10 symptoms). In severe cases, the person will have markedly impaired functioning, somatic features and possibly psychotic delusions or hallucinations (World Health Organisation 2004/2010, p147).

Major depression is a serious disorder, which carries a lifetime risk of 20% for males and 25% for females (Parker 2002/2004, p6). Up to 75% of patients who have one episode of MDD will have, on average, a further eight episodes (World Health Organisation 2004/2010, p149), and the risk of suicide increases with the severity and frequency of relapse (Parker 2002/2004, p142).

TREATMENT OPTIONS FOR MDD

While milder forms of depression may resolve with minimal or no intervention (Parker 2002/2004, p20), 'clinical' or major depression generally requires medication and possibly also electroconvulsive therapy (ECT) (Parker 2002/2004, p22).

Many experts, including Bates (2011), Shreeve (2005), and the World Health Organisation, recommend psychotherapy as an adjunct to antidepressant medication, to strengthen the patient's coping skills and reduce the likelihood of a relapse (World Health Organisation 2004/2010, p155).

Research by the Black Dog Institute in Sydney has determined that a number of personality traits contribute to the onset and course of depressive disorders. These are: anxious worrying, irritability, social avoidance, personal reserve, self-criticism, perfectionism, interpersonal sensitivity, and self-focus (Parker 2002/2004, p59).

While recognising that biological factors play a significant role in MDD, and that stressful life events, particularly in childhood, add to the likelihood of a depressive episode, Parker's recommendation is for contributing personality factors to be addressed via psychotherapy, in addition to treating the biological factors with medication (Parker 2002/2004, p59).

I will now examine two forms of treatment that might help patients with MDD develop better forms of self-management, reduce or eliminate the need for long-term medication, and prevent further relapse.

MINDFULNESS-BASED COGNITIVE THERAPY (MBCT)

MBCT is a relapse prevention program developed by a group of cognitive psychologists, who applied the methods of Jon Kabat-Zinn's Mindfulness-Based Stress Reduction (MBSR) training to patients with a history of MDD. These psychologists, Segal, Williams and Teasdale (2002/2013), saw parallels between MBSR and cognitive behaviour therapy (CBT). They combined elements of both in a mindfulness program specifically for patients with a history of MDD (Segal, Williams & Teasdale 2002/2013, p5).

Segal et al identified that negative, ruminative thinking habits were more common in patients whose depression relapsed, and recognised that MBSR training helps people switch to a 'decentred' mode of thinking (Segal et al 2002/2013, p36), which enables them to disengage from their negative thoughts. Mindfulness involves developing an attitude of welcoming and allowing the full range of one's thoughts, sensations and feelings, from a mental orientation of 'being' rather than 'doing' (Segal et al 2002/2013, p58).

Kabat-Zinn defines mindfulness as 'the awareness that emerges through paying attention on purpose, in the present moment, and non-judgementally, to things as they are' (Kabat-Zinn 1990, p29). It is important to note that MBCT does not attempt to analyse or change a patient's thoughts, as regular cognitive therapy would do. Instead, it offers to teach people a new way of relating to their thoughts (and other experiences): one of observation and gentle acceptance; so that, through practice, they can cultivate this attitude towards themselves and their problems (Segal et al 2002/2013, p89).

MBCT follows the 8-week group format of regular MBSR, and incorporates the same core themes and exercises. It teaches participants to observe their 'driven-doing' mode of thinking, learn to let that go, and adopt an accepting attitude towards what comes into awareness.

In MBSR, the attitudes that are taught and encouraged are: non-judging, patience, beginner's mind, trust, non-striving, acceptance and letting go (Kabat-Zinn 1990, p33-40). MBCT replicates this, and the instructor's role is to model all these qualities to participants, particularly kindness and compassion (Segal et al 2002/2013, p137). This avoids presenting self-compassion as another 'thing' participants must do, and instead encourages this attitude in the practice of mindfulness.

A key difference between MBCT and standard cognitive treatment is that it 'does not provide a solution to anyone's problems, including depression' (Segal et al 2002/2013, p145). Hence, it is clearly an educational tool, and the authors acknowledge it is applicable for patients not currently suffering MDD, who have experienced three or more previous episodes, and so are at risk of relapse (Segal et al 2002/2013, p97).

The program teaches participants to meditate, by paying attention to their thoughts, feelings and sensations, through observing the breath, mind and body. The basic technique, which the authors acknowledge is only learned through many hours of practice, is to bring the awareness back to the chosen focus, gently and patiently, every time it wanders off. Participants are encouraged to notice all the mental habits that take the focus off the present moment, and then return their focus to the breath.

The groups include both experiential exercises and feedback discussions. In the latter, facilitators help identify the mental habits such as self-blame, self-criticism, dwelling on the past or the future, etc., which contribute to depressive thinking, and model a spirit of inquiry and acceptance of 'things as they are' (Segal et al 2002/2013, p253). 'The core skill to be learned is how to exit... these self-perpetuating cognitive routines... freeing oneself from the need for things to be different' (Segal et al 2002/2013, p89).

The MBCT program requires participants to practice mindfulness exercises every day at home, to gradually build these new mental habits. The authors stress that commitment, patience and perseverance are needed, and add that cultivating a kinder, gentler attitude towards themselves is 'one of the most important things people learn from an MBCT program' (Segal et al 2002/2013, p137). Rather than teaching self-compassion in a didactic way, MBCT models and invites participants to try this new way of viewing life and the self.

MBCT, like MBSR, has an impressive evidence base. A number of randomised controlled trials found that MBCT significantly prevented relapse of MDD in patients who had experienced three or more episodes (Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau 2000). The relapse rate for one MBCT group was 37% compared to 66% in the control group (Segal et al 2002/2013, p397).

In a 2004 study, MBCT reduced relapse from 78% to 36% in patients with three or more episodes of MDD (Ma & Teasdale 2004). A meta-analysis in 2010 reviewed 39 studies of MBCT and found an overall effect size of 0.95 for improving mood symptoms in the 1,140 patients who received MBCT (Hoffman, Sawyer, Witt & Oh 2010).

MBCT has been shown to be as effective as continuing with antidepressant medication in preventing relapse, and 'more effective than medication in reducing residual depressive symptoms... and improving quality of life' (Segal et al 2002/2013, p403).

However, the research showed one important and curious result: that MBSR is *less* effective, and possibly even detrimental, with patients who have experienced only one or two previous episodes of MDD. The authors speculate that patients in this category may come from a different 'base population', whose depressive episodes started later in life, and are triggered more by external conditions than those whose episodes appear 'out of the blue' (Segal et al 2002/2013, p401).

Contraindications for using MBCT with MDD patients are therefore: 1) if they are currently experiencing an episode of depression; and 2) if they have had only one or two previous episodes. Segal et al acknowledge that the home practice requirements could be a deterrent to some patients, and state: 'those who are most prone to ruminate and/or avoid difficult experiences are most likely to drop out early' (Segal et al 2002/2013, p99).

EMOTION FOCUSED THERAPY (EFT)

EFT was developed by Greenberg and others at York University, Toronto, in the 1980s. It came out of extensive research into the process of therapeutic change, which demonstrated a significant correlation between positive outcomes and the following factors: empathy, therapeutic alliance, depth of experiencing, emotional arousal, making sense of aroused emotion, and productive emotional processing (Greenberg 2010, p32).

EFT's treatment model combines a collaborative, empathic relationship with appropriate therapeutic processing of the client's emotions, and the integration of new meaning (Elliot, Watson, Goldman & Greenberg 2004, p34). EFT is neo-humanistic and experiential. It holds that emotion is biologically adaptive, and assists humans to process information and choose appropriate actions. Emotion also co-ordinates and unifies experience, informs cognitive processing, and is crucial to meaning construction (Elliot et al 2004, p24).

EFT postulates that emotional experiences that are repeated become established as habitual neural patterns or 'emotion schemes' in the person's implicit and explicit memory. Emotion schemes are defined as 'complex self-organizing processes which are continually constructed and reconstructed from moment to moment' (Elliot et al 2004, p26).

EFT distinguishes between adaptive emotions, which help a person understand and deal with their experience, and maladaptive emotions, which are unhelpful and repetitive. While maladaptive emotions should be accepted but not dwelt upon, adaptive emotions need to be accessed and explored for their usefulness in reorganizing meaning and behaviour (Greenberg 2010, p34). Thus, EFT explicitly helps patients to 'approach, accept, tolerate and symbolize emotions, rather than avoid them' (Greenberg 2010, p35).

In EFT, depression is seen as a reaction stemming from an 'emotional disorder of the self'. It postulates that patients suffering from MDD carry an emotion scheme of a 'powerless, hopeless, weak/bad self-organization', in which the sense of self has been encoded as 'worthless, bad, incompetent and inadequate' (Greenberg, Watson & Goldman 1998, p231).

Greenberg et al have observed, in both practice and research settings, that depressed patients commonly manifest self-critical splits, self-interruptions and unresolved feelings regarding unfinished business with significant others. They tend to engage in escalating cycles of secondary self-criticism, which further evoke core maladaptive schemes of failure and loss (Greenberg et al 1998, p229-32).

In the treatment of MDD, EFT recommends establishing a strong therapeutic alliance, to the extent that 'the personhood of the client is never made subservient to the task or goal' (Greenberg et al 1998, p234). Empathy and interpersonal support are thus critical in providing worth and care to the patient, as a modeling tool, a corrective emotional experience, and a platform of security for the therapeutic work.

In this context, emotional processing tasks will include identifying and processing self-critical splits, self-interruptions and unfinished business. In EFT, all parts of the self are validated and listened to, and patients are supported to resolve their inner conflicts through dialogue, emotional expression, understanding and compassion (Greenberg 2002, p246). Learning to soothe the hurt, discouraged parts of the self is a key element in developing integration and self-acceptance (Greenberg 2002, p205).

EFT for depression focuses on helping clients process their emotional experiences so they can access primary adaptive emotional responses to situations (Elliot et al 2004, p288). It also aims to develop clients' capacity for self-regulation and self-compassion, through contacting their primary emotional needs and facilitating a new relationship to the self. This is not done prescriptively, but through an empathic exploration of the client's experience (Elliot et al 2004, p48).

Research studies have shown EFT to be more effective in treating MDD than client-centred therapy. Exponents of EFT suggest this may be due to the deeper levels of emotional experiencing and increased emotional expression in EFT, which allow clients to reach a greater resolution of their cognitive-affective problems (Greenberg et al 1998, p241). A clinical trial of EFT in Germany, with 412 moderately to severely depressed patients, showed a significant pre-post effect size of 1.05, 22 months after treatment had ended (Elliot et al 2004, p49).

Angus & Greenberg cite three separate studies, from 1998, 2003 and 2006, that found EFT to be 'equally or more effective than both client-centred and cognitive behaviour treatment for MDD (Angus & Greenberg 2011, p13). In a 2009 study, EFT was demonstrated to be highly effective in preventing relapse of depression, producing a 77% non-relapse rate (Angus & Greenberg 2011, p13).

The evidence base of EFT has grown steadily over the past 25 years, and major depression is one of the disorders for which it has shown repeated effectiveness. It generally involves 10, 20 or up to 40 individual sessions, and is suitable for patients both during and after a depressive episode.

Angus & Greenberg argue that EFT 'appears to work by enhancing the ways in which clients express their most important stories in sessions, which in turn facilitates a type of emotional processing that helps clients accept, experience, transform and understand their emotions, for the articulation of new narrative meanings and new story outcomes' (Angus & Greenberg 2011, p16).

COMPARATIVE EVALUATION: MBCT AND EFT

Many similarities strike me between these two approaches to treating MDD, even though one is an educational group-based method and the other an individual therapeutic approach. Both forms of treatment aim to teach clients, experientially, how to increase their self-compassion, and both use the facilitator/therapist as a primary model in this.

Not surprisingly, both methods have identified that patients with MDD tend to engage in repetitive self-critical thinking, tend to avoid their feelings and have negative views about their worth, their capacities and their prospects in life. Both treatments offer a way to reduce the negative thought and emotion cycles that are common in MDD, and to build clients' ability to be more gentle, accepting and compassionate towards the self.

In both MBCT and EFT, clients are encouraged to observe and recognise their negative experiences, and accept rather than reject their feelings and needs. However, the methods of achieving this are different in each approach.

EFT uses emotional processing of a person's difficulties and inner conflicts, within a supportive and empathic therapy relationship, to help them verbalise and understand their experience. This allows the resolution of personal problems to emerge from the processing. The modeling of empathy and understanding by the therapist encourages the client to find more space in which to accept their different aspects, and resolve any conflicts between different parts of the self.

MBCT does not explore individual problems, but instead teaches a more detached approach, in which patients can learn to accept everything they observe, just as it is. This implies one's difficulties do not need to be 'worked on' in order to find a different attitude towards them. The self-observation and -acceptance taught in MBCT helps clients shift their focus and thereby find more space in which, if needed, they can make decisions and changes in their life, without the involvement of a therapist.

Both treatments stress the importance of meeting the patient with acceptance, compassion and gentleness, to encourage them to face their difficulties, and also, to model a new way of being. In my view, this marks both approaches out in positive contrast to more didactic, task-oriented methods of treating MDD, such as Acceptance and Commitment Therapy (Strosahl & Robinson 2008). I believe the explicit emphasis on empathic engagement is a strength of both EFT and MBCT.

One critique I have of MBCT is that it requires patients to do up to an hour of daily homework, which may be quite challenging for some, particularly if difficult feelings and thoughts keep arising. I wonder about the drop-out rate in MBCT groups, and what impact the sense of failure may have on those who cannot maintain the daily practice.

Related to this is a query about how long participants would need to continue meditating, in order to prevent a relapse: might it be a self-care practice they would need to continue for many years, or the rest of their lives? Another limitation is that MBCT is not suitable for patients who are currently experiencing a depressive episode, a fact that may highlight the degree of challenge it involves.

The EFT treatment model offers clients the support and opportunity to explore and process their unresolved difficulties, which I believe, for those who want it, could lead to deep positive changes in their sense of self and their relationships. Such changes might offer permanent protection against a relapse of depression, if the person stabilises a more positive self-structure via psychotherapy.

One drawback of EFT is that it requires more resources per patient, and relies on more intensive support and 're-parenting' by the therapist than an MBCT group. Another is that not all patients might want to expose and explore their inner difficulties in therapy, particularly if they are not currently depressed, and for those, perhaps an educational group may be preferable.

CONCLUSION

In summary, I believe both EFT and MBCT offer effective treatments to help patients with MDD process and restructure their negative patterns of thought and emotion. Both require commitment and effort, in different ways, and both offer support for patients to face the inner experiences that have contributed to their depression. Both offer an empirically proven method to educate clients towards greater self-compassion, something that has been recognised as 'an underlying factor in effective psychotherapy, and emotional healing in general' (Germer 2009, p4).

While each technique will appeal to some clients more than others, in my view EFT is more appropriate for addressing the inner conflicts that underlie an individual's depression, whereas mindfulness training is more suited to situations that call for acceptance rather than change, such as chronic pain or recurrent depression which has no apparent cause.

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