BJPsych The British Journal of Psychiatry (2012)
201, 260–261. doi: 10.1192/bjp.bp.112.109454

Editorial

Psychological interventions for difficult-to-treat depression†

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Summary
Mindfulness-based cognitive therapy (MBCT) may be helpful in preventing relapse in those with three or more depressive episodes. Recent research suggests it may also benefit those who have experienced fewer previous episodes of depression. If confirmed, this raises challenges of how MBCT is offered, accessed and supported.

Declaration of interest
C.W. has written a range of cognitive–behavioural therapy self-help materials addressing depression and other topics.

Chris Williams (pictured) is Professor of Psychosocial Psychiatry at the University of Glasgow, Scotland, UK. His main clinical and research interest is in the area of cognitive–behavioural therapy and in particular in looking at ways of disseminating this approach more widely. Dr Nicki Ridgway is research assistant on a randomised controlled depression study and honorary research fellow with the University of Glasgow.

For the majority of people living with major depressive disorder, it is not a single episode with a clear start and final end-point. Instead, it is a chronic condition characterised by multiple episodes of relapse over their lifetime. The National Institute for Health and Clinical Excellence (NICE) recommend individual cognitive–behavioural therapy or mindfulness-based cognitive therapy (MBCT) in the treatment of relapse prevention.[1] These treatments are considered particularly effective, as they aim to treat the residual symptoms that persist following an episode of depression. It is these residual symptoms that are thought to adjust cognitive processes leading to the onset of further depressive episodes.

Cognitive–behavioural therapy has been recommended as a maintenance therapy based on the proposed protective properties of identifying and then challenging the evidence for and against such thoughts before coming to a balanced appraisal based on all the evidence. Such approaches often utilise quite complex homework diaries (thought identification/challenge sheets) and also aim to enhance helpful levels and types of activity. It has been argued that the traditional language of CBT means that it can only be easily used by people with above average reading ages.[2] Mindfulness-based cognitive therapy on the other hand has less of a focus on challenging negative thought patterns and focuses instead on teaching individuals to become aware of and note upsetting thoughts and feelings and to conceptualise them as 'mental events' instead of an internalised realistic representation of themselves or the situation they are in.[3] Mindfulness-based cognitive therapy is recommended by NICE[1] for relapse prevention in depression, however a caveat of MBCT is that it is only reported to be associated with a differential risk of relapse for those with three or more previous depressive episodes.[4] In contrast, recent evidence presented by Geschwind *et al*[5] in this issue suggests that MBCT is associated with a significant 30–35% reduction in residual depressive symptoms compared with the control sample, regardless of the number of previous episodes of depression.

Delivered in different ways

The findings outlined by Geschwind *et al* are particularly interesting as they have potentially strong clinical implications if replicated in a clinical population. The conclusions suggest that MBCT could be implemented more widely and earlier within treatment pathways and no longer exclude individuals with two or fewer previous episodes of depression. If replicated in a further study, their findings raise issues of how such treatment could be made available, as currently access to MBCT is limited. Few practitioners are trained compared with other approaches such as CBT. Furthermore, the treatment choice is not as simple as CBT *v.* MBCT. Currently, both CBT and MBCT are offered in time-intensive (high-intensity) forms requiring significant support time from a suitably qualified health worker. In recent years CBT has increasingly been delivered in low-intensity formats requiring less specialist support time. Such approaches include guided CBT self-help,[1] where recent reviews have suggested equal outcomes for both low- and high-intensity versions of CBT for anxiety and depression.[5] Behavioural activation is another case where high- and low-intensity formats are available. High-intensity behavioural activation is as effective as 'full' CBT[6] and remains effective when delivered to participants living with severe long-term depression, even when delivered by generic mental health workers with no prior experience in behavioural activation.[7] However, there is no fully evaluated low-intensity package currently available that addresses relapse prevention in depression and this is an area that deserves attention as a research priority.

Delivered using suitable delivery formats

Mindfulness-based cognitive therapy is usually delivered in extended high-intensity groups that require attendees to attend eight sessions lasting 2 h, plus 1 day-long class after the fifth session. Although there have been attempts to reduce the length of classes,[8] the eight-session approach is fairly ubiquitous and seems to have been developed to fit the length of US summer holidays and has been continued subsequently through convention. Some newer ways of delivering MBCT have been developed (e.g. online or via telephone), however to date these have not been evaluated systematically. If further studies confirm

†See pp. 320–325, this issue.

that MBCT can helpfully be offered to individuals with fewer than two prior episodes of depression as an early intervention, it will be hard if not impossible to deliver the approach without the development and testing of low-intensity versions of MBCT. However, it is not known what the effective components of MBCT are – the impact of being in a class, the mindfulness or cognitive strategies. Studies are needed to dismantle and test these separate components, and to evaluate whether low-intensity delivery models can be developed and delivered. It is likely that only when there are evidence-based high- and low-intensity formats available that widespread roll-out of these therapies could be achieved.

Delivery via appropriate service delivery models

Whatever short-term treatment interventions are offered (CBT, behavioural activation, CBT self-help or MBCT) for chronic depression, they are only a part of the need for ongoing management of what is a chronic condition. Current practice relies on stepped and stratified models of care to guide treatment options.[9] Stepped care models suggest that everyone should begin at a low-intensity approach, stepping-up to high-intensity approaches for individuals who do not benefit from the former. Stratified approaches, in contrast, match patients to an appropriate therapy based on their clinical complexity and preferences. However, there is a paucity of evidence to guide which approach (stepped or stratified) would be best adopted. Furthermore, with emerging literature suggesting that even low-intensity approaches may suit complex cases of depression,[5] the situation becomes further confused. Currently, little research is available to guide these choices but there is an emerging body of literature that suggests that patient preference and learning style is an important consideration when making this choice.[10] It is particularly important that these treatment decisions are based on the patient's preferences and not biased by therapist training, affiliations and beliefs.

Although, it remains difficult to understand which therapy would best suit an individual, a collaborative care approach may provide an effective organisational system to implement a structured management plan that can oversee patient care while ensuring a multiprofessional approach with patient continuity of care at its core.[11] A collaborative care approach would be managed so as to overcome the backgrounds and affiliations that individual therapists may otherwise have. Such an approach would allow the incorporation of a range of possible treatment options from medication, low- and high-intensity forms of CBT, MBCT and behavioural activation, while managing patient treatment options that are most suitable for the individual.

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First received 17 Apr 2012, final revision 31 Jul 2012, accepted 13 Aug 2012

References

1 National Institute for Health and Clinical Excellence. *Depression: The Treatment and Management of Depression in Adults (Update)*. NICE, 2009.

2 Martinez R, Whitfield G, Dafters R, Williams CJ. Can people read self-help manuals for depression? A challenge for the stepped care model and book prescription schemes. *Behav Cogn Psychother* 2008; **36:** 89–97.

3 Ma SH, Teasdale JD. Mindfulness-based cognitive therapy for depression: Replication and exploration of differential relapse prevention effects. *J Consult Clin Psychol* 2004; **72**: 31–40.

4 Geschwind N, Peeters F, Huibers M, van Os J, Wichers M. Efficacy of mindfulness-based cognitive therapy in relation to prior history of depression: randomised controlled trial. *Br J Psychiatry* 2012; **201**: 320–5.

5 Cuijpers P, Donker T, van Straten A, Li J, Andersson G. Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? *Psychol Med* 2010; **40:** 1943–57.

6 Gortner E, Gollan J, Dobson K, Jacobson N. Cognitive-behavioural treatment for depression: relapse prevention. *J Consult Clin Psychol* 1998; **66**: 377–84.

7 Ekers D, Richards D, McMillan D, Bland JM, Gilbody S. Behavioural activation delivered by the non-specialist: phase II randomised controlled trial. *Br J Psychiatry* 2011; **198**: 66–72.

8 Chadwick P, Hughes S, Russell D, Russell I. Mindfulness groups or distressing voices and paranoia: a replication and randomized feasibility trial. *Behav Cogn Psychother* 2009; **37**: 403–12.

9 Richards DA, Bower P, Pagel C, Weaver A, Utley M, Cape J, *et al.* Delivering stepped care: an analysis of implementation in routine practice. *Implement Sci* 2012; **7**: 3.

10 Williams C, Morrison J. A new language for CBT: new ways of working require new thinking as well as new words. In *Oxford Guide to Low Intensity CBT Interventions* (eds J Bennett-Levy, D Richards, P Farrand, H Christensen, K Griffiths, D Kavanagh, et al): 69–83. Oxford University Press, 2010.

11 Richards DA, Lovell K, Gilbody S, Gask L, Torgeson D, Barkham M, et al. Collaborative care for depression in UK primary care: a randomized controlled trial. *Psychol Med* 2008; **38:** 279–87.

https://doi.org/10.1192/bjp.bp.112.109454 Published online by Cambridge University Press