

Mindfulness for Depression?

A critical analysis of mindfulness-based cognitive therapy (MBCT)

Originating from Buddhist traditions, mindfulness is intended to cultivate inner peace through non-judgemental observation and acceptance of our moment-to-moment experiences. However, conflicting perspectives emerged as these practices were introduced and proliferated in the West. This article will define mindfulness, elaborate on the controversy surrounding mindfulness in Western wellness spheres, and assess its efficacy when integrated into standardized therapeutic approaches. Specifically, this article will include a literature review evaluating mindfulness-based cognitive therapy (MBCT) for depression. Despite criticisms on mindfulness, there is evidence that mindfulness skills gained in therapy are beneficial and can act as mechanisms for change in patients' experiences of depression. MBCT has demonstrated success as a supplementary treatment and relapse prevention method for recurrent depression. Compared with other treatments, MBCT significantly decreases depressive symptoms and increases response rates among vulnerable patient groups at a higher risk of relapse and those with treatment resistant depression. A final discussion of implications related to the COVID-19 pandemic will highlight how online MBCT can help address the increasing need for accessible mental health services. Given the significance of these findings, future research should examine the efficacy of MBCT as a stand-alone therapy, and its generalizability to other disorders.

Keywords: mindfulness, mindfulness-based intervention, mindfulness-based cognitive therapy, depression treatment, relapse prevention, online therapy

With increasing coverage in media and accessibility to services through mobile apps (e.g., Calm, Headspace), mindfulness has gained traction in Western wellness spheres. Its traditional form has been distilled into mainstream adaptations seemingly to enhance marketability and appeal to consumers. Critics emphasize issues with secularization, commodification, and weaknesses in definitions and methodologies used in research. Despite controversy around mindfulness, it is important to consider proven benefits of mindfulness-based interventions for patients with depression. In



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this article, I will expand on definitions of mindfulness from various cultural perspectives and explore contentious issues in research. A literature review will then support my argument that criticisms on mindfulness should not discredit the efficacy and effectiveness of standardized therapeutic approaches that incorporate mindfulness. Focusing on mindfulness-based cognitive therapy (MBCT; Segal et al., 2002), my goal is to raise awareness of its viability for reducing depressive symptom severity and preventing relapse. The article will conclude with a discussion of the increasing need for mental health support during the COVID-19 pandemic, advantages of online MBCT, and overall implications of findings.

WHAT IS MINDFULNESS?

There are many things that come to mind when one thinks of mindfulness. For some, these practices may easily be associated with peace and conceptions of Zen; for others, they may breed resistance to a trend proliferating across the Western world. However, the applications of mindfulness in Eastern traditions and Western clinical settings extend beyond these preconceived notions. So, let's set some definitions. What is mindfulness?

Mindfulness involves acknowledging inner experiences amid the everchanging backdrop of our external world. Eastern mindfulness originated in India through Buddhist philosophies and traditions; it stems from the ancient Pali word "sati" which can sometimes be translated as "awareness" or a clarity of mind that is focused yet open to passing thoughts, breaths, and sensations (Carmody, 2014; Olendzki, 2014). In this context, it is intended to enhance inner peace by replacing ignorance and desire with self-awareness (Carmody, 2014). As the practice of Buddhism has expanded, the expression of its core principles and overarching goals has undergone significant alterations to adapt to the structures available in the languages of its diverse practitioners. The transformation in the conception of mindfulness in this context has resulted in the accentuation of differences between East and West (Carmody, 2014; Djikic, 2014).

The integration of mindfulness and meditation into conventional medical settings and Western society at large has been significantly influenced by the work of Jon Kabat-Zinn, according to whom mindfulness is a universal practice that shines a light on each person's ability to experience awareness at any given moment, completely and wholeheartedly; it inspires a present-centred state of being, encouraging us to observe and accept our experiences without judgement; and it promotes insight through sitting comfortably with both pleasant and unpleasant experiences, all of which is meant to alleviate suffering, enhance well-being, and carve out transformative paths toward healing (2015). Since we all have the capacity to turn inward and access presence, mindfulness can be cultivated in daily living and extended to those struggling with mental illnesses.

CRITICISMS OF WESTERN MINDFULNESS

Adapted to suit Western lifestyles, mindfulness prompts various critiques on the transference of a traditional practice to the mainstream as well as on the lack of consensus in concepts used in research. Loy (2013) emphasizes how processes of secularization and commodification have led critics to dismiss Western mindfulness as “McMindfulness.” Mindfulness was removed from its traditional and religious roots to appeal to consumers, which disregards the ethical foundations and core purposes of the practice in its origins (Loy, 2013). Hyland (2016) reiterates the flaws of this reductionist approach to a practice rooted in deeper understandings of the self and suffering and expands on the notion of “McMindfulness,” stressing its use of streamlined practices for quick-fix solutions, predictable and quantifiable procedures, and control on human behaviours through non-human technology (e.g., mindfulness apps). By capitalizing on more marketable aspects of mindfulness, its authentic qualities are disrupted, and its origins are threatened. This could be viewed as a form of cultural appropriation in which acceptable aspects of a culture’s practices are being embraced while others remain neglected.

Van Dam et al. (2018) reviewed existing sources on mindfulness and meditation and analyzed two major issues that have not been sufficiently treated in the literature: definitions of mindfulness and the methodologies that have been employed. The researchers emphasized how conceptualizations of mindfulness, including Kabat-Zinn’s, disregard the lack of consensus in the word’s meanings and scientific measures used across studies. For example, mindfulness questionnaires varied depending on types of “mindfulness” evaluated (e.g., general, observing, awareness, nonjudging) and whether it involved a specific practice (e.g., meditation). With regard to methodological issues, Van Dam et al. explained that ambiguity makes it difficult to ensure that researchers are measuring the concept they intend to. Inconsistencies in delivery of mindfulness-based interventions and interpretation of results risk misleading individuals who suffer from serious diseases. The criticism that Van Dam et al. offer highlights gaps in this field of research, as well as areas demanding clarification and rigor.

Critics claim that mindfulness is often sold as a quick-fix solution that glosses over profound suffering and is plagued with ambiguous definitions and flawed research methods; yet this is where major contention arises. Carmody (2014) reflected on the potential superficiality of Western mindfulness, while also acknowledging the stance that it is not as important how differently the practices are led if positive effects are achieved. Regardless of the shortcomings of Western mindfulness, we must acknowledge the value of MBCT developed specifically for depression. Mindfulness may not be the answer to all life struggles; however, learning these skills in therapy can enact change and prove beneficial to individuals with depression and potentially with other mental illnesses.

HOW IS MBCT DIFFERENT?

Over the course of our lifetime, many of us have either experienced or know someone who is experiencing the pain and resilience of mental illness and recovery. Of particular concern is the prevalence and severity of depression, which calls for treatment and relapse prevention options that help to reduce distress and impairment in functioning. In the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (2013), depression is classified as a mood disorder commonly characterized by feelings of sadness, worthlessness, and hopelessness. Other symptoms may include difficulty concentrating, decreased enjoyment in daily activities, weight loss or gain, fatigue and low energy, trouble sleeping or excessive sleeping, and thoughts of suicide. Despite criticisms of Western mindfulness and the fact that research is in preliminary stages for its use in the treatment of other mental illnesses (e.g., eating disorders and substance-related and addictive disorders), the efficacy of MBCT for depression is well documented with strong research support (Division 12 of the American Psychological Association, 2016).

As a third-wave cognitive behavioral therapy (CBT), MBCT integrates mindfulness to inspire self-awareness and encourage a shift in patients' attitudes toward their thoughts, emotions, and behaviours, according to the description given by Philippot & Segal (2009). They report that it was adapted from Kabat-Zinn's mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1982; 1994) program involving mindfulness exercises to reduce stress in individuals with health conditions. Zindel Segal, Mark Williams, and John Teasdale designed MBCT with components of psychoeducation and cognitive therapy to prevent depressive relapse and maintain remission for those who have already undergone treatment. These components support patients in identifying symptoms of relapse, irrational thoughts associated with depression, and concrete ways to prevent depression (Philippot & Segal, 2009).

Following a manualized set of guidelines, therapists ensure MBCT is consistently administered across settings and patients. Within specified guidelines, patients are required to commit to 2.5-hour group sessions once a week over the course of eight weeks. These meetings begin with a mindfulness exercise (e.g., body scan, sitting meditation), followed by a check-in about the exercise and discussion on homework from the previous meeting. A topic of focus is then presented to enhance understanding of aspects of mindfulness, and how they can be practiced. For example, presentations might touch on staying present when the mind wanders or moving away from autopilot and stepping into awareness. Before the end of session, a daily 45-minute practice of mindfulness is assigned as homework, and sessions conclude with another mindfulness exercise (Philippot & Segal, 2009).

The manualized approach of MBCT clears up ambiguity in definitions and preserves consistency in therapy administration and outcome evaluation. This short-term intervention equips patients with tools to carry out mindfulness in everyday life, thereby strengthening neural pathways into sustained habits for positive well-being.

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For individuals looking for supplements to treatment as usual (TAU), MBCT can help decrease depressive symptom severity and prevent relapse, especially in vulnerable populations and those resistant to treatment.

EFFICACY OF MBCT FOR DEPRESSION

Extensive research on MBCT substantiates the powerful effects for patients with residual symptoms and recurrent depression. In real-world healthcare settings, nascent evidence suggests that MBCT is a safe, effective, and acceptable second-line treatment for various stages of depression (Tickell et al., 2019). This builds on research demonstrating that MBCT can be efficacious in reducing depressive symptoms (Finucane & Mercer, 2006; Kenny & Williams, 2007; Kingston et al. 2007; Eisendrath et al., 2008; Kuyken et al., 2008; Barnhofer et al., 2009) and preventing relapse/recurrence (Teasdale et al., 2000; Ma & Teasdale, 2004) even as effectively as maintenance antidepressant medication (Kuyken et al., 2008; Segal et al., 2010). The course of mental illness is often complex, and healing is not linear; still, there is hope in MBCT as an option for reducing depressive symptoms and risk of relapse regardless of the number of prior depressive episodes (Geschwind et al., 2012). These benefits, among others, are reflected in recent advancements in research.

In line with symptom reduction, benefits were noted in a study conducted by Van Aalderen et al. (2012) who compared MBCT + TAU to TAU on its own. In this case, TAU included antidepressant medication or prior experience with CBT or meditation. The researchers primarily focused on pre- and post-intervention and follow-up responses to interviews assessing symptoms of depression. Results indicated that in comparison to TAU alone, the addition of MBCT significantly decreased symptoms, worry, and rumination predictive of depression, and significantly increased psychological aspects of quality of life and mindfulness skills protective against relapse. Also, patients who were experiencing a depressive episode at the time of the study, as well as those who were not, experienced improvements attributed to MBCT.

This adds to what is known about MBCT and its efficacy for patients at different stages of depression or remission. The findings suggest that along with its originally intended use to prevent relapse, the benefits of MBCT extend to individuals suffering a depressive episode at the time of intervention itself. When delivered through structured therapeutic programming, mindfulness teachings can be effective tools for protecting against depressive risk factors. By increasing metacognitive awareness, or the ability to separate oneself from negative thoughts/feelings and view them as passing events (Teasdale et al., 2002), MBCT taps into mechanisms of change that help reduce depressive symptoms and relapse.

Additional research has found that MBCT is especially effective for individuals deemed more vulnerable in their experience of depression. Williams et al. (2014) compared MBCT + TAU to cognitive psychological education (CPE) + TAU, and to

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TAU alone for patients with recurrent depression. Since all patients were in remission, TAU involved continuing any treatment regimens required or suggested by their doctor. CPE was designed to follow psychoeducation and cognitive therapy components of MBCT while excluding mindfulness practices. By narrowing in on comparisons this way, the researchers could illustrate whether it was the mindfulness component in particular that was creating differences between outcomes.

To evaluate the impact of these interventions, Williams et al. (2014) administered interviews to assess how much time had passed before a depressive relapse occurred—pinpointed as accurately as possible by date of onset. Results demonstrated that MBCT + TAU was as effective as other interventions used for comparison, and all three were quite strong in protecting patients from relapse. Analyzing the data through a different lens, the researchers then compared patients who had a history of childhood trauma against those who did not. They found that MBCT + TAU was significantly more successful than CPE + TAU and TAU alone at preventing relapse in patients with childhood trauma caused by abuse and parental indifference.

A similar pattern emerged when Kuyken et al. (2015) compared patients on maintenance antidepressants for relapse prevention to those in an MBCT with support to taper or discontinue antidepressant treatment (MBCT-TS) group. There were no significant differences between MBCT-TS and medication alone until researchers took into account severity of childhood trauma and found a lower rate of relapse for more vulnerable patients in MBCT-TS. As noted earlier, MBCT supports the development of mindfulness skills and shifts perspectives surrounding negative thoughts or feelings. Although alternate treatment options exist and have shown comparable success, MBCT should be noted for its more-pronounced effects within a subgroup of patients at greater risk for relapse due to traumatic childhood experiences. The findings highlight the added benefit of sitting with deep-rooted pain and attending to it with mindfulness for enduring maintenance of remission in at-risk groups.

Additionally, MBCT is valuable in its potential to reduce symptom severity for patients with treatment-resistant depression (TRD). TRD is characterized by the failure to go into remission after trying two types of antidepressants, leading to lower quality of life and poorer predicted course and outcome of the disorder (Eisendrath et al., 2016). In response to the need for suitable TRD interventions, Eisendrath et al. evaluated differences in patient outcomes between MBCT and a health enhancement program (HEP) as add-ons to medication TAU. HEP required participants to engage in healthy physical and nutritional activities, and MBCT was adapted specifically for patients with TRD. While researchers have found equivalent effectiveness of these treatments for patients in remission from major depressive disorder with residual symptoms (Shallcross et al., 2015), MBCT has greater benefits for patients with TRD. Eisendrath et al. (2016) found low remission rates for both interventions among TRD

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patients, which is not unusual since this form of depression is often resistant to treatment; however, results illustrated a higher percent decrease of depressive symptom severity and a higher percent increase in response rates among patients receiving MBCT + TAU compared to HEP + TAU.

In comparison to TAU, Cladder-Micus et al. (2018) also found that chronic, TRD patients completing MBCT + TAU benefited from significantly higher quality of life, mindfulness skills, and self-compassion. Moreover, a larger proportion of MBCT + TAU patients attained partial or full remission, lower rumination, and lower depressive symptoms if they attended more than four treatment sessions. As a supplement to medication, MBCT invites a sense of relief and hope for TRD patients who have not found success in antidepressants alone. Overall, the novel experience of positive change stemming from MBCT may create momentum and inspire openness to healing for symptomatic patients, patients in remission, and more-vulnerable patient groups.

ONLINE MBCT

Another advantage of MBCT is the ease surrounding its adaptability and utility in the aftermath of the COVID-19 pandemic. Although mass quarantines have been imposed to minimize the spread of COVID-19, they have also resulted in prolonged periods of isolation, worry, and inevitable psychological effects. Based on trends from previous infectious disease outbreaks, it was predicted that frontline workers, survivors of the illness, individuals with pre-existing mental illnesses, and other vulnerable groups would be most largely impacted (Levin, 2019; Usher et al., 2020; Galea et al., 2020; Rubin & Wessely, 2020). Similar trends are reflected in emerging data. For example, a nationwide survey found that 40% of Canadians reported that their mental health has deteriorated since the beginning of the COVID-19 pandemic, with vulnerable populations accounting for higher proportions of those struggling (Canadian Mental Health Association, 2020). Now more than ever, the importance of cultivating resilience has been brought to the forefront. Levin (2019) suggests that helpful techniques include seeking support, implementing proactive treatment plans, and practicing mindfulness and relaxation. MBCT would provide a refreshing perspective to support healing, and virtual group offerings would create a sense of community to enhance patient well-being.

Lockdowns and physical distancing regulations have also required therapists to adapt their services and offer sessions over phone or via video calls. The move to online therapy was quick and drastic for many therapists who previously were not comfortable, interested, or trained in this medium (Aafjes-van Doorn et al., 2020). Not only has this reframed the way therapists work and the way patients access services, but it has also revealed wider-spread long-term benefits filling a gap that already existed. The growing trend toward online therapy is particularly beneficial to patients who faced difficulties accessing services even before the pandemic. Some

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examples may include patients who live in rural communities and those who struggle with financial barriers, specific disorders, or obstacles in scheduling and distance that make it inconvenient or impossible to physically show up in session regularly (Bouchard et al., 2007; Simpson et al., 2015; Varker et al., 2019).

Although there is promise in MBCT to reduce relapse and residual symptoms, there have been access barriers and shortages in trained professionals qualified to conduct sessions (Dimidjian et al., 2014). Online therapy increases accessibility, and it has proven to be as effective as in-person therapy for mental illnesses (Varker et al., 2019). This is significant because numerous clinics offer online MBCT groups, and researchers have found success in online adaptations. Mindful mood balance (MMB) is an online version of MBCT with components of CBT and mindfulness to support emotion regulation, improve depression management, and help patients relieve negative thought patterns. Programming consists of personal practices and reflections, interactive learning modules, and learning material offered in videos, audio files, and handouts (Dimidjian et al., 2014).

Boggs et al. (2014) analyzed patient responses to interviews at the end of MMB, or at the time of early withdrawal, to gauge subjective experiences of learning materials, website functions and features, and parts of the program that helped or hindered patients in following through on their home practice. Responses were categorized into key themes, and researchers found that patients had a good grasp of the concepts and provided helpful feedback for program improvements. For example, the lack of in-person group meetings or an actual therapist impacted accountability and relational benefits of MMB groups. Time and commitment challenges emerged for some, while flexibility in accessing the platform provided a sense of personal agency for others. Patients generally described positive impacts associated with meditating often, affirming that they would consciously use what they learned moving forward.

In addition to these findings, Dimidjian et al. (2014) reported that MMB significantly reduced depressive symptoms, more effectively than usual depression care, and effects were sustained up to six months after treatment. This aligns with findings on the positive impact of traditional in-person MBCT. Results also showed that MMB reduced rumination and improved mindfulness for the whole sample, but not for a subgroup of patients with residual depressive symptoms. Although MMB was deemed an acceptable form of therapy, levels of engagement were not as optimal as they had been for in-person MBCT (Dimidjian et al., 2014). Considering time elapsed since these MMB evaluations were published, it would be interesting to investigate whether there have been program modifications and shifts in engagement since therapists and patients were forced to become accustomed to online therapy during the pandemic. As mental health services adapt, therapists must tap into a sense of mindful creativity to keep patients motivated and actively engaged—whether that be in person or through a screen.

CONCLUSION

While criticisms exist surrounding research on mindfulness and its commodification and secularization in the West, mindfulness-based interventions have proven efficacious for various life stressors and as an add-on treatment for depression. The numerous definitions of mindfulness complicate attempts at quantifying the concept; however, a standardized therapeutic approach has allowed researchers to attribute patient outcomes to the manualized procedure being followed. There is evidence that MBCT is not only efficacious in its intended use to prevent depressive relapse, but also in its ability to increase mindfulness and decrease symptom severity, worry, and rumination during a depressive episode. These effects are especially pronounced for patients with childhood trauma, those at a higher risk for relapse, and those with treatment-resistant depression. While critics of “McMindfulness” also oppose mindfulness practices mediated by technology, circumstances hindering in-person gatherings reveal advantages of online therapy. Online adaptations of MBCT address accessibility barriers and hold great potential for supporting patients with depression, particularly during difficult times of increased mental health challenges such as the COVID-19 pandemic still afflicting the world at the time that this article is being published. Ongoing acknowledgment of constructive criticism and improvements based on feedback will only help enhance the healing properties of mindfulness-based interventions delivered in person and online.

In fast-paced societies of the West, mindfulness skills support patients in fully experiencing and accepting the present moment rather than harbouring pain by focusing excessively on unreliable distortions of the past and projections into the future. Given the findings on MBCT’s efficacy in research clinics, as well as its effectiveness in real-world healthcare settings (Tickell et al., 2019), future research could explore its potential as a stand-alone therapy, as well as treatment integration for subclinical depression and other mental illnesses (e.g., eating disorders and substance-related and addictive disorders). Continued research into MBCT is essential given its potential to improve patient quality of life and reduce strain on the healthcare system by addressing mental health issues before they worsen or even arise.

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