

# How can mindfulness help depression?

An Article written for the South African Depression and Anxiety Support Group

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The past 15 years has seen an exponential rise in the interest in mindfulness. This has occurred in a number of different contexts, but nowhere more so than in mental health. One major driving force of this interest has come from the development of Mindfulness-Based Cognitive Therapy (MBCT) for preventing relapse in depression. This is due to the rigorous theoretical foundation and compelling empirical research demonstrating its efficacy in depression. Currently, there are six randomised clinical trials (n=593) which show that MBCT is associated with a 44% reduction in relapse risk compared to usual care in patients with 3 or more previous episodes of depression (Williams & Kuken, 2012). This article will explain what mindfulness is, how it is relevant to preventing relapse in depression and how it is taught in the MBCT programme.

## Mindfulness – what is it?

Segal, Williams and Teasdale (2012) define mindfulness as the awareness that arises when we pay attention in a particular way: on purpose, in the present moment, non-judgementally, to things as they are. In this state we are not thinking or worrying about the future or rehashing the past, instead awareness rests in our moment to moment experiences. When mindful, we are present with our experiences as they unfold in the moment without being invested in them being different from how they are.

A central distinction which helps understand mindfulness is that between ‘perception’ and ‘apperception’. By ‘perception’ we refer to the direct sensory experiencing of phenomena – both internal (thoughts and emotions) and external (via the senses). Apperception, as it’s used in psychology, is the process whereby the initial sensory experience goes through secondary processing – we begin to think about it and understand it within our existing conceptual frameworks or simply judge it as nice/pleasant or not nice/unpleasant.

So mindfulness is not what you think or feel (judge) about an event. It is the sensory-perception of phenomena in the moment. If, for example, if a feeling of sadness is present, mindfulness awareness is about allowing the emotion and observing it with an attitude of curiosity. This is in contrast to how we might relate to sadness in a normal state of mind: most likely judging it as unpleasant and trying to get rid of it as quickly as possible.

Moving into mindful awareness is often explained as shifting gears from a goal-orientated ‘doing/driven mode of mind’ (Segal, Williams & Teasdale, 2012) to a ‘being mode of mind’. In a doing/driven mode our focus is on getting things done or achieving our goals as quickly as possible. Therefore, experiences in a moment are only relevant to the extent to which they move us towards these goals. For example, eating in the doing/driven mode is about getting the food into the belly, so that you can get on to the next task (for example, resume work). The implicit intention/goal is to satisfy hunger or obtain nutrition as quickly as possible, so that you can continue to work on other goals.

Eating mindfully is about being present to the *process* of eating and *experiencing* the colours, textures, tastes, etc. of the eating experience *and* the feelings and thoughts which

arise in the moment. With mindful awareness each moment is an end in itself and we are sensitive to the details and subtleties of the moment. Whereas, in the doing mode, the moment is really just a means to some other end.

## **Understanding vulnerability in depression**

Before we can understand how mindfulness might help in reducing the risk of relapse in depression, we need to understand the dynamics involved in relapse. Why are people who have had a major depressive episode (MDE) in the past more vulnerable to having another MDE than the rest of the population?

In an episode of depression low mood is accompanied by negative thinking and body sensations such as heaviness and fatigue. Because these elements in depression occur together an association is formed between them (in line with the principle 'neurons that fire together, wire together'). As a result of this association, at a later stage when any one of these aspects is activated the others are often activated as well. If this happens, the probability of relapse is very high.

In a situation where lowered mood activates negative thinking, the negative thinking can further depress the mood which will result in more negative thinking and so on. In other words, feedback loops form between the negative cognitions, the mood and the body state such that each exacerbates the other. For example, if a person is in remission and there is a mild rejection which leads to lowered mood, this could activate negative cognitions, such as 'no-one really likes me' and memories of past rejections (from experimental studies, we know that lowered mood negatively biases memory, so that a person is more likely to recall negative aspects of their history), which would then make the person feel more hopeless about forming social relationships, which would lead to more negative thoughts about how worthless they are, which would further depress their mood.

By this stage the person is upset not so much by the current rejection, but by the thoughts and memories of all past negative social interactions and rejections. All this is happening in a body which is feeling fatigued and heavy, which adds fuel to the flames of negativity. In contrast, someone without a history of depression might experience rejection and the accompanying low mood but it will not reactivate negative thoughts. Therefore they will be able to shrug it off without getting lost in a quagmire of negativity.

The more depressive episodes a person has, the lower the threshold becomes for loading the 'depressive package'. This implies that whereas an early episode would need to be triggered by losing one's job or a break-up of a relationship (high threshold), later episodes could be triggered by relatively minor events such as not being invited to a party or being turned down for a date (a lower threshold).

The description above deals with the activation of negative *content*, but another important reason why people with a history of MDEs remain vulnerable to relapse has to do with the way their minds react to the lowered mood. Someone without a history of MDEs will react to the experience of low mood and negative thoughts by distracting themselves. Whereas in a person with a history of depression, this state will tend to produce a thinking style which focuses the person on the negativity of their current state. So using the example above, the person may begin to ask why s/he feels so badly about this rejection, why these negative thoughts have returned, why this always seems to happen to them and why they have not

managed to solve this problem. Nolen-Hoeksema called this the 'ruminative response style' and it forms part of the whole depressive package of changes which can get activated in previously-depressed individuals in reaction to lowered mood.

Rumination is driven by the (understandable) desire to feel better. A person feels sad and they want to feel happy. This discrepancy activates thinking, which is designed to reduce the mismatch between how the person actually feels and how they want to feel or think they should feel. In this example, the aversion to feeling sad, creates the rumination which increases vulnerability.

The authors of MBCT (Segal, Williams & Teasdale, 2012) argue that the 'depressive package' is actually a whole mode of mind, which is inclined to selectively remember negative past events, think negatively about the self and future events, feel particular body sensations such as heaviness and fatigue and attempt to deal with the current state through ruminating. Level of vulnerability is directly related to whether or not, and how easily, this depressive package becomes loaded. An effective treatment will need to address the whole package (negative thoughts and feeling, associated body states and rumination) or mode of mind which gets activated at times of lowered mood.

### **How can mindfulness help with relapsing in depression?**

The nature of mindful awareness is such that thoughts and feelings are experienced within a wider context. Thus, one is able to see negative thoughts and feelings as passing events rather than reflections of reality or aspects of the self. For example, in mindfulness awareness the thought 'no-one likes me' is held within the broader awareness of the body, sound, and breath sensations and therefore a person is able to see the thought as simply an event occurring in mind. As such, it can be disregarded much the same as a sound of a car passing by. This is in contrast to reacting automatically to the thought as a true fact (which is likely to happen if awareness is pulled into a conceptual framework), which would lead to lowered mood and further negative thinking. By relating to thoughts with this kind of meta-awareness, the thought loses its ability to hook further mood or thought and the downward spiral of depression can be avoided.

Mindful awareness also helps reduce the probability that rumination will be activated. Since mindfulness is characterised by non-judgement and acceptance, it leads to a different relationship to lowered mood: one allows the mood to be present (as it's already there) and explores it with a kind of curiosity. Mindful awareness is only oriented toward being present; it is about learning to be with what is present in the moment and there is no goal to feel better. Since there is no goal, there is no discrepancy and the relationship to the sadness is changed such that it need not be avoided. Without the discrepancy, there is no driver for rumination and it is less likely that it will be activated.

The difference in the mental attitude from 'goal-oriented' to 'being-with' allows awareness to become more familiar with different mood states, which allows a person to recognise them more quickly. Thus, one is able to 'catch the spark, before the flame' and by catching mood earlier, it is less likely to escalate. Furthermore, there is improved clarity about one's current state, which can lead to creativity in how to constructively manage it (as opposed to falling into old patterns of self-defeating rumination).

Conscious attention is a limited-capacity channel and the deliberate utilisation of attention whereby one focuses the mind on a present moment experience, such as the breath, takes up the processing resources that could otherwise be used for negative thinking and rumination.

### **Learning Mindfulness – The Mindfulness-Based Cognitive Therapy Programme**

MBCT is a structured 8 session program which is designed to teach mindfulness. It is taught in small groups of between 8-12 participants. In addition to the 8 sessions, participants are required to do mindfulness practice between sessions for at least 30 minutes on a daily basis. In MBCT, mindfulness is taught through formal and informal practises. Formal practice requires participants to carve time out of their day to develop mindful awareness – for example, practicing mindfulness of breathing. Informal practice is about integrating mindfulness into one's daily activities – such as eating, walking, showering, etc. The aim of the programme is for participants to develop skills in mindful awareness in the formal practice and then generalise them to their daily life through informal practice.

It was originally designed for the prevention of relapse in depression, but there is now evidence for its effectiveness with a range of other psychiatric disorders and currently it is considered a 'transdiagnostic' intervention.

### **References:**

Segal, Z.V., Williams, J. M. G. & Teasdale, J.D. (2012). *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*. 2<sup>nd</sup> Ed. New York: Guilford Press.

*Williams JMG. and Kuyken W. (2012) Mindfulness-based cognitive therapy: a promising new approach to preventing depressive relapse Br. J. Psychiatry*