

Editorial

Could mindfulness-based cognitive therapy prevent a lifelong recurrent course of depression or anxiety by addressing key mechanisms of vulnerability in high-risk adolescents?

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Summary

We explore the potential of mindfulness-based cognitive therapy, a skills-based intervention that provides participants with sustainable tools for adaptive responses to stress and negative mood, for the large group of young people with depression or anxiety who only partially or briefly respond to currently available first-line interventions.

Declaration of interest

T.B. is the co-author of a book on mindfulness-based cognitive therapy (MBCT) and has received fees and honoraria for teaching MBCT workshops. W.K. is Director of the University of Oxford

Mindfulness Centre. He donates all speaker fees to the not-for-profit Oxford Mindfulness Foundation. J.F. has been paid to deliver mindfulness-based intervention (MBI) programmes in the workplace and has delivered MBIs to elite performers at his own expense.

Keywords

Mindfulness; MBCT; depression; anxiety; young people.

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Depression and anxiety often commence in childhood or adolescence, and run a fluctuating, episodic course; fewer than half the young people who are affected maintain their recovery into early adult life, and many experience repeat recurrences.¹ The modification of psychological and biological processes that may underlie the vulnerability to relapse, the amelioration of subclinical symptoms that are indicative of such vulnerabilities, and the prevention of future episodes should be a clinical priority. Aside from the immediate need to reduce distress, the attainment and maintenance of recovery in adolescence is likely to limit adverse educational and social outcomes in addition to protecting mental health in adulthood. In this editorial, we explore the potential of mindfulness-based cognitive therapy (MBCT), a skills-based intervention that provides participants with sustainable tools for adaptive responses to stress and negative mood, for the subgroup of young people with depression and anxiety who only partially or briefly respond to currently available first-line interventions. Our focus is on

young people with emotional disorder attending specialist mental health services who are either not sufficiently recovered to be discharged despite compliance with an evidence-based intervention or who rapidly relapse. The terms used to describe their psychological difficulties and response to treatment reflect those used in the quoted literature.

Psychological approaches targeting depression in young people also improve symptoms of anxiety and *vice versa*, and are moderately effective in the short term, but 20–40% fail to respond and beneficial effects are often not maintained.^{1,2} There is evidence for the efficacy of cognitive-behavioural therapy (CBT), but families and practitioners would benefit from more evidence about different types of psychotherapy as well as indicators of which young people are most likely to benefit from them.² Similar levels of efficacy have been reported for the use of antidepressant medication in the acute treatment of depression among young people, whereas the combination of medication with psychological approaches may improve outcomes as well as shorten the episode of depression and reduce the likelihood of relapse.² These approaches still leave a substantial number of young people with residual difficulties – as many as 40% according to estimates from a recent review.²

Both treatment non-response and residual symptoms strongly predict subsequent difficulties among young people with depression and anxiety,^{1,2} so indicate future vulnerability. Targeting residual symptoms may prevent relapse, although current evidence is limited and mostly based on data from young people who initially recovered. The Cochrane review retrieved nine trials, which allowed only limited synthesis; medication reduced the proportion of young people who experienced relapse of depression from two-thirds to 40%. Psychological approaches were encouraging but less frequently studied and when included were mostly tested in combination with medication. All five trials that evaluated psychotherapy used CBT in various forms and the absence of alternative psychotherapeutic approaches other than systemic behavioural family therapy (one study) is striking. There is an important need

for more research on other approaches as the evidence base for children and young people's mental health remains limited compared with that for adults, and alternatives to CBT have rarely been studied.²

A large body of evidence demonstrates that maladaptive responses to negative mood, such as rumination or worry, may be key.³ Recent commentaries have reinforced both a general psychopathology factor, best understood as a reflection of the extent of impairment or dysfunction in a person's life, and a bi-factor model, which includes an internalising psychopathology factor characterised by an increased propensity to respond to stress and negative mood with maladaptive repetitive thinking.³ Such responses are likely to become increasingly automatic and habitual with recurrent exposure to symptoms, and may drive relapse. Interventions that improve the young person's ability to respond adaptively to stress and negative mood may thus be key to fostering recovery and resilience, although there is little research into mechanisms in this age group.²⁻⁴ Given a large subgroup who fail to respond to initial treatment (40%), and high rates of relapse (50–75%), it seems sensible to explore interventions that might offer adjunctive treatment to existing combinations of manualised psychotherapy and antidepressant medication.²

MBCT is an 8-week, group-based programme that combines mindfulness practice with cognitive-behavioural elements. It aims to teach people the skills to recognise the early warning signs of relapse and respond in more adaptive ways, and was specifically designed to target engagement in unhelpful, maladaptive patterns of repetitive thinking. There is now a substantial body of evidence for its effectiveness and cost-effectiveness in relapse prevention for depression among adults.³ Indeed, preventative effects of the intervention are increased among patients who are suffering from residual symptoms and those who experienced childhood maltreatment, an important predictor of poor response to intervention for depression in young people.² Notably, research has shown that the utilisation of core skills learned during MBCT is maintained and even increased after the actual intervention, which suggests a lasting potential for buffering responses to negative mood and stress.³

There is growing interest in the application of mindfulness-based approaches with young people and some tentative evidence to support their use in clinical populations; theoretically, the mid-to-late teens might be a particularly effective period in development to enhance mindfulness-based skills, because of brain plasticity.⁴ To date, only a small number of studies have used randomised controlled designs, but in a recent systematic review and meta-analysis, the most robust studies suggested MBCT may be effective for young people with anxiety and depression.⁴ To our knowledge, there have been no trials of MBCT restricted to adolescents with residual or relapsed depression or anxiety, but two small evaluations suggest that MBCT is both acceptable and feasible in this context.⁵ Importantly, both demonstrated symptomatic improvement among young people who had not completely responded to initial interventions or had rapidly relapsed as assessed by the referring mental health practitioner. Although they were presenting only for the first or second time, they were at a life-stage where poor function may radically alter life trajectory and thus were at high risk of becoming the adult population for whom MBCT is demonstrably effective.⁵

Adaptation of MBCT for young people needs to accommodate the contributing factors specific to adolescence to optimise treatment response. Young people's functioning is strongly determined by family contexts, and there is considerable evidence to support the intergenerational transmission of depression.¹ Parental anxiety or depression predicts the severity and persistence of emotional disorders among young people,¹ whereas family conflict

predicts a poorer response to intervention.² Hence the clinical consensus that the involvement of parents in the treatment of their child is important. Although parental involvement is widely endorsed and included in most manualised psychotherapies, current service restraints may undermine its use in routine practice.⁵

Our pilot MBCT programme for young people who needed continuing support or relapse rapidly after completing a first-line psychological intervention for depression or anxiety included a parallel MBCT group for parents.⁵ The addition of the parallel parent MBCT group seems to offer a particularly powerful approach in highly vulnerable young people who have not responded fully to previous treatment and for whom intergenerational transmission is more likely to have played a role in their presentation. More than half of the attending parents reported a personal history of depression, and a quarter were taking antidepressant medication. Parental involvement was strongly endorsed by young people, parents and the referring clinicians. Although primarily designed to support young people's mindfulness practice, which is assumed to be the major vehicle of therapeutic effect, the parent group provided similar content to the young people's group and was experienced as therapeutic. Parents reported that it supported them through the emotional impact of parenting an adolescent with poor mental health and, in line with previous reports of beneficial effects of mindfulness training on interpersonal functioning,⁵ both young people and parents reported significantly improved family relationships. Parents as well as young people reported statistically significant reductions in rumination and improvements in self-compassion and de-centring, which suggests that this joint intervention may protect or enhance parental mental health.⁵ Given the interrelated nature of mental health within a family, any benefits might be expected to amplify over time and might extend to other family members, such as siblings and the other parent.

Based on theoretical reasoning and preliminary data, MBCT offers a promising therapeutic option for the subgroup of young people with depression or anxiety who do not fully respond to initial treatment or who relapse rapidly after initial recovery. Practitioners, children and families in this predicament need an array of evidence-based therapeutic options from which to choose. We suggest that MBCT, particularly if combined with a parallel parent group, could prove to be effective and should be evaluated further. There is a need for adequately powered, randomised controlled trials, with validated measures of potential mediators as well as clinical outcomes to test its potential to counter vulnerabilities that otherwise might easily fuel a life-course of recurrent emotional disorder.^{1,2,4,5}

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First received 21 Jun 2018, final revision 28 May 2019, accepted 3 Jul 2019

Funding

K.W.'s and V.B.'s time on this work was supported by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care, South West Peninsula (PenCLAHRC).

Acknowledgements

The authors would like to thank Jerry Fox for submitting a question to PenCLAHRC about the potential role of mindfulness-based cognitive therapy with young people. The PenCLAHRC prioritisation of this question supported the collaboration that underpins this work. The PenCLAHRC aims to bring together local universities and their surrounding National Health Service (NHS) organisations to test new treatments and new ways of working in specific clinical areas, to see if they are effective and appropriate for everyday use in the health service. Where potential improvements are identified, PenCLAHRC helps NHS staff to incorporate them into their everyday working practices, so that patients across the local community receive a better standard of healthcare. The authors also wish to thank Hannah Durkin for her support in finalising this paper. The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the National Institute for Health Research, NHS or the Department of Health.

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psychiatry in history

Henry VI: catatonic stupor, and the case series of 15th-century psychiatric miracles attributed to his posthumous intercession

Greg Wilkinson

In early August 1453, Henry (1421–1471), ineffectual King of England and France, ‘the Founder’ of Eton and King’s College, Cambridge, was ‘smitten with a frenzy and his wit and reason withdrawn’, reputedly due to an unexpected fright – news of defeat at Castillon on 17 July 1453, with the loss of nearly all English holdings in France. Aged just 31, Henry did not talk, sat slumped, had to be fed and moved, did not recognise or respond to others and was incapable of government for a year and a half despite all medical attention. About New Year’s Day 1454, no response but a glance was elicited from him when Queen Margaret brought ‘her son’ Prince Edward (born October 1453 – and rumoured illegitimate) for blessing. In March, a delegation of Lords could elicit no answer from him. By September, he was capable of handing the Cross of Office to the Archbishop of Canterbury. At Christmas-time he revived. He asked the Queen his son’s name and said that until then he had not known where he had been nor what had been said to him. Afterwards, there are suggestions of persistence and/or relapse. *Rota Fortunae!* Henry was imprisoned in the Tower of London in 1465; restored in 1470; and, in 1471, returned to the Tower and allegedly overcome by melancholy and/or murdered on Edward IV’s orders (Henry’s remains were exhumed in 1910 – his skull was broken in several places).

Henry’s body was placed at Chertsey Abbey, where a cult developed on his reputation for sanctity and miracles. In 1484 his relics were moved to the Chapel of St George at Windsor, which became a healing shrine of national importance. Pursuit of canonisation (failed) instigated the preservation of miracles attributed to him. Original depositions by monks in English detailed at least 368 but are lost. The surviving record is a redaction of 174 in Latin, identified by name, date and place – implying accurate recording. Psychiatric and other claimed miracles, including children, adults, animals and accidents, are described in matter-of-fact, if not credulous, detail. Some 24 depict: madness; depression supervening on pain, physical illness and disability; suicide, attempted by throat cutting and hanging; and chronic somatic and neuropsychiatric symptoms. Miraculous recovery was essential, supporting psychosocial process or natural resolution. For example, Ashby St Ledgers, Northamptonshire, 23 July 1486:

‘The wife of Geoffrey Brawnston became disturbed one hot July. The onset was sudden, with a rapid build-up to fury: she roamed immodestly, and was a pest to all. After a day, she came to the church when the congregation was gathering, shouted at some, made terrifying rushes at others, and set the rest laughing with silly and dirty ramblings. The respectable wanted to bind her with ropes, but the vicar forbade unkindness and urged them to bind her with compassion by praying to the Virgin and to Henry. She waited quietly in a corner and slipped home afterwards. She raved again at midday but improved, and she was composed and sane on the third day.’

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The British Journal of Psychiatry (2020)
216, 177. doi: 10.1192/bjp.2020.15