Mindfulness-Based Cognitive Therapy

Innovative Applications

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Introduction

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Stuart J. Eisendrath

Zindel Segal, John Teasdale, and **Mark Williams** brought Mindfulness-Based Cognitive Therapy (MBCT) into wide exposure with their 2002 treatment book [1]. MBCT was built on the infrastructure of Mindfulness-Based Stress Reduction and it presented a radical departure in the approach to relapse prevention of major depressive disorder. This disorder, with an often chronic and relapsing course, called for a preventive approach in order to decrease the disability and suffering that were so often prevalent. Early studies demonstrated its efficacy in depression relapse prevention [2, 3]. Its utility in preventing relapse in major depressive disorder has demonstrated an efficacy that is not inferior to maintenance antidepressants, the gold standard of prophylactic treatment [4].

MBCT's metacognitive approach indicated that attention to the thought process was important and perhaps even more so than attention to thought content as in traditional cognitive therapy approaches. The metacognitive awareness of thoughts, feelings, and sensations can lead to greater acceptance of mental events and consequent less experiential avoidance. For example, paying attention to thought processes and not content was one of the important shifts in approach that allowed many patients to engage with the therapeutic process. Previously, they were often firmly attached to a particular thought content that kept them rigidly locked in a specific life stance. MBCT allowed a softer stance, with more self-compassion and flexibility. The mindfulness approach permitted a bigger gap between stimulus and response, with a consequent ability to have a broader range of skillful approaches to situations.

MBCT's applications broadened since its introduction to treatment of a variety of conditions, of which only a limited sampling has been gathered in this book. Ranging from medically unexplained symptoms to social anxiety, and epilepsy to insomnia, the palette of MBCT has covered a wide spectrum. Taking one pass through multiple MBCT applications, as the authors of the chapters in this volume illustrate, MBCT has had a broad international reach. Moreover, the range of chapters indicates MBCT has begun to emerge as a modality with a wide range of utility. MBCT has been drawing substantial investigations that demonstrate transdiagnostic effects. Exactly which component of MBCT produces these effects remains to be elucidated, but the authors raise a number of possibilities. In addition, a number of the authors describe the increased activation of brain areas such as the dorsolateral prefrontal cortex and the anterior cingulate, that are associated with enhanced emotion regulation. At the same time increased

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activation of the insula is associated with internal somatic awareness, one of the areas that MBCT helps individuals to focus on.

The book's chapters are divided into primarily focusing on medical problems or psychiatric disorders. Melissa Day begins by describing the application of MBCT to chronic pain. She describes the value of the pain patient changing his/her relationship to such pain catastrophizing thoughts such as "I'm totally useless because of my pain". She lays out the adaptations of MBCT for the pain population that her group has been investigating including psychoeducation regarding pain as well as mindful awareness and acceptance. Day describes her group's work with a headache pain population in finding decreased pain interference and increased acceptance after completing MBCT. She reviews the growing literature on MBCT for other painful conditions as well as Internet-delivered MBCT. She then examines practical issues in the selection of participants and the delivery of MBCT.

Marian González-García, Xavier Borràs, and **Javier González López** bring MBCT into focus as a particularly useful intervention for people living with HIV (PLWH). This population suffers high levels of stress, stigma, anxiety, and depression. Her group's randomized controlled trial of MBCT demonstrated large effect sizes in reducing stress, anxiety, and depression levels. Psychological factors posited to play a role include attention, meta-awareness, and self-regulation. The authors build a strong case for neural mechanisms of change that may involve areas of the brain associated with increased alerting and executive attention including the anterior cingulate cortex (ACC) and dorsolateral prefrontal cortex (DLPFC). The insula may be associated with meta-awareness of experiences of the present moment and bodily states and emotional processing. These issues may be related to self-regulation, including the nonreactivity facet of mindfulness. This, in turn, is also associated with the ACC and its connections to other areas of the brain.

Nancy Thompson, Robin McGee, and **Elizabeth Walker** shine an important light on the potential of distance-delivered MBCT. Their research, including Project Uplift, has examined the impact of MBCT on individuals with chronic medical illnesses such as epilepsy or cystic fibrosis. For such patients, the advantages of telephone or Internet-enabled MBCT have important advantages such as ease of access, low cost, avoidance of transportation problems, and reduced stigma. There are however potential problems with such delivery and the authors address such limitations straightforwardly. They also describe the literature in distance delivery including their own randomized controlled trials. The authors explain the modifications to MBCT that they made and the rationale that went into their decision. In the trials, participants' physical health did not change, but their quality of life improved. This was consistent with the mindfulness facet of improved acceptance as a means of reducing suffering. They call for further research into distance delivery to broaden MBCT's reach.

The problem of traumatic brain injury is being increasingly recognized in a wide-ranging population, from sports participants to military casualties. Depression is one of the most common sequelae of these injuries. **Lana J. Ozen, Carrie Gibbons,** and **Michel Bédard** investigate the impact of MBCT on depression in this population. They point out that often the impact of traumatic injury is amplified by stress, depression, and decreased satisfaction with life. Mindfulness interventions have the potential to impact all of these areas. The authors review the literature examining the utility of mindfulness-based treatment for traumatic brain injury. They then present data from their own groundbreaking work in applying MBCT to this population. Using a pilot study, and randomized controlled trials, the authors found decreased depression, improved quality of life and increased mindfulness and self-compassion in their MBCT cohorts compared to wait list controls. These effects were substantial at levels that were clinically significant. They describe in detail the modifications necessary for working with this population, including patient selection, home practice, and facilitator training. Although future research is necessary, MBCT may represent an important first step in dealing with the emotional after effects of traumatic brain injury.