Comparing the Effectiveness of Group Meta-Cognitive Therapy and Schema Therapy on Decreasing Severity of Depression and Rumination in Patients with Treatment Resistance Depression

T.Moazzeni, S.Gholamrezae, F.Rezae

ABSTRACT
Background: Meta-cognitive therapy and schema therapy are two important methods in treatment of mental disorders special in treatment of depression. This study aimed to compare the effectiveness of group meta-cognitive therapy and schema therapy on decrease severity of depression and rumination in patients with treatment resistance depression.
Method: This study was a quasi-experimental with a pre-test, post-test design that 48 patients with treatment resistance depression were selected through available sampling method and randomly assigned to three groups. The experimental groups educated 8 to 12 sessions of 90 minutes by group meta-cognitive therapy and schema therapy methods. All groups completed the questionnaire of Beck depression (BDI-II) and rumination response scale (RRS). Data was analyzed with using the SPSS software and by multivariate analysis of covariance (MONCOVA) method.
Results: The findings showed there was not a significant difference between group meta-cognitive therapy and schema therapy on reducing severity of depression and rumination. (P>0.05). But there was a significant difference among group meta-cognitive therapy and schema therapy with control groups (P<0.0001).
Conclusion: Therefore, counselors and therapists can use group meta-cognitive therapy and schema therapy for decreasing symptoms of depression disorder and rumination.
Keywords: group meta-cognitive therapy, schema therapy, severity of depression, rumination, treatment resistance depression

Introduction
Although acute depressive episodes in major depressive disorder (MDD) can be well controlled by medication, treatment of continuous and residual depression symptoms has received less attention than acute depression episodes and most of depression views emphasize on its episodic nature. While evidence suggests that the number of people with major depressive disorder (MDD) do not get rid of this episodes and show signs of continuous and residual MDD [1]. In some cases, after controlling severe symptoms of the episodes, sub-syndromal symptoms of depression are common and even continuous [2] and in other cases patients show symptoms in a relatively long time (24 months) and even with the exorbitant costs they will not be improved which are known as treatment-resistant depression (TRD). Despite improvements in diagnosis of public health importance of treatment-resistant depression, a certain definition that accommodate everyone is still not provided. Garden (2001) believes that major depression remission should be the ultimate goal of the treatment and non-remission should be considered as the criterion of the presence of treatment-resistant depression (TRD) [3]. Berlim and Turecki (2007) suggest that treatment-resistant depression is an episode of major depression that, even after applying two
courses of drug treatment with enough time and dose has not been improved (p. 73). They also believe that treatment-resistant depression (TRD) should be considered as a continuum range of partial response to complete resistance to therapy not as an all-or-nothing phenomenon [4]. One of psychiatric therapy recently used for the treatment of patients with treatment-resistant depression is metacognitive therapy (MCT) [3]. MCT is a third wave therapy which unlike cognitive behavioral therapy (CBT) does not focus on the content of thoughts but also on the thought process [5]. The considerable style for MCT is Cognitive Attentional Syndrome (CAS) which is identified with extreme conflict in persistent theological thought and preoccupation in the form of worry and rumination and research support the role of rumination in depression [6]. MCT is based on the principle that negative automatic thoughts which are very important in cognitive behavioral therapy (CBT), are considered just as inefficient processing style triggers (such as rumination) as the axis of metacognitive therapy [5]. According to the meta-cognitive approach (Wells & Matthews, 1996) schemas are not regarded as irrelevant information that the therapist can remove them from the patient's mind and instead replaces realistic assumptions because people make beliefs and revise them actively based on their internal rules [6]. So, what is important is formulation of internal cognitive processing and laws and the mechanisms that cause the patient to interpret incompatible beliefs. And what is needed is a complete cognitive framework for the representation of the interaction between their knowledge and emotional distress. Therefore, meta-cognitive therapy focuses on reducing uneffective cognitive processes and facilitating metacognitive styles of processing. The treatment enables the patient to rupture the mental ruminations, reduce self-uneffective monitoring tendencies and create adaptive styles [7]. In this regard, recent studies indicate the effectiveness of metacognitive therapy on recurrent and chronic major depression [8]. Wells et al (2012) applied Meta-cognitive therapy (MCT) on 10 patients with treatment-resistant depression that, the results showed the effectiveness of this treatment in reducing symptoms of depression and rumination [9]. More recently Hjemdal et al (2016) and McEvoy et al (2015) in patients with major depression showed that the use of meta-cognitive therapy leads to a significant reduction of depression, anxiety, rumination, worry and metacognitive beliefs. In these studies, the effect size was moderate to high [10 and 11]. As in recent meta-analysis the effectiveness of cognitive behavioral therapy (CBT) is estimated even more [12]. In all the studies listed MCT has been done individually and the need to evaluate the effectiveness of group meta-cognitive therapy (GMCT) on rumination and depression increases. Among the few studies with group meta-cognitive therapy its efficacy in depression and rumination has been indicated [13 and 3], but it requires further review because only in papageorgiou and Wales’ sample (2014) the sample clinically resistant to therapy has been used and the effectiveness of group meta-cognitive therapy in reducing the severity of depression and rumination has not yet been compared with schema therapy in any case study [3]. Another treatment designed for treatment-resistant patients is schema therapy. According to the theory of schema therapy, patients with mood disorders have maladaptive schemas leading to severe symptoms of this disorder. Schemas lead to our purposive interpretations of events, and these biases in psychopathology for interpersonal misunderstandings, distorted views, wrong speculations, and unrealistic prospects are identified [14]. Schema therapy approach focuses on self-destructive patterns, feelings and behaviors that originate from one's childhood and are
repeated throughout a person's life. These patterns are called "early maladaptive schemas" [15]. These maladaptive schemas lead to the growth and development of psychological problems. Harmful schemes which are started from early growth flow and continues throughout life [15]. Early maladaptive schemas are the deepest level of cognitive structures which show themselves in relation to the environment and others and are activated in certain circumstances [16] and lead to the rumination [7]. Given that depression episodes may be perceived as unpleasant experiences, it seems that these experiences will create dysfunctional beliefs about depression and its consequences. Later, events that are consistent with these schemas (e.g., negative mood, lack of pleasure, decreased or increased sleep and appetite, lack of concentration and fatigue), lead to activation of this scheme and formation of a new depressive episode or the recurrence of depression and thus reduce treatability [17]. Therefore, dealing with this part of the psychological characteristics of depressed people is essential because on the other hand, research has shown that, schemas in treatment-resistant patients even with the drug, can maintain their stability in a 9-year period [18]. Schema Therapy takes wide aspects of one's life and are essentially used for people with high durable emotional and behavioral problems [15], because it is expected to help people with treatment-resistant depression have emotional stability problems. In this regard, studies support the effectiveness of schema therapy on major depression [19, 17, 20 and 21]. But so far no study has not evaluated the effectiveness of schema therapy on patients with treatment-resistant depression and did not compare it with MCT. Just in a study conducted by Ashoori (2014) with 60 students who had symptoms of depression and anxiety, the effectiveness of schema therapy and individual MCT was compared with each other and finally it was reported that both treatment protocols have resulted in a significant decrease in symptoms of depression and anxiety. However, schema therapy is significantly more effective in alleviating the symptoms compared to MCT. This difference was also significant in the two-month follow-up period. Therefore, the aim of this study was to compare the effectiveness of metacognitive therapy and schema therapy on reducing the severity of depression and rumination in patients with treatment-resistant depression [22].

Methodology
This study is practical in terms of purpose and, quasi-experimental with pretest - posttest in terms of data collection. The study population included all patients with treatment-resistant major depression referred to the psychiatric ward of Oil Corporate and Sadoughi hospitals from June 2015 to July 2016. Of this population due to the volume effect of 0.35 at level of 0.05 with test power of 97 (23) 48 cases (11 men, 19 women) with a mean age of 33.53 ± 9.63 were selected with available sampling. Then they were randomly assigned to three groups of group metacognitive therapy, schema therapy and control group. Criteria for inclusion were: Getting a score higher than 19 on the Beck Depression Inventory (BDI-II), receiving a diagnosis of major depressive disorder in the structured interview for axis I disorders (SCID-I), using antidepressants over a period of at least 3 months without improvement and the reluctance to use drugs now, having age between 19 to 50 and literacy at school level. Exclusion criteria were as follows: diagnosis of bipolar disorder, diagnosis of borderline personality disorder in the structured interview for Axis II Disorders (SCID-II), using antidepressants now, having physical and medical diseases, drug dependence, high risk for suicide plans (score above 19 on a scale of